Luton Safeguarding Children Board

Serious Case Review Overview Report in respect of

Child G

Jan 2020

FINAL with further anonymisation by Fran Pearson LSCB Chair, of an original report by independent authors:

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1.0 Introduction

1.1 This report has taken a long time coming to publication and Luton Safeguarding Children Board acknowledges this. There are two reasons for this. First of all, legal proceedings involving this child took several years. Secondly, at the point it was possible to finalise the report because the legal proceedings were over, the Board members were determined not just to protect this young person from being identified but also to work with Child G, by now a young adult, to share the report appropriately and at the young adult's pace. These steps are now concluded.

1.2 An original version of this report was agreed by Luton LSCB in March 2018. It was further adapted by another independent person, Fran Pearson, Chair of Luton Safeguarding Children Board, following legal advice in June 2018, that before approaching the Child Safeguarding Practice Review Panel about how and where this review was best published, there should be no room for doubt that every effort had been made to protect Child G's identity. The independent chair requested the legal advice because of concerns, shared by all members of Luton Safeguarding Children Board, that publication via the LSCB could identify Child G. All board members endorsed every necessary step to address this risk.

1.3 The Independent Chair of the Luton Safeguarding Board (LSCB), commissioned a Serious Case Review (SCR) in 2014 into what was perceived at the time as a case of complex abuse. It was about sexual abuse, but should also be viewed as a case of neglect which was not fully recognised by professionals, as they were focussed on the issue of sexual abuse which diverted them from important work with a neglected child and that child's family. The original report contained greater reference to legal proceedings, but all these references have been removed in the interests of protecting Child G's identity. The removal of elements of the original report in no way reduces the Board's commitment to addressing the issues raised. In addition the Board has had consistent oversight during the lengthy process of signing off this report, of the improvements and assurance that stem from the process.

1.4 For the purposes of learning, all that the reader needs to know is that this was a case about a secondary school pupil, at school outside Luton, and involving allegations of familial sexual abuse. Removing substantial identifying detail from the report means there is minimal description of this child's journey, which is a limitation. The Luton Safeguarding Children Board however, agreed that this was an appropriate format, given that protecting the identity of Child G was of overriding importance.

The Terms of Reference

1.5 The terms of reference as agreed at the SCR Reference Group, established to oversee and support the SCR, were agreed on the 30th January 2015, as follows:

1. **Whether the standards expected of professional practice across the partner agencies, were met in this case regarding:**
   a. The voice of the child being heard and made evident, within recordings and assessments?
   b. The planning of the work/actions specifically addressed the child's disability and what action was taken to meet these additional needs?
   c. Whether in each agency, notice was taken by the case managers of the worker's level of experience and expertise in carrying out the work required to safeguard the child?
   d. The quality, scope and range of information used within the assessments - were they sufficient to enable sound decision making to be made, and whether the level of reflective analysis and professional judgement used in the conclusion of the report, was justified in relation to the assessment?
   e. Whether the workers had received training appropriate to the role they were asked to carry out?
   f. What case management direction was given to the workers in the supervision of the work taking place, and whether the case manager took a rigorous approach to critiquing the assessment and approving subsequent actions?

2. **Whether, from each agency's perspective, multi-agency involvement was adequate in this case:**
   a. Do the records indicate whether multi agency enquiries were made during the assessments?
   b. Is there any evidence that agencies raised concerns about the welfare of any of the children in the family, and if so, whether these concerns were appropriately responded to, and whether escalation procedures were used if agencies were dissatisfied with a response?

3. **Whether information sharing in this case, reached the standards expected under the LSCB information sharing policy:**
   a. Do the records indicate whether there were any issues regarding information sharing in the case?
   b. Do the records indicate whether any action was taken if a problem around information sharing became evident?

4. **Whether the lack of a Luton specific Complex Abuse procedure, and an understanding of what constitutes complex abuse, had an impact on the management of the case:**
   a. Do the records indicate whether the case managers recognised the complexity of the case as the issues developed, and the range of the allegations became apparent?

5. A period of time that was in scope for the review was also agreed, and there was a clear rationale for it. That period covered approximately two years and in this report to assist the reader, events are allocated to "Year 1" and "Year 2".

6. The **Methodology** for this report was that of self analysis by agencies, in the form of Individual Management Reports. These were analysed by the independent

reviewers, and that analysis shared with the panel of local agency managers who supported the SCR process. Some interviews with practitioners were carried out. Once consensus on the analysis was reached, the report was sent to the SCR sub group of the Board, for quality assurance.

1.6 The agencies represented at the SCR subgroup were:

Luton Safeguarding Children Board

CAFCASS

Service Manager, CAFCASS

Head of Service, CAFCASS

NHS England

PPU, Bedfordshire Police

Luton NHS Clinical Commissioning Group

East London Foundation Trust

Luton Borough Council

Central Bedfordshire Safeguarding Children Board (CBSCB)

Cambridgeshire Community Services

1.7 Agencies that provided independent managers to contribute to the Review by providing chronological information and Individual Management Reports (IMRs) were:

Representative	**Agency**	IMR or chronology, and in relation to which service
Review Officer	Cambs/Beds/Herts Police	
Independent Safeguarding Consultant	Luton Borough Council	
	NHS Community Health Services Provider Trust	School Nursing
Head of Community Services Law	Luton Borough Council	
Learning and Development Coordinator	LSCB	

The Independent Review Authors

1.8 Neither Glenys Johnston OBE nor Dr Russell Wate QPM have had any previous involvement with Luton Borough Council, both have extensive experience in producing SCR Overview Reports and both independently chair Local Safeguarding Children Boards

2.0 Key Events/Practice Issues and Analysis

The involvement of the Children and Learners Service

2.1 During the period covered by this Serious Case Review, the involvement of C&L was as follows: at the start of Year 1 of the review period, Social Work Team 1 received referrals from Child G's school about Child G's angry behaviours; self-harming (involving superficial cutting to the arms); and allegations about things that had happened at home.

2.2 Social Work Team 1 convened a strategy meeting with the police the next day. A police officer and a social worker saw Child G at school, who did not make any allegations of physical abuse in this interview, or in two further interviews with the social worker. Related interviews with family members took place

2.3 Social Work Team 1 closed the case and transferred it to Social Work Team 2, two weeks later. The next fortnight was one of intense activity by professionals as allegations and new developments were followed up. This fortnight concluded with an Interim Care Order being made and Child G being placed with a foster carer

2.4 Over the next two months Child G self-harmed or talked about self-harming, made different disclosures to school, police and social workers; withdrew some of these; attended A&E where it was recommended that Child G be admitted for a psychiatric assessment, which Child G refused; and was taken on by the local Child and Adolescent Mental Health Service, as meeting their criteria for support. The CAMHs prescribed two sorts of medication.

2.5 While these events were happening, several complex abuse strategy meetings were convened, bringing together staff from several teams in C&L as well as the police. There were no Luton specific complex abuse procedures at the time, and the Luton/Bedfordshire Multi – Agency procedures only contained a very brief paragraph with a link to the 2002 Department of Health/Home Office guidance. As a result, this case led to managers consulting with others, both externally and internally and as part of changes made in response to this case, Luton specific 'organised and complex abuse' procedures were added to the LSCB procedures.

2.6 Child G had not by this time made any allegations through 'Achieving Best Evidence' (ABE) interviews, although Child G spoke of wanting to tell of the 'big thing/bad thing', the interpretation of which was that this was an allegation of sexual abuse. Care Proceedings and Review Child Protection Conferences were by now in train.

During one of these, the category of sexual abuse was added to the existing category of emotional abuse.

2.7 Over a further four-month period, a psychological assessment was completed on Child G which concluded as follows:

- Child G: “has not given any spontaneous general account of the abuse” and was “not willing or able to engage in any discussion to give specific details of … concerns” but "has made references to ... experience of abuse". The report listed the distressing behaviours and concerns that troubled Child G and concluded that "[such a] presentation suggests [having] been severely traumatised which correlates with [Child G's] previous allegations of sexual and physical abuse"

2.8 Next, the local authority asked for advice in relation to the handling of this case. This was provided by an independent professional. The overview authors have read this report, and believe that it was a good decision by the local authority to seek this independent advice, and they concur with all the comments made within in it.

Two key recommendations were made:

1. That a senior officer from the local authority, at Assistant Director Level, should convene a senior strategic multi-agency meeting. This would have given, if it had taken place, strategic management oversight and ‘grip’ of this enquiry.
2. That there was a lack of local multi-agency procedures for arrangements for dealing with complex and organised abuse cases.

2.9 For information on the Achieving Best Evidence interviews, see section 9.

2.10 Family proceedings took two years, and resulted in directions to the local authority regarding which social worker from which team could be allocated to work with Child G. This meant Child G experienced two changes of social worker in three months, having had one social worker for the previous two years.

The involvement of schools

The involvement of schools prior to the period covered by this SCR

2.11 The initial disclosure made by Child G met the ‘Working Together’ (2010) definition of physical abuse, indicating risk of ‘significant harm.’ However, this was not referred to C&L for consideration of an assessment, instead the school made the decision to monitor the situation, though how this was going to happen and over what time was unclear. There is no record of the outcome of the monitoring that was to be undertaken.

2.12 School records from the following year, demonstrated a level of concern about Child G's behaviour. In terms of why Child G may have been self-harming, the staff’s starting point was that they wanted to discount the possibility that the self - harming was due to what they considered to be adolescent self-expression. They were mindful that Child G may have been aware of other pupils self-harming and

thought this had led Child G to replicate this behaviour. Appropriate signposting took place in relation to the school counsellor. However, there was a missed opportunity to consider Child G's wider circumstances via a holistic assessment such as the Common Assessment Framework or a referral to C&L. There is however, no recording to indicate whether Child G did access the school counsellor and as such it is unclear what was in place to support Child G's safety and welfare at this stage. Luton LSCB's thresholds document that was in place at the time, ranked self-harm at 'level 2' which indicates that a co-ordinated multi agency response should be considered to safeguard and promote children's welfare. The school did not liaise with the School Nursing service about Child G's self-harm, which was an assessment and support option available to the school. There is no evidence that school staff considered or made a referral to CAMHs which was an option available to them in relation to Child G's emotional wellbeing and mental health.

2.14 There continued to be missed opportunities for a holistic and multi-agency assessment and response to Child G's emotional needs. Consideration of the fact that Child G may be a 'child in need' or at risk of 'significant harm' is not evident within the recording and was not considered at this stage or shared with C&L in accordance with the Luton LSCB's threshold document. It was confirmed to the review team for this Serious Case Review that the school was unaware of the Luton LSCB's threshold document and as such their decision making in this case was based on their safeguarding training and professional judgement. The original report cited a number of examples of these.

2.15 Despite the concerns and information the school had, they provided a referral to the educational psychologist that was poor because it shared insufficient information, and led to the educational psychologist minimising the concerns in relation to Child G in a subsequent report.

2.16 However, during interview for this review, all staff articulated an appropriate and genuine level of concern for Child G, and a desire to take actions to promote Child G's welfare. It is therefore regrettable that this did not lead to action that could have supported Child G at an earlier point.

2.17 It is relevant that the school's systems for safeguarding recording did not include a chronology of concerns or filing the information together, which may have contributed to individual incidents being viewed in isolation of the wider history. It also prevented the school tracing and monitoring the outcome of any actions undertaken to support Child G.

During the period covered by the SCR

2.18 The school recorded 16 entries about Child G's concerning behaviour in Year 1 of the two years covered by this review. A child protection referral was made by school to Social Work Team 1, which summarised the school's concerns. Following this, the school continued to frequently record concerns and actions, but there is no evidence that the school shared these incidents, apart from sharing drawings with the social worker and attending Child Protection Conferences and Core Groups.

2.19 Over a further three months there was an incident involving a rope and Child G asking about where in the school was the quietest room, in order to end her life there. Child G had many conversations with staff regarding self-harm and school staff offered to seek specialist help for Child G.

2.20 Three months later, a looked after child review took place that included two very different descriptions of Child G. One account, from school, was that things had improved for Child G there. In contrast however, CAMHs noted increased self-harm, had diagnosed Child G with severe depression, but the anti-depressants prescribed were not being taken and referred to G being in a 'dark mood'.

2.21 For another nine months, the school continued to record concerns about Child G's statements, writing, and drawings of what could have been suggestive of an increasingly sexual nature, incidents of self-harm and suicidal ideation. Two months later, records noted that Child G was not coping in school and several instances of self-harm were recorded over a further four months.

2.22 The frequent records summarised above indicate the involvement of school was consistent and considerable; and their concern for Child G genuine, as was their desire to take action to promote Child G's welfare. It is therefore all the more regrettable that this did not lead to action that could have supported Child G earlier. The Education Individual Management Report mentions that the school's systems for safeguarding recording were disjointed. However, as the staff involved with Child G were consistent, it is reasonable to assume that they were aware of Child G's history and were escalating concerns in relation to increasing risk. What the recording systems did not support was a holistic overview of these risks and concerns, nor the ability for the school to track and monitor the outcome of any supportive actions.

The involvement of Community Health Services

2.23 The first record of involvement of the School Nursing service was when the school nurse attended the Initial Child Protection Conference in relation to Child G. Thereafter the school nurse continued to attend core group meetings and undertake well-recorded health assessments. The organisation providing Community Health services identified in their Individual Management Report that there was appropriate involvement of the school nurse, speech and language therapists and the health visitors in the period under review, a view which the authors agree with.

The involvement of Hospital Services

2.24 The IMRs indicate little involvement of these services and nothing remarkable or of significant concern.

The involvement of CAMHs

2.25 When CAMHs became involved, the seriousness of Child G's risk necessitated 37 assessments and nine medical reviews, during their engagement. Due to a changeover of provider, it has not been possible to establish why so many assessments and medical reviews were undertaken and whether any subsequent plans were made

2.26 The involvement of CAMHs with the C&L social worker was good with regular communication and a collaborative approach. However, the IMR states there is no evidence of their involvement with Looked After Children reviews, and little evidence of CAMHs involvement with Child G's school.

3. Issues of religion, race and disability

3.1 This section has been greatly edited because it could identify Child G. In summary, there is no reference in the records in relation to identifying whether Child G had any needs in relation to religion or race. However, sufficient information was provided to the Serious Case Review to form a view about how well services responded to Child G's special needs. These were in part addressed but by no means fully, early enough, or consistently.

4. Assessment

4.1 Neither a Core Assessment nor a Parenting Assessment was undertaken by either social work team involved with Child G, or the lack of one challenged by any agency. This is a key area of poor practice. This is despite the Initial Child Protection Conference and Plan stating that a Core Assessment was to be completed so that there could be *"a fuller understanding"* of particular issues. The timescale for completing the Core Assessment was *"immediate"*. Further the minutes of the Conference say *"there is a very apparent need for further assessment* and specifying what should be covered.

4.2 The only detailed assessment that is on the system, is a specialist psychological assessment commissioned for a specific purpose. The need for a second, more specialist, assessment was also required as part of the Child Protection Plan. Despite this plan, at the following Review Child Protection Conference, neither the Core Assessment nor the specialist assessment had been completed. The Serious Case Review found no record of the specialist assessment. The electronic records state on a few occasions that the Core Assessment had been completed, although the record itself is an empty template. The Team Manager of Social Work Team 2 told the reviewers that the lack of a Core Assessment was never escalated to her by the Child Protection Conference Chair or Core group members. The failure to complete a multi-agency Core Assessment was a significant omission because it was a missed opportunity to develop an understanding of a number of issues. These issues were set out in the original version of the report, and are all entirely valid, but are not reproduced here as they might identify Child G.

4.3 A Core Assessment could have tested hypotheses, focussed the scope of the enquiries, given pause for multi-agency thought and reflection, enabled greater engagement/partnership with Child G's family, and importantly, provided the opportunity to share information with agencies. The absence of a comprehensive, holistic, multi-agency assessment is a significant failing which is not solely the fault of C&L - a range of agencies attended multi-agency meetings including the Child Protection Conference, where it was decided a Core Assessment would be undertaken but did not challenge the fact that this did not happen. The testing of hypotheses is particularly relevant in this case - by not testing two theories put forward by Child G's school through the tool of a Core Assessment, the original report identified a significant missed opportunity.

4.4 Also of concern is that Child G did not receive any medical assessments (other than the routine health assessments as a Looked After Child and the interventions by CAMHs) in relation to some very serious and specific allegations made by the child. There may have been a clear rationale about why medical assessments were not progressed, but there is no record of any discussions about such assessments, the relevant decision-making and why professionals did not raise or escalate their concerns.

5. The legal issues involved

The learning for the Board in relation to legal issues is reflected at the end of the report.

6. CAFCASS

6.1 The Children and Family Court Advisory and Support Service has an Operating Framework which sets out how the organisation uses resources effectively to provide the best service to those children and families referred to them. The core element of the CAFCASS role is to provide the court with an independent overview of the child's situation, and of the options available to the court, to make recommendations to safeguard and promote the welfare of the child. The Operating Framework, supports this view and states: *'In all public law and private law cases that go beyond the First Hearing, practitioners need to communicate effectively with children to understand their wishes and feelings, to set these out before the court and, informed by them, to offer an evidence-informed view about what steps will most effectively safeguard and promote children's welfare'*.

6.2 The first CAFCASS guardian appointed to work with Child G made a conscious, recorded decision, based on professional judgement, not to have any direct contact with Child G, preferring to gather information about the child from a range of other sources, rather than hearing Child G's wishes and feelings directly. Irrespective of this decision, the guardian then made no further contact with the child before leaving CAFCASS. In fact this first guardian only had limited contact with other agencies, including the allocated social worker. The guardian and the social worker appear to have followed different pathways, as opposed to maintaining a communication process and escalating any difficulties.

6.3 If a child is to be properly assessed and safeguarded, then appropriate expertise and guidance is essential in providing an informed background and identifying a pathway for the professionals. The decision by the first appointed guardian not to see the child meant the opportunity to ask the local authority to make a referral to CAHMs was missed.

6.4 The appointment and duties of the CAFCASS guardian is covered by Practice direction 16a of the Family Procedure Rules. Taking this practice guidance into account, it must be acknowledged that there is no absolute requirement for a guardian to see a child and the decision may have been made because the social worker advised, based on what would have been valid grounds, recognised by the authors, that Child G should not be seen. Nevertheless, in view of what subsequently happened, the authors are of the view that seeing the child was important.

6.5 A new, second, (self-employed) guardian, was appointed but this was after a gap of almost two months, which was not good practice, given that the role of the guardian is time limited to the proceedings and is task centred.

6.6 Although guardians work independently, their role requires a level of support, supervision and management. CAFCASS do have a good system of supervision in place as commented on positively by the national Ofsted inspection (2014). But in Child G's case, there is no record that the decision not to see the child had any management or supervisory oversight.

6.7 The second guardian clearly addressed the issues with an immediate response and a focus on Child G's needs, A clinical psychologist was appointed to examine Child G's cognitive functioning. This was a critical assessment, and one that other agencies needed to be aware of to address Child G's needs accordingly.

6.8 A third appointed guardian identified a range of risks to which Child G had therefore been exposed. It was this observation, seen as good practice, that ultimately led to the case being the subject of a Serious Case Review.

7. Police Investigation and assessments

7.1 After Child G's disclosure of possible sexual abuse, which led to a strategy meeting, Child G did not wish to be interviewed by the police. This meant that the forward momentum in the case continued to be driven by the social worker as a single agency, and Child G was placed in care. This next section considers the practice of the local police force in carrying out an *Achieving Best Evidence* interview process.

7.2 The section 47 assessment indicated that Child G *was "not able to provide an ABE at the moment because of [Child G's] withdrawn demeanour and unwillingness to discuss this any further at this point."*

7.3 Intervention at this time could have been made by the police more incisively; all that was happening in terms of any investigation was waiting and recording any update from the social worker. There was little supervision recorded of the police input at that time. The police were invited to several meetings, which included both the Initial Child Protection Conference, and a complex strategy meeting; no representative attended either meeting, and this left a significant gap for the police in the emerging issues.

7.4 The police become more active six months after the Initial Child Protection Conference, when they were informed of disclosures of sexual abuse. In terms of practice a key opportunity to involve an intermediary was missed. By this time, there was significant and relevant information from a clinical psychologist that could have informed an approach to interviews.

7.5 A formal ABE interview took place some three months after the disclosure, and 10 months from the first mention of sexual abuse. No intermediary was used, although the lead interviewing police officer had indicated that it was her intention to consider an intermediary if and when Child G was ready to disclose. That point had been met by this time.

7.6 Whilst the later interpretation of the quality of the interviews, including this one, is subjective and open to opinion, the interviews do lack the intervention support of an independent intermediary. There is national training and practice guidance available (provided by the College of Policing in conjunction with the National Police Chiefs Council) to police officers undertaking these interviews. The police officer in this case was appropriately trained and up to date with guidance.

7.7 The use of an intermediary and preparatory planning to maximise the objectives of an ABE interview could have assisted the police officers (social workers and the guardian) in the planning, preparation and interview structure.

7.8 The review authors would not go as far as to specify any particular method of support to the process, as a judgement needs to be made on each case. There are however, examples of how victim/witness issues have been overcome without detriment to legal process and can be seen in toolkits that are available from the Advocates Gateway[1]. These are a valuable tool for practitioners and a number of agencies would benefit from using these in professional practice.

7.9 In this case the objective should not have been to react to when Child G wanted to disclose and be interviewed, but to have sought the independent support of an expert intermediary who could address Child G's specific needs. Police officers do not have specific training to address these issues, but they do have access to support through professional networks which includes a database of intermediaries for a range of conditions and behaviours. This is a network that extends nationwide. This network should have been used in this case.

7.10 Supervision was not recorded on Child G's file until seven months later and after four ABE interviews. Long lists of actions were still required to develop the investigation further. Advice from the Crown Prosecution Service (CPS) advice was never sought as it was not felt appropriate.

7.11 This case is not deemed by the review authors as complex in terms of abuse procedures, but instead, it is a complicated case. Although there were no local LSCB multi-agency complex abuse procedures in place, the police did have national guidance on dealing with complex abuse issued by the Association of Chief Police Officers (ACPO) in 2009. However, there was no requirement to initiate these from a police point of view.

7.12 The issue was that the police dealt with this case on a purely reactive basis and no proactive investigation took place.

7.13 The review authors recognised some specific demands upon the police investigating officer, arising from the numerous communications in a particular context. Some of the response to this context could have benefited from more challenge by the police. The authors and review panel were satisfied by the end of the review process that in similar situations now, there is much more productive partnership working between police and relevant agencies.

[1] www.theadvocatesgateway.org

7.14 The authors weighed up information provided to the review about Child G's needs, and used it to form an opinion of the quality of the ABE interviews. To include a great deal of detail would risk identifying Child G, but in summary the process was found to be wanting in a number of ways. The authors identified one particular aspect of the police process that was contrary to guidance. This was addressed by Bedfordshire Police during the SCR process, and has been the subject of further assurance to the Luton Safeguarding Children Board.

7.15 The authors also noted that the police officer in the case was not informed of the many interviews conducted by social workers with Child G and this was not discovered until it emerged in the context of another process, more than a year later. This would have been crucial knowledge to the police for pre-assessing ABE interviews or making decisions whether they would have been appropriate after such interviews had been conducted.

7.16 The overview authors were satisfied that the training of officers on the case was to nationally approved standards, and they had expertise in their professional roles, with specialist skills in dealing with child victims of abuse and sexual abuse. The officers' training was up to date and the lead officer had considerable experience in the investigation of child abuse over a number of years.

8. Management and supervision

8.1 This case could have had better management and supervision by several agencies. Overall there was insufficient supervisory management 'grip', challenge and oversight in this case and of staff, one of whom was an agency worker.

8.2 Effective supervision and case management of the social worker in C&L was lacking particularly in terms of recording decisions made. Previously this was a task that was undertaken by the supervisee. However, the Team Manager's learning from this case has meant that supervision notes are now put on the child's records by an administrator.

8.3 Five supervision records on Child G's case file were found as follows for the period under review. There are no supervision records on file for either the social worker from Social Work Team 1, or the social worker who undertook most of the casework in Social Work Team 2. The records that are available on the system are sparse, and not sufficient to clarify whether supervision was challenging, reflective or rigorous in critiquing practice.

8.4 The authors evaluated the supervision and support available to an assistant social worker on this case, by means of interviews with this professional and their line manager. This established that supervision took place at six weekly intervals by the Team Manager, and found these to be supportive, reflective and constructively challenging, and in addition, the worker's caseload was significantly reduced to enable a focus on the needs of Child G. In addition, training was arranged for knowledge and skills in the 'nature and impact of sexual abuse'. This supportive practice was not reflected in recording on the child's casefile, which contained only

one entry about supervision. However, the authors were showed contemporaneous notes that appear to have been completed at the time recorded.

8.5 Two workers from Social Work Team 2 then worked with Child G. There are four supervision records for the first worker, whose period of involvement was much shorter than that of the second allocated social worker. These records are on the child's electronic file. However, additional paper copy supervision records are indicative of regular supervision having taken place.

8.6 There are no records of supervision available for the second social worker who undertook the main casework with Child G, and this is a significant omission. The Team Manager has informed this review that two formal supervision sessions took place, although records are not available. The social worker's own recollection is vague, but suggested there may have been one supervision meeting during the period under review.

8.7 The authors interviewed the social worker and drew additional data from the IMR, by an independent person, for the C&L directorate in order to form a judgment about the availability of supervision and the size of caseloads. There are no written records to evidence what cases were and were not allocated however, the C&L IMR author concluded that the information provided by the Team and Service Managers was credible and was impressed by the comments made and the support they gave to all staff on this case, including reducing caseloads.

8.8 It is apparent that both the Team Manager and the Service Manager sought to offer an approachable and supportive management style and were committed to ensure practice which was child centred and that the developmental needs of the professionals working with Child G were met

8.9 However, the lack of management oversight is evident. Indicators of this include:

- Difficulties in holding one social worker to agreed supervision sessions
- Lack of recorded decisions on Child G's case file on the two occasions this worker was supervised
- That the Core Assessment was never completed.
- That the Conference Chair did not escalate to the Team Manager that the Core Assessment had not been completed. Notwithstanding that, it is a core supervisory/management role to ensure that basic safeguarding tasks such as completion of Core Assessment are undertaken.
- The quality of the observations on the file is variable and a number of records are not on the system. The management function of supervision is important for setting and monitoring standards for recording on cases.
- For some critical visits, no recording is made. An example is a visit in which Child G is said to have made an allegation of physical abuse and sexual abuse. This is not recorded at all and it is therefore not known who else was present, how long the interview took, nor what was said.
- Some very general comments are made, such as 'many discussions have taken place with the family' or 'Child G has been visited over and above statutory

timescales'. These are instead of records of specific contacts and they do not assist in casework planning and management;

- There are records which present opinions as facts;
- There are a number of documents loaded on the children's electronic casefile system and referred to as 'completed' but which are only blank templates, such as the Core Assessment and the Chronology;
- Some records are placed on the electronic case file several times over; other records are not present at all, for example, pictures and writings that Child G did at school indicating distress are missing, as are court documents.

Further examples were cited in an earlier version of the report, but they have been removed from this version as they risk identifying Child G. They were however noted by Safeguarding Board members as having been addressed.

Police supervision

8.10 Police supervision of the case through the Child Abuse Investigation Unit lacked insight and direction. There needed to be early action in the investigation and the subsequent challenges on how to approach the initial disclosures by Child G, as opposed to playing what became a 'waiting game'. This was double edged in that it neither served to protect Child G from risk, nor did it pay due regard to the complex needs of the child. Although the police acted with what they felt was an appropriate response, this probably added pressure to the social worker to move the investigation forward and contributed to the silo working. This should not have been a single agency investigation following the implication of the disclosures made by Child G.

8.11 When momentum finally gathered, the police response was not swift or incisive and took several months to complete and was made without supervision, looking at the wider issues, rather than just those of the criminal investigation. This case required a rigorously led criminal investigation by a senior police officer which would have linked into the complex abuse that was apparent, and would have led to effective case meetings and strategies by respective agencies.

8.12 Since the investigation and management of this case, the police have completely restructured how they investigate child abuse, which has improved levels of supervision and management oversight.

CAFCASS Supervision

8.13The involvement of the original guardian from CAFCASS lacked meeting and listening to the victim. There appears to have been no management and supervision of this guardian's involvement with the case, or the significant gap in process between where there was no guardian input. It is acknowledged that a CAFCASS supervisor had this case in their caseload for this period. CAFCASS have a supervision policy (positively commented on by Ofsted 2014) that it is at the point of need and that for directly employed staff no longer than two months apart. The

management of the case was therefore left in the hands of the social worker and legal services.

Legal Services

8.14 The local authority's legal services appear to have addressed the requirements by the court in a professional manner, but have been hampered by other agencies and individuals supplying relevant material in a timely manner.

School supervision

8.15 There were no formal structures within the school for supervision. In relation to this case during the review period, the authors received assurance about the emotional support provided to staff in the school. However, there were no structures for reviewing decision making or practice in relation to the staff involved with this case. It was suggested that that support is available from a member of the Governing Body who has some qualifications that equips them to do this; but there is no evidence that this was offered or utilised.

School Health supervision

8.16 The supervision of the school nurse was insufficient for the complexity of the case and in the light of the individual's post-qualifying experience; the responsibility for this lies with both the supervisee and the supervisor. The school nurse needed help to identify that the case was complex and subsequently there were implications for the amount of supervisory support that was needed. The IMR helpfully reflects that the research evidences that a failure to recognise the risks of aggression to professionals can have an impact on professionals in recognising and accepting there may be similar risks to the children.

9. The Voice of the child

9.1 It is apparent that the school did not always 'hear' Child G's voice and there was a lack of consideration or professional curiosity about what life was like for Child G and what the child was communicating through drawings and writing. This led staff to assume that Child G was demonstrating 'attention seeking behaviour' and that Child G's-self-harm was part of teenage culture. However, they did recognise that Child G was vulnerable, and as such provided time and space for Child G to be with staff and if desired, to talk. This demonstrates good practice by the school. Child G was supported in school emotionally and this contributed to Child G developing a secure attachment to two members of staff. These staff continued to support Child G throughout the child protection process and subsequent developments. The secure attachment contributed to Child G feeling able to talk about matters that were concerning. The time staff spent with Child G enabled them to understand Child G's character and communication. This in turn enabled the school to support professionals from social care and police in their interaction with Child G. However, the very close relationship that developed became too close, with professional boundaries becoming unclear.

9.2 After the initial referral from school, social workers and the assistant social worker gave every opportunity for Child G's voice to be heard. Records indicate the sheer

volume of opportunities given to Child G on a variety of occasions when Child G requested to see the social worker. A few observations note that Child G was seen over and above statutory minimum timescales. Some observations indicate the detailed knowledge that the social worker and assistant social worker had of Child G, suggestive of time spent talking with, and listening to the child. The authors had confirmation from data provided to the review of appropriate responses to Child G's wishes and feelings. This includes the scheduling of ABE interviews. A second example was also given in the original report which provides credible data about the way professionals responded to Child G's wishes and feelings but it is not included here for reasons of anonymity.

9.3 Despite these positive examples, there are numerous times when recordings of the child's stated comments are not evident, or records do not offer clear details. Most worryingly, there are many occasions - some central to how this case was managed - where the social worker's own opinion/impression was stated as being Child G's. Two striking examples of this were included in the original report.

9.4 In terms of the practice around 'looked after children' Reviews, Child G attended some of these but did not wish to attend others and there is reference to the Independent Review Officer meeting Child G separately for the review. The authors' analysis of a sample of the reviews concluded that some did not record Child G's views in the meeting. It is important that looked after children reviews are consistent in their approach to seeking and integrating the child's views in the planning and decision making. This needs to include inviting children to their reviews, using consultation processes in advance of the meeting, using advocates and Independent Review Officers meeting with children during the process.

9.5 The records of the school nurse clearly include the voice of the child.

9.6 The considerable involvement of CAMHs was responsive to Child G's needs wishes and feelings and the work undertaken was sensitive, for example when Child G asked that notes were not taken during the sessions, this was respected.

10 Conclusion

10.1 This was undoubtedly a challenging case for professionals. Many neglectful families share common characteristics and experience of adversities, they can be chaotic, with poor boundaries and inappropriate relationships; domestic abuse, drugs and alcohol, mental ill health and illiteracy are often features, sexual abuse is more commonly found and their children suffer from physical, emotional, intellectual and psychological difficulties which can have a long term impact (Devaney et al.2013 Living with adversity: a qualitative study of families with multiple and complex needs).

10.2 The needs of families like this are considerable and demands occur frequently, the need to respond to concerns and incidents on an almost daily basis can overwhelm practitioners and divert them from an overall perspective and a clear plan. The focus on obtaining evidence of sexual abuse, diverted practitioners from the damaging impact of neglect and the risks of physical and emotional abuse.

10.3 There needs to be sufficient capacity within agencies to provide support within a clear plan. Well informed, effective multi-agency arrangements are essential, accompanied by frequent communication and strong management oversight and supervision. Although there was some good inter-agency communication and extensive support for the social worker and assistant social worker, effective supervision, including challenge was lacking in this case at significant points.

10.4. The way that children present themselves physically, socially or emotionally, how they perform at school or whether they meet their developmental milestones can provide practitioners with important pieces of information about the life and experience of that child and the parenting that he or she is receiving.

10.5 Lists of behavioural and presentational features can provide useful triggers and check-lists in terms of children's needs and characteristics, that may indicate they are being neglected. However, these need to be taken along-side other considerations such as the age of the child, their stage of development, whether they have a disability or how long they have been a feature of the child's life.

10.6 Of importance to practitioners, is their knowledge of individual children through listening and observation, engaging and building relationships with children and their families so that they can hear and be receptive to what they are being told. They need to be able to think from a child's perspective and consider their professional concerns in terms of what they may mean to that particular child. What is the impact on them and what effect will it have on their developmental needs both at present and into the future?

10.7 During the review reference to the lack of complex abuse procedures was cited as a problem and a reason for poor practice. There are numerous indications that managers, including senior managers and those from other organisations were extensively involved in this case, including the court processes and in relation to this matter being viewed as a complex abuse issue.

10.8 The social worker's concern that this case was a complex abuse case was taken seriously by senior line managers and resulted in numerous complex case abuse meetings which involved professionals from other agencies and managers/practitioners from teams across the local authority who were working with members of the extended family, in both children and adult safeguarding services. This included consultation with external agencies regarding the development of Luton specific complex abuse procedures.

10.9 In terms of the management of this as a complex case, a senior manager was allocated to chair the complex abuse management meetings. However, it appears that no further complex abuse management meetings took place and the matter was not addressed again. It is not clear why this occurred or how this decision was made and authorised.

10.10 The authors do not fully share the view that the lack of written, multi-agency complex abuse procedures was a significant problem, although complex abuse management meetings should have continued. It is the basic management,

supervision and practice (including the identification of risk, assessments and plans) that should have been better executed.

10.11 There is evidence of some good practice in this case, the child was largely at the centre of practitioners' concern but the late referral by school to C&L was a significant issue and there should have been an earlier referral to CAMHs and medical assessments.

10.17 A programme of work around neglect, led by the LSCB, was developed to respond to cases of neglect of very young children. In recognition of the needs of adolescents the Board commissioned and continues to lead, work around older children as well as one of the Board's three priorities, based on identified need in Luton.

11. Recommendations

11.1 Each of the agencies that completed IMRs has compiled action plans which contain individual learning arising from this SCR that they will implement, these have included the provision of ABE training.

11.2 Although there is significant learning from this case, little of it is new as it is a question of sound basic safeguarding practice being followed. There are therefore few additional recommendations for the Board to address, but it is recommended that the Luton Safeguarding Children Board should:

a. Assure itself that all agencies have in place and follow, effective safeguarding supervision and management oversight procedures, and remind agencies of the importance of appropriate challenge and escalation.
b. Establish clear self-harm procedures and pathways.
c. Extend and build on the agreed pathway (established between the local authority legal services and the police) for information sharing by a Standard Operating Procedure/Memorandum of Understanding, to also include health commissioners and providers as well as Education, by the establishment of the appointment of single point of contact in each case in the respective agency. This will ensure a smooth flow of information that is timely where parallel processes occur and does not prejudice the respective processes and will identify matters where legal challenge can be appropriately addressed.
d. Assure itself that effective support is provided to disabled children and their families to enable them to communicate and effectively participate in plans for their support and care.
e. Assure itself that there is compliance with the procedures for child protection medicals and the inclusion of consultant paediatricians in strategy discussions or meetings, so that their specialist knowledge can make an effective contribution.
f. Assure itself that there are effective escalation policies and procedures and that the use of these is monitored.
g. Assure itself that when unexpected decisions are made by the court, within Care Proceedings these are followed by a multi-agency planning meeting to agree future involvement in the case.