MSCP SCR Briefing sheet

Serious Case Review Faith January 2020

Until September 2019 Local Safeguarding Children Boards undertook Serious Case Reviews (SCRs) when a child dies or has been seriously harmed, and abuse and/or neglect are suspected or known to be a factor, and/or there are concerns about how local agencies worked together. The purpose of such reviews is to learn lessons and improve practice. These reviews have been replaced by local Child Safeguarding Practice Reviews. Any reviews commissioned before the change remain as SCRs.
This publication, produced by the MSCP, aims to share the learning from the Faith SCR to allow professionals to reflect on their own practice. The full overview report is published on the MSCP website.

Trigger event

A retrospective health review identified that as a child Faith had been seen by health practitioners with symptoms that may have been indicative of sexual abuse and that there appeared to have been a failure of multi-agency responses to indicators of risk throughout Faith's childhood. At the time Faith was open to health services and confirmed she had been sexually abused by a neighbour for a number of years and that her mother knew about it. Although there has been no prosecution of any offender, there are many occasions when the possibility that Faith was being sexual abused should have been acted upon.

Faith, now an adult, has engaged with the review process and the review team is grateful for her contribution.

Summary of known background

Faith has two older half siblings, and two younger siblings. Little is on record regarding Faith's mother and father. It was established that Faith's father has a number of convictions including imprisonment for drug offences.

As a small child most of Faith's contact with professionals was police and health practitioners. Police involvement was as a result of neighbour disputes, drug offences, domestic abuse between her parents and an allegation of sexual abuse within the family; this was taken no further as the victim, a relative of Faith's, did not want to proceed.

A child and family assessment noted that Faith had been to the GP on several occasions who made an urgent referral to the Community Paediatric Department highlighting symptoms that could be indicative of sexual abuse. It also detailed sexual behaviour beyond developmental stage of a 6 year old and family social problems that was not taken into account in reaching the conclusion (after a long delay) that there was no evidence of harm. No child protection referral was made.

Faith's school identified changes in that Faith went from a bright and happy child to one who was "weak and unable to concentrate". The school made a referral to children's social care with serious allegations against neighbours. There was no further action as the neighbours had moved away. No consideration was given as to why Faith's family had not protected her.

Police made a referral after Faith's father allegedly assaulted her mother. This led to the children being placed on child protection plans but with a plan of tasks with little evidence of how these would improve the safety and wellbeing of the children. The case was stepped down. There were numerous allegations of crimes between the family and neighbours.

During Faith's time at secondary school further referrals were made with concerns about housing and Faith's mother. Faith moved between her parents and Faith was noted as extremely distressed. She was placed on a child protection plan again due to mother's alcohol use and Father's violence and cannabis use. She went to live with her sister whilst her father was not granted a Residency Order for her he did get one for Faith's two younger siblings.

Faith was then accommodated on two occasions and moved through several placements. These included foster care placements and then later when Faith was a teenager, residential homes and semi or supported independent living. There was no clear placement planning and no clear plan for family contact. During her time in care concerns were raised to social care about medical problems that were deemed as self-inflicted; they occurred after visits to people that posed a risk to Faith. Faith also went missing from her placements and returned to family members mainly her mother; she took an overdose after making a partial disclosure of sexual abuse when she was aged 9 and 11. Faith had not wanted to discuss this further. At the later placements there were concerns about sexual exploitation that was not followed up. Faith made further disclosures of sexual abuse in the residential settings. Whilst this was reported to police no further action was taken due to conflicting statements. This information was not shared with the GP. Faith was also assaulted by another young person in the residential setting. Initially she was not living with her father but visited and expressed concerns for her siblings that lived with him; due to inconsistencies from Faith's and her father's accounts of matters no further action was taken. Faith was later returned to her father's care after placement with her sibling broke down. Contact with her mother was to be supervised but there was no court order to back this up.

A private psychiatrist was commissioned due to concerns about Faith's emotional wellbeing but for reasons still definitively unknown the terms of reference for assessment stated that no enquiries should be made of Faith in respect of sexual abuse. The conclusions of the psychiatrist showed the characteristics of a child who had been subject to significant traumatic experiences. The report recommended in-depth therapeutic work. At this stage of Faith's life there was a loss of focus by social care and access to information was poor.

Faith had regular meetings with CAMHS but did not attend in school counselling. Faith's challenging behaviour in school is attributed to parental substance misuse and domestic abuse within the family during her early childhood. There is no mention of sexual abuse or assault as part of her experience. Faith's contact with CAMHS was with the same worker for 2 years until they left. Faith's self-harm escalated but there was no female therapist to allocate Faith to. Faith was moved out of area to a therapeutic placement but did not settle. She moved to live with her sister, when they became homeless she was again accommodated. She went missing and was then arrested for assault and attempted robbery; she was allocated a worker from the youth offending team (YOT).

Faith continued to go missing and showed a pre-occupation with her mother's needs. Reports demonstrate this was a volatile relationship and she was having unsupervised contact with both mother and father. There were concerns about Faith being exploited but this was not assessed. Faith shared her experiences from her childhood with the YOT worker which were recorded as "horrific". It was at this point that the nurse for looked after children began a health history in preparation for Faith leaving care and uncovered the safeguarding concerns that led to this serious case review.

Faith's experience

There is evidence throughout Faith's history that supports Faith's feeling of not being listened to. She spoke to professionals that either did not follow up on what they were being told or took the accounts of adults as the truth over Faith's; even when Faith told professionals her parents had told her to lie about what was happening at home. Faith's behaviour as a teenager was labelled as "challenging. Faith felt she was being punished for her behaviour rather than anyone recognising how she was feeling.

Although they had a volatile relationship Faith was desperately worried about her family. Faith feels that more should have been done to support her sister who she lived with and that she was let down by her social worker.

Findings

Faith was let down by a safeguarding system that failed to recognise signs and indicators of abuse and to take action to protect her as a small child and teenager. There were a number of pivotal points in Faith's life where alternative practice decisions could have made a difference. Whilst the review identified poor practice the organisational systems did not provide the checks and balances that are needed to ensure children are kept safe from harm. Managerial oversight and supervision of individual practice did not provide sufficient scrutiny and challenge, particularly within social care, and organisational systems did not identify where processes failed, for example the delay in responding to a GP referral to the paediatrician.

Finding one: Over many years the signs and indicators that Faith had been sexually abused were not recognised and acted upon and her "voice" was not heard.

Finding two: Assessments and plans were limited in their analysis of the history of both parents, the dynamics of relationships within the family and relevant health information.

Finding three: There was no clear plan to give Faith a permanent safe home and the legal framework was not used effectively. When she was accommodated, planning lacked focus, did not manage family contact and there were missed opportunities to explore the meaning of her behaviour, particularly at times of placement breakdown.

Recommended service improvements

- Partner agencies in Medway should review their staff development activities in relation to child sexual abuse and sexual exploitation to ensure that all practitioners have the required knowledge, skills and confidence to recognise and respond to child sexual abuse within the family including hearing the "voice" and lived experience of the child.
- Consideration should be given by Medway Hospital to pre-pubescent girls being jointly seen by a gynaecologist and a paediatrician (or a relevant specialist children's practitioner). Best practice would be a joint paediatric/gynaecologist clinic for these patients.
- All partner agencies should promote the use of the sexual abuse pathway in cases of sexual abuse and sexual exploitation, emphasising the use of the Sexual Assault Referral Centre (SARC), and make sure that the pathway is embedded into day to day practice.
- All partner agencies should work together to consider the effectiveness of recognition and response in situations where criminal exploitation may feature in a young person's life.
- Partner agencies should work together to develop an agreed multi-agency whole family approach to work with complex families. This approach should include expectations regarding information sharing and understanding and working with the root causes of adult issues that are affecting parenting capacity.
- Medway Safeguarding Children Board should seek evidence from Children's Services that legal planning is used at an early enough stage and that this provides the framework for thorough assessments and ongoing work with the child and their family.
- Medway Safeguarding Children Board should seek evidence from Children's Services that the cause of placement breakdown is analysed via disruption meetings and that findings are incorporated into ongoing planning for the child.
- Partner agencies should establish a multi-agency approach to the provision of therapeutic services to children and young people and that this approach should clarify roles and responsibilities and at a minimum involves schools, health and social work services.
- NHS England should review the system for accessing both electronic paper and archived primary care records in order to ensure that it is fit for purpose in assisting GPs in their current practice and also any required statutory reviews.

Single agency action plans and a multi-agency action plan for the MSCP will be monitored by the MSCP Learning Lessons subgroup.