Windsor and Maidenhead
LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD F

OVERVIEW REPORT

Independent Lead Reviewer:
Moira Murray
April 2015

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INTRODUCTION

1. Background to the Review

1.1 This report will summarise the findings of the Serious Case Review which was conducted in respect of Child F for the period between February 2011 and January 2014.

1.2 In February 2011 when Child F was aged 12, she was arrested with her Mother for shoplifting. At the Police Station Child F made a disclosure that her older brother, when aged 15, had anally raped her on two occasions over the previous two years. It was further alleged that that he had also physically abused her and had made threats to harm her. Her brother, 'B' was subsequently arrested and was bailed to live away from the family home, in the care of his Father.

1.3 Child F later retracted the allegations, however, a Section 47 enquiry, the Children Act 1989 was initiated, which resulted in an Initial Child Protection Conference being convened in March 2011. There was concern that Child F had been under pressure from her parents and extended family members to withdraw her allegations. The Conference decision was that Child F and her five siblings, including 'B' were at risk of significant harm and they were made subject to Child Protection Plans, category sexual abuse.

1.4 Given that Child F had made her disclosure following her arrest for shoplifting, had then withdrawn her allegations and 'B' had made no admissions, the Crown Prosecution Service decided there was insufficient evidence to charge 'B'. There was however sufficient concern about the risk posed to Child F and her siblings that the Child Protection Plan stipulated that 'B' should continue to live away from the family home until a core assessment and a specialist risk assessment had been completed.

1.5 There was significant delay in the local authority commissioning the specialist risk assessment. This did not happen until February 2012 and was undertaken by independent consultants specialising in assessing young people who have sexually harmed. There was further delay in the specialist risk assessment commencing and being completed and its findings were not presented to Children's Social Care (CSC) and members of the Review Child Protection Conference until July 2012. The specialist risk assessment found on the balance of probabilities that 'B' probably did commit the assaults. It recommended that 'B' start an individual programme tailored to his learning difficulties.

1.6 During this period of 16 months there had been a disclosure from 'E', the youngest sibling aged 6 years, that she had been physically abused by her Mother. This allegation was subject to a single agency Section 47 enquiry; however 'E' remained at home.

1.7 On reaching the age of 17, 'A' the eldest daughter moved out of the family home to live with her boyfriend, who was of a different faith and culture. This caused considerable difficulties for 'A' who faced threats of violence for her actions from extended family members. Child F was forbidden to have contact with her older sister.

1.8 The Social Worker allocated to the family believed that during this time 'B' remained living away from the family home, as stipulated by the Child Protection Plan and Written Agreement. Additional concerns also identified by

Children's Social Care (CSC) were being addressed. These included chaotic sleeping and living arrangements, all the children being over-weight and health and dental appointments not being attended.

1.9 In January 2013 it was decided that all the children should no longer be subject to a Child Protection Plan, but a Child In Need plan. This was because the consultants undertaking the specialist risk assessment concluded that 'B' presented a low risk of sexual abuse, although a monitoring plan would need to be in place should he return home. Agencies working with the family reported increasing engagement by the parents, despite their refusal to believe that 'B' had sexually harmed Child F.

1.10 'B' returned to the family home in September 2013. Child F's school attendance began to decline in the summer and autumn terms of 2013 and her appearance changed. She began wearing make up and dressed in western clothes. There was concern among some agencies that she may be subject to child sexual exploitation. In a Strategy Meeting Police were asked about whether Child F was in contact with a known sex offender; however there was no evidence to suggest that this constituted Child Sexual Exploitation. Following further Police investigations it became apparent that Child F's Father had been sexually abusing her. It also became evident that 'B' had returned to the family home when he had been forbidden to do so under the terms of the previous Child Protection Plan and written agreement. Further allegations were made concerning 'B's sexual abuse of Child F.

1.11 Child F and her siblings were removed from the care of their parents and made subject to care orders. Her Mother, Father and 'B' have been charged with criminal offences and are awaiting trial.

1.12 FAMILY COMPOSITION TABLE

Name	**Relationship**
Child F	Subject of Review
'A'	Sister
'B'	Brother and alleged perpetrator
'C'	Brother
'D'	Brother
'E'	Sister
	Mother
	Father
	Grandmother
	Aunt

2. Arrangements for the Serious Case Review

2.1 On 19 February 2014 the Windsor & Maidenhead Local Safeguarding Children Board (W&M LSCB) Independent Chair decided to initiate a Serious Case Review (SCR) concerning Child F. The initial findings presented to the SCR Sub-Group suggested that the case raised concerns about inter-agency working to protect Child F, particularly the effectiveness of the Child Protection and the Child In Need Plans over a period of three years.

2.2 The Independent Chair of the LSCB changed in April 2014. This led to some delay in progressing the SCR, the newly appointed LSCB Independent Chair took over as Chair the Serious Case Review and an SCR Panel was convened on 16 June 2014. Moira Murray was appointed as the Lead Reviewer, with responsibility for writing the Overview Report. Details concerning the Chair and the Author can be found at Appendix 1.

2.3 The Panel was made up of the following representatives:

- LSCB Independent Chair
- Moira Murray, Independent Lead Reviewer, Overview Report Author
- Head of Service Early Help & Safeguarding, Royal Borough of Windsor & Maidenhead (RBWM)
- Head of Education, Strategy & Commissioning, RBWM
- Safeguarding Children Team Leader, Berkshire Healthcare Foundation Trust
- Deputy Director of Nursing, Berkshire CCGs
- Child Abuse Investigation Unit, Thames Valley Police

2.4 The agencies listed below were requested to contribute a report to the review:

RBWM Children's Services

Thames Valley Police

Primary Care Services (GP)

School 1

School 2

Specialist assessment and treatment organisation and consultants

Crown Prosecution Service

Berkshire Healthcare Foundation Trust

Wexham Park Hospital

It is a government requirement[1] that Overview Reports from Serious Case Reviews are published, unless there are particular circumstances as to why publication would not be appropriate. This report has been written in anticipation that it will be published but it is appropriate that some confidential information is not disclosed, to ensure the children's right to anonymity is maintained. At the time of writing several family members are subject to criminal proceedings and are awaiting trial. Given these circumstances a decision was taken by the SCR Panel that it would not be appropriate to contact family members to ascertain whether they would like

[1] See Working Together 2013

to contribute their views to the Review until the outcome of the criminal proceedings was known.

2.5 From discussions between the Lead Reviewer and Child F's Social Worker it became apparent that given Child F was in psychologically vulnerable and fragile situation, seeking her views concerning the SCR at this time was not in her best interests. This may be appropriate after the outcome of criminal proceedings is known.

2.6 The Terms of Reference for this SCR are attached at Appendix 2. They are drawn from the statutory guidance contained in Working Together 2013, as well as specific issues relevant to the circumstances of this case.

3. Methodology

3.1 The Overview Report is derived principally from the agency Individual Management Reviews (IMRs) which were based on an analysis of agency records and interviews with staff.

3.2 A learning event was held on 27January 2015 for practitioners to enhance learning and to inform the SCR process. Advice and careful consideration was given as to who was invited to the event, to ensure that the parallel criminal proceedings were not compromised. The event proved extremely helpful to those attending and to the Overview report author in gaining a greater understanding of the family and of the issues presented to agencies at the time. Some of the issues raised at the event are included in this report.

3.3 Those who attended the event:

- The Named GP
- The GP Practice
- RBWM Social Work Staff
- Specialist Consultants
- NHS Berkshire School Nursing
- Berkshire CCGs
- Named Nurse for Child Protection, Wexham Park Hospital
- Thames Valley Police

3.4 The themes explored at the event were as follows:

- Risk, harm, strengths and protection issues in the case
- Exploration of family and cultural dynamics- learning from the experience of practitioners involvement in the case
- How practitioners work with complex cases

3.5 Messages from the learning event will be disseminated to frontline workers, managers and LSCB partners

3.6 The report is also informed by Panel discussions, dialogue with IMR authors, Child F's current Social Worker and relevant research.

3.7 This report is structured as follows:

- A factual summary of key events on based on the information provided to the SCR;
- The Child's Experience (Voice of the Child);
- Key themes identified by the review process, incorporating an analysis of each agency's involvement, issues emanating from the Learning Event and consideration of the Terms of Reference;
- Conclusions and Lessons Learned from the Review;
- Recommendations.

Family Involvement

3.8 Involvement of family members in the review was not possible due to the current criminal proceedings. Child F and family members will be invited to contribute to the review, once the criminal trial is over.

3.9 Sharing of the final report prior to publication with Child F will be dependent on expert medical advice as to whether it is appropriate.

4. FACTUAL SUMMARY OF THE CASE – KEY EVENTS

Family Background:

4.1 This section of the report contains some background information about the family which is considered to be relevant prior to the period under review; as well as a summary of their contact and involvement with relevant services during the review period.

4.2 The period under review is from February 2011, when Child F and her Mother came to the notice of Police, until January 2014, following the children's removal from the family home.

4.3 The family is of British Pakistani heritage. They are of the Muslim faith and the children attended a local Mosque on a daily basis to learn Quran. Urdu, Punjabi and English were the languages spoken within the home. All family members spoke English, although Mother's knowledge and understanding of English was known to be limited. Mother was provided with the services of the same interpreter throughout the period under review.

4.4 Mother and Father were born in Pakistan and came to England in 1994, following an arranged marriage in 1992. Extended family members of both mother and father were already living in the area where the family settled, as well as elsewhere in the UK. However, until 2011 when the family became involved with statutory agencies, there appears to have been relatively little contact with the extended family.

4.5 All six children were born in the UK. The family lived in a three bedroom property which they owned. Father was in full time employment and Mother remained at home as the main carer of the children. Child F is their second eldest daughter, third oldest child.

4.6 All of the children had some degree of developmental delay. At birth 'B' was medically diagnosed with Congenital Hydrocephalus and was subsequently identified as having special educational needs. 'B' continued to be under paediatric review because of a heart murmur and issues with high blood pressure. Child F was also monitored for a heart murmur**.** Both 'B' and his

young sibling 'C' had statements of educational need. There was some question as to whether the parents also had some level of learning difficulty; however, neither was subject to any formal assessment. During the course of agency involvement concerns about the appropriateness of the children's diet became apparent (all the children were overweight) and their lack of attendance at dental, ophthalmic and health appointments emerged as an indication of overall neglect and lack of appropriate parenting.

February 2011 to December 2011

4.7 In February 2011 Child F was arrested with her Mother for shoplifting, for which she was issued with a Youth Restorative Disposal (YRD) and Mother was given a Police Caution. Whilst at the Police Station Child F disclosed that she had been anally raped by 'B', her older brother when she was 11 years old. This had happened on a second occasion several months prior to her arrest for shoplifting.

4.8 After she was released from custody, but whilst still at the Police Station, Child F was interviewed by Police Constable 1, an Officer from the Child Abuse Investigation Unit (CAIU). Child F described the abuse 'B' allegedly perpetrated against her and said that her Mother and older sister ('A') knew about it. Child F said that her Mother had cried, and asked her not to tell anyone. Child F had told 'A', her older sister that she thought she might be pregnant. A pregnancy test had been purchased but not used. Child F disclosed in interview that her brother had threatened to kill her if she told anyone. Child F stated that her sister had believed her, saying that 'B' should be punished. Child F was concerned however that her Father would throw 'B' out of the family home.

4.9 The interview with Police Constable 1 was an assessment interview and although part of the Achieving Best Evidence (ABE) process[2] was completed before the recorded video evidential statement. The day of Child F's disclosure was a Saturday and Police contacted Social Services Emergency Duty Team (EDT) to arrange for a Social Worker to be present for Child F to be formally interviewed. The EDT did not have a Social Worker available to attend and Police Officers decided to progress the investigation and 'B' was arrested at 19.30 hours that day. 'B' was aged 15 at this time. Child F was interviewed the next day.

4.10 After speaking with Child F's Father, who appeared eager to cooperate, Officers decided that it was suitable for Child F to return home in the care of her parents. Child F was also requesting to go home and it was decided that alternative accommodation should be found for her brother. No foster care placement could be provided and the EDT was unable to provide anyone to attend as an Appropriate Adult for 'B'. The family's suggestion that an uncle could fulfil this role was rejected as inappropriate by Police and 'B' remained in Police custody over night.

4.11 The next day Child F was interviewed by way of a Visually Recorded Interview (VRI) and reported the abuse perpetrated by her brother. Her Father was present in the building, as an Appropriate Adult. Child F repeated that her Mother was aware of the abuse and that her Mother had begged her not to tell

[2] The video interview, referred to at the time of this incident as Achieving Best Evidence (ABE) is one of several special measures that could be used to enable vulnerable or intimidated witnesses, such as children, to achieve best evidence in court, The process is now known as Visually Recorded Evidence (VRI)

anyone. Her Father commented at the interview that Child F should have told him about it and '*he could have sorted it out'.*

4.12 A Strategy Discussion took place over the telephone between Police and the EDT that day, a Sunday at 13.30 and it was agreed that the case would be a S47 Joint Investigation. It was also agreed that: Police interview notes would be shared with CSC; a medical would be arranged for Child F and assessment interviews would be arranged for Child F's siblings. Later that evening Police records show that the EDT Manager telephoned the CAIU Officer to say that '*she was shocked to find that Child F had been interviewed without a social worker being present'*. It was explained that no one from the EDT had been available to attend the interview and Police had decided to complete the interview to expedite the investigation.

4.13 Following a no comment interview, at which an appropriate adult from Children's Social Care and a legal representative were present, 'B' was bailed on condition that he did not attend the home address; he made no contact with Child F and his siblings and that he had no contact, unless supervised, with any child under 16. As no fostering placement was available, 'B' moved into Bed & Breakfast accommodation with his Father, which was funded by the local authority. It is not known how this decision was reached and/or whether it was reviewed.

4.14 A second Strategy Discussion took place at Children's Social Care offices the day after the interviews with Child F and 'B' had taken place. Decisions made included that the medical examination of Child F would be progressed and S47 checks would be completed by CSC. 'B's school was informed of his bail conditions.

4.15 Several days after Child F's interview and 'B's arrest, Father contacted the GP Surgery. When the doctor returned the call, Mother answered the phone and explained that she was concerned about the absence of Child F's periods. Mother assured the GP that Child F was not sexually active and in turn received reassurance that there was no reason to be concerned. Several days later the GP was informed by the Social Worker of the disclosures made by Child F and that a pregnancy test had proved negative. The GP was subsequently informed of the findings of the Community Paediatrician's examination of Child F (see below).

4.16 In early March 2011 Child F told her Social Worker during a home visit that she had made up the allegation against her brother, because it was her first time in a Police Station and she was scared. The following day Police Constable 1 and a Social Worker from the Referral & Assessment Team visited Child F at school. During the course of the interview Child F gave differing accounts of what had happened, as well as stating that she had made up the story as her brother had beaten her and she wanted him to feel scared. She also said that she had been put under a lot of pressure at home by her family to tell Police that 'B' had not raped her. She had been told to say that she had lied. Child F explained that she did not want to get her brother into trouble and wanted him to come home. At the same time she herself was worried about going home as she was afraid her Father would shout at her.

4.17 On that same day Child F was medically examined by the Community Paediatrician to establish whether there were any signs of trauma associated with rape. There was no conclusive evidence that Child F had been raped, however the examination did not rule out that it had occurred.

4.18 Police were concerned about the pressure being exerted on Child F by her parents. Both Father and Mother were spoken to individually by Police Constable 1, and it was made clear to Father the importance of him not exerting pressure on Child F to withdraw her allegation. Mother refused to make a statement to Police about the allegation and maintained that the whole family wanted 'B' to return home.

4.19 An Initial Child Protection Conference (ICPC) was called at the end of March 2011, with the outcome that all the children were made subject to Child Protection Plans, under the category of sexual abuse. SW1 Social Worker from the Children in Need Team was allocated to the family. The Child Protection Plans included that a Core Assessment be initiated. There was a focus on Child F and 'B' having access to emotional and therapeutic support. Consideration was to be given to a specialist risk assessment of 'B'.

4.20 Until her disclosure there had been no concerns expressed by School 1 about Child F. Following the ICPC the school was asked to monitor Child F and to contact CSC with any new concerns. Throughout Year 7 & 8 the school had no concerns about Child F's progress and her attendance of 92% continued to be good.

4.21 At the beginning of April 2011 the Crown Prosecution Service (CPS), having reviewed the case, decided that 'B' would not be charged with any criminal offences. The decision was based on there being too many weaknesses in the case. Children's Social Care was informed by the Police of the CPS decision and the following day visited Child F's parents to tell them of the outcome. It was made clear to the parents that Children's Social Care would continue to be involved with Child F and the family, and that all the children would remain subject to Child Protection Plans.

4.22 A Core Assessment was started in April 2011 and was completed in June 2011. 'B' was still required to live in bed and breakfast accommodation as part of the Child Protection Plans. 'B' was attending school and the school was required to make appropriate arrangements to ensure that he did not come into unsupervised contact with children under 16. The allegations concerning 'B's alleged abuse of his sister came as a surprise to staff at School 2, the school that 'B' attended, as there had been few concerns about him as a student prior to February 2011. The school commented that 'B' found the conditions that he had no unsupervised contact with students under 16 and the supervision arrangements at break/lunch times constraining and frustrating. However, the school reported that these frustrations appeared to abate and 'B' appeared to be more subdued and pre-occupied. 'B's attendance whilst at School 2 during the period under review was 88.78% in 2011 and 81.91% in 2012. However, the majority of these absences were authorised due to his need to attend medical appointments.

4.23 Both Child F and 'B' engaged with the School Nursing Service, which given they were overweight was in the main focussed on dietary issues. Child F was known to have a heart murmur but this was appropriately monitored and was not considered to be a serious health problem. It was not until September 2013 that Child F's sexual health was discussed with her by the School Nurse.

4.24 During the course of a statutory Child Protection visit to the family home in late April 2011, Child F's younger sibling 'E' aged 6, disclosed to SW1 that her Mother '*hit her on her head, back and toes'* and that she felt '*unloved and*

isolated.' This information was not reported to Police at the time it became known and as a result Police did not interview the parents. A telephone strategy discussion took place almost two weeks later with Police and CSC. As 'E' was unable to elaborate on what had happened and as there were no visible injuries, the outcome of the discussion was for CSC to undertake a single agency S47 investigation. As the allegation was unsubstantiated and denied by the parents, no further action was taken.

4.25 In June 2011 the Paternal Grandmother arrived from Pakistan to assist with the care of 'B'. A request was made by Father to CSC for 'B' to return to the family home and to go to Pakistan with his Grandmother. Both requests were refused. By the time of the first Review Child Protection Conference (RCPC) at the end of June 2011 the specialist risk assessment had not been commissioned and the focus of the Meeting was on establishing a Family Group Conference (FGC) programme. Concern was expressed about the parents' unwillingness to acknowledge that Child F had been sexually abused by 'B', and for the welfare of 'A', Child F's older sibling who had a white British boyfriend. No progress was made on identifying therapeutic services for Child F (a referral to the NSPCC was suggested, however this never materialised). All the children continued to be subject to Child Protection Plans, with the exception of 'A' who by then was 18 years old.

4.26 A Family Group Conference was held in July 2011, which involved Child F, 'B', the parents and extended family members. The outcome focussed on developing better family relationships, especially with 'A', establishing routines and hobbies, and ensuring that the children accessed appropriate television programmes. By August 'A' had moved out of the family home and went to live with her boyfriend.

4.27 By this stage the Core Assessment had been completed, however there had still been no progress in commissioning the specialist risk assessment of 'B'. Neither had the referral of Child F to the NSPCC nor the referral to the Family Centre for parenting work with Mother and Father been progressed. SW1 expressed concerns to ATM1, her Supervisor, that although there had been some progress with the family, she thought the children were being coached about what to say to her, and by August 2011 she had concerns that the children were not disclosing that 'B' was visiting the house.

4.28 From July to December 2011, SW1 undertook regular statutory child protection visits to the family home and had individual sessions outside of the home environment with Child F. 'B' was also visited in his bed and breakfast accommodation. He expressed his frustration and anger about the length of time it was taking for the specialist risk assessment to be organised and at being considered as not safe to return home. It was also apparent that his parents wanted 'B' to return home, did not acknowledge that he had abused his sister and that the girls in the family were treated differently to the boys, especially 'B' who was given superior status to his siblings.

4.29 From individual sessions, SW1 was aware that Child F was required by her parents to do an inappropriate amount of housework and she disclosed that her father had 'smacked' her when he had discovered her talking to her sister's boyfriend on a webcam. Child F told her Social Worker that she no longer had access to Facebook as her Father had discovered that she had boys on her friends list. She also disclosed that she felt frightened when left alone in the house as friends of 'B' had knocked on doors and windows and

had left abusive messages concerning her sister 'A'. Child F also told SW1 that she had given her Father £100 as he was short of money. It is not known to the review as to how Child F accumulated this amount of money.

4.30 It was not until the beginning of December 2011 that ASW1 from the Family Centre started a programme of direct parenting work with the parents. The same interpreter as had attended Child Protection Conferences was used to support Mother. The session concentrated on sleeping arrangements and daily family routines. ASW1 noted that the parents did not recognise the child protection concerns of CSC and that Mother 'went along' with Father's decisions.

4.31 The second Review Child Protection Conference took place in mid- December 2011. The Conference was told that a specialist assessment had been organised for the New Year. Contact arrangements with 'B' and the family were arranged for Child F's birthday and Christmas. The parenting sessions between ASW1, the parents and Paternal Grandmother were ongoing, however there continued to be no acknowledgement that Child F had been sexually abused. The children remained subject to Child Protection Plans.

January 2012 – December 2012

4.32 At the beginning of January 2012 it was noted that 'B' had been hospitalised for two nights due to high blood pressure and had been referred to a consultant.

4.33 A Core Group Meeting took place at the end of January where there was challenge from members as to why the specialist risk assessment had not commenced and no date was known for when it would commence. SW1 informed her Supervisor that the situation was being risk managed and that the family was seen to be working with CSC.

4.34 There was no action to expedite the assessment, however the parenting work undertaken by ASW1 from the Family Centre continued. Two issues of concern were identified: Mother appeared to minimise the potential risk of 'B' returning home and dismissed the suggestion that there was differential status between the boys and the girls in the family. The case was closed in February 2012 to the Family Centre, with a report from ASW1, stating that *"Mother and Father had engaged well in the parenting work and seemed to be taking practical advice – use of rooms had changed and diets changed. Both parents stated that they are confident in parenting their children and don't feel the need for further support."*

4.35 At the end of February 2012 'B' had moved out of Bed and Breakfast accommodation and into a flat with his Paternal Grandmother. The need for a specialist risk assessment had originally been raised at the Initial Child Protection Conference in March 2011, and was confirmed as being required by the Core Group in early April 2011. Agreement for the assessment to commence was not confirmed until the end of February 2012. The expectation was that it would be completed within 6 – 8 weeks; however the assessment report was not presented until July 2012. The specialist consultants, who undertook the assessment on behalf of a specialist assessment and treatment organisation, were provided with information from CSC records, were made aware of the allegations against 'B' and took into account the cultural ramifications of interfamilial sexual abuse in Asian communities. They were fully informed of 'B's special educational needs.

4.36 By the end of April the specialist assessment was in progress and following a statutory child protection visit to 'B' in May, SW1 was of the view that the risk of sexual abuse by 'B' had reduced because of the 'Keep Safe' work she had undertaken with Child F and the other children. The issue of the children sharing bedrooms (Child F had on occasions shared a bedroom with 'B' prior to her disclosure of sexual abuse) had also apparently been addressed. During this time Mother was seen to have bruising to her eyes, for which different accounts were given. One explanation was that Child F had accidentally closed a window in her Mother's face. SW1 was concerned about the nature of these injuries and considered whether Mother had been subject to domestic abuse; however no definitive explanation was forthcoming.

4.37 Child F shared with the School Nurse, with whom she had regular contact to discuss her diet and weight, that she was being forbidden by her Father to have contact with her older sister. Child F was particularly close to 'A'. This information was not shared by the School Nurse at the Core Group Meeting in early May, but SW1, was told of the situation after the meeting. By this time 'A' had received threats from extended family members because of her relationship with her white British boyfriend. Despite this and Father's expressed wishes that no contact should be made with 'A', both Child F and Mother were secretly seeing her.

4.38 A third Review Child Protection Conference took place at the end of May 2012. No representative from the specialist organisation was able to attend, because of the short notice of the invitation. The Conference was informed that the specialist assessment would take a further four weeks to complete. Concerns about threats to 'A' from extended family members were discussed. It was noted that Child F appeared more confident and Father told the Conference that Child F was *'working for him to give her a Blackberry'.* Father also stated that all the children wanted 'B' to return home. The outcome of the Conference was for all the children to remain subject of Child Protection Plans and that a further Review Conference would be arranged for the middle of July 2012 in order for the outcome of the risk assessment to be discussed.

4.39 'B' engaged with the specialist consultants undertaking the assessment on behalf of the specialist organisation and generally cooperated with requirements of the assessment. 'B' did at times express his frustration that the process was taking such a long time and told SW1 that he found some of the questions asked concerning sexual abuse '*disgusting*'. The findings of some elements of the assessment 'B' completed led the specialist consultants to conclude that he was capable of scoring 'a fake good' for psycho-social measures and it was noted that 'B' became defensive when asked about this. Other scores indicated a lack of openness and a denial of sex drive and interests. His special educational needs were reflected in the results of reading tests undertaken as part of the assessment.

4.40 Mother, Father, Child F and the younger children were also interviewed as part of the specialist risk assessment process. Child F spoke at length about 'B's behaviour towards her and of him threatening to put a naked photograph of her on the internet. Child F maintained however that she had made up the allegation that he had raped her. In their assessment of whether Child F had indeed invented the allegation against her brother, both the specialist consultants were firmly of the view that this was unlikely to be the case and concluded that 'B' had been responsible for sexually abusing his sister '*in*

much the same way as she described it in her initial disclosure.' It was their opinion that family pressures had prompted Child F to say that she had lied about what had happened.

4.41 The specialist risk assessment findings were presented to the Review Child Protection Conference in mid July 2012. The specialist consultant, on behalf of the specialist organisation attended the Conference, as did Mother and Father, who had already been informed of the outcome of the assessment. The Conference was told that the assessment had concluded that 'B' presented a low risk of sexual assault, but this was based on his behaviour of the previous six months, when he had been living outside the family home. Thus, it was reported that it would be difficult to assess whether 'B' would revert to old behaviour if he returned home. At the same time CSC reported that Child F was feeling more confident and safer as a result of the 'Keep Safe' work. The consultant reiterated that it was not possible to guarantee that these changes would persist if 'B' went home and Social Worker input was withdrawn.

4.42 The assessment recommended that before 'B' could return home, there was a need for him to undertake some intervention work, that a risk management plan should be developed (to be reviewed regularly) and that Social Work involvement needed to continue over a prolonged period. Father wanted the intervention work to be completed within a period of 1-2 months to enable 'B' to return home; the Conference Chair however specified that this needed to conclude within 4 months. The Conference decided that given the findings of the assessment, SW1 should continue to work with the parents to enable them to acknowledge that the abuse did occur. All the children remained subject to Child Protection Plans.

4.43 Initially CSC anticipated that they would carry out the intervention work concerning sex education and relationships with 'B'. However at the beginning of August 2012, it was recognised that this was not going to be possible and specialist consultants were commissioned to undertake to work with 'B'. Funding was agreed for the intervention work to commence in mid August, however this did not begin until the end of September by which time 'B' was spending considerable time at the family home.

4.44 Over the 5 month period, from September 2012 to February 2013 that the intervention work took place it became apparent to the specialist consultants that 'B' was not residing at the flat, as still stipulated in the agreement with CSC. 'B' was frequently not in when they called at agreed times and admitted to the specialist consultants to spending the day, and sleeping over on occasions at his family home. The consultants told SW1 of this information, although SW1 was already aware from her visits to the family home that 'B' was frequently present, when he should have been residing at the flat with the Paternal Grandmother.

4.45 In early November 2012 School 1 informed SW1 that Child F had disclosed that Father was trying to obtain a visa to send her to Pakistan. A Strategy Meeting took place between Police, CSC and the School the day after the disclosure. Child F was also interviewed that day at school by a Police Officer and her Social Worker. Child F confirmed her worries that her Father wanted to send her to Pakistan as he "*felt that she was or would become 'ruined'. She said she did not want to go as she did not like it there and her mum did not want to go either. She was asked about comments from the school in*

relation to marriage but told the officer that her mum wanted her to marry her cousin, but Child F did not want to as she was not religious". Child F did not want her Father to be informed that she had disclosed this information to Police and CSC.

4.46 As a result of the interview an Honour Based Violence (HBV) pack was completed with Child F's consent. This involved taking her finger prints, DNA and a photograph, which would be kept on record. An HBV risk assessment was completed with Child F and a safety plan was put in place. Child F said she felt safe, as she could seek help from her sister, 'A'. The home address however was not 'flagged' by Police.

January 2013 – January 2014

4.47 The final Review Child Protection Conference took place in mid January 2013. There was no representative from the specialist organisation or the CAIU[3] at the meeting. Positive reports were received that 'B' had engaged with the intervention work undertaken by the specialist consultants, contact was taking place three times a week, the family was working with professionals, Keep Safe work had been undertaken with all the children and Child F had grown in confidence and was regularly accessing a focus group, to which she had been referred, at school. It was recognised however, that the parents still did not accept the alleged sexual abuse perpetrated by 'B' against Child F. It was decided that the children should be removed from Child Protection Plans and be subject to Child In Need (CIN) plans, on the basis that "*'B' presents a low risk of sexual abuse to his siblings".*

4.48 Shortly after the conference SW1 was promoted and her last visit to the family was in May 2013. She did however visit the family two days after the Conference and found Child F to be wearing make up with her hair straightened. In addition, the family diet appeared to have reverted to having plenty of sweets and crisps. However, Child F said she was 'okay' about 'B' returning home and SW1 informed her that visits under the CIN Plan would now take place once every four weeks rather than every ten days. The case was due to be allocated to ASW2, and there was a plan in place for 'B' to fully return home by September 2013. A risk management plan and written agreement was in place.

4.49 The specialist organisation involvement with 'B' ceased in March 2013 when they presented a report to CSC concerning their intervention programme with 'B'. The report concluded that: "*We are aware that there is ongoing social work involvement with this case. We would of course highlight that 'B's return to live with his family will be a difficult period of transition for all the family members and will need close scrutiny at least initially, with reviews put in place to evaluate how well 'B' has integrated back into the family home."*

4.50 Due to personal circumstances the case was not allocated to ASW2, but instead was passed to ASW3 (Assistant Social Work). ASW3 made her first CIN visit at the end of May. Child F was noted to be wearing make-up and western dress and said she had no concerns about 'B' returning home. A CIN Review Meeting took place at the beginning of June, which Child F's parents attended, and where positive reports were received from the School Nurse

[3] Police do not send representatives to review conferences normally. If there is an open investigation they would attend. Reports are sent to the chair before each conference of any developments and any actions set are picked up.

and from the school who said she was doing well and had a good set of friends. Arrangements were in place to ensure that 'B' slept downstairs on his return to the family home and would be supervised by his parents.

4.51 ASW3 made an unannounced visit in early July 2013. Whilst she found the younger children appropriately dressed in school uniform, Child F was "*wearing a short leopard print dress and black cardigan with black sheer tights and leopard print shoes. She had very heavy make-up and her hair heavily back combed. It would seem that Mother was embarrassed by Child F's appearance."* Child F was also heard to swear at her mother, but there is no evidence in CSC records that ASW3 spoke to Child F or her mother about her presentation or behaviour.

4.52 The only occasion ASW3 saw 'B' prior to his permanent return to the family home was for fifteen minutes at the end of August. There had been a plan for 'B' to have phased return home, with some overnight stays in June, July and August. 'B' returned home at the beginning of September 2013. Two weeks later, in mid-September, Child F disclosed to staff at School 1 that 'B' had been hitting her and that she '*wanted to go into care for her own safety.'* ASW3 was contacted by the school, and she in turn contacted Police CAIU.

4.53 A Strategy Discussion followed (with Police and CSC) which led to a joint Section 47 investigation, resulting in ASW3 and a representative from CAIU visiting Child F at school. Child F disclosed that 'B' had hit her about the face and grabbed her neck, and had made threats of seeking revenge. CSC agreed that Child F would be removed from home for her own protection and informed the Police and the school that this would happen. It was also agreed that CSC would inform the parents.

4.54 It would seem that Child F was under the impression that she was subject to a Child Protection Plan, category physical abuse. She did not wish to press charges against her brother but wanted to be safe, away from him and did not believe her parents could manage the situation and protect her. Given her unwillingness to press charges, Police were no longer involved in this incident.

4.55 'B' was still subject to a written agreement with CSC that he was not to have unsupervised contact at the family home. Both the School and Police IMRs record that following this discussion a decision was made by CSC that Child F would be placed in foster care. However, this did not happen immediately.

4.56 Following her meeting at school with Police and the ASW, Child F was taken to the CSC offices by ASW 3. The Team Manager (TM1) decided that a medical was required and Child F was taken to the local area hospital by the Duty Social Worker DSW 1. ASW 3 did not accompany Child F. Following a medical examination, which was agreed to by Child F and Mother, no evidence of physical injuries was found. Child F did not want to remove her clothing as part of the medical examination and the doctor examining her, who respected her wishes, was not aware that she had been previously subject to a Child Protection Plan because of sexual abuse.

4.57 Father arrived at the hospital and was dismissive of the incident. However, later that afternoon DSW 1, made a home visit and met with Child F's three younger siblings who all said they had no fear of their older brother. A decision was then taken that Child F would remain at home, as both parents signed an agreement, drawn up by CSC that Mother and Father would refrain

from allowing 'B' into the family home until the local authority had assessed it was safe to do so. They also agreed to ensure that Child F was protected from her brother and that Police would be called if he arrived at the family home.

4.58 'B' was required by CSC to leave the family home and live with paternal grandmother. CSC would monitor the situation to ensure that Child F was safe. Child F remained at home for a further two months before being removed and placed in a foster home. This was despite Child F informing CSC that she felt unsafe as she believed her parents could not protect her from 'B'. Child F also disclosed that she was having difficulties at school as girls were spreading rumours she had been raped and was pregnant.

4.59 In late September 2013, Child F disclosed to a Teaching Assistant that she had had unprotected sex with a 17 year old whilst drunk. Child F was aged 14 at the time and the incident had happened during the summer holidays. This information was passed to the School Nurse, who informed CSC and Police. The School Nurse arranged to see Child F to discuss sexual health screening and pregnancy testing. Child F further disclosed that she had had a sexual relationship when she was 12 years old and the boy had been 14. It is unclear if this was a disclosure that 'B' had sexually abused her.

4.60 The School Nurse was of the opinion that Child F was being sexually exploited as there was concern that a naked photograph of Child F was circulating on the internet and that 'B' was aware that she was being sexually exploited. The School Nurse felt that there had been a change in Child F's behaviour over the summer holidays and that Mother was not protecting her from harm.

4.61 A Strategy Discussion followed this disclosure. There were concerns that Child F was possibly linked to CSE and a decision was taken that Police would undertake a single agency investigation. The case was reviewed by a Specialist Officer who decided that the circumstances did not fit the criteria for CSE. Child F refused to disclose the identity of the 17 year old or the location of the incident and because of this it was decided that the investigation would proceed on a single agency basis by CSC.

4.62 The review has been informed that practice has since changed concerning the investigation of possible cases of CSE. These are now referred to the CSE and Misper[4] Group which meets monthly.

4.63 At the end of September 2013 ASW3 who was still the allocated case worker took Child F to the Sexual Health Clinic to do a pregnancy test. Child F told the nurse at the clinic that she had had sex with three different boys but she had not had anal sex. Her parents were unaware of this information. The nurse discussed with Child F how to protect herself and Child F also had tests for sexually transmitted infections. These were negative, as was the pregnancy test. Child F was still aged 14.

4.64 The case remained allocated to ASW3. In a supervision session with the Assistant Team Manager (ATM2) at the beginning of October 2013, a decision was made that the family should be visited every ten days and the case would become one of Child Protection. It was the view of ASW3 that 'B' was not living at home at that time, but was staying with Paternal

[4] Misper: children and young people who run away or go missing from home or care

Grandmother at the flat and that the young children were not presenting any concerns at school. Child F "*had a good level of resilience with regard to being vocal and not seeming to do anything she does not want to*."

4.65 Within days of this supervision session, School 1 raised concerns about Child F. A meeting took place in mid-October 2013 with the Head of Year at School 1, ASW3 and the School Nurse. The following concerns were noted by the school about Child F and included:

- Her attendance had dropped to 84%
- She had changed from being a quiet girl to one who did not seem to care
- She was attending a behavioural centre weekly
- She had fallen out with a group of friends
- Inappropriate pictures of her had been posted on the internet
- Changes in her dress and appearance
- She was going out to the park after school
- Rumours she was meeting older men
- Worries she was being sexually exploited

4.66 Following this meeting there was a CIN Meeting, which the parents attended. Father stated that he no longer felt he was in charge at home and that Child F was swearing at him and her mother. He intimated that the reason 'B' was upset with Child F was because her behaviour was embarrassing to him. The outcome of the Meeting was for a written agreement to be drawn up with the parents and 'B' to enable him to attend a party at home that day.

4.67 Concerns that Child F was at risk of significant harm led to a review Strategy Discussion towards the end of October 2013. A single agency section 47 investigation was initiated two weeks later. Child F remained at home during this time. Concerns for her safety began to escalate, when in mid-November 2013 Police became aware that threats of rape had been made to Child F by a 17 year old male who had been barred from contacting underage girls. Child F was interviewed by Police and CSC. The information she disclosed in the interview indicated that she was at risk of CSE. Police took her mobile phone and copies of her Facebook pages.

4.68 The following day a referral was made by ATM2 to the fostering team for a placement for Child F. It was noted that Child F "*would need a placement until she was 18 years old because her family did not believe in the lifestyle she had chosen."* No placement was available however, and Father was contacted by ATM2 to request that Child F remain at home.

4.69 Further concerns about her safety at home were raised by Child F when she attended school the following week. Child F disclosed to ASW3 that she had been grabbed and punched by Mother and that 'B' was again sleeping with her in her bedroom. Child F also disclosed that 'B' was frequently hiding in the house when Social Workers visited the family home, when it was stipulated that he should be living at the bed and breakfast accommodation or at the flat with Paternal Grandmother.

4.70 It was not until the beginning of December 2013 that Child F was accommodated under Section 20, the Children Act 1989. The day after she

was placed in foster care, Police informed CSC of information discovered on her mobile phone which indicated that Child F was being sexually abused by her Father.

4.71 An Initial Child Protection Conference (ICPC) was convened at the beginning of December, which resulted in Child F remaining a Child In Need, with her three other siblings made subject to Child Protection Plans, category sexual abuse. The ICPC Chair raised the issue that "*there had been serious concerns for years and professionals needed to consider whether or not there were high levels of disguised compliance exacerbated by cultural issues and the embarrassment of having Social Care involvement*."

4.72 Following the ICPC Child F was re-interviewed by Police in the presence of SW2. She disclosed Father had sexually assaulted her and that 'B' had raped her, when she 12 and 13 years old, and again when he returned to live at home. Father had assaulted her as recently as the week before her removal to foster care. They had stopped calling her by her first name, but referred to her as 'slag' and 'slut'. Her younger brothers were also encouraged to call her these names. It was apparent from Child F's interview that Mother was aware that Child F was being abused, but failed to protect her.

4.73 The day after Child F's interview all three younger children were made subject to Police Protection Orders. Father, Mother and 'B' were subsequently arrested. All three have been charged with criminal offences and are awaiting trial.

4.74 All the children were made subject to interim care orders in late December 2013, and subsequently full care orders have been granted. No contact was allowed with their parents or 'B'.

4.75 It is known that the children have settled well in their foster placements. Their health has improved and they are progressing educationally.

4.76 'B' is living with his parents and is not in education, employment or training.

5. The Child's Experience

5.1 The purpose of this section of the report is to provide some understanding of the day to day environment in which Child F lived from her perspective. Information is taken from the IMRs provided to the review, based on case records and interviews with staff, additional documentation, as well as information which emerged from direct discussion with practitioners at a learning event. The aim is that knowledge will be gained of the impact Child F's disclosure had on her life, the degree of care and protection offered to her whilst she lived home with her parents and the involvement of professionals with the family.

5.2 Little is known of Child F's early childhood experience. At the time the abuse came to light, the family lived in a three bedroom house, which they owned. Given the limitations of the accommodation the sleeping arrangements were difficult and chaotic. Descriptions of where the parents and children slept vary. It seems that until 'A' left home she had her own small room at the top of the house, all the boys slept in one room and Child F, her Mother and younger sister in another bedroom. Father slept downstairs on the sofa, because he often worked late at night. It was known however that at times Child F also shared a bedroom with 'B'. Bedtimes were not set and the

children, but particularly 'B', had access to adult television programmes containing sex and violence. 'B' also had his own laptop, about which he was known to be possessive and secretive.

5.3 All family members were described as being overweight and it was evident once CSC became involved that the family's diet and eating arrangements were not conducive to a healthy lifestyle. Two of the children, 'B' and Child F were known to have cardiac disorders and all the children required dental treatment due to tooth decay.

5.4 'B' and 'C' had a statement of special education need and although Child F had some degree of learning difficulty she attended a local secondary school, where she fully participated in the school curriculum. Child F's attendance was good until the summer and autumn terms of 2013 and she had a group of friends, with one special friend. School was an important part of Child F's life and became even more so after her disclosure that 'B' had sexually abused her. It was apparent that Child F welcomed the opportunity to utilise the facilities of the student support facility and this was especially so after her older sister and confidante moved out of the family home. It was particularly fortunate that Child F was able to disclose her fears at school that Father was taking her to Pakistan in November 2012 and that immediate action was taken.

5.5 A picture has emerged of the different attitude the parents adopted towards the children. The boys received preferential treatment to that of the girls, as illustrated by 'A' being ostracised for forming a relationship with a white British male, Child F being expected to undertake household chores, being required to serve 'B' his food and find his shoes, not being allowed to go to the gym, whilst Father encouraged 'B' to do so. When asked why she had retracted her statement, Child F told professionals that she wanted to '*stop him beating me up.'* She related how this had started when she was in Year 6 of primary school and 11 years old. When asked what this physical violence consisted of, Child F said that 'B' would punch her, pull her hair and swear at her, calling her a 'bitch'. Child F related that she would cry and her Father '*would have a go at him when he got home*.' 'B' had not attacked her younger sister as yet, but Child F was fearful that he would do so. Her Mother was not subjected to this behaviour because she '*always does things for him.'* It was because Child F did not do as 'B' asked, for example get his shoes that she would be subject to abuse. When Child F made her disclosure that 'B' had raped her she said he had offered to give her a mobile phone if '*she did it with him*.' Subsequently, he threatened to put a naked photograph of her on the internet if she did not do as he demanded.

5.6 A picture emerges of 'B' having a degree of omnipotence in the family. He was the eldest son and was born with hydrocephalus, had additional health needs and learning difficulties. To compensate for 'B's health needs his parents had seemingly agreed to whatever he requested. He was a treasured son and described his Father '*as his best friend'*. It is known that 'B' made demands on his sister, and it is apparent that Child F resented having to acquiesce to such demands.

5.7 It is evident that once Child F made her disclosure of rape she came under tremendous pressure from the family, including extended family members, to retract the allegation. It was known that Father took her on a 'long drive' and that Mother, 'A', Paternal Grandmother and an Aunt had all said that she

needed to withdraw what she had said. Given that 'A' had previously supported Child F and encouraged her to tell the school about the physical abuse she was experiencing from 'B', it must have been difficult for Child F to understand why her elder sister was now asking her to withdraw the allegation of rape. What is not known is whether 'A' was under pressure herself from her parents and other members of the family to persuade Child F to withdraw her statement. From a cultural perspective and for their standing in the local Pakistani communities, it may have been preferable for the parents that Child F to retract her statement, for her to remain within the confines of the family home and for the abuse allegation to be discredited. This was especially significant given that it later emerged that Father was also sexually abusing Child F.

5.8 It is recognised that pressure to prevent the disclosure of CSE is a characteristic of sexual abuse in whatever setting, but more especially where interfamilial abuse is concerned. Denial and the need to maintain the secrecy of the abuse on the part of the perpetrator is a common factor in child sexual abuse cases, and has featured significantly in this review

5.9 Child F was re-interviewed in school by a Social Worker and a Police Officer, following the retraction of her statement. She explained that she had been asked to do so by the family and although somewhat confused about what constituted rape, the description Child F gave was consistent with what she had previously disclosed. At that interview in early March 2011 Child F stated that she did not wish to return home. Police were concerned that Child F had been subject to witness intimidation and spoke to Father about this and the consequences of him having done so. Both parents assured Police and CSC that they had not put any pressure on their daughter and that she had lied.

5.10 Having disclosed what was happening and having been seen as responsible for her brother's removal, as well as bringing shame upon the family, Child F was returned home to deal with the consequences of her actions; to be left in the home environment for a further 18 months. Despite having heard Child F's account and knowing that the parents considered she had lied, believing their son not capable of such abuse, CSC decided that she was safe in the care of her parents. CSC and partner agencies became overly reliant on Mother and Father's assurances that they had not pressurised their daughter. Child Protection and Core Group Meeting Minutes show that agencies believed that the parents were prepared to engage with professionals to effect change in the family lifestyle and that Child F was safe to remain in their care.

5.11 From the outset it was evident that this was not the case. For the parents to maintain that Child F had lied about her brother abusing her and that they had not pressurised her was clearly untrue. It was known that the parents were concerned that Child F might be pregnant, having bought a pregnancy test prior to her and Mother's arrest. Subsequently, Father and later Mother spoke to the family GP, seeking advice about Child F, as there were concerns that given her periods had ceased she may be pregnant. As Mother maintained that Child F had not been sexually active, reassurance was given that Child F's menstrual cycle maybe irregular. The GP was unaware at that time of the alleged abuse and the Initial Child Protection Conference had not yet been convened.

5.12 For 'A' to have joined her Mother and Aunt in persuading Child F to withdraw the allegation must have been extremely distressing for her, as 'A' had

previously said she believed her sister. 'A' was someone with whom Child F had shared her concerns and frustrations about 'B'. 'A' had advised Child F to share with the school that 'B' was physically abusing her prior to her disclosure of sexual abuse. When 'A' left home to live with her White British boyfriend, both Mother and Child F were upset and distressed. This was also the case for 'B', but from a perspective that 'A' had brought shame on the family. Child F disclosed when interviewed as part of the specialist risk assessment that "*'B's Asian male friends had used bad language and were abusive to 'A' about her white boyfriend and 'posted something on Facebook' about this…….there had been a recent argument between 'B' and 'A', as he does not like his friends seeing 'A' around and coming to visit him.*"

5.13 Although Father had forbidden any of the family to have contact with 'A', both Mother and Child F continued to do so in secret. There is evidence that SW1 consistently advised Child F to tell her Father that she and was seeing her sister. This was not only unrealistic but possibly dangerous advice. Given that Child F had disclosed that 'B' was abusing her and had then been pressured into denying this had happened, for Child F to then admit she was defying her Father could have put her (and Mother) at serious risk of abuse.

5.14 From the time SW1 became the allocated Social Worker she ensured that Child F and the other children were given the opportunity to see her individually to discuss any concerns they might have. The Core Assessment had identified that in addition to 'Keep Safe' work with the children, issues concerning parenting and home management needed addressing. However, apart from seeing the Social Worker and using the student support facility at school, Child F was essentially left to deal with the situation at home on her own. The referral to the NSPCC specialist therapeutic services was never seemingly progressed on the basis that Child F 'should not be bombarded with professionals'. Once the decision was taken that the children need no longer be subject to Child Protection Plans, Child F was further isolated, as regular contact between her and SW1 ceased from early 2013.

5.15 Once the case was 'stepped down' to one of Child In Need the focus of intervention changed with a change of allocated worker. In May 2013, the case worker became ASW3, an Assistant Social Worker. In interview with the CSC IMR author she explained that when she was allocated the case she understood that all the elements of work and concerns in relation to the abuse of Child F had been dealt with and that her remit was to support the reintroduction of 'B' into the family home. ASW3 did speak with Child F on occasions about her feelings concerning her brother's return home, and Child F '*had always replied positively'*. When asked for her view as to the reason for the changes observed in Child F's appearance and behaviour during the summer of 2013, it is of note that ASW3 replied: "*She had known 'A' and thought Child F was taking after her"* She went on to explain that: "*The concerns from the parents and the school about Child F's changed behaviour were [due] to her going through a difficult stage and because she saw the abuse aspects of the case as having been dealt with she did not question what else might have been going on with Child F*"

5.16 It was during the summer of 2013 that Child F's presentation underwent a radical transformation. From a girl who dressed modestly she began to wear revealing clothes, heavy make up and spoke disrespectfully to her Mother. On her return to school in September her attendance began to deteriorate and she disclosed that she had engaged in unprotected sex whilst drunk. Child F

was 14 at the time. The School Nurse arranged for Child F to access appropriate sexual health advice and expressed her concerns to the school that Child F maybe subject to CSE to CSC. Child F later admitted to the nurse in the sexual health clinic that she had engaged in sexual activity with three different males, but made no disclosure that Father was sexually abusing her.

5.17 Within weeks of 'B's return home at the end of September 2013, however, Child F was able to disclose at school that she was being threatened and physically assaulted by her brother. Child F made it clear to CSC that she did not feel safe at home and requested that she be placed in residential care. Despite the school and Police being given to understand by CSC that Child F would be removed immediately, this did not happen for a further two months.

5.18 Child F was returned to an abusive and threatening situation. Child F informed CSC on several occasions during late September and early October 2013 that she did not feel safe, as she did not believe her parents could adequately protect her from 'B'. This was manifest in the way in which the parents reacted to Child F's disclosure that 'B' had been ill-treating her, and the way in which risk was assessed by CSC. It was known that on Father's arrival at the hospital when Child F underwent a child protection medical he dismissed her account that 'B' had hit her. It was known that SW1 had concerns that the younger children were being coached in what they said. Yet the Duty Social Worker seemingly felt reassured by the three younger siblings saying that they did not fear 'B'. Similarly, the Team Manager considered that 'B's removal from the family home, the parents signing an agreement and CSC monitoring the situation with visits to the family every ten days, offered sufficient protection to Child F.

5.19 It needs to be asked whether the case file was read before reaching such a decision, and why ASW3 the worker allocated to the family did not accompany Child F to the hospital. It is extremely concerning that the lack of an available 'in house' foster placement at the time impacted on the reason to leave Child F in the care of her parents. The plan put forward for protecting Child F at this time was almost identical to that of the previous three years, without the proviso of the children being subject to Child Protection Plans.

5.20 The lack of immediate action on the part of CSC effectively abandoned Child F to deal with a frightening situation where her brother had once again established his position within the home and indicated to Child F that he would seek revenge for what she had done. It was not until early December 2013 when Child F disclosed that Mother had grabbed and punched her and that 'B' was back in the house, sleeping in her bedroom, that CSC removed her. The day after her placement with foster carers, Police discovered through accessing Child F's mobile phone that Father had been giving her alcohol as a prerequisite to sexually abusing his daughter. It is not known when the abuse began, but Child F was eventually able to confirm in a Police interview that both Father and 'B' had raped her. She also disclosed that her parents had colluded with 'B' in allowing him to return home when he should have been living away from the family.

5.21 It is apparent from considering Child F's experience as a child living in her home environment that:

- There was a lack of robust analysis in the Core Assessment of the risks posed to Child F by returning her home after she had made the allegation that 'B' raped her;

- The parents were challenged about pressurising Child F into withdrawing her statement;
- The parents never acknowledged that 'B' had abused Child F, but were not robustly challenged about the basis for this belief;
- The needs of 'B' were put above those of Child F by Father and Mother;
- The parents presented a disguised picture of engagement and compliance with statutory authorities;
- Child F felt frightened and threatened, for example when she told the school about her fears that she may be taken to Pakistan and more importantly when 'B' had returned home, but no action was taken to remove her from her parents care;
- The younger children were under pressure from the parents not to disclose what had happened between 'B' and Child F, nor indeed what day to day family life was like;
- Child F lost not only a sister but also her confidante when 'A' left the family home, leaving her isolated in an abusive situation;
- Mother offered little or no protection to Child F;
- Child F was subjected to verbal, physical and sexual humiliation by 'B' and her parents;
- Issues of culture and diversity may have influenced how Child F was viewed by agencies, for example when it was thought she was 'taking after her sister' and 'choosing a different lifestyle';
- Child F was never availed the opportunity to discuss her experience of inter-familial sexual abuse in a specialist therapeutic setting;
- Child F lived in an atmosphere where she continued to experience abuse and to be blamed for bringing shame and dishonour to the family;
- Child F was a victim of interfamilial abuse.

6. Evaluation of the way in which agencies worked with the family

6.1 This section of the report will analyse the way in which agencies worked together to safeguard Child F and her siblings, in the context of the specific terms of reference. Comment will be made on the help which was offered to the family and its effectiveness in identifying risk to Child F and preventing significant harm. Consideration will be given to understanding why decisions and actions were taken in the context of the events that happened at the time.

The effectiveness of early help services

6.2 It is evident that prior to the arrest of Child F and her Mother there had been no known child protection concerns which required agency involvement with the family. The family had however required input from universal health and education services due to 'B's health needs as a result of a congenital condition and his subsequent learning difficulties that required special education provision.

6.3 'B' and subsequently Child F were identified to have heart murmurs. 'C' was visually impaired, which was later found to be significant when he was placed

with foster carers. All the children, as well as their parents were considered to have some degree of learning difficulty, and like his older brother, 'C' had a statement of special educational needs. Mother had the additional problem of a limited knowledge of English.

6.4 Prior to Child F's disclosure of sexual abuse, there appears to have been no consideration given to the need for early help provision for the family. The completion of a CAF[5] would have assessed the children's needs and may have identified additional services that could have benefited them, however this did not happen. The extent of 'B's health needs and his and 'C''s learning difficulties did not warrant the involvement of the local authority Learning and Disability Team. A referral for 'B' to this team was considered at the Core Group Meeting in January 2012, however no service was offered to the family.

6.5 It was only when the children were made subject to Child Protection Plans in March 2011 that these and further concerns about their general health and well-being became apparent. The Core Assessment undertaken by CSC, following the Section 47 investigation identified that as well as child protection concerns, there were also issues concerning 'B's health needs, the parents and children's learning difficulties and that the three eldest children were significantly overweight, which was linked to their poor diet. Additionally, 'A's weight was found to be related to a medical condition, which caused her significant embarrassment and low self-esteem. 'A' did not however receive appropriate treatment to improve her appearance, for which she had been bullied at school, and as a consequence her confidence, until she was subject to a Child Protection Plan. All the children were also found to have significant dental decay as a result of a diet high in sugar, requiring several of them to have extensive teeth extractions. In addition, Child F required orthodontic intervention.

6.6 It was as a consequence of these concerns about neglect being highlighted at the Initial Child Protection Conference and the subsequent Core Group Meeting in April 2011 that the school nursing service became actively involved in working with 'A', 'B', Child F and their parents to improve the family diet. This was the area of concern identified as the responsibility of the School Nurse in the Child Protection Plan. As a result the School Nurse had meetings with 'A' until she left school and regular sessions with Child F and 'B' to discuss diet and exercise, and to monitor their weight. The services of a dietician, organised by the School Nurse, were utilised by Child F, whilst she was subject to a Child Protection Plan. However, Child F was dependent on her parents to book and take her to appointments, and having attended four sessions, engagement with the dietetic service ceased in August 2012 when she failed to attend the appointment and subsequent requests to re-book were not responded to by the parents. 'B' was only seen once by the dietician and when asked by the School Nurse if he wished to continue with the service displayed ambivalence. It is however evident that the School Nurse took these

[5] Common Assessment Framework - the CAF is a four-step process whereby practitioners can identify a child's or young person's needs early, assess those needs holistically, deliver coordinated services and review progress. The CAF is designed to be used when: a practitioner is worried about how well a child or young person is progressing (e.g. concerns about their health, development, welfare, behaviour, progress in learning or any other aspect of their wellbeing); a child or young person, or their parent/carer, raises a concern with a practitioner; a child's or young person's needs are unclear, or broader than the practitioner's service can address. The process is entirely voluntary and informed consent is mandatory, so families do not have to engage and if they do they can choose what information they want to share. Children and families should not feel stigmatised by the CAF; indeed they can ask for a CAF to be initiated. The CAF process is not a 'referral' process but a 'request for services'. The CAF should be offered to children who have additional needs to those being met by universal services. Unless a child is presenting a need, it is unlikely the CAF will be offered. The practitioner assesses needs using the CAF. The CAF is not a risk assessment. If a child or young person reveals they are at risk, the practitioner should follow the local safeguarding process immediately. HM Gov, DFE

responsibilities seriously and it is commendable that she undertook a joint home visit with ASW1 from the Family Centre in January 2012 to discuss healthy eating and lifestyle with the parents.

6.7 Although it appeared that the parents were taking account of the concerns expressed by professionals about the children's weight, it is evident that there was little real progress in improving the family diet and lifestyle. Both parents attended all Child Protection and Core Group Meetings from March 2011 until the children were made subject to Child In Need plans in January 2013. Father was the main spokesperson and it is evident from records of the Core Group Meetings that he presented a very positive picture of compliance and engagement with the requirements of professionals. However, despite the parent's apparent willingness to engage, as the Berkshire Healthcare Trust IMR Author points out: "*it is unclear if the very poor weight management by the parents was given enough consideration when considering indicators of harm. As the plan progressed it became apparent that the parents did not have the ability to make changes but all the right actions appeared to have been taken."*

6.8 The same comment could also apply to measures taken by CSC to address the inadequacy of the family's sleeping arrangements and lack of boundaries to ensure that the children were protected, including accessing inappropriate adult television programmes and films, which came to light during the Child Protection investigation. The sleeping arrangements were chaotic, with children having no set bedtimes or allocated beds in which to sleep. That the parents considered it appropriate for 'B', aged 15 and his sister, aged 12 to share a room on occasions was either an indication of their lack of intellectual capacity or lack of awareness to recognise the inappropriateness of such an arrangement, which essentially facilitated the rape and physical abuse of Child F. Concerns were addressed by means of SW1 visiting the family every ten days whilst the children were on Child Protection Plans to ensure that appropriate sleeping arrangements were put in place and to monitor the situation that 'B' was not residing at home. SW1 also undertook 'Keep Safe' work with the children. A referral was made to the Family Centre for a parenting skills programme to be instigated for the parents, although work did not start until late November 2011.

6.9 The adequacy of this level of Social Work intervention needs to be questioned, given that it was apparent to SW1 in July 2011 that there were concerns that the children were hiding the fact that 'B' was visiting the family home. Although SW1 was undertaking 'Keep Safe' work with all the children, and 'wishes and feelings' work with Child F, it is not known to the review what this entailed. However it is presumed that the sessions involved work to enable the children to build self-esteem and develop an increased confidence and assertiveness relating to feeling and being safe[6]. Given the environment in which Child F and her younger siblings lived, with pressure from both parents not to disclose what was happening in the family, it is difficult to see how this intervention could have succeeded. There was no early provision made to Child F of specialist independent help to enable her to talk about her feelings about being abused by her brother, or whether she felt safe and secure in the care of her parents. A referral to the NSPCC specialist

[6] Protective Behaviours, Safety Net

counselling service, which was a recommendation of the Core Group in April 2011, was never progressed.

6.10 Given that neither Mother nor Father wished to believe or acknowledge that 'B' had raped his sister, and maintained throughout she was lying, it was especially important that Child F had the opportunity to confide in a professional with expertise in interfamilial sexual abuse. However, Child F was never availed of this opportunity for early intervention. Instead the Core Group considered in May 2011 that '*the school would be able to provide additional support if Child F felt this was needed*. *There is consensus that Child F should not be overtly 'bombarded' with professionals however if the school could monitor her progress and stay aware this would provide [an] opportunity to stay aware of her needs and act on them when necessary*." That Child F did access and utilise this facility, at times on a daily basis, not only showed her willingness to engage, but also needs to be seen as indication of her desire to talk to professionals outside her home environment. Although staff at School 1 showed a high degree of care and vigilance in their involvement with her, Child F should have been offered the facility of an independent, specialist professional counselling service. If this had been provided Child F may have felt sufficiently confident to disclose that she was being abused by her brother and her Father, which could in turn have led to earlier intervention to prevent further significant harm.

6.11 The lack of timeliness in commissioning a specialist risk assessment of 'B' is discussed at 6.34. However, it is of significance that 'B', like his sister was left without access to specialist counselling services and relied on the student support facility at School 2 until the direct involvement of the specialist consultants in February 2012. This was despite a recommendation of the Core Group in May 2011 that 'B' should be referred to the NSPCC for therapeutic specialist work. By this time it was known that 'B' would not face criminal proceedings for the alleged rape of his sister, but he was required to live outside the family home, at least until the outcome of a specialist risk assessment was known. At the time that 'B' was alleged to have first raped Child F he would have been 13 years old, and was aged 15 when the abuse was disclosed. Although an alleged perpetrator, 'B' was also a child who was subject to a Child Protection Plan. There is little evidence that he was afforded the rights of a child. There is no indication that any provision was made during this time to accommodate 'B's particular needs as an alleged perpetrator of sexual abuse, apart from the facility of the student support facility provided by the school, visits from SW1 and discussions with the School Nurse about his diet and weight. All of this took place in the context of a requirement that he had to reside outside the family home.

6.12 Whilst it is now known that 'B' was a frequent visitor home, an arrangement with which his parents colluded, it is an unacceptable, if not an unachievable expectation that such an arrangement could have been maintained for almost two years, without specialist help provision. The lack of early intervention by CSC in seeking a resolution to what was in effect an unworkable Child Protection Plan was not in the best interests of 'B', Child F or any of their siblings.

6.13 The effectiveness, appropriateness and timeliness of assessments undertaken in identifying the needs of and risks posed to Child F

Thames Valley Police Assessment

6.14 When Child F disclosed that she had been sexually abused by 'B' after her arrest on a shoplifting charge, an assessment interview was conducted by Police Constable 1, a member of the Child Abuse Investigation Unit (CAIU) whilst she was still at the Police Station. The allegations were of a serious nature and Police decided that an immediate assessment needed to be made of the situation. This was not an ABE interview. The ABE process and what it entailed was explained to Child F, which she agreed to think about.

6.15 The day of Child F's arrest and disclosure was a Saturday and Police made several telephone calls to the Social Services Emergency Duty Team (EDT) to request that a Social Worker attend the Police Station for Child F to be interviewed that day. Had the arrest occurred within office hours between Monday and Friday, Police Officers would have contacted CSC for a Social Worker to be present whilst Child F was interviewed. A strategy discussion would have taken place and a decision taken as to how a section 47 investigation would proceed. Due to pressure of work, Police were informed that the EDT did not have anyone available to attend the Police Station for Child F to be interviewed that day and the Police IMR states that: "*actions were agreed for the Police officers to continue with the investigation, i.e. for Child F to be interviewed the same day in order to progress the investigation and for 'B' to be arrested."* Despite requests for information from the EDT to enlighten the review as to the working arrangements for that period, no information has been provided.

6.16 The Serious Case Review Panel was informed by the Police representative that the lack of an Appropriate Adult being provided by the EDT is not an uncommon occurrence. It is a continuing resource issue, and is a situation, which Police are increasingly facing. It is not possible to determine that if a Social Worker from the EDT had been provided, to act as an Appropriate Adult, the decision that it was safe for Child F to return home would have been made.

6.17 Child F was not formally interviewed until the following morning, by which time 'B' had spent the previous night in Police custody. 'B' had been arrested at 19.30 hours on the Saturday. As no one was available from the EDT to attend as an Appropriate Adult and given no foster placement could be identified, 'B' remained in the cells overnight. It was on this basis that a decision was made that it was safe for Child F to return home on Saturday with her parents, which she was requesting. The following morning Child F was interviewed by way of a Video Recorded Interview (VRI) with her Father present as an Appropriate Adult.

6.18 Police Officers appropriately rejected the EDT suggestion that an uncle could act as an Appropriate Adult when 'B' was interviewed and insisted that a Social Worker attend. Whether the decision to allow Father to act as an Appropriate Adult in respect of Child F, although not unusual, but may have had any bearing on the outcome of Child F being returned home, has already been referenced in paragraph 6.16. It is accepted that it was good practice that Police recognised 'B's vulnerability, given his learning difficulties and required a Social Worker to attend his interview as an Appropriate Adult. However, little was known about the family circumstance and dynamics. It seems that the decision to allow Child F's Father to act as an Appropriate Adult and to allow her to return home afterwards was based on Father's

presentation as "*eager to cooperate in anyway possible*" and the unavailability of a Social Worker from the EDT (although Children's Social Care had been consulted with). Additionally, having made a 'no comment' interview 'B' was released on bail, on condition that he resided at bed and breakfast accommodation, did not attend the family home and had no contact with Child F or his siblings. It was thus decided that it was safe for Child F to go home.

6.19 The Police IMR states that "*all the children were assessed by CSC; however Police do not have details of these assessments*". A Strategy Discussion did take place between Police and the EDT during Sunday, after the VRI with Child F and her Father; where it was agreed that: Police interview notes would be shared with CSC; a medical would be arranged for Child F and assessment interviews were to be arranged for the other siblings. However, it does not appear that any such assessment of Child F or her siblings occurred, as no reference is made in the CSC IMR to such assessment being undertaken on that day.

6.20 On Sunday evening the EDT Manager contacted the CAIU to express her shock that Child F had been interviewed without a Social Worker being present. The Manager was informed that conversations had been conducted throughout the previous day with a member of the EDT and it had been agreed that in order to progress the investigation expeditiously the interview would proceed. Information concerning the investigation had apparently not been shared between colleagues within the EDT.

6.21 The benefit of hindsight has provided information to the review, which substantiates that Child F and her siblings were at risk of neglect, physical and sexual abuse at this time. It was however also known from Child F's VRI that she had told Mother and 'A', her sister, of the abuse allegedly perpetrated by her older brother. Mother's reaction was to deny that anything had happened. Yet, there was no questioning of Mother's knowledge or involvement in 'covering up' the alleged abuse. Whether this was because Mother could not be questioned without the aid of an interpreter is not known. It was not for Police to explore where or from whom 'B' had learnt about the sexual abuse he allegedly perpetrated. However, the lack of a multi-agency section 47 being initiated to comprehensively assess the situation meant that Child F remained vulnerable to possible continued abuse and family pressure to withdraw her original allegations.

6.22 A second Strategy Meeting took place the next working day after the weekend of Child F's disclosure. Although Police have no record of attending this discussion, CSC records show that two CAIU Officers were present. It was decided that the other children in the family would be interviewed by Police and CSC the following day. No disclosures were made, however comments by one of the children, as recorded in the CSC IMR indicated that Father may have been coaching them to say everything at home was fine.

6.23 By early March 2011 Child F had withdrawn her allegation. However it was evident from her interview at school with the CAIU Officer and Social Worker that she had been placed under a lot of pressure by her family to maintain that 'B' had not raped her. The withdrawal of her allegations followed Child F being taken on 'a long drive' by her Father. Father was spoken to by Police about the consequences of witness intimidation, but the no charges against 'B' were brought by the CPS.

6.24 Police and CSC appropriately decided that a medical examination due to take place that day of Child F should go ahead and that the case met the threshold for a child protection investigation.

CSC Core Assessment

6.25 Following the Initial Child Protection Conference in March 2011 the case was transferred within CSC from the Referral & Assessment Team to the Child In Need Team. A decision was made by the Child In Need Team Manager (TM1) that an in depth assessment was required as "*this family were not known to Social Services previously, the Core Assessment therefore needs to explore each of the six children's individual needs to look at risks within the family, keeping the children safe and ascertain if there are any issues of concern within the family*." The Core Assessment was started in the second week of April 2011 and the minutes of the June Review Child Protection Conference state that it had been completed. It was undertaken by SW1 and ASW2.The assessment was to address the health, education, developmental needs, and family and social relationships of all the children including 'B' who continued to live in bed and breakfast accommodation. Under the parenting capacity section it was recorded that both parents minimised the possible risks within the family and that they refused to consider that there may be a possibility that what Child F had disclosed actually occurred. SW1 recorded that "*As a result they are unable to safeguard Child F and the younger children".* The Core Group Meeting Minutes of May 2011 reflected the concerns of SW1 that family members were not proactive in addressing the issues regarding 'B's return to the family home and did not acknowledge the relevant risks. The Core Group members were all in agreement with these concerns. However, the outcome of the Core Assessment was to conclude that it was safe for the children to remain at home in the care of their parents.

6.26 It is evident that SW1 visited the family regularly to complete the assessment and undertook statutory visits as a requirement of the Child Protection Plan. She spent time speaking with Child F on an individual basis to ascertain her wishes and feelings, and also had discussions to explore the issue of 'B' abusing Child F with the parents and Paternal Grandmother who had arrived to assist in the care of 'B'.

6.27 Child F continued to maintain to SW1 that she had lied about the abuse and said that she and the family wanted 'B' home. Mother, Father and Paternal Grandmother were all in agreement that Child F had invented the allegation, with Grandmother suggesting that "*she had mental health issues even as a child*". Neither parent was prepared to acknowledge that 'B' had abused his sister and 'B' continued to state that he had not done so.

6.28 Throughout her involvement with the family, it is apparent that SW1's concerns that Child F and her siblings were at risk of abuse continued. Such concerns were reflected in the discussions of the Core Group Meetings and in social work supervision sessions. They were further compounded by SW1 having to carry out a Section 47 investigation during the course of the Core Assessment following 'E' (a child subject to a Child Protection Plan) disclosing to her that Mother had hit her and that she 'felt unloved'. This investigation, however, appears to have been perfunctory in the manner it was conducted. The Police were not informed immediately and it was subsequently decided that it should be a single agency investigation by CSC. Mother denied the

allegation. No medical examination was arranged for 'E' and the matter was closed on the basis that it could not be substantiated.

6.29 The CSC IMR author makes the point that Social Work service delivery should include an "*ongoing assessment of need, risks and protective factors."* There was evidence from the examination of CSC case and supervision records that SW1 continued to gather information about the family. There is no evidence however to suggest that the Core Assessment was updated or used as a tool to assess the risk to Child F and the other children, despite the ongoing concerns about the family. This is reinforced by the CSC IMR author referring to a key theme of her examination of case file records being the ongoing *"worries that SW1 had throughout her involvement and indeed, in the interview with the author she stated that she was always worried about the children because they were 'closed off and would not share' and had secrets*."

6.30 Given the above it is difficult to understand the justification for leaving the children in the care of parents, who were known to have pressurised Child F into withdrawing the allegations against 'B', who it was thought had coached the younger children into saying that all was fine at home and who were persistent in their request for 'B' to return home. There had also been the disclosure from 'E' that Mother had hit her.

6.31 Whilst it is recognised that a Social Worker's 'worries' about the safety and well being of children subject to Child Protection Plans are not sufficient to justify seeking to remove them from the care of their parents; there is no evidence to suggest that the case was discussed with Legal Services to decide whether there was sufficient evidence to meet the threshold for a Public Law Outline or Care Proceedings. Nor is there any indication that the case was reviewed holistically to ensure that all areas of concern were assessed appropriately.

6.32 The review has been informed that the analysis and the risk assessment sections of the Core Assessment were not completed. The original justification for a Core Assessment, given by the Child In Need Team Manager, was that an in depth assessment was needed as the family was not known to CSC and an exploration of the risks to 'each of the children to ensure that they were kept safe' was required. On this basis it cannot be concluded that the Core Assessment appropriately or effectively identified and analysed the degree of risk to the children. Nor was it timely, given that it was not completed within the 35 working day timeframe as then required under Working Together, 2010.

Specialist Risk Assessment of 'B'

6.33 The initial referral for a specialist risk assessment of 'B' was made by CSC to a specialist organisation. At that time community assessments were subcontracted to an independent consultancy company, who contributed an IMR to this review, were the two consultants who owned the consultancy company and who undertook the specialist assessment of 'B'. Both consultants are now employed by the specialist organisation.

6.34 From the information provided to this review it has not been possible to ascertain who in CSC, how or under what terms the services of the specialist organisation were commissioned. The Initial Child Protection Case Conference minutes of March 2011 document that "*a specialist assessment of 'B' will be considered focussing on sibling abuse and make recommendations*

for further work to reduce the risk". It is evident from this statement and the unanimous decision for all six children to be made subject to Child Protection Plans that the Case Conference decided early on that despite Child F's withdrawal of the allegations against 'B' he was considered to be at risk, as well as presenting a risk to his siblings.

6.35 It was SW1 who was tasked with contacting the specialist organisation to request that they undertake the assessment. There was initial telephone contact, followed by email correspondence between SW1 and the specialist consultants at the beginning of August 2011. The consultant set out the issues and areas of work the assessment of 'B' would seek to address. At that time funding had not been agreed, although the specialist organisation had provided costings for the work to SW1.

6.36 The consultants state in their IMR that prior to undertaking work with a young person it was their "*usual protocol to establish a professionals meeting in order to include as many other professionals involved in the case.*" This meeting did not take place and it was not until the middle of February 2012 that SW1 made further contact with the consultants to confirm that CSC wished the specialist assessment to proceed. CSC was informed that it would take approximately 6-8 weeks for a report to be completed and at the end of February 2012 it was confirmed that funding had been agreed.

6.37 Throughout the eleven months it took to organise the specialist assessment members of the Child Protection Conference and Core Group were kept informed by the Social Worker of its lack of progress. Minutes of these Meetings show that the commissioning of the assessment was a standing action from March 2011 until February 2012. There was however no challenge from the Chair of the Child Protection Conference or members of the Conference and the Core Group about the delay, until the January 2012 Core Group Meeting which questioned why the assessment had still not commenced and no date known as to when it would commence.

6.38 The reasons for this long delay were explained as being due to difficulties in securing funding. During this period 'B' was required to live away from his family, Child F had been pressured into withdrawing her allegations, the parents continued to disbelieve that Child F had been abused by 'B', older sister 'A' had left home and the younger siblings were considered to be at risk of harm. Despite there being recommendations from Child Protection Conferences and Core Group Meetings that both Child F and 'B' should receive specialist therapeutic counselling from the NSPCC, neither referral was progressed. Thus, for almost twelve months the children and their parents were left waiting for the assessment to commence. Yet, it could be said that the outcome was already known before it started, given the ICPC recommended that a specialist assessment of 'B' would focus on sibling abuse and *"make recommendations for further work to reduce the risk*".

6.39 The lack of challenge about this delay by any of the professionals involved in multi-agency meetings or by those responsible in CSC for managing the case raises serious concerns. It would appear that little or nothing happened to progress the initial referral for a specialist risk assessment. By the time it was finally commenced it was known that 'B' was making unauthorised visits home, with Child F remaining at risk of harm from him, with a lack of protection from her parents. The Social Worker consistently voiced concerns about the children to her Line Manager and to the Core Group, and yet in

January 2012 she informed her Supervisor that the situation was being risk managed and that the family was seen to be working with CSC.

6.40 The delay in commissioning the risk assessment also had a profound impact on the findings of the assessment itself as the consultants based their findings on the current circumstances and consideration of the six month period prior to the commencement of the assessment. By that stage 'B' had been required to live outside the family home for over a year. The consultants acknowledge that "*as such it is difficult to assess whether he would revert to his old behaviour if he returned home.*"

6.41 The consultants had originally anticipated that it would take 6–8 weeks to produce their report. In the event, the assessment which started in early March, took well over four months to complete, with the specialist consultant presenting a forensic report to the Social Worker in July 2012.

6.42 It is recognised that the assessment was not straight forward. It needed to take account of 'B's learning difficulties, the requirement for him to live outside the family home, the family's Pakistani heritage and Mother's limited command of English, thus necessitating the use of an interpreter. The importance of interviewing the parents and Child F was also recognised as part of the assessment process. The specialist consultants had however assured CSC that they were experienced in dealing with this level of complexity in their assessment of young people involved in sexual abusive behaviours.

6.43 Early on in the assessment process both consultants formed the view that despite Child F's retraction of the allegation of rape against her brother, "*'B' had been responsible for sexually abusing his sister Child F in the way she described it in her initial disclosure. In our opinion it was family pressures, as has been suggested elsewhere that have prompted Child F to say that she had lied about what had happened*." The specialist consultants make the point in their IMR that "*whilst the risk assessment was not concerned about establishing guilt, it was important when discussing risk and safeguarding to work under this assumption*." Given these assertions and what was known of the parent's refusal to recognise that 'B' had abused his sister, for a specialist risk assessment to take four months to complete was an unacceptable delay and led to an increased degree of risk to Child F.

6.44 Prior to undertaking the psychometric aspect of the forensic assessment the specialist consultant assessed 'B's reading age and his level of comprehension. The outcome of these tests indicated that despite 'B's significant learning difficulties with language delay, he was able to undertake the battery of psychometric tests that formed part of the assessment process. During the four month period of the assessment, whilst there some areas of strength, it emerged that 'B' had views and beliefs which raised significant concerns. These related to his desire to present himself in an overly positive light resulting in 'fake good' scores, to which little credibility could be given to the results.

6.45 There were also concerns from results related to how 'B' dealt with anger, which indicated that he was overly defensive with a desire to mask rather than represent a true reflection of his anger levels. Other findings indicated that he felt more emotionally lonely than was average for his age and that he may have had particular difficulties in coping with his own emotional distress and that of others. Further, 'B' was shown to deny 'sex drives and interest' for a

young person of his age, and again it was concluded that credibility could not be afforded to these results.

6.46 The assessment concluded that because of 'B's position as the eldest male child of Pakistani heritage, and because of his health needs and learning disability, it was possible that he "*has been able to get away with being disciplined for aggressive behaviour and it has been excused due to his health issues….Mother commented that she would ensure that her son would not have to wait for things, which suggests that she would appease him. This alongside his position within the family may have given him a sense of power over his young siblings. He expressed a strong belief in the need to 'respect your elders' however; according to Child F this manifested itself in ordering her around and expecting her to do things for him. If she did not do as she was told then he would become aggressive and verbally abusive."*

6.47 The assessment goes on to stress that 'B' perceived that Child F lacked respect for him, which in the view of the consultants, would have led to resentment and anger on his part. Most significantly the assessment noted that because of the overcrowding and sleeping arrangements in the house, 'B' was provided with the opportunity '*to act out his aggressive feelings on his sister through anally raping her……Through his actions 'B' may well have felt that he had re-established a sense of power over his younger sister and along with sexual gratification this motivated him to repeat his abusive actions.'* Furthermore the assessment identified a significant concern about 'B's belief that it is wrong to 'grass.' This was likely to impact on how he felt about his sister and how he responded to her, given the allegations she made against him and the consequent impact this had on his life.

6.48 Given the above, coupled with the knowledge that 'B' did not acknowledge his guilt nor did the parents believe Child F's allegation, it is difficult to understand the conclusion the risk assessment reached that 'B' was within the low level range of risk of further sexually harmful behaviour. This level of risk was based on an assessment of the circumstances at the time the specialist risk assessment was undertaken. Reference was seemingly only made to 'B's previous six month history when seeking to establish the presence or absence of risk factors. The assessment acknowledged however that during this time 'B' was living away from his siblings and outside the family home context and "*as such it was difficult to assess whether he would revert to old behaviours if returned to the family context."* Yet, the consultants informed the social worker of their concern that 'B' was not staying full time at the flat (when undertaking additional work with him) and could find little signs of permanent occupancy. The Social Worker had also voiced her own suspicions that 'B' was spending increasing amounts of time at the family home.

6.49 The consultants had, however, been informed by the Social Worker that the parents had cooperated with the requirements of the Child Protection Plan and had engaged with the parenting programme provided by the Family Centre. They therefore concluded that social work intervention had proved effective in that the parents had implemented changes to the structure and boundaries in the household and had also curtailed the children's access to inappropriate and violent media. Further, Child F was assessed to be more confident and as a result would be more willing to share concerns with professionals. Yet the assessment also commented that the parent's behaviour had clearly demonstrated a preference for believing their son over

their daughter. Thus, the continuance of 'keep safe' work with all 'B's younger siblings was deemed to be vital if they were to be protected from harm.

6.50 The assessment made a further recommendation that despite 'B' being assessed as posing a low risk of sexually harming his sibling/s it was important that a comprehensive sex and education programme of work was required and that further exploration of 'B's attitude towards females should be considered. It was also recommended that a programme of Cognitive Behaviour Therapy (CBT) would be beneficial to 'B' to work on his emotional expression and on coping strategies to manage strong emotions.

6.51 It was considered essential for a risk management plan to be developed involving social work intervention over a prolonged transition period, which would need to be reviewed regularly with feedback from all family members.

6.52 Whilst maintaining confidentiality professional advice[7] has been sought to inform this review concerning the methodology used by the specialist consultants in assessing the level of risk posed by 'B'. Advice provided to the Overview Author suggests that an assessment was required which took account of all aspects of information known about 'B' and his family, over a period longer that the previous six months. The Author's own experience of dealing with specialist assessments[8] would support this view. Any assessment of risk of sexually harmful behaviour needs to be holistic, taking account of all factors associated with the young person being assessed.

6.53 The specialist risk assessment undertaken by the specialist consultants not only highlighted significant concerns about 'B's views and beliefs concerning females, anger and emotions, it also raised serious concerns about the ability and willingness of the parents to protect Child F and the other siblings. It therefore seems contradictory to suggest that 'B' posed a low risk. However the authors of the assessment then set out a series of recommendations for a detailed programme of sex education and relationship intervention. The assessment that 'B' could only be considered as low risk if a risk management plan, with social work involvement over a prolonged period was in place, and only if he had first completed the education programme, does not translate into a workable outcome for 'B', Child F or his siblings.

6.54 It is accepted that a specialist risk assessment of 'B' was appropriate and informative to the Child Protection process. It is also recognised that it was necessary for this to be undertaken by specialist consultants with experience of working with children and young people with additional needs, as in 'B's case. The CSC IMR suggests that this could have been achieved using an AIMS[9] assessment undertaken by the Youth Offending Team. The Overview Author disagrees with this observation as an AIMS assessment is generally considered unsuitable for children with learning disabilities.

6.55 Whether an appropriate commissioning process was undertaken in March 2011 when it was decided to approach the specialist consultants to do the assessment is not known to this review. What happened in the fifteen/sixteen months before the assessment was completed in July 2012 was that professionals involved with the family and especially those engaged in the

[7] Former Independent Safeguarding Authority non-executive board members expert in undertaking specialist risk assessments.
[8] Non-executive board member of the Independent Safeguarding Authority, 2008 - 2012
[9] The Assessment, Intervention and Moving (AIM) Framework for the assessment of needs of young people, aged between 10 and 17 years, who display sexually harmful behaviour.

child protection process became overly intent on: firstly commissioning an assessment, even though it took an extraordinary length of time to do so, without challenging the delay; and secondly accepting the outcome of the assessment without questioning the findings.

6.56 Given the known risk of the parents supporting their son over their daughter and their denial of any sexual abuse on the part of 'B', it could be argued that an expert assessment of their ability to protect Child F and the younger children would have been more informative and beneficial to the child protection process. In the event there was a reliance on the parenting skills programme delivered by an Assistant Social Worker from the local family centre. It is regrettable that although further information has been requested from the family centre to clarify the aims and objectives of their work with the family, no information has been provided to the review.

6.57 Although the specialist risk assessment report was presented to the social worker prior to the Review Child Protection Conference in July 2012, due to short notice no one from the specialist consultants could attend the conference. Thus, the importance of having a risk management plan involving continued social work intervention was not highlighted. The Conference focussed on the assessment of 'B being a low risk and agreed that further work in the form of the comprehensive programme of education as suggested by the specialist consultants be implemented.

6.58 Although the specialist consultants were subsequently commissioned to undertake this programme with 'B, because neither were able to attend the Review Conference in January 2013, and because the minutes of the conference were not read by either of them, the risk management plan as the specialist consultants envisaged was never implemented. As a result once the education programme was completed the case was 'stepped down' to Child in Need and 'B' subsequently returned home. Due to promotion SW1 was no longer the social worker and in the event ASW3, Assistant Social Worker, was allocated the case.

6.59 At the very time when the children, especially Child F, were most at risk the family was assessed as having engaged with CSC and positive change having been achieved, a conclusion which was deeply flawed. This, together with an over reliance on the outcome of the specialist risk assessment by those professionals involved in the child protection process, was to lead to Child F being left at risk of further significant harm.

Diversity issues and whether these affected the way in which agencies worked together

6.60 Child F was the second eldest daughter of six children of Pakistani heritage, all of whom had been born in the UK. Until the episode of her arrest with Mother for shoplifting the family were unknown to statutory child protection agencies.

6.61 School 1, attended by Child F, had a diverse school population with over 25% of ethnic minority pupils and as a result staff were well informed on issues of diversity. Whilst subject to a Child Protection Plan the school carefully monitored Child F and reported no concerns in 2011 through to 2012. Child F attended school regularly, showed good/excellent effort in her grades and was making reasonable progress. She appeared happy and mixed well with her peers. Although Child F was not subject to a statement of special education

needs the school was aware of the support she needed to achieve her potential.

6.62 In November 2012 Child F reported to staff at the student support facility that her Father was trying to obtain a visa for the family to go to Pakistan and she was worried that she would be taken there to be married or left there with no passport. The School acted immediately and appropriately in informing Police and CSC, which resulted in measures being put in place to protect Child F from leaving the UK. This was good practice and reflected the school's awareness of Child F's vulnerability to the possibility of forced marriage or forced removal from the UK. When Child F expressed similar concerns for a second time in October 2013, again staff acted promptly in informing the appropriate authorities.

6.63 Child F was able to utilise the School Nurse to disclose her unhappiness and fears about her Father's hostility to her having contact with her older sister 'A', who by August 2011 had left home to live with her white British boyfriend. This information was passed on to the Social Worker. When further concerns about Child F's sexual behaviour and her disclosure that 'B' was being violent towards her began to emerge in late September 2013, School staff and the School Nurse immediately informed CSC. The School and the School Nurse were conscious that Child F's behaviour, appearance, attendance and educational achievement had deteriorated during the autumn term of 2013. They were not aware of the dramatic change in Child F's appearance which had been observed by ASW3 during the summer holidays of that year. However, the School Nurse did immediately report her concerns that Child F may be subject to Child Sexual Exploitation, after she had disclosed sexual activity with several older males.

6.64 The actions of School 1 staff displayed a good awareness of the pressures Child F was experiencing as a child in a Muslim family who had disclosed interfamilial sexual abuse, of her isolation following 'A' leaving the family home, of her feared possible removal to Pakistan and of the possibility of her being sexually exploited.

6.65 Other professionals involved with Child F and the family were conscious of diversity issues and their possible impact on the protection of Child F. It is evident that professionals who attended Child Protection Conferences and Core Group Meetings experienced first hand the leading role that Father played in the family. Although the same interpreter was always in attendance for Mother, in the main it was Father who spoke on behalf of his wife. It was apparent that Mother was aware before Child F's disclosure to Police that 'B' was sexually abusing her daughter, as a pregnancy test had been bought because Child F had not had a period for some time. She was just 12 years old at the time. However, it was Father who in the main liaised with the GP surgery and was in attendance at the children's medical appointments.

6.66 SW1 knew that the girls in the family were treated differently to the boys as evidence by information provided by 'B' during the specialist risk assessment and by Father deciding that it was appropriate for the boys to go to gym sessions at the leisure centre, but not the girls. SW1 was also told by 'A' that the family were putting up a pretence by going to the Mosque and praying, which she maintained that they did not do before CSC became involved. 'A' told the Social Worker that she 'felt victimised and isolated'. There is no

evidence that this was further explored with 'A', nor is there any indication that 'A' was asked whether she had experienced sexual abuse.

6.67 When 'A' moved away from home in August 2011, the family was subject to threats of violence from 'B's Asian friends and extended family members. Child F voiced her anxiety to the Social Worker about being at home alone in the house, but there appears to have been no further exploration or action taken because of these concerns.

6.68 The CSC IMR points out that SW1 was 'mindful of the cultural aspects' of the case and makes specific reference to a file entry which noted: "*'B' is an Asian male and the oldest of his siblings – I am a white woman who is asking uncomfortable questions."* Although ASW2 who was involved in the Core Assessment with SW1 was Asian, there is no indication that consideration was given to the possibility of co-working the case with an Asian male colleague to explore family dynamics and the implications of interfamilial abuse within Muslim communities.

6.69 Although SW1 stated in her interview with the CSC IMR author that the younger children were happy to engage in 'Keep Safe' work, she admitted disquiet that 'the children were always somewhat closed'. Whether this was due to their cultural upbringing or having been coached by their parents not to disclose too much information to CSC is open to question. It was known however that once the children were placed in foster care they disclosed information about ill treatment, neglect and 'B' hiding in the house when the Social Worker visited.

6.70 ATM1 commented, when asked about the work CSC undertook with the family that they had been friendly, welcoming and compliant but not overly compliant. "*She said that Children's Services had been respectful of the culture and asked a reflective question about the degree Social Work staff had let it get in the way*".

6.71 An important consideration of this case is that Child F disclosed that 'B' was anally raping her. The reasons why he was abusing his sister in this way are not known. Neither is it known from which source 'B' learnt this form of sexual activity. At the learning event the Named GP and a representative from the GP practice, both of whom are of the same cultural heritage as the family, commented that rape of this type is not only totally unacceptable but is also unusual in their experience, whatever the culture of the patient.

6.72 The Learning Event enabled professionals to explore issues of culture, family dynamics and the abuse of children in an environment which encouraged open discussion, which is not always possible in the context of day to day case management.

6.73 It is known that Child F's appearance dramatically changed in the summer of 2013 from being that of a child in traditional dress to one of wearing tight, short clothing and heavy make-up. The situation was to change further after 'B' moved back into the home in September 2013. Child F subsequently disclosed when in foster care that at this time she was not referred to by her first name by her brother or parents, but called 'slut' and 'slag'. It is now known that Father had also been sexually abusing her.

6.74 It is extremely concerning to this review that a referral made in November 2013 by ATM2 (but not immediately processed due to a lack of placement) stated that a foster placement for Child F would be needed until she was 18

years old "*because her family did not believe in the lifestyle she had chosen.*" This is either an indication that ATM2 was not fully conversant with the details of the case or a distinct lack of awareness of the indicators of child sexual abuse and child sexual exploitation. References by professionals to children making conscious lifestyle choices whilst experiencing sexual abuse and exploitation has been a criticism of recent serious case reviews concerning the organised sexual exploitation of children. It is a criticism relevant to this review and is an indication of a lack of empathy and concern for a child who had suffered years of significant harm from her brother and as we now know her Father, with no protection being offered from her mother.

6.75 Those undertaking the specialist risk assessment of 'B' make clear the need for awareness and importance of the family's cultural diversity. Reference is made in their IMR to the necessity for due consideration to paid to issues of communication when English is not the first language and the use of interpreters, which is particularly important with sexual offences since "*sexual matters are taboo with Asian communities*. *Vocabulary is important as is an understanding of the role of culture and religion as being a central feature of family life….sex as a subject is never discussed and sexual offending would bring shame ('sharam') upon the whole family. The family honour ('izzat') is destroyed and the family standing is reduced both within the extended family and the wider community leading to the possibility of isolation and being ostracised from their community*". The IMR questions whether these considerations were fully considered by CSC when undertaking their assessment of this family. The consultants suggest that they were not and together with the differing levels of learning difficulties understood to be present within the family '*could be identified as a significant impediment to effective working'*. This is a finding with which the Overview Author concurs.

6.76 The issue of whether all members of the family had learning difficulties has already been referenced in this report. However, no formal assessment was made of the parents and a referral to the Learning and Disability Team in respect of 'B' did not result in any intervention. Thus, the full extent of the learning difficulty of the younger children and 'C's disability was not fully assessed until they were removed from their parents. Once the children were placed in foster care it became evident that they were significantly delayed at school and that 'C' had a serious visual impairment, which had not received appropriate attention whilst he was at home.

6.77 That Police took account of 'B's learning needs is apparent in their action to ensure that an Appropriate Adult was in attendance when he was interviewed following Child F's allegations. The lack of resources in the EDT resulting in no Social Worker being able to attend the interview with Child F and Father acting as an Appropriate Adult have already been explored. However, given the cultural heritage of the family and the implications of interfamilial abuse in Asian families, as previously referenced, this was an important decision early on in period under review. Whilst Father was not present in the interviewing room, his attendance as an Appropriate Adult may have enabled him to subsequently pressurise his daughter into withdrawing the allegations and maintain that she lied.

How did family members cooperate with agencies working to safeguard Child F's welfare?

6.78 From the time of Child F's initial arrest for a shoplifting offence Father expressed his willingness to cooperate with Police. Mother was known to require the services of an interpreter and because of his command of English it was Father who was the single point of contact for agencies. Following 'B's arrest and detention overnight in Police custody, an assessment was made that it was safe for Child F to return home, which she was also requesting. As no Social Worker was available from the EDT Police decided that Father could act as an Appropriate Adult for Child F during her ABE interview. This was presumably on the basis that Father came across as being concerned about his daughter and willing to fully cooperate with Police. During the course of the interview however it is of note that Father told Child F that she should have told him about the situation and he *'would have sorted it'*.

6.79 It was apparent that within days of the interview and with a 'No Comment' interview from 'B' resulting in his release on Police bail, Father was putting pressure on Child F to withdraw her statement. Whilst maintaining a façade of cooperation Father and in turn Mother were exerting demands on their daughter to say that she had lied in order to facilitate 'B's return to the family home. Police were aware of Father's influence and warned him that in no way should he be pressuring Child F.

6.80 Whilst 'B' was on bail the parents cooperated with CSC and Police in ensuring that Bed and Breakfast accommodation was found for 'B' and Father initially stayed with him and both Mother and Father attended the Initial Child Protection Conference and Core Group Meetings. The parents accepted that a Social Worker would be allocated given the children were subject to Child Protection Plans and expressed their willingness to address CSC concerns about the chaotic sleeping arrangements for the children. They also engaged with the need to improve theirs and their children's lifestyle and diet.

6.81 When in April 2011 the CPS decided not to proceed with the prosecution of 'B', the parents assumed that he would now be able to return home. Throughout the criminal and child protection investigation they had strongly maintained that 'B' had not assaulted his sister and that she was lying. Thus, when CSC did not agree for 'B' to go home until a specialist risk assessment had been completed; it required the parents to remain engaged with CSC for a prolonged period of time. This proved to be frustrating for Mother, Father and 'B' as the commissioning of the assessment took almost a year and the assessment itself four months to complete. Even after the forensic report had been delivered with a finding that 'B' presented as 'low risk' he still could not return until the completion of a comprehensive programme of education carried out by the specialist organisation.

6.82 Given the cultural implications of having Police and Social Workers involved with the family, as well as language communication problems and possible learning difficulties, it is not surprising that the parents expressed negativity about the process for getting their son home and the length of time it was taking. Throughout however they continued to maintain a degree of engagement with agencies. The allocated Social Worker made announced and unannounced visits to the home, met regularly with Child F and the younger children to undertake 'Keep Safe' work and the parents continued to engage with Child Protection and Core Group Meetings. Paternal

Grandmother arrived from Pakistan to assist with the care arrangements for 'B' and also made her views known about Child F's credibility to the Social Worker. Family Group Conferences were attended, including by extended family members and the worker from the Children's Centre undertook a parenting programme with the parents. All the children's school attendance was in the main satisfactory and Father was in regular contact with the schools. Once the specialist assessment was underway the parents agreed to be interviewed as part of the process. Medical appointments for 'B', Child F and 'C' were in the main kept and it appeared that all the family was willing to lose weight and have a healthy lifestyle.

6.83 It could be presumed from the above that the parents cooperated fully with the agencies to safeguard Child F's welfare. On closer examination however it is apparent that such compliance was superficial. If outcomes for the children had been consistently and holistically reviewed it would have become apparent that little real change had been effected. The biggest hurdle for professionals to overcome if Child F was to be protected was to be confident that her parents were protecting her. This involved them acknowledging that she was telling the truth and that 'B' had sexually assaulted his sister. This never happened and if anything suggests that the parents were possibly seeking to remove the problem, i.e. by suggesting that Child F (and 'B') might be taken to Pakistan. SW1 has admitted that she was worried about the children throughout her involvement with the case. She also had evidence that 'B' was in the family home when he should not have been. Despite these concerns once the specialist risk assessment was concluded and the follow up programme of work with 'B' completed, it was the unanimous decision of the Review Child Protection Case Conference that the children should be removed from Child Protection Plans because the risk of sexual abuse had been reduced. However, the Conference Minutes state that: "*The parents still do not accept that 'B' may have been sexually abusive to Child F. Equally, 'B' does not acknowledge that there is concern about his past behaviour*."

6.84 In January 2013 the parents agreed to a 'risk management plan' being put in place in preparation for 'B's permanent return home, which required them to demonstrate that they were '*able to manage the plan for the long term to protect the children from any sexual abuse*'. The case then became one of Child In Need, SW1was no longer the allocated Social Worker and the implementation and monitoring of the risk management plan was left to an Assistant Social Worker. This change happened at the most critical and what was to prove dangerous time for Child F, as is evidenced by the events which followed 'B's return home.

Appropriate Information Sharing

6.85 Apart from the lack of Police information being shared between members of the EDT at time of Child F's disclosure, information was in the main appropriately shared within and between agencies. However, the GP report for the Review Child Protection Conference in May 2012 was considered by the School Nurse to be illegible and the GP was asked to resubmit the report after the Conference. The GP was unable to attend any of the Child Protection Conferences.

6.86 Attendance at Child Protection Conferences and Core Group Meetings was generally good and those agencies that could not attend received minutes of the meetings. The School Nurse consistently updated the GP surgery about

the sexual abuse and possible sexual exploitation of Child F. Information from CSC records was made available to the consultants before they commenced their risk assessment, but a professionals meeting to share information prior to starting the assessment, which was part of the specialist organisation protocol, was not convened.

6.87 Information concerning 'B' visiting the family home when he was not allowed to was passed on by the consultants to SW1, as were their suspicions that 'B' was not residing at the flat.

6.88 School 2, attended by 'B', attended Case Conferences and shared and received information concerning 'B's progress. School 1 was exemplary in passing on their concerns to Police and CSC and in monitoring Child F whilst at school.

Policies and Procedures

6.89 All agencies, with the exception of the consultants who undertook the specialist risk assessment had appropriate Child Protection policies and procedures in place.

6.90 Issues concerning following appropriate procedures when Child F first made her disclosure of being sexually abused have already been referenced in this review.

6.91 The Primary Care IMR author makes the point that best medical practice requires adequate documentation of sexual health assessment for children and young adults. When the School Nurse contacted the surgery to inform the GP that Child F had disclosed that she had unprotected sexual intercourse, best practice required that the GP contacted CSC to discuss this further. However, there is no documentation in the medical or CSC records to suggest that this occurred.

Management and Supervision

6.92 Children's Social Care was the lead agency for managing this case. It is evident from reviewing the information available that the EDT Service Manager was involved when Child F made her initial disclosure and questioned the decision by Police to interview her without a Social Worker being in attendance. This, and the decision to agree funding of the specialist risk assessment, was the only point at which a Service Manager was involved in the case during the period under review.

6.93 The case was initially dealt with by the Referral & Assessment Team before being transferred to SW1, Child In Need Team following the Initial Child Protection Conference (ICPC) at the end of March 2011. There is no evidence on file of supervision records during the transition period from the Referral & Assessment Team to the Child In Need Team. SW1 was to remain the allocated Social Worker for the family, including 'B', until May 2013. She was tasked with undertaking the Core Assessment and was assisted in this by ASW2.

6.94 SW1 received regular monthly supervision until September 2011 from ATM1 when a decision was made that TM3 would take over the supervision of senior workers in the team.

6.95 It is of concern that apart from SW1 being assisted in the Core Assessment by an ASW, Managers considered it appropriate for the case to be allocated

to a single Social Worker. This was a complex case concerning a large sibling group, which involved issues of cultural diversity, learning difficulties, inter-familial abuse, child on child abuse and neglect. SW1 was responsible not only for all six children on Child Protection Plans, she was also required to supervise and work with an alleged perpetrator who was angry at being removed from the family home. In addition, SW1 was also responsible for obtaining funding for the specialist risk assessment, with seemingly little support from line management.

6.96 A review by those supervising this case could have led to a re-assessment of whether it should have been co-worked, with allocated individual Social Workers for Child F and 'B'. The expectation that a lone female Social Worker could manage the demands of this case was over optimistic and misjudged.

6.97 It had been a decision of the ICPC that a specialist risk assessment of 'B' needed to be considered '*focussing on sibling abuse and recommendations to reduce risk.*' At her supervision session with ATM1 in mid April 2011, SW1 was tasked with setting out the reasons why a specialist assessment was needed. The next supervision session took place four weeks later and reference was made to a referral being made to the Youth Offending Team (YOT) for an AIMS assessment or to another specialist assessor.

6.98 During this time SW1 had been undertaking the Core Assessment and 'B' had been staying in Bed & Breakfast accommodation, which the Local Authority was funding. The Core Assessment had been expected to be completed in early June 2011. This did not happen until the end of June, but as referenced at 6.33 without the analysis or the risk assessment sections being completed. This was not challenged by ATM1 or the Review Child Protection Conference. It was at the supervision session at the end of June that the first reference to a referral being made to the specialist organisation is evidenced. It is not known on what basis the specialist organisation was chosen as the most appropriate provider, what the Terms of Reference for the specialist organisation engagement were or whether a referral to the YOT for an AIMS assessment was made.

6.99 Supervision records indicate that from the end of June 2011 until February 2012 when funding was confirmed to undertake the specialist assessment, this issue was a regular feature of supervision discussions. However, there appears to have been no urgency to expedite the assessment and no escalation or questioning of senior management for a decision to be made about funding the work. At that time, the decision to agree funding remained with the Head of Service, a situation which led to severe delay in the assessment of 'B' and left Child F at continued risk. Arrangements for funding assessments have changed, as previously referenced in this report. Once the specialist organisation was commissioned there was a similar lack of urgency in questioning why it took the consultants four months to produce their report. From September 2011 onwards management of the case had passed to the Child In Need Team Manager, yet no challenge was made as to why the assessment was taking so long to arrange and then to complete.

6.100 During a period of eighteen months 'B' had moved from Bed & Breakfast accommodation into a rented flat with Paternal Grandmother. He was only allowed supervised contact with his family and his only access to any form of counselling support was via the student support facility at School 2. He was described as being lonely and was frustrated at being excluded from his

family. A referral to the NSPCC specialist therapeutic service regularly featured at supervision discussions but no progress appears to have been made in implementing this action, which was part of 'B's Child Protection Plan. Whist it is clear that SW1 did take her responsibilities seriously as the allocated Social Worker for the family, (e.g. by visiting regularly, chairing Core Group Meetings, undertaking Keep Safe work and arranging for a parenting programme to be initiated) there is little evidence of any real progress being made in the case. Further, the essential issue of the risk presented to Child F by her remaining in the care of her parents and their ability and willingness to protect her, given that they stated she had lied about the abuse, was still outstanding.

6.101 It could be said that because 'B', the main perpetrator, was living away from the family home and because the parents appeared to be complying with the requirements of the Child Protection Plans, the case was allowed to drift. There was an over reliance by professionals attending Child Protection Conferences and Core Group Meetings on the specialist risk assessment and its outcome. Yet there is no evidence of challenge about the delay in commissioning the assessment or the quality of the report when it was presented, either in supervision or by those involved in the Child Protection process.

6.102 In January 2013, a decision was made by the Child Protection Conference that the children should no longer be subject to Child Protection Plans and the case became one of Child In Need. This coincided with a gap in supervision of three months, from January to March. The CSC IMR suggests that the reason for this may have been due to the case being 'stepped down' from a Child Protection case and thus did not require monthly supervision. This was at the very time when the risk to Child F had increased, given that 'B' was in the process of being returned to the family home. Continuous monitoring of Child F and her siblings should have remained in place, especially given that the specialist risk assessment had stated that a risk management plan, requiring social work involvement was essential if the risk 'B' presented was to remain low. Neither had the sex and relationship education programme recommended by the specialist organisation been completed when this decision was made.

6.103 Supervision of the case reverted back to ATM1 during April and May 2013, when it was transferred to ASW3. No supervision records were found by the CSC IMR author until July 2013, by which time ASW3 was being supervised by ATM3. It is significant that ASW3 indicated that she was under the impression that by the time the case was allocated to her child protection concerns had been addressed and her role was one of a Child In Need worker. Visits were less frequent and it is questionable as to what was the focus of the work, apart from monitoring and reporting.

6.104 It was precisely at this time that Child F's appearance and behaviour began to significantly change. ASW3 equated this with Child F following her older sister 'A's example of wanting a Western lifestyle, however, there was no challenge in supervision of ASW3's assessment of Child F in July 2013. There is no record of supervision taking place thereafter until October 2013, by which time there was a further change of Supervisor when ATM2 became responsible for supervising the case.

6.105 It was totally inappropriate for this case to be allocated to an ASW, as was the decision to remove the children from Child Protection Plans to Child In Need plans. The complexities of the family dynamics, as well as the abuse perpetrated against Child F were well known when the case was stepped down from one of child protection to Child In Need. There was nothing to indicate that the situation for Child F had changed, except that 'B' was assessed to be of low risk of perpetrating further abuse. Although the specialist consultant's report concluded that the risk presented by 'B' was considered to be low, the report also recommended that Social Worker involvement and a risk management plan was essential. Despite this the case was allocated to an ASW who mistakenly believed that the child protection concerns had been addressed. The Serious Case Review Panel was informed by the CSC representative that such a decision to allocate the case to an ASW would not happen now.

6.106 Even though SW1 provided social work continuity for over two years, there was no real change in outcomes for the children. Little progress was made in the standard of care provided to the children and dietary issues were never fully resolved. Most importantly the parents continued to maintain that they believed that 'B' had not abused his sister. The case was not managed holistically. If it had been consideration may have given to providing a Social Worker for 'B' in his own right, as stated above. Instead it was assumed that the allocated worker had sufficient experience and skill to work with him, Child F and the family. This was mistaken, as events proved when it was discovered that Father had also been sexually abusing Child F.

6.107 As previously referenced School 1 contacted and informed partner agencies appropriately when concerns about Child F's safety and well being arose. The School's Child Protection Officer had oversight and full management responsibility for the decisions and actions of all school staff involved with Child F. This supervisory arrangement worked well as is manifest in the monitoring and swift reporting of child protection concerns and is also evidenced in good internal communication and sharing of information between teaching and pastoral staff and the school nursing service.

6.108 A representative from School 2 regularly attended Child Protection Conferences, but the school is not recorded as attending Core Group Meetings. Little comment can be made as to the management and supervision of the case by the school due to the paucity of information provided by the school's IMR. The IMR author states that it was 'believed' that Senior Managers, other organisations and professionals were involved where they should have been and that there was sufficient accountability for decision making. This comment is a reflection of the lack of involvement by this agency with this Serious Case Review, but may also indicate an unwillingness to engage in or a lack of understanding of the Serious Case Review process.

6.109 The Primary Care IMR notes indicate that there was no documentation of any discussions concerning the risk to Child F's sexual health, following information shared by the School Nurse with the GP. This was despite the GP being informed by the School Nurse of her serious concerns about Child F being sexually active and possibly exploited. Neither is there documentation to indicate that the GP discussed the case with the Named GP. There is evidence that SW1 regularly updated the GP about child protection concerns and the GP received invitations to and minutes of Child Protection Conferences. There is however no indication of awareness on the part of the

GP of the seriousness of the risk posed to Child F of interfamilial sexual abuse.

6.110 During the period under review there were only three School Nurses serving the whole of the local area, and the School Nurse Manager was aware of the resulting pressure on the service. Given this situation it was fortuitous that the same School Nurse was able to offer consistency to both Child F and 'B' by seeing them regularly. She also attended Child Protection Conferences and Core Group Meetings. The Child Protection Plan stated that it was the responsibility of the School Nurse to address the weight and dietary needs of both Child F and 'B'. Whilst these responsibilities were undertaken seriously and punctiliously, the issue of interfamilial sexual abuse, where the alleged perpetrator was a sibling, was outside the experience of the School Nurse. Thus, the School nurse felt unable to explore this area of concern with Child F. However, when Child F confided in her that she had engaged in sexual activity with a number of males the School Nurse acted appropriately in ensuring that Child F received appropriate sexual health services and also informed partner agencies.

6.111 The School Nurse did receive child protection supervision in accordance with policy, between April 2012 and October 2013. School Nurses hold a large caseload and choose the cases they have most concerns about to bring to supervision. The School Nurse, however, did not bring this case to all her supervision sessions during the period Child F was on a Child Protection Plan and it is of concern that this did not happen. If it had the School Nurse's inexperience and lack of confidence concerning her knowledge of sibling abuse may have been explored, with appropriate advice and training been made available. This may in turn have initiated interaction and exploration between Child F and the School Nurse of the abuse which it is now known Child F was experiencing at that time. As a result of this review changes have been made to supervision arrangements for School Nurses to review all cases during supervision where children have been on a Child Protection Plan for more than a year.

6.112 It is understood that the School Nurse has since attended a specialist course on child sexual abuse and Berkshire Health Foundation Trust is reviewing the training provided on sexual abuse for all School Nurses. In addition, all School Nurses have completed an e-learning course on Child Sexual Exploitation.

6.113 Given that Heatherwood and Wexham Park Hospitals had contact with both Child F and 'B' (because of cardiac problems) during the review period, the BHFT IMR author makes the point that *'paediatric services should have been aware of the child protection conference minutes whilst offering services to Child F and her siblings'*. This was especially important as Child F attended a child protection medical.

6.114 The independent consultancy company undertaking the specialist risk assessment on behalf of the specialist organisation consisted of two practitioners. There was no management structure in their company as both held joint responsibility for decisions made in the case. There appears to have been no process by which the specialist organisation quality assured the report before it was delivered to Children's Social Care. There had however been no consultation on the part of those in CSC prior to commissioning the assessment with appropriate health colleagues as to the suitability of these specific consultants undertaking the work. Once the report was delivered

there was no request for expert advice from health colleagues who may have been able to comment on the appropriateness of the methodology, findings and recommendations of the risk assessment. It was presented to the Child Protection Case Conference in July 2012, with the recommendations accepted by CSC and partner agencies. No questions were asked as to why it took four months for the assessment to be completed (once it had been funding had been agreed) and no concerns were raised that the finding that 'B' presented a low risk was based on a previous six month history. This resulted in a lack of management accountability on the part of CSC as well as those agencies party to the Child Protection Conference and is further discussed in this report at Section 7: The Child Protection Conferencing Process.

6.115 Management of the case by Police was in the main consistent with policies and procedures. The possibility of Child F being subject to child sexual exploitation when she disclosed she had engaged in sexual activity whilst drunk with a 17 year old male was assessed by a Specialist Officer, who decided that the case did not meet the criteria. This decision was possibly influenced by Child F not being willing to disclose the identity of the male involved and given the information available at that time it can be seen as appropriate. When it later transpired that Child F had been involved with other males, including one who had an exclusion order preventing him from contacting underage girls, Police undertook an appropriate investigation, which was to subsequently lead to the discovery that Father had been abusing Child F. The Section 47 investigation of 'E''s disclosure that Mother had hit her was undertaken as a single agency by CSC, but Police were expecting to be informed of the outcome, which seemingly did not happen. Review and supervision of the case by appropriate ranking Police Officers was undertaken throughout the period under review.

Knowledge and Skills

6.116 Helpful information has been provided by the CSC IMR author concerning the knowledge and experience of the social workers and managers involved with the family during the course of the review period. Several of the staff involved with the case have left the local authority and information is not available as to their qualifications and training experience.

6.117 It is evident however that SW1 who was the allocated Social Worker for the majority of the review period had been qualified for over ten years and had completed child protection training, with some cultural and diversity training during the period she was responsible for the case. ASW3 who became the allocated case worker in mid 2013 had completed a child protection course during 2013. There is no information concerning the other CSC professionals involved.

6.118 The School Nurse was an experienced specialist practitioner and practice teacher, and had completed appropriate child protection training in line with intercollegiate standards. This was however a complex case of sibling abuse of which the School Nurse had no experience. She did not feel confident to explore this issue with Child F and maintained that it was not appropriate to do so, given the criminal investigation. The BFHT IMR author suggests that this lack of experience may have contributed to the School Nurse's willingness to accept the consensus of the Core Group that Child F's sexual and emotional health needs were being met.

6.119 School 1 staff had responsibility for not only monitoring Child F whilst in school but also offering her pastoral support at their student support facility. It is evident that the teaching staff involved with child protection issues concerning Child F were experienced teachers who had undergone appropriate child protection training. The non teaching staff working in the student support facility were established student mentors and had also completed recent child protection training. Whilst it is recognised the School did all that was required of them to support Child F, it is evident, as has already been referenced in this report that Child F did not receive therapeutic counselling from specialists proficient in dealing with sibling and interfamilial abuse, throughout the period under review.

6.120 From the information supplied to the review from School 2 it is not possible to asses whether staff had appropriate training to meet the needs of this case. The IMR only states that it is believed they did. No further details are provided.

6.121 The consultants undertaking the specialist risk assessment state they had many years experience of working in this field of sexual abuse. One is a qualified Social Worker and the other a Chartered Forensic Psychologist, with experience of working with children with intellectual disability who have sexually harmed.

6.122 Child F's initial disclosure was dealt with by Police Constable 1 who was new to the CAIU, but was an experienced Officer who had undergone training in investigative interviewing and ABE training prior to joining the unit. All the other CAIU Officers who worked on the case were accredited detectives.

6.123 The family GP is stated to have requisite skills, knowledge and experience to deal with the case, although no detail is provided as to what child protection training the GP or surgery staff had undertaken. It is significant to note that managerial staff were experienced to scan documentation and correspondence between different agencies involved, however the primary Care IMR does not state whether such information was summarised prior to being scanned onto patient records.

Organisational Matters

6.124 CSC and Berkshire Healthcare Foundation Trust were the two agencies which experienced organisational difficulties during the period under review.

6.125 During this time there were staff vacancies and long term sick leave within the school nursing team for Windsor & Maidenhead and Slough. This necessitated the school nursing service being run corporately, with school nurses covering work in other localities as well as their own. The team had no clerical support during this period and this not only increased the work load, but also meant that contemporaneous filing of documentation was not undertaken, with paperwork relating to child protection process not always being uploaded onto the system in good time.

6.126 The impact of these difficulties on the team was such that the school nursing service in East Berkshire was on a risk register.[10] Given this situation, it was

[10] A risk register held in each locality which identifies issues the Berkshire Healthcare Foundation Trust Board needs to be made aware of. During the period under review this was due to staff vacancies and capacity.

good practice and commendable that the School Nurse for Child F and her family remained consistent throughout.

6.127 CSC was experiencing considerable organisational difficulties during the review period. An Ofsted inspection of Safeguarding and Looked After Children Services in March 2012 evaluated the service as 'adequate' overall but identified significant areas for improvement, which included the following, considered pertinent to this review:

- Ensuring assessments of need contain robust analysis of risk as well as fully identifying the needs of children and that quality is overseen by Managers;
- Improving the oversight, direction and support to practitioners in the implementation of Child Protection Plans;
- Ensuring Child Protection Plans are detailed and objective related with timescales and contingency plans in place.

6.128 A Local Government Association Safeguarding Practice Challenge undertaken in January 2013 identified the need for a review of the social care threshold document to support the 'step up' and 'step down' process of cases, consolidated improvements in the use of chronologies, risk assessment and reflective supervision processes. Concerns were also raised about the consistency of partnership engagement in Core Groups and Child Protection Conferences and significant risk was identified in the capacity of the organisation, with 20% agency staff required.

6.129 Although there was consistency in this case, with the same Social Worker allocated to the case from April 2011 to May 2013, there was a significant period of staff instability during the period under review. A change in staff terms and conditions resulted in a large number of staff leaving and being replaced by locums. When interviewed for this review, one of the CSC supervising managers commented that at one point 80-90% of the Child In Need Team consisted of locum staff. This impacted on morale and management time available to support staff and provide consistent reflective supervision. There were significant delays in progressing work and actions, as evidenced by the delay in agreeing funding for the specialist risk assessment and making the referral to the Family Centre for the parenting work programme.

6.130 At the time funding was requested for the specialist risk assessment of 'B' the procedure was for the request to be made to the Head of Service. It has not been possible to ascertain exactly when the funding request was made for the assessment or why it took twelve months to make the decision. What is apparent is that there was no escalation for a decision to be expedited, either through line management or the Core Group.

6.131 The current process for funding requests is through a newly established Resources Panel which meets every two weeks to ensure all requests for external services are considered and dealt with appropriately and quickly. Decision sheets are prepared and placed on the case file, thus ensuring transparency of the time the request is made, the reasons for the request and the decision outcome.

7 The Child Protection Conferencing Process

Focus on the child

7.1 All six children were subject to Child Protection Plans under the category of sexual abuse from March 2011 until January 2013. The three younger children were subject to Child Protection Plans from January 2014 until they were removed from their parents care. It is evident that the needs of each child were individually discussed during the course of Child Protection Conferences and Core Group Meetings. There was focus on issues concerning a healthy lifestyle, diet and the children's sleeping arrangements. The parents and other family members regularly attended meetings and appeared to engage with agencies and the child protection process. Regular child protection visits were undertaken in line with statutory requirements by SW1, who also engaged the children in 'Keep Safe' work.

7.2 It is apparent however that there was a lack of rigor on the part of the Chair and those attending Conferences and Core Group Meetings in addressing the needs of the children.

7.3 'A' was on a plan for only 3 months. There was, however, no exploration with her as to whether she had experienced interfamilial abuse, despite her being willing to engage with SW1 and share information about family life. This was a missed opportunity as not only was 'A' particularly close to Child F she also had insight into the dynamics within the family. This was especially so when she was perceived to have rejected her cultural heritage, after moving in with her boyfriend.

7.4 Although she was seen on an individual basis and received support from mentors at the student support facility, the referral for Child F to receive independent expert therapeutic counselling never progressed. Child F's disclosure that she had been raped by her brother was not disbelieved by any of the professionals involved, however there was a failure by agencies to assess the risk she faced by remaining in the family home in the care of parents who openly stated it was their view she had lied about the abuse. Child F stated her fears about the possibility of being taken to Pakistan by her Father. She also told the Social Worker that her Father and Mother had hit her and once 'B' returned home she disclosed how he had threatened and beaten her. It is of concern that once Child F disclosed her fears about remaining at home in September 2013, and requested to be taking into care, that she was left with her parents for a further two before being removed.

7.5 Child F voiced her concerns very clearly to the school and CSC about remaining in the family home, after 'B' had physically attacked her. The school acted promptly in bring this to the attention of the CSC and were informed that Child F would be removed to foster care. Child F was not immediately removed to foster care due to a lack of placement being available and Child F remained at home. When she was removed it was to an Independent Fostering Agency placement. The fact that there was no internal fostering placement available should not have influenced the decision as to whether Child F was safe to remain in the family home. The matter should have been escalated to senior management to ensure that a placement was found for her at the time she disclosed the abuse by 'B'.

7.6 'B' was subject to a Child Protection Plan for almost two years, and should have had a Social Worker in his own right. From Child F's disclosure it would

seem that he had been abusing his sister from the age of 13. He was 15 at the time the abuse was disclosed and he was required to live away from his family in Bed & Breakfast accommodation, financed by the local authority. He was still a child, with special needs, and was at this time along with his siblings made subject to a Child Protection Plan, category of sexual abuse. But it is apparent that he was being treated essentially as an adult perpetrator. A request had been made on the weekend of his arrest in February 2011 for a foster placement, but none was available. It would appear that once 'B' was out of the house in Bed & Breakfast and subsequently in a flat with Paternal Grandmother, the possibility of a foster placement was not revisited. No further action was taken or questions raised as to whether this was an appropriate arrangement for a child with his specific needs.

7.7 There appears to have been a lack of curiosity on the part of professionals in the Core Group as to whether 'B' had been subject to sexual abuse himself (despite him being subject to a Child Protection Plan for this very reason) or whether he had learnt such behaviour from accessing pornography on the internet and/or watching adult programmes depicting violence and sexual behaviour. Professionals involved in the Child Protection process relied on the outcome of the specialist risk assessment to provide answers to these questions. Little attention was paid to the possible effect of 'B' having to live away from his family for over two years was having on him. It was known at the time and has since been confirmed that 'B' was surreptitiously visiting and staying at home. This placed pressure on all family members to ensure that this arrangement remained secret. There was inexcusable delay in not only commissioning the specialist risk assessment but also in completing it, which only served to add to the understandable frustration of 'B' and his parents and increased the pressure on Child F and the younger siblings. Allowing him access to the younger children under these circumstances could be considered as abuse in its own right. Yet no agency escalated their concern about this undue delay.

7.8 Once the assessment had been completed, 'B' was still expected to comply with an education and relationship programme before his reintegration and return home could be completed, a process which took almost two and a half years. During this time little in the way of specialist services, apart from the involvement of the assessment consultants, was offered to 'B'. Like his sister no referral was made for specialist therapy to the NSPCC. No assessment of his needs was made as part of the child protection process, for example whether 'B' would have benefited from a specialist residential placement assessment or whether another agency could have undertaken the assessment within the community. The focus was on ensuring that 'B' complied with the requirements of the Child Protection Plan i.e. that he remained living away from the family and that he only had supervised contact with his siblings. Unfortunately, throughout this process 'B' was not seen as a child with specific needs, but was treated as an adult perpetrator of sexual abuse.

7.9 The distinct lack of challenge by members of the Review Child Protection Conference held at the end of June 2011, following 'E''s disclosure that Mother had been hitting her, is concerning. This disclosure from a six year old child subject to a Child Protection Plan was not shared with agencies at the time of the disclosure and was not appropriately investigated by CSC as the single agency tasked with the Section 47 investigation. No child protection

medical was arranged for 'E', and the Core Group which was held almost three weeks prior to the Review Conference (at a time after the incident had occurred) was not informed of the alleged physical abuse. It was not until the day of the Review Conference that the Child Protection Coordinator chairing the Conference and Conference members were informed of this incident. That there was no questioning of the actions of CSC in the way that the investigation was undertaken is an indication of a lack of child focus by those agencies in attendance at the Conference.

Implementation of Plans

7.10 The threshold was met for the children to be made subject to Child Protection Plans following two initial case conferences. It is however questionable as to whether it was appropriate for the three younger children to be placed on a plan under the category of sexual abuse in January 2014. The Conference was convened on the basis of physical abuse by 'B' which Child F had disclosed. There was no indication that the younger children had been sexually abused. By this stage Child F was a Looked After Child and was placed on a Child In Need plan.

7.11 The Child Protection Plans, resulting from the Initial Child Protection Conference in March 2011 and the Review Conferences that followed, identified outcomes, actions and individuals responsible for their implementation. What was missing was timescales for those actions and outcomes to be achieved. This led to a lack of challenge by the Chair and those attending the Conferences, as manifest in the severe delay in commissioning the specialist risk assessment and once commissioned its late delivery. There was no questioning as to what happened to the NSPCC referrals for both Child F and 'B' for specialist therapy. The Conference and the Core Group accepted that both children could be supported by their school student support facility. There was no debate as to whether these facilities were appropriate for the children's needs. Without any evidence base it was accepted, as the Core Group note of May 2011 states that: '*Child F should not be bombarded with professionals'* whilst it appears that the NSPCC referral for 'B' was not followed through.

7.12 With the exception of 'A' the children remained on Child Protection Plans for almost two years from the time of the Initial Case Conference in March 2011 until January 2013. Despite being subject to a Child Protection Plan, albeit for three months, 'A' was never asked whether she had been abused, and although she has subsequently disclosed that she had been, this concern should have been considered and explored with 'A' at the time. Throughout this period the parents consistently maintained that 'B' could not have abused Child F. However, once the specialist assessment was completed with the recommendation that 'B' presented a low risk and could with provisos be reintegrated into the family, the Child Protection Conference swiftly decided that it was appropriate for the case to be 'stepped down' from one of child protection to one of Child In Need. The reasons for this unanimous decision, although Police were not in attendance, appear to be based on the recommendations of the specialist risk assessment (even though the assessment concluded that in all probability 'B' had raped his sister and that Child F had been pressurised by the family to withdraw her allegation). In addition, good work was seen to have been undertaken with the parents, who

were said to have engaged well and complied with the requirements of the Child Protection Plans.

7.13 The decision to remove the children from Child Protection Plans came at the very time when the children, but most especially Child F was most at risk. Given there had been continuity for chairing conferences over this two year period, with two Child Protection Coordinators having responsibility for this task (the first chair was replaced when she left the organisation in May 2011) and stable membership of both the Review Conferences and the Core Group, it is difficult to understand the reason why such a decision was made at the point when 'B' was being reintegrated to the family. This was a crucial time of change and happened at a point when Social Work intervention shifted from being one of statutory visiting every ten days to once a month. Core Groups no longer took place and the opportunity to share information became dependent on individual agencies contacting CSC. Although SW1 was to continue as the Social Worker until May 2013, the allocation of the case to an ASW was made on the basis that child protection concerns had been addressed and that the case was now one of Child In Need. This was a flawed assessment.

7.14 It has been asked in the course of this review whether there may have been pressure for the case to be 'stepped down' from one of Child Protection to Child In Need, given that the children had been subject to plans for almost two years. It has been clarified that long running child protection cases were challenged and reviewed by senior management if they did not progress. However, although both Child Protection Coordinators had regular supervision, it would seem from information available that supervision sessions were brief and cases were not discussed in detail. Thus, it may not have been because of undue pressure that the case was deemed no longer one of child protection, but simply because those engaged in the process were of the view that 'B' presented a low risk to his siblings. This was based on a misinterpretation of the findings of the specialist assessment, an over optimistic view that the parents had engaged well with professionals and a misconception that Child F as a result of Keep Safe work had greater confidence and would be able to disclose if she was at risk of abuse.

7.15 Such professional optimism was misplaced and Child F was left at risk of significant harm, with minimal intervention from statutory agencies.

8 THEMES ARISING

Recognition of risk posed to children who disclose abuse

8.1 When Child F was arrested for shoplifting she took the opportunity to disclose the abuse she was experiencing from her brother. Police have confirmed to the review that such disclosures from young people in these circumstances are not unusual and it was evident that Child F saw an opportunity to inform a statutory authority about what was happening to her at home. Police took the allegations seriously and took immediate action and arrested 'B', thus reinforcing to Child F that she was believed.

8.2 Her actions resulted in the removal of 'B' from the family home and at her request, Child F returned to the care of her parents. The situation was considered to be safe, once 'B', the perpetrator, had been removed. The consequences however were to prove more complicated. From the outset

Police decided, because of capacity issues in the EDT that it was acceptable to interview Child F in the presence of her Father, with him acting as an Appropriate Adult. Whilst there was nothing to indicate that Father may have been abusing Child F at that time, it was known that Mother was aware of the abuse alleged by Child F against 'B'. Father also indicated at the interview that the matter should have been left to him to deal with. It could therefore be reasonably assumed that the parents were aware of the abuse, but had failed to protect their daughter. Given the ethnicity and cultural heritage of the family, consideration should have been given to the shame which Child F's disclosure would have brought upon all family members if information concerning the alleged abuse reached the Pakistani community. Given this situation the desire of the parents to discredit any such allegation should have been considered. This was seemingly not taken into account and Child F returned home.

8.3 Within days of making her statement Child F withdrew the allegation. This happened after she went on a 'long drive' with Father. There was also pressure exerted by other family members for the allegation to be retracted. Police warned Father that he could face charges of witness intimidation if he persisted in pressuring Child F, yet little consideration was given to the risk which she faced by remaining at home.

8.4 It was evident that Police believed the account that Child F had given, as despite the withdrawal of the allegation the case was put before the CPS for a decision as to whether 'B' should face charges. The CPS decided that Child F was an unreliable witness and as the allegation of sexual abuse was made after her arrest for shoplifting it could not be considered as credible. Whilst accepting that the CPS have to decide on the credibility of evidence as to whether a case merits an alleged offender being charged, this decision offered little in the way of confirming to Child F that her disclosure had been worthwhile. It could however have been interpreted by her parents as supporting their position that Child F had lied and confirmed their stated belief that 'B' was not capable of perpetrating the abuse Child F had described. It also displayed a lack of awareness on the part of the CPS of the complexity of child sexual abuse and the pressures faced by children who disclose abuse, particularly interfamilial abuse.

8.5 At the time of the disclosure Child F indicated that she simply wanted to scare 'B' and for the abuse to stop. She had not expected that he would be required to live away from home, resulting in the family being split apart for years. The consequences of her actions had a profound effect on Child F, and although she had the consistency of the same Social Worker for over two years, Child F was essentially left isolated in a family where she was seen as the reason for 'B's exclusion.

8.6 Recently published research by the NSPCC[11] concerning social workers' working with cases of child sexual abuse, makes the point that *"children who have been sexually abused are sensitive to the responses of adults when they disclose (Malloy, Llyon & Quas, 2007) and inappropriate responses reinforce any sense of guilt, shame and powerlessness that they already feel. In 2010, 58 young people aged between 10 and 21 and a group of young women at the NSPCC Child Trafficking Advice and Information Line took part in*

[11] Social Workers' knowledge and confidence when working with cases of child sexual abuse, Martin L et al, NSPCC November 2014

discussions about child sexual abuse (Brown et al., 2011). Amongst other issues, they talked about not being believed or understood; feeling betrayed and let down by those close to them and then by the 'system'; the need for local services that meet their needs and that recognise the impact of sexual abuse on the whole family; and, the need for social workers and police officers to have more training in working with sexual abuse."

8.7 These concerns are echoed in this case, not only for Child F but also for 'B'. The importance of timely, robust assessment, particularly in cases of sibling abuse, cannot be underestimated and is a lesson learnt from this review. However, it is apparent that the risks presented to Child F by 'B' were not fully explored by the professionals involved with them. This in turn led to an inappropriate response to their needs: in Child F's case for protection and for 'B' a suitable assessment of the risk he presented as well as an opportunity to explore specialist therapy to address any such risk.

The Child Protection Process

8.8 Despite Child F retracting her allegation of rape there were sufficient concerns on the part of Police and CSC to instigate child protection procedures. This is manifest in the decision to visit Child F at school soon after she withdrew her statement. Unease for Child F's safety particularly on the part of SW1 continued and is evident in the diligence with which she visited the family home, the action taken when Child F voiced her fears that she may be taken to Pakistan and the ongoing concern that the children were being pressurised and coached in what to say by their parents.

8.9 Five of the children remained on Child Protection Plans for almost two years, yet during this time no scrutiny appears to have been made of the appropriateness of this decision, by members of the Core Group, the Child Protection Conference or the Conference Chair. Little consideration was given as to whether the case should be referred to legal services to assess whether there was evidence to instigate care proceedings, but equally there was no questioning of the children remaining subject to plans. There was little questioning by the Child Protection Conference Chair or professionals attending the Core Group as to the objectives of the Child Protection Plans and whether they were being achieved. It would appear that Child Protection Conference and Core Group decision making was dependent on the outcome of the specialist risk assessment. Although there was some questioning by Core Group members as to the delay in commissioning and commencing the specialist risk assessment, these concerns were not escalated to higher management in CSC. It was SW1, as the allocated Social Worker and chair of the Core Group, who was left to resolve the situation. Once the assessment had been made that 'B' presented a low risk, the focus shifted away from Child F and her younger siblings in favour of creating a situation which would enable 'B' to return to the family home.

8.10 The decision to remove the children from Child Protection Plans to Child In Need plans in January 2013 coincided with them being subject to child protection procedures for almost two years. There was at the time pressure within CSC to meet targets that ensured children were not subject to Child Protection Plans for more than two years. It was policy to highlight those cases where progress was not being made and to enable appropriate escalation of decision making. It cannot be substantiated that this had any bearing on the decision to step down the case to one of Child In Need.

However, the case should have been subject to proper scrutiny by the Chair, Conference and Core Group members to prevent drift. As has been stated throughout the review, it would seem that over reliance on the findings of the specialist assessment unduly influenced the child protection decisions made in this case.

Specialist risk assessments

8.11 The importance of commissioning appropriate specialist risk assessments has been a major feature of this review. It has not proved possible to ascertain sufficient information so as to fully understand the process by which specialist consultants were commissioned to undertake the assessment of 'B'. From what is known it would seem that SW1 was tasked with identifying a suitable agency to undertake the work. It is evident that it was unrealistic to expect a Social Worker, after discussion with her Supervisor to identify such expertise. Once it was agreed that the specialist organisation would be approached, however, it was then for the Head of Service to decide on funding the assessment. The overall process took almost a year. The issue of the specialist risk assessment was an agenda item on every social work supervision session, Child Protection Conference and Core Group Meeting until February 2012 when funding was finally agreed. There was no challenge on the part of agencies involved in these meetings about the delay nor was there any escalation of the issue on their part or by the Manager responsible for supervising the case. This was an unjustifiable situation, with the matter being allowed to drift to the detriment of 'B', a child himself, who remained outside the family and to Child F who remained at risk because of her actions. This is manifest in the physical and verbal abuse Child F experienced from both parents and 'B'.

8.12 Once the assessment was finally commissioned the delay in delivering the report also went unchallenged, as did its findings. The methodology employed by the consultants when undertaking their assessment on behalf of the specialist organisation only took into account 'B's behaviour during the six months previous to the commencement of the assessment. This resulted in 'B' being evaluated as low risk because he had been 'said' to be living away from the family. No holistic assessment appears to have been made of 'B', and despite there being significant concerns about his behaviour and that of his parents the recommendation was for him to return home. There was a caveat to the assessment of low risk 'B' presented, which was the need for considerable social work input and a robust risk management plan in place before his return home. Unfortunately, due to the short notice of the case conference where their report was discussed, neither could attend the meeting, to discuss their findings and put them into context. It was also unfortunate that the minutes from the Conference were not read by either of the specialist consultants, and thus the implications of the case becoming one of Child In Need on the basis that 'B' presented a low risk, was missed.

8.13 The lack of quality assurance of the risk assessment has already been referenced in this review and is a lesson learnt. The report was not quality assured by the specialist organisation before it was delivered, and nor was it quality assured before it was presented to the Child Protection Conference. The need for expert advice in interpreting the findings and outcome of such specialist assessments is crucial if appropriate decisions are to be made which affect outcomes for children at risk of abuse. The requirement to have a

clinical lead to advise on the terms of reference and commissioning of specialist services, as well as being available to interpret the findings of such assessments on behalf of Case Conference and Core Group members is a recommendation from this review for the LSCB to consider.

8.14 The specialist organisation commissioned is recognised for specialising in the assessment of young people displaying sexually abusive behaviours. It is recognised that the Child Protection Conference and Core Group was over reliant on the outcome of the specialist risk assessment, which in turn meant that the assessment of child protection risks were essentially 'put on hold'. The delay in delivering the assessment and the quality of the findings present significant concerns to this review. These are issues which need to be brought to the attention of the specialist organisation senior management in order that such concerns do not arise in future assessments.

Disguised Compliance

8.15 Disguised compliance on the part of families is a frequent finding of Serious Case Reviews[12] and is one which is applicable to this review. It can be said that superficially Child F's parents, especially Father (who was the main spokesperson for the family), was willing to engage with agencies, the Family Centre, attend Child Protection Conferences and Core Group Meetings, adhere to the requirements to change the sleeping arrangements and diet of the children. It was also apparent that the fundamental requirement to offer protection to Child F was not complied with.

8.16 From the outset neither parent was willing to support Child F in her allegations against 'B' and following 'B's arrest they did their utmost to persuade her to withdraw her statement. It was known that Child F faced enormous pressure from immediate and extended family members to redact the allegations. Once she did so she was perceived by the family to be a liar and a child who had brought shame on the family.

8.17 This information was known to professionals attending multi-agency meetings, as was the concern that the younger children were being coached into saying what their parents required of them. It was also known that 'B' was visiting the family home when he should not have been and questions were raised with the Social Worker by the specialist consultants as to whether he was actually residing with Paternal Grandmother. All these concerns were confirmed once the children had been removed from the care of their parents and felt secure enough to disclose this information to foster carers.

8.18 Another consideration as to the possible reasons for disguised compliance was that it is not known when Father's abuse of Child F commenced. There is no evidence to exclude the possibility that this abuse was long standing and may have been occurring at the time of her original disclosure. It is significant that it was after Father 'took her on a long car ride' that Child F withdrew her allegation. It is not for this review to speculate as to what occurred or what was said during that journey however its significance cannot be discounted. The failure of agencies to explore the broader sexual behavioural issues within the family, for example the reasons for 'B's sexually abusive behaviour, may have also mitigated against Father's abuse of Child F coming to light.

[12] Brandon et al New messages from research, 2012

8.19 In his 2003 report into the death of Victoria Climbié, Lord Laming stated: *"I recognise that those who take on the work of protecting children at risk of deliberate harm face a tough and challenging task…Adults who deliberately exploit the vulnerability of children can behave in devious and menacing ways. They will often go to great lengths to hide their activities from those concerned for the well being of a child."*[13]

8.20 This comment resonates with the findings of this review. It is recognised that SW1, the Social Worker who had responsibility for this case during most of the period under review, was a committed professional who visited the children regularly, sought their views and endeavoured to undertake work to 'keep them safe'. She faced a difficult task, which she readily admitted as a white woman working with a family of Pakistani heritage. The superficial compliance on the part of the parents, together with the outcome of the specialist risk assessment may have influenced the decision to remove the children from Child Protection Plans at a crucial time, which was to leave Child F in a vulnerable situation for a further eleven months.

Diversity

8.21 The family's Pakistani heritage was acknowledged by all the agencies involved and it was good practice that the same interpreter was provided for Mother throughout the period under review. The use of interpreters in cases of interfamilial abuse is particularly sensitive within certain communities. A finding from research undertaken by the NSPCC, previously referred to at 8.6, was the concerns Social Workers had about the lack of training for interpreters used in child sexual abuse cases. These included "*the discomfort some interpreters displayed in response to the nature of the discussion they were being asked to interpret, the accuracy of the interpretation, hostility or disapproval displayed by some interpreters towards families, the implicit messages given to families through delivery of the interpretation and the barrier to developing an appropriate ambience through body language, expression and delivery, which the skilled social worker is able to create."*[14]

8.22 The role of interpreters in child protection cases is crucial. A non-judgemental environment of transparency and trust is essential if families are to be encouraged to engage with agencies without fear of information being disclosed to the wider community. In this case it appears that the interpreter was aware of the need for discretion and confidentiality, but the need for interpreters to receive appropriate training before being engaged in cases of child sexual abuse is an important consideration which this review has highlighted.

8.23 It was explained at the Learning Event for Practitioners that at the GP Surgery, which the family attended, there were doctors who spoke the same language as Mother and who would have been able to communicate with her without any difficulty. Thus, the GP was surprised to learn that Father was speaking with doctors about Child F's menstrual cycle and accompanying her to medical appointments, a situation where a Mother would have normally been expected to attend. This raises the issue as to whether Mother was prevented by Father from discovering, what was later to become apparent,

[13] The Victoria Climbié Inquiry, the Lord Laming Report, 2003:3
[14] Social Workers' knowledge and confidence when working with cases of child sexual abuse, Martin L et al, NSPCC November 2014

that he was abusing their daughter, whether she was colluding in the abuse or whether Father accompanied Child F to these appointments to ensure that she did not disclose to a medical professional the abuse she was experiencing.

8.24 The degree of learning difficulties experienced by all family members, with the exception of 'B' and 'C' who had statements of special educational need, did not significantly feature in the way in which agencies engaged with them. Although both parents were said to have some degree of learning difficulty, no formal assessment was made of their needs and it did not feature as part of the parenting work undertaken by the Family Centre.

8.25 It was however appropriate that 'B's special needs were fully taken into consideration by Police and by the specialist consultants when they undertook their assessment. Both consultants were experienced in working with children and young people with learning disability.

Management and Supervision of Cases of Child Sexual Abuse

8.26 The importance of case management and reflective supervision is evident from this review. Unusually in this case there was continuity of Supervisor and Social Worker for over two years. However, as has been illustrated throughout this report, there was a lack of direction in the supervision offered, poor assessment of risk and little sense of urgency that situations needed to be resolved. There is no evidence of reflective supervision. The allocated Social Worker was left to manage the case for over two years with no indication of challenge on the part of her Supervisor (or the Core Group) as to the lack of progress, particularly in respect to the specialist risk assessment of 'B'. The Supervising Manager and the Core Group should have escalated concerns about the delay in funding the assessment to senior management, but nothing happened in this regard, and the situation was left to drift.

8.27 Sufficient attention was not paid to the situation that 'B', a vulnerable and potentially dangerous young person, was left in for over two years. Only at the time of his arrest was a fostering placement considered and when no placement was available, quickly discounted. For 'B' to remain out of the family, in essentially a position of 'limbo' is extremely concerning.

8.28 Similarly, there was no challenge of the fostering placement panel when no internal fostering placement was available for Child F in September 2013. This resulted in her being exposed to continuing risk of sexual and physical abuse in the family home for a further two months.

8.29 No progress was made in the provision of specialist therapeutic help for either Child F or 'B'. This was a complex case involving issues of diversity, interfamilial sibling abuse, learning disabilities and neglect. The expectation that the allocated Social Worker should be responsible for monitoring and supporting all six children, one of whom was considered to be a perpetrator, without access to expert advice was unrealistic.

8.30 There appears to have been little attention paid to the need for professional development and specialist training for those working with such complex issues, as manifest in this case. Social workers and managers interviewed as part of the NSPCC research[15] emphasised the importance of training and developmental aspects of Child Sexual Abuse, with social workers reporting

[15] ibid

that "*generic mandatory training tended to focus on child protection procedures rather than the wider dimensions of social workers' support and intervention roles."* Whilst it is known that SW1 undertook child protection training and some diversity training during the time she was the case worker, she did not seemingly have access to specific training on child sexual abuse involving siblings. The School Nurse admitted that she lacked experience in this aspect of child protection and as a result did not feel confident to discuss this with Child F. This situation has since been rectified with the School Nurse having attended appropriate training.

8.31 The effect on professionals involved in cases of child sexual abuse cannot be underestimated. The importance of regular support and reflective supervision to ensure that a case is approached holistically by developing a practitioners skills and confidence is essential and is a lesson learnt from this review.

9. Conclusions

9.1 This was a complex case of interfamilial abuse which was initially thought to only involve a sibling. It later emerged that Child F had been subject to sexual abuse from Father. Whilst this review has been unable to determine when the abuse of Child F by her Father commenced, it remains a possibility that it may have been happening for some time, and certainly during the period when Child F would have been under a Child Protection or Child In Need plan. That Child F was being abused by her Father was only discovered as a result of concerns being raised by Police that she was in contact with a convicted sex offender. Had Police not examined Child F's mobile phone in the context of this investigation then the fact that Father was sexually abusing her would not have come to light at that time.

9.2 There were aspects of positive practice by some agencies in this case. Police rightly identified the special needs of 'B' and ensured that a Social Worker acted as an Appropriate Adult. Police and CSC were especially concerned that Child F was being subjected to pressure from the family to withdraw her allegation and undertook a joint agency interview. This was followed by Father being warned by Police not to intimidate Child F. Despite Child F withdrawing her allegation Police appropriately decided that the case should be put before the CPS for a decision as to whether 'B' should be prosecuted. The swift actions of both Police and CSC when Child F was fearful that she may be taken to Pakistan was in keeping with the Honour Based Violence protocol and is an example of good practice.

9.3 School 1 monitored Child F and offered her support at times of crisis and reported all child protection concerns. The School Nurse carried out her responsibilities as prescribed in the Child Protection Plan and acted swiftly and appropriately when she was concerned that Child F may have been sexually exploited. She was however lacking in knowledge and confidence on how to deal with sibling on sibling abuse, but has since accessed training.

9.4 SW1 undertook her duty to visit the children diligently and attempted to engage with the parents to improve the family's lifestyle. However, she faced a difficult task in having sole responsibility for six children on Child Protection Plans, one of whom being an alleged perpetrator of sexual abuse, but also a child in his own right. The complexities of culture, language, learning difficulties, all feature in this case, but SW1 was also responsible for finding and commissioning a specialist risk assessment with little support from

immediate line management or from the Child Protection Conference and the Core Group.There was no escalation of concerns by SW1's Line Manager or the Core Group when no decision on funding the assessment was forthcoming from senior management for twelve months.

9.5 Unusually, there was continuity of social work involvement and supervision in this case. There was however an overall systems failure.

9.6 There was no questioning of the appropriateness of the children being subject to Child Protection Plans and the adequacy of the plans themselves, the delay in commissioning the specialist risk assessment, the delay in producing the assessment or the findings of the assessment report by any of the agencies involved. The case was allowed to drift for nearly two years whilst the children (with the exception of 'A') were on Child Protection Plans, with responsibility and decision making essentially remaining with the Social Worker.

9.7 It is concerning that there was no evidence of reflective supervision, challenge, holistic assessment or review of the case on the part of the responsible Supervisor who was seemingly content for decision making to be left to the Social Worker.

9.8 Unfortunately, Child F was left in the care of her parents despite the serious concerns of professionals that she remained vulnerable to abuse. It was known that 'B' was visiting the family home when he should not have been. Child F expressed her fears for her safety when 'B' was at home. She was later to describe violence perpetrated against her by 'B', but her requests to be removed from the care of her parents were not acted upon for several months.

9.9 As stated above there was no escalation of concerns by any agency involved in the child protection process about the time it took for funding to be agreed for the specialist risk assessment of 'B'. Apparently, it was sufficient reassurance that as the perpetrator 'B', was living away from the family home Child F was protected.

9.10 As has been evidenced in this review there was a lack of a suitable commissioning process for the specialist risk assessment of 'B'. This was followed by insufficient scrutiny and quality assurance of the report when it was presented to CSC who commissioned it and the Child Protection Conference which failed to question its findings. There was an over reliance on the need to wait until the outcome of the specialist risk assessment was known before decisions were made as to the direction of the case. However, once the assessment findings were delivered the recommendation that a risk management plan be put in place with social work intervention and monitoring was not followed as the case changed from being one of Child Protection to one of Child In Need. The allocation of the case to an ASW at the very time when it could be said Child F was most vulnerable, was a flawed decision and appears to have been based on the case being stepped down from one of child protection to one of Child In Need. It is reassuring to note that under current arrangements no ASW has sole responsibility for a case.

9.11 Throughout the period under review the parents maintained that Child F had lied about 'B' abusing her and supported him in his denial. Their refusal to acknowledge that 'B' had abused Child F was known by all agencies whilst she was subject to child protection. Even though they presented a semblance of compliance with the requirements of the Child Protection and Child In Need

plans, Mother and Father prevailed in their support of their son, and thus could not provide Child F with the protection she needed to remain safe.

9.12 Given that the family was not known to agencies until Child F's disclosure in February 2011 it would not have been possible to prevent her being abused by 'B' prior to that time. However, once the case became one of child protection, the further abuse which Child F sustained from her brother and her Father could have been prevented if she had been removed earlier from the care of her family. 'B' was essentially treated as an adult perpetrator, which meant that the focus was not on ensuring that Child F was adequately protected from abuse but that a means was found for 'B' to eventually return to the family. Unfortunately, this resulted in Child F being left vulnerable to an environment underpinned by fear, anxiety and sexual violence.

10 LESSONS LEARNT AND RECOMMENDATIONS

10.1 EMERGENCY DUTY ARRANGEMENTS

An appropriately resourced and reliable Emergency Duty service including Appropriate Adults able to attend Police Stations is vital.

The lack of Emergency Duty cover and its impact, especially the availability of a Social Worker as an Appropriate Adult to attend Police interviews, was a significant factor at the outset of this case. The review heard that this is a situation experienced frequently by Thames Valley Police, and that this still continues.

Whether the provision of a Social Worker as an Appropriate Adult, when Child F was first interviewed at the time of her disclosure, instead of Child F's Father, would have prevented her return to the family home is a matter of conjecture. It would however have allowed her an opportunity to speak about the abuse she had experienced to an independent professional, and may have also enabled a joint section 47 investigations to have been undertaken over the weekend, instead of the following week.

Recommendation 1

That the LSCB call on Children's Social Care to review the current arrangements in place for Emergency Duty Team cover and take steps to address the shortfalls identified in this case.

Recommendation 2

That the LSCB commissions an audit of EDT activity and availability to seek assurance that the service is operating at safe and acceptable levels.

Recommendation 3

In cases involving alleged interfamilial abuse, a family member should not be used as an Appropriate Adult. Thames Valley Police to give consideration to the production of guidance which addresses these and other related circumstances.

10.2 LISTENING TO THE VOICE OF THE CHILD

The need to listen to and believe children who disclose abuse is crucial if they are to be protected and their well-being promoted.

Although Child F withdrew the allegation of rape against her brother, it was clear to all professionals working with her that she did so under duress because of pressure from family members. This was manifest in the decision to place all six children on

Child Protection Plans and by seeking an expert risk assessment of 'B'. By disclosing what had happened to her, Child F expressed her hope that the abuse would stop. Unfortunately, this did not happen.

It is however recognised that Police and CSC worked together to protect Child F when she voiced her fear that she may be taken to Pakistan.

Even when Child F openly stated her fear of 'B' when he returned home in September 2013 and disclosed how he had attacked her, she was essentially not listened to by those in a position to remove her from this abusive situation.

Teachers and Police Officers were informed by CSC that Child F would be immediately removed from the family home. Social Workers heard her distress and having agreed that Child F would be removed, did not do so, but proceeded to seek an agreement from her parents that they would protect her from 'B'. A decision which mirrored the previous child protection and Child In Need plans.

Recommendation 4

That partner agencies are asked to reassure the W&M LSCB that they have systems in place to gather and listen to the voice of children and young people, prior to making decisions for intervention.

10.3 SPECIALIST RISK ASSESSMENTS

The delays in commissioning, completing, and the eventual over-reliance on a specialist risk assessment was a significant factor in the management of this case.

The review heard of the lengthy delay in the approval of funding to commission the assessment, and a subsequent extended time period in which the work was undertaken and reported. There was no evidence that this delay was being escalated.

When the work was completed its limitations were apparently not considered and it was relied upon to justify the ending of the Child Protection Plan status of the children and the return home of 'B'.

Recommendation 5

The W&M LSCB seek an assurance that Children's Social Care have undertaken a review of the effectiveness of commissioning arrangements for specialist risk assessments of children.

Recommendation 6

That those arrangements include the development of commissioning guidance for the engagement of specialist assessments[16], to include: consideration of timescales for funding, commissioning the appropriate agency to undertake the assessment and set timescales for the delivery of the assessment.

Recommendation 7

In circumstances where a specialist risk assessment is required that advice is sought and taken from the Designated Doctor as to which provider should be commissioned.

[16] similar to that of the Law Society's Guidance on the appointment of expert witnesses

10.4 DECISION MAKING AND FUNDING

Decisions about the appropriateness of a child returning home are fundamental and a delay in acting upon a decision that a child should not return home for her/his safety places that child at an unacceptable level of risk.

Child F was seriously let down by Children's Social Care. By returning her home, having assured Child F and professional colleagues that she would be removed, Children's Social Care enabled the abuse to continue for a further two months.

Whilst it cannot be said that the sole reason why Child F was returned to her parents was one of financial expediency, (there was no 'in house' foster placement available at the time and an expensive agency foster-carer would have been the alternative) it is vital that resource constraints do not impinge on the best interests of the child. This decision was not only professionally unacceptable, it took no account of what was in Child F's best interests and showed little regard for the main principle of safeguarding children, i.e. the welfare of the child is paramount.

Recommendation 8

- That W&M LSCB seeks assurance from Children's Social Care that decision-making regarding the placement of children away from the family home is not affected by any issues other than the welfare of the child, and that in particular financial matters do not impinge on decision making or implementation of those decisions.
- That W&M LSCB reminds partner agencies of the importance of listening to children and of their duty to act in situations where a child is at risk of significant harm. Where an agency has been informed that a child will be removed, but becomes aware that immediate action has not been taken, concerns about the child's safety should be escalated using the W&M LSCB Escalation Policy.

Recommendation 9

That an audit of placement decisions be conducted to provide assurance that delays are not occurring in securing safe placements where these are required.

10.5 ISSUES RELATING TO INTERFAMILIAL ABUSE

There is a critical need to consider all of the children within a family where interfamilial sexual abuse has become known.

10.6 THE PERPETRATOR AS A CHILD

The perpetrator of sexual abuse must continue to be regarded as a child and their needs appropriately considered.

Throughout the conduct of this case, 'B' appears to have been treated as a perpetrator, with little consideration given to his needs as a child. He was subject to a Child Protection Plan which focussed on him being restricted from living in the family home but did little in terms of exploring or meeting his needs.

Despite being on a Child Protection Plan little seems to have been achieved in safeguarding 'B's future and it is disappointing to note that now over the age of 18, 'B' is not in employment, education or training, and is the only member of the sibling group who continues to reside with his parents.

Seeing 'B' as a perpetrator and not as a child in his own right, who may have experienced sexual abuse himself, was compounded by an over reliance on the part

of members of the Child Protection Conference and the Core Group on the findings of the specialist risk assessment. There was little or no challenge of the delay in commissioning and completing the assessment by any professionals.There was no questioning of the findings of the assessment, just as there was no questioning of the lack of provision of specialist therapy to either Child F or 'B'. It was accepted that 'B' presented a low risk and agencies involved in the case agreed that the case should be stepped down from one of child protection to one of Child In Need, at the very time when Child F was most at risk. This was an ill judged decision based on the findings of a risk assessment which essentially drew its conclusions from the previous six month period when 'B' was living away from the family home. Disguised compliance on the part of the parents also played a part.

Recommendation 10

W&M LSCB to review the appropriateness of procedures to ensure that:

- where there are complex cases of sibling sexual abuse, both victim and perpetrator are seen as children in their own right. As part of Child Protection/Child In Need Plan, an individual social worker should be appointed for the victim and another appointed for the alleged perpetrator,
- where children are in need of specialist therapeutic services arrangements are put in place to provide this facility in order to avoid children who have been involved in sexual abuse being left unsupported at times of crisis. This should apply to both victim and perpetrator.

10.7 SUPERVISION AND MANAGEMENT OF THE CASE

The absence of robust arrangements for reflective, but challenging supervision of professionals involved in this case was significant.

Challenging and reflective supervision for those holding complex cases involving child sexual abuse is vital, but was absent in this case. Holistic management of the case was lacking, which in turn allowed a situation where 'B', who was awaiting the outcome of a specialist risk assessment, to drift on for almost two years. This was detrimental to both 'B' and Child F. However, as has already been stated to expect an individual social worker to have what was essentially sole responsibility for a case as complex as this one was unrealistic and unworkable, and led to missed opportunities to fully assess the risk presented to Child F.

The need for professionals to have the confidence and the means by which to challenge such decisions is a lesson learnt from this review. It is somewhat reassuring to know that changes have been made and requests for the funding of placements for young people is now decided by a multi-agency panel on a case by case basis. However, if vulnerable children and young people are to be protected this process needs careful monitoring by all those involved.

Recommendation 11

W&M LSCB to seek assurance that an audit of social work supervision is undertaken, with the findings presented to the LSCB by Children's Social Care.

Recommendation 12

W&M LSCB seeks assurance that a training programme is in place for School Nurses concerning sexual abuse, including interfamilial and sibling abuse, and that

safeguarding supervision of School Nurses is monitored to ensure that cases which have been on a Child Protection Plan for over a year are discussed.

Recommendation 13

W&M LSCB to consider reviewing supervision arrangements by way of a multi-agency audit on cases involving child sexual abuse.

Recommendation 14

W&M LSCB to consider providing a programme of multi-agency specialist child protection training focussing on sibling abuse, interfamilial abuse in Black, Asian and Minority Ethnic communities.

Recommendation 15

W&M LSCB is assured that interpreters employed by Children's Social Care in child protection cases have received sufficient training to maintain awareness of and adherence to the importance of impartiality, confidentiality and transparency when using interpreting skills in these circumstances.

Recommendation 16

W&M LSCB to facilitate Learning Events for Practitioners, on completion of the Serious Case Review, to ensure that lessons from the review are disseminated.

SUMMARY OF RECOMMENDATIONS

Recommendation 1

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Recommendation 2

That the LSCB commissions an audit of EDT activity and availability to seek assurance that the service is operating at safe and acceptable levels.

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W&M LSCB to facilitate Learning Events for Practitioners on completion of the Serious Case Review to ensure that lessons from the review are disseminated.

11. REFERENCES

Brandon M, Peter Sidebotham, Sue Bailey, Pippa Biddlerson, Caroline Hawley, Catherine Ellis & Matthew Megson – University of East Anglia and University of Warwick 2012: New Learning from serious case reviews: a two year report

Department for Education – Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, 2013

The Victoria Climbié Inquiry, the Lord Laming Report, 2003

The Local Authority Ofsted Report

Social Workers' knowledge and confidence when working with cases of child sexual abuse, Martin L et al, NSPCC November 2014

Law Society guidance on the appointment of expert witnesses: http://www.lawsociety.org.uk/support-services/family-court-resources/

Appendix 1:

Biography of Lead Reviewer - Moira Murray:

Moira Murray is a qualified Social Worker and has worked in the area of child protection for local authorities and voluntary sector agencies for over thirty five years. She was seconded for 12 months in 2006 to the Department for Children Schools and Families (now Department for Education) to undertake an historic file review of referrals to List 99 (teachers barred list). She was a non-executive board member of the Independent Safeguarding Authority from 2007 – 2012, and in 2009 co-authored Safeguarding Disabled Children: Practice Guidance (HM Govt, DfE).

Moira Murray began working independently in 2010. Since then she has chaired and written numerous Serious Case Reviews, undertaken safeguarding audits for local authorities and the NHS and delivered safeguarding training. In 2012 she was appointed as Safeguarding Manager for the Olympic and Paralympic Games, and has more recently undertaken a review of Child Protection and Whistle Blowing Policies and Procedures for the BBC.

Biography of the LSCB and SCR Subgroup Chair – Terry Rich:

Terry Rich has been the independent Chair of Windsor & Maidenhead Local Safeguarding Children Board and Safeguarding Adult Board since May 2014. He was previously Director of Social Services and of Adult Social Care in three authorities over a period of 12 years. He now works as an independent consultant in improvement and change in health and social care.

Appendix 2 Terms of Reference

Serious Case Review Panel

Serious Case Review – Terms of Reference

STRICTLY CONFIDENTIAL

Childs reference	**Child 'F'**

Aims of Review

- To determine why Child F was a victim of sexual and physical abuse even though she was subject to child protection procedures, including a Child Protection Plan.
- To agree what improvement action is needed to local services.

Period of Review

26 February 2011 to 31 January 2014 (changed from 01 December 2013)

Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and LSCB.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were child focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Seek contributions to the review from relevant practitioners and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

Key Areas of Enquiry

- To establish if early help services were offered and if these were effective. If not, why not?
- To establish what assessments were undertaken and if these were effective in identifying the needs and risks of Child F. If not, why not?
- To establish if there were appropriate and timely assessments of the risks posed to Child F by her brother (including the specialist assessment). If not, why not?
- To establish if child protection procedures were followed, including the effectiveness of the Child Protection Conference and Core Group arrangements. If not, why not?
- To establish if the Child Protection Plan and the Child In Need Plan were effectively monitored and reviewed, including the risks while Child F remained at home. If not, why not? What aspects of the plans worked well, what did not work well and why?

- To establish if Child F's voice was heard and how this impacted on meeting her needs. If not, why not?
- To establish whether consideration was made of diversity issues for the child and family?
- To establish how cooperation or lack of cooperation, from family members assisted or impeded work to safeguard Child F's welfare. If lack of cooperation is a factor, how was this managed by the agencies?
- To establish if there was appropriate information sharing between agencies. If not, why not?
- To establish if the practitioners involved had received appropriate training to meet the needs of this case. If not, why not?
- To establish if there were any capacity issues within any agency which limited the service provided to Child F.
- To establish if the consultations or supervision provided to, or available to, practitioners assisted in identifying and meeting Child F's needs. If not, why not?
- To what degree did agencies challenge each other regarding the effectiveness of the plan, including progress against agreed outcomes for the child? Was the protocol for professional disagreement invoked? If it was not invoked, why wasn't it?
- Were there obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This should include consideration of both organisational issues and other contextual issues.
- To assess whether the initial responses and interventions following a child making an allegation help to protect children.
- To assess how agencies can best continue to protect children when an allegation of sexual abuse is not substantiated.
- To establish what impact the decisions by the CPS had on the plan to protect Child F.

Specific tasks of the Review Panel

- Identify and commission a Lead Reviewer to report to and work with the SCR Sub Panel.
- Agree the time frame.
- Identify agencies, relevant services and professionals to contribute to the review.
- Produce a timeline and an initial case summary.
- Produce a merged timeline, initial analysis and hypotheses based on the agency reports.
- Plan with the Lead Reviewer a learning event for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the Lead Reviewer the contact arrangements with the child and family members to seek their views (after the practitioners' event).
- Receive and consider the draft review report to ensure that the terms of reference have been met, the initial hypotheses addressed and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan, and make arrangements for presentation to the LSCB for consideration and agreement.

- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.
- Identify any lessons already learnt and action already taken prior to review commencing.

Tasks of the Local Safeguarding Children Board

- Receive draft report from Lead Reviewer and SCR Sub Group.
- Consider and agree learning points to be incorporated into the final report and the action plan for improvement.
- Confirm arrangements for the management of the multi-agency action plan for improvement by the SCR Sub Group, including how anticipated service improvements will be identified, monitored and reviewed.
- Plan publication (e.g. LSCB website), including notifying the National Panel on Serious Case Reviews and DfE.
- Agree media strategy.
- Agree dissemination to agencies, relevant services and professionals.