Warrington Child Safeguarding Practice Review
Executive Summary – Case AB

THE HANDLING OF A CASE INVOLVING ALLEGATIONS OF INTRA-FAMILIAL SEXUAL ABUSE AMONG FIVE FAMILIES

Learning	Child's voice; ACE's and lived experience; Understanding the impact of SEND; Inter-agency information sharing; Multi-agency working; impact of domestic abuse; Child and parental mental health; failure to access and follow extant procedures; foster care arrangements; child in need processes
Summary recommendations	Agencies to rethink information-sharing approaches, to rethink approaches to ABE interviewing, in terms of focus on victims and adherence to latest guidance, to champion procedures related to addressing organised and complex abuse
Keywords	Intra-familial Sexual Abuse, effective multi-agency working, achieving best evidence

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Introduction

This document is the Executive Summary of the Warrington child safeguarding practice review report into Case AB, conducted on behalf of Warrington Safeguarding Partnership.

The review focussed on the multi-agency management of allegations of intra-familial sexual abuse involving five families who resided in the Warrington Borough Council (WBC) district and focussed on three children, all siblings. The review process involved professionals from across the range of agencies that had been involved with the main investigation as well as professionals that were working alongside the families in different capacities. The review considered what went well, where agencies could improve, and makes several recommendations so that these improvements can be embedded into practice.

Summary of the case

In April 2017, care proceedings commenced in respect of all three children, as a result of allegations of sexual abuse made by the eldest child in relation to a member of her extended family. The siblings were subject of Special Guardianship Orders, to the same extended family members, following earlier care proceedings conducted by a different local authority. Once the siblings become looked after children and were placed in foster care, the younger two children made extensive allegations of sexual abuse in relation to a number of adult members of the extended family living in Warrington and 3 other local authorities.

These allegations, were made over a period of time and described a paedophile ring involving a significant number of adult members of the extended family. The siblings made allegations that other children in their wider family had also been abused by several adult members of their wider family – though no allegations were made by any other children who have been subject to social care involvement.

Care proceedings commenced in relation to the children of the alleged perpetrators in Warrington and by the other local authorities within whose boundaries some of the children were ordinarily resident.

There followed a prolonged and extensive police investigation involving Warrington Borough Council's Children Social Care and Cheshire Constabulary. The criminal investigation involved a total of sixty-seven best evidence interviews undertaken with the three siblings. There were no criminal prosecutions following the CPS determining the criminal threshold had not been met.

A fact-finding hearing was held and concluded, April 2019, that the siblings had been abused, and the originally-identified extended family members had perpetrated the abuse or had been involved to a greater or lesser extent. No findings were made against any other party, some parties were exonerated and none of the other children identified were found to have been abused or to be at risk. In terms of agency involvement, the fact-finding hearing concluded that the agencies involved had no option other than to launch litigation, found that there was a lack of familiarity with current investigatory guidelines i.e. that achieving best evidence interviews and wider investigatory practices were not consistent with best practice. It was found that there was insufficient senior leadership oversight between key agencies during the course of the investigation and that some key officers were insufficiently experienced.

The Warrington child safeguarding practice review sought to examine the multi-agency handling of the case in order to identify the lessons that needed to be learned from this case, and to make recommendations to Warrington Safeguarding Partnership.

Lessons Learned

Adverse childhood experiences (ACEs) and lived experience

- The impact of neglect and adverse childhood experiences (ACE) on children's social, emotional and cognitive development, the more ACEs a child experiences the greater the effect on their physical and psychological health.
- If practitioners are to have a positive impact on the lives of abused neglected children then making sense of and understanding their lived experience, what life is like for them, is essential.
- It is also important to understand the lived experiences of parents and carers who may have experienced trauma, live with domestic abuse, substance abuse or mental health issues and the impact this has, example, the parent/child relationship and attachment

Understanding the impact of SEND

- When working with children and young people with special educational needs and/or disability (SEND), professionals must remain mindful of the fact that not all disabilities are visible. Children/young people may present as more able than they are. In addition, SEND may be further affected as a result of the child's lived experience and the impact of neglect on the brain's development. It is important the skills of educational and SEND specialists are accessed, utilised and maximised.
- In ABE (achieving best evidence) planning, due consideration should be given to recruiting the support of an educational psychologist to ensure a full and robust understanding of the child's special educational needs or disability, including the best approach to facilitate disclosure.

Communication, multi-agency information sharing, and multi-agency working

- The NSPCC in Warrington undertook face to face work with one of the children central to this case between 2013 and 2017. The child talked about relevant factors to this case, but the review could find no evidence that this had been shared with CSC. The work undertaken was not focussed on the child's agency, to be empowered to explore their world and lived experience.
- Effective communication between agencies, which is fundamental for effective partnership working; for social workers it is a core competency be able to engage in inter-professional and inter-agency communication.
- Information sharing and partnership working between the police, CSC and the local authority legal team did not always work well in this case and was sometimes very poor. This impacted on the ability of professionals to work openly and transparently with families and on occasion impeded CSC professionals undertaking risk assessments.
- Social workers did not always understand the statutory duties placed on educational settings from early years to colleges and the important role they play in the identification of abuse and support for vulnerable children and young people.
- Professionals must be alert to "exaggerated hierarchy", whereby professional status becomes magnified and other professionals perceive themselves to have comparatively lower status; this was manifested when the police assumed the central role of investigator and case manager, often making decisions in isolation of CSC and were allowed to do so due to a lack of professional challenge by CSC and legal services

- There was a failure by professionals from all agencies to exercise timely professional challenge at the time the case was active or to implement the Pan-Cheshire escalation procedure when information was effectively being withheld
- Preventing closed professional systems, where one agency assumes a dominant position or view of a case and fails to pay attention to conflicting information or information that fails to support their views and hypothesis

The framework for the assessment of children in need and their families

There was evidence that the assessment framework and the three domains of the child's development, parental capacity to parent and family and environmental impact was not always effectively utilised most importantly in the following areas:

Familial history

- Familial history, impact and relationships between family members. During the planning of any assessment, it is important to determine who knows the child(ren) and family and holds information about them, including information held within CSC records, and by neighbouring authorities where children have moved into the area; education settings, early years provision and schools; health services (both universal and specialist e.g. mental health services); and third sector, e.g. IDVAs, drug and alcohol specialists and the NSPCC, who provide a range of services in Warrington. In this case all of these services held information about the familial history, historical and current, however information was not always shared.
- The three siblings had experienced extensive neglect in the care of their birth parents and were subject of care orders to another authority and then special guardianship orders agency records held significant historical information which was not accessed
- There was a limited understanding current and extended family functioning, inter-familial relationships and the impact for the children and young people, both positively and negatively
- Many of the families were blended and there was a lack of information regarding the contact and inter-personal relationships of children not living in the household but having contact

Impact of domestic abuse

- Consideration of the impact of domestic abuse was not clearly evidenced, this was a particular concern in this case, where perpetrators assumed care of identified children during investigation and proceedings.
- In addition, the impact this can have the child/parent relationship

Impact of mental health

- Consideration of the impact of parental mental health in relation to parenting was not clearly evidenced. There were several references to parents suffering low mood but no analysis of this especially when they were victims of abusive relationships, were faced with the complex needs of children with medical conditions or were isolated and vulnerable.
- Further, one parent had significant mental health issues, the significance of which was not immediately apparent in the IMR's nor was the impact of this explored for all the children in the family
- In addition, the impact this can have the child/parent relationship

Failure to access and follow extant procedures

- Warrington has in place ratified and agreed procedures on multi-agency escalation and on investigating organised and complex abuse, however no agency accessed or relied on the procedures that already exist and are accessible by all.

Foster care arrangements

- Children and young people should be carefully matched when placed in foster care; whilst this is not always possible in an emergency, foster carers should have a clear understanding of their lived experience, any SEND and how this impacts in terms of meeting their needs

Child in need processes

- CiN meetings and robust administration being in place to address issues were raised in this review and by agencies e.g. the rescheduling cancelled meetings, distribution of meeting notes; Further, any agency involved in a CiN meetings should have an identified role and action in any plan e.g. plans stated there was no role for the school and the rationale for stepping down from child in need was not always clearly communicated in meetings or in the notes of the meeting

What worked well?

Focus on needs and voice of the child

- Continuity of primary school provision for the three siblings
- The siblings retained the same social worker throughout
- When one of the children disclosed inappropriate touching through the online counselling service, Kooth, they informed EDT[1] ; the police and CSC held a strategy discussion and completed a joint visit the same night
- DSL and DDSL's[2] in schools followed up events and actions when there was no immediate feedback from CSC[3]
- The DDSL at one of the children's high schools appropriately challenged CSC when they were disinclined to act following an allegation of inappropriate touching made to a learning mentor, and again when they were concerned for her welfare in one of her foster placements
- Cheshire Constabulary assigned a dedicated team of experienced officers that were fully trained in public protection matters
- Cheshire Constabulary have adopted 'Operation Encompass', providing prompt notifications to schools in relation to domestic abuse incidents
- A registered intermediary was appointed by police to support the three siblings in their ABE interviews
- Provision of emotional support by schools, cross phase, was outstanding and included play and art therapy, counselling, LEGO®-based therapy, nurture groups, along with excellent pastoral support
- Two of the siblings received support around coping strategies, arranged through RASASC[4]
- Two of the siblings were referred to CAMHS[5] for support in respect to their emotional well-being
- An appropriate referral was made to paediatrics due to faltering growth of a baby
- The CCG[6] has refreshed its safeguarding children standards

[1] EDT - Emergency Duty Team who provide out of office hours cover for children social care
[2] DSL and DDSL - Designated and Deputy safeguarding lead in schools and colleges
[3] CSC - Children's social care
[4] RASASC - Rape and sexual abuse centre
[5] CAMHS - Child and adolescent mental health service
[6] CCG - Clinical commission group who plan and commissioning of health care services for their local area

- CSC reassessed contact between a parent and her children due to the negative emotional impact of the mother's absence
- A young baby remained with their mother throughout proceedings, including when the mother was voluntarily admitted to a mother and baby unit
- Professionals involved undertook a range of observations of, in particular, young children and their interactions with family members during assessments and contact sessions

Engagement with parents

- An NNEB nurse supported a vulnerable parent around behavioural issues presented by her eldest child
- The NHS[7] have updated domestic abuse packs and pathways
- A social worker persevered through considerable difficulty in building a relationship with the parents of one of the involved families, eventually the family agreed to CiN[8] meetings being held. There was evidence of clear benefits for the family from this point, as they were, then, part of formulating a multi-agency plan to support them, which increased communication and engagement
- A school nurse involved with one of the families demonstrated outstanding practice when she provided clear advice to the parents, signposting them to appropriate support, and her records provided an excellent insight into the lived experience of the children, the impact for parents of the ongoing proceedings and the voice of the child is clear
- CiN meetings, where held, were beneficial for families
- A vulnerable parent failed to attend a family support meeting, so professionals took the meeting to her home address

Partnership working

- The review found evidence of good partnership working between schools and CSC
- Schools worked with IDVAS[9] when a parent disclosed domestic abuse
- Timely referral made for early help services as a result of ongoing allegations of domestic abuse and intimidation
- Appropriate CiN meetings held to support families and their children
- When the mental health of one of the parents involved in this case deteriorated and a voluntary admission to a mother and baby unit became necessary, a joint home visit was undertaken by the allocated social worker and CPN
- Meetings were held with social workers and key agencies across all 4 local authorities to share information with regards to the families involved, which helped when managing risk

Contact and care arrangements

- Where possible, all of the children remained in the care of either their birth fathers or grandparents
- Care proceedings were instigated in respect of all children involved in the case and Warrington Borough Council legal services co-ordinated the fact finding proceedings across all geographical areas
- A challenge was made by a family against the amount of contact made available with a young child; increased contact was not supported by CSC and others involved in the child's care; the matter was placed before the family court and an agreement was reached to increase contact outside court

[7] NHS: National Health Service
[8] CiN: Child in need – s17 Children Act 1989
[9] IDVAS - Independent domestic violence advisor service

- A contact agreement was drawn up with a paternal grandmother of one of the children with clear consequences if broken

Parenting support and assessments

- Parenting assessments undertaken as part of care proceedings generally concluded positively

Recommendations

1. NSPCC (Warrington) should consider adopting “my life” being rolled out by Children Social Care (CSC), which incorporates a chronology of direct work.
2. NSPCC (Warrington) should ensure information/concerns/allegations are communicated to CSC in a timely manner, whether verbally or in writing, and that a response is received from CSC as to what action is being taken; where there is no response it is recommended that this is followed up promptly, or escalated.
3. WSP should review the role it takes in supporting information sharing between and within organisations, and address any barriers to information sharing, including between neighbouring authorities. This should be supported, as necessary, by single and multi-agency training, reinforcing when and how information can be shared and in accordance with working together to safeguard children (2018) and keeping children safe in education (2019).
4. WSP should consider what further action is required and/or available to it specifically in relation to a local authority involved in this case, who failed to cooperate, share information, or properly discharge their duties when expressly requested to do so.
5. WBC CSC and Cheshire Constabulary should present a joint report to the QA group of the WSP setting out what action will be taken to address issues identified in this review; this should include social workers and police planning and undertaking joint ABE interviews; effective partnership with the involvement of an educational specialist when supporting victims who have SEND; continuous assessment of the balance between evidential thresholds; contingency planning and oversight by the CPS to ensure ABE interviews are consistent with guidance and retaining a real focus on the welfare of vulnerable children and young people.
6. WSP should consider making all Chief Executives of all agencies in Cheshire and their respective locally elected leaders aware of this case given the serious concerns raised in relation to the lack of information sharing. For the Cheshire Constabulary, specifically information sharing and ABE interviews.
7. WSP should assure itself that all partner agencies are aware of the organised and complex abuse procedures and receive appropriate training and guidance in its use and application.