Oxfordshire Safeguarding Children Board

CHILD A AND CHILD B

A SERIOUS CASE REVIEW

Kevin Harrington JP, BA, MSc, CQSW

1. INTRODUCTION

1.1 This Serious Case Review (SCR) concerns two siblings, referred to in this report as Child A and Child B, who were both under 5 years old at the relevant times. There had been concerns for the welfare of the children throughout their lives. They both had special needs, as did their birth parents. They had lived, separately and together, with a number of different carers. There had been extensive involvement with health and social care agencies and the Family Court.

1.2 That involvement had led to the placement of the children with a couple, Mr K and Ms L, under a Special Guardianship Order (SGO) made by the Family Court. They lived with them for about a year but were removed when evidence emerged suggesting they both had been seriously sexually and physically abused by Mr K. A number of serious criminal charges were brought against him, some of which were found proved. He received a very lengthy custodial sentence as a result.

1.3 These matters were brought to the attention of the Oxfordshire Safeguarding Children Board (OSCB). The Chair of that Board at the time, Ms Maggie Blyth, having consulted the relevant agencies, decided that the circumstances of the case met the criteria for an SCR, in line with the government's guidance[1]. This is the Overview Report from that review.

2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

2.1 This SCR was formally initiated by Ms Blyth on 29/7/15. The OSCB appointed an experienced independent person – Kevin Harrington[2] - to act as Lead Reviewer and to write this report. Mr Harrington has been supported by the officers of the OSCB and a panel (the Panel) of senior representatives from the agencies which had been involved in the children's lives.

2.2 All those agencies were required to submit an Individual Management Review (IMR), either containing a narrative and an analysis of their involvement where that had been substantial, or a narrative account of events where involvement had been less significant. Those agencies are detailed in the table below.

AGENCY	NATURE OF INVOLVEMENT
Children, Education and Families Services, (CEF) Oxfordshire County Council (OCC)	The County Council, through its children's social care services (CSC) was the lead statutory agency, responsible for protecting the children and promoting their best interests.
Thames Valley Police (the police, TVP)	TVP were involved in a number of relevant criminal investigations

[1] "Working Together to Safeguard Children" (2015), referred to in this report as Working Together
[2] See Appendix A

Law and Governance, Oxfordshire County Council (Legal Services)	Legal Services provided advice and representation in bringing the concerns for the children to the Family Court
Oxford City Council	Oxford City Council was consulted in making arrangements for the SCR but had no continuing role.
CAFCASS	Cafcass represents children in the Family Courts
Oxford Health NHS Foundation Trust	This Trust provided health visiting and a range of specialist therapeutic services
Oxford University Hospitals NHS Foundation Trust (OUH)	OUH provided emergency and continuing specialist health services to the children
Oxfordshire Clinical Commissioning Group (OCCG)	OCCG has reported on the involvement of General Practitioners (GP)
Adult Services, Oxfordshire County Council	Adult Services had been in contact with the birth parents of the children as a result of their learning disabilities

2.3 Agencies were asked to review their involvement from January 2013, when the family requested that there should be a Family Group Conference, until the end of May 2015, when the abuse of the children came to light.

3. METHODOLOGY USED TO DRAW UP THIS REPORT

3.1 This report draws on the content of the IMRs, dialogue with IMR authors and other staff, and family members.

3.2 This report consists of

- A factual context and brief narrative chronology.
- Commentary on the family situation and their input to the SCR.
- Analysis of the part played by each agency, and of their submissions to the review.
- Identification and analysis of key issues arising from the review.
- Conclusions and recommendations.

3.3 The review has been carried out in accordance with the underlying principles of the statutory guidance, set out in Working Together: The review

- *"recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*

- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight[3];*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings".*

3.4 The government has introduced arrangements for the publication of Overview Reports from Serious Case Reviews, unless there are particular reasons why this would not be appropriate. This report has been written in the anticipation that it will be published.

4. KEY EVENTS

4.1 Introduction

4.1.1This section of the report briefly summarises the care arrangements made for these children. Further detail is then provided where appropriate throughout the report. The family composition, and the various care arrangements for the children, are complex.

4.1.2 Child A and Child B are siblings, born in 2010 and 2012. Their parents are Mr C and Ms D, who were in their twenties when the children were born. Both Mr C and Ms D have at times received services as adults who have a learning disability.

4.1.3 Ms D had a child, Child E, with another partner two years before the birth of Child A. There had been concerns about the care of Child E who, as a consequence, lives with Ms D's parents, under an SGO.

4.1.4 Child A and Child B have a younger sibling, Child P, who also lives with a member of the extended family under an SGO.

4.1.5 Child A was the subject of a Child Protection Plan before birth. Mr C and Ms D then cared for Child A until the age of two, when they said that they were unable to continue to do so. CSC had been extensively involved and Child A was then admitted to the care of the local authority. Child A remained in care, at two placements, until moving to live with Mr K and Ms L in March 2014, aged nearly three and a half. The first placement was terminated in October 2013 following allegations, which were not eventually substantiated, of physical abuse by the foster-carer. When the matters leading to this review came to light Child A returned to live with the second set of foster-carers and remains there.

4.1.6 Child B lived with Mr C and Ms D from birth for 10 months, before moving to live with the paternal grandmother, PGM. PGM wanted to continue to care for Child B but it was decided that she could not meet Child B's needs

[3] This review does not rely on hindsight, and tries not to use hindsight in a way that is unfair. It does use hindsight where that promotes a fuller understanding of the events and their causation.

in the long term. Child B remained with her until moving to live with Mr K and Ms L in April 2014. During the period with Mr K and Ms L Child B also spent time in a respite placement with the carers who had most recently cared for Child A. When it emerged that Mr K had been abusing the children, Child B returned to those foster-carers with Child A, and remains there.

4.2 The placement with Mr K and Ms L

4.2.1 In March 2013, following the suggestion of a family member, a Family Group Conference (FGC) was held to discuss the various concerns for the children and what plans might best be made for them. An FGC is a process led by family members which can plan and make decisions for a child who is at risk in some way. Ms L is a distant relation, by marriage, of the maternal family – her maternal uncle is married to the sister of child A and child B's paternal grandfather. She and Mr K, her partner for some three years, were said to be involved in supporting the birth parents in their care of the children and attended the FGC.

4.2.2 Mr K and Ms L expressed an interest in caring for the children. CSC carried out a "viability assessment" which did reveal some causes for concern. There were criminal records for offences of dishonesty. Ms L had experienced some sexual abuse within her family as a child. The records note that this left her
"more determined to ensure that children are listened to and protected from any form of harm"..

4.2.3 Ms L was "*upfront*" about her lack of child care experience and the support she would need, from both her partner and the child care agencies. She had previously made an application to adopt, with a former partner, but withdrew because, she said, that partner was not sufficiently committed to adoption. The local authority decided to carry out a full "Connected Persons Assessment[4]" of the couple, which proceeded over the coming months.

4.2.4 Meanwhile the local authority had concluded, through due process, that neither birth parent could meet the children's needs. The local authority initiated care proceedings in the Family Court and both children were made subjects of an Interim Care Order in September 2013. A permanency planning meeting was held to consider where the children should live. At this point the assessment of PGM for Child B was still underway. The assessment of Mr K and Ms L had been completed and it was agreed that they could be considered as carers for both children if necessary.

4.2.5 It was then in October 2013 that allegations were made of physical abuse of Child A by the foster-carer so that Child A moved to a second foster-placement. Soon after that, in December 2013, the local authority Fostering Panel concluded that Child B could not, in the long term, remain with the paternal grandmother because of concerns about PGM's ability to provide

[4] This refers to the placement of a Looked After Child with a relative or friend who is not already approved as a foster carer at the time of the placement.

care adequate to Child B's needs. Child B remained with PGM on a short term basis.

4.2.6 By the end of 2013 the plan was to reunite the two children and place them with Mr K and Ms L, with a view to seeking an SGO. Child A was placed with them in March 2014 under "regulation 24"[5] arrangements. The Family Court, at the beginning of April 2014, agreed with the local authority's recommendation and made the SGO, leading to the immediate move of Child B to join Child A in the care of Mr K and Ms L. The Family Court also made an order that the local authority should continue to supervise the children for the following 12 months.

4.3 The Special Guardianship placement: April 2014 to March 2015

4.3.1 The agencies involved put in place or maintained a range of services and support arrangements for the newly constituted family, including some day care provision. From the local authority the ATTACH[6] team became involved, a specialist local authority service supporting the placements of children looked after, or placed with a view to adoption, by the authority. The children continued to be seen formally as "children in need" and monitored under those provisions[7] as well as the requirements of the Supervision Order.

4.3.2 The children, and particularly Child B, were reported to have displayed some unsettled behaviour from the outset. Child B was said often to scream for long periods and to upset Child A. In July 2014 Child B was noted to have a number of bruises. This led to an Initial Child Protection Conference where all agencies eventually agreed that the bruising could have been caused accidentally. This incident is discussed further below. Case management continued through the "child in need" planning arrangements.

4.3.3 Through the enquiries arising from the bruising it emerged that Mr K was under investigation by police. He had been involved in the criminal misuse of a debit card belonging to a colleague. In due course he admitted offences and received a Conditional Discharge from the courts.

4.3.4 The children's behaviour continued to cause concern. Child B's reported behaviour included self-harm, head banging and hair pulling, and pinching different areas of the body. Child A was observed to be exhibiting '*unco-operative*" behaviour at nursery. Mr K was the carer most involved in working with the ATTACH Team.

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[5] Regulation 24 of the 2010 Care Planning Regulations provides for the temporary approval as a foster-carer of someone known to a child in exceptional circumstances for up to 16 weeks to allow an immediate placement and sufficient time for appropriate further steps to be taken.

[6] The ATTACH Team (Attaining Therapeutic Attachments for Children

[7] Section 17 of the Children Act 1989 defines a child in need as a child who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of appropriate services; or a child whose health or development is likely to be significantly impaired, or further impaired, without the provision of services; or a child who is disabled.

4.3.5 In late 2014 one of the children was seen at nursery with facial bruising. Mr K said that this had been accidentally caused. The nursery contacted the social worker who advised that no further action was necessary on the basis that there were often injuries because the child's behaviour was difficult to manage.

4.3.6 There was a similar incident involving the other child in January 2015. Again facial bruising was noted at a Children's Centre, a social worker was informed and advised that no further action need be taken for the same reason.

4.3.7 It was decided that some "respite care" arrangements should be introduced for Child B. In January 2015 Child B spent about two weeks with the foster-carers who had most recently cared for Child A. They were very concerned at Child B's presentation and behaviour when placed but the child was reported to settle well with them.

4.4 The discovery of Mr K's abuse of the children

4.4.1 Towards the end of March 2015 Ms L contacted Thames Valley Police. She had become concerned that Mr K might be having an affair and had covertly placed a recording device in their home. When she had listened to it she heard both children crying and Mr K making violent threats, sexual comments and noises. Police responded promptly and Mr K was arrested that same night.

4.4.2 In the following days medical examination revealed multiple bruising to both children. Ms L told police that she had not been aware of the extent of the bruising, nor how it had been caused. Child protection procedures were initiated and, with the agreement of all professionals involved, the children were brought back into the care of the local authority and placed with their current carers, the same foster-carers referred to in paragraph 4.3.7 above.

4.4.3 Mr K was released from custody on conditional bail, and remained on bail until November 2015 when he appeared in court to face a number of charges of sexual and physical abuse of both children. He admitted all the charges of physical abuse / cruelty. He denied all the sexual charges but was found guilty of the rape of one of the children. He received a lengthy prison sentence for the sexual offence and cruelty.

4.4.4 The SGO was formally discharged by the Court in January 2016.

5. THE FAMILY

5.1 The birth parents, the former female Special Guardian and the current foster-carers agreed to speak to or meet with the author of this report. Their comments are summarised below.

5.2 The birth parents

5.2.1 A meeting was arranged with the birth parents but, on the day, they felt unable to attend. They receive continuing support from Mencap, whose staff are talking to them about the SCR and its findings.

5.3 The female former Special Guardian

5.3.1 Ms L no longer has any contact with Mr K. She was keen to contribute to the SCR and has submitted a detailed statement. She had become and remains very dissatisfied with the local authority's input and management of the case. Some of the points she has made are echoed in this report, particularly the decision to place both children with inexperienced carers. There was little preparation or contact with Child B before that child was moved to the Special Guardians. She also expresses dissatisfaction with the continuing support provided by the local authority though that is not so well evidenced.

5.3.2 It was as a result of speaking to Ms L that it emerged that there had been two incidents where the local authority had received reports of facial bruising to the children. She herself had accepted Mr K's account that the injuries were caused in day care settings. The way in which the local authority dealt with these incidents, and the fact that they were not reported by the local authority to this review, are considered in section 6.2 of this report.

5.3.3 Ms L's dissatisfaction with the local authority continued after the children had been removed from her care. She found herself in the position of being a party to the legal proceedings through which the Special Guardianship Orders were discharged. She reports that she felt personally severely criticised by the local authority, when, prior to her disclosure of Mr K's abuse,
"there had been nothing but positive comments and praise".

5.3.4 Ms L had made a complaint through the statutory complaints arrangements for local authority children's social care services in June 2015. The complaint had been concluded in February 2016. There are various aspects to the complaint but essentially it is about Ms L's feeling that she and Mr K had been inadequately supported by the local authority before and during the placement.

5.3.5 When the complaint was being concluded Ms L was told, in respect of certain issues, that
"The (Complaints) Panel are aware that this case is now subject to a Serious Case Review and that this matter may be part of the considerations of that

comprehensive multi-disciplinary enquiry, and do not wish to comment further".

5.3.6 It would have been appropriate that the local authority advise the SCR that

- a complaint had been made, the substance of which might overlap with the SCR process, and that
- the complainant had been given an indication that the SCR would deal with matters originally raised as complaints.

5.3.7 The local authority may wish to clarify this with her and ensure that there are no outstanding matters of complaint which she expected this process to deal with.

5.4 The foster-carers

5.4.1 The foster-carers have been keen to contribute to the SCR. They had very serious concerns when they provided respite care for Child B. The child had substantial areas of bruising when arriving at their home. The child settled very quickly with them and there was no evidence of screaming, crying, headbanging or any of the reported disturbed behaviour which had led the Special Guardians to seek a respite placement. The foster-carers were concerned that the child's presentation might be linked to maltreatment and spoke to social workers about this but this did not lead to any action. The foster-carers asked that the local authority should look again at what it does to equip foster-carers in such a situation to express and pursue such concerns. The local authority has agreed to follow these matters up.

5.4.2 The foster-carers shared concerns about Special Guardianship which echo some of the points made in section 7.6 of this report. They feel that it can be used as a "cheap option" and one that lacks the thoroughness of the processes of assessment and review for foster-carers and adopters. In this case they remarked on the very tenuous nature of the family connection between the children and the carers, yet that connection served to carry a degree of legitimacy in the placement arrangements.

5.4.3 At some point in the future they would like to be able to tell the children that their experiences have led to improvements in services to children in need.

6. THE AGENCIES

6.1 Introduction

6.1.1 These children have a wide range of special needs and their lives, from birth, have been troubled. This has brought them into contact with many health and social care agencies, providing some very specialised services. The “parent agencies” for all these services have evaluated their overall involvement with the family and the following sections of the report briefly summarise and consider that evaluation.

6.1.2 It is inevitable, and appropriate, that such a comprehensive analysis will identify learning points and things which could have been done better. However it is right to say that the overall picture that emerges is one of agencies and individuals working together with a real commitment to promoting the best interests of two very needy children.

6.2 Oxfordshire County Council, Children’s Social Care Services

6.2.1 CSC is the agency at the centre of this review. Their involvement with the family as a whole is long standing. They have had the most significant role in respect of planning and managing the care of the children who are the subjects of the review, and ensuring that those children were properly protected, wherever they have been living.

6.2.2 In terms of protection from the serious harm inflicted by Mr K, for CSC as for the other agencies, it is accepted that the matters leading to this SCR could not have been anticipated. However there are learning points arising from the way in which the agencies, and particularly CSC, responded to injuries to the children. The events of July 2014 have implications for a number of agencies and are discussed separately in section 7.3 of this report. Events in late 2014 / early 2015, in which the actions of CSC are particularly significant, are considered in paragraphs 6.2.9 to 6.2.12 below.

6.2.3 The quality of CSC’s longer term work, planning and managing the care of the children, also raises concerns. That is evidenced firstly in the decision, in February 2011, that child protection planning was no longer needed for Child A. This was a decision taken with proper process – independently led and supported by all agencies – but the lead responsibility sits with CSC. Their report to this review accepts that it was perhaps an “*over optimistic*” decision. That degree of optimism continues throughout these events.

6.2.4 Soon after that decision Ms D was pregnant again, with Child B. That pregnancy did not lead to a pre-birth risk assessment, nor any formal review of the decision to end child protection planning. Child B was born in February 2012 and it was not until December of that year that it was accepted that the care provided by the birth parents was inadequate so that Child B could not stay with them.

6.2.5 Child B moved to live with the PGM, effectively a family initiative to which CSC acceded. This was despite the well known problems PGM had experienced in caring for her own son, Child B's father, which were also raised as a concern by MGM. Moreover PGM's problems were not solely historical. Agencies were also involved in supporting her in the care of Child B's paternal aunt and, in October 2013, one of those agencies raised concern about PGM's use of alcohol and a violent partner living in the home.

6.2.6 Despite the concerns about PGM a LAC review in early October 2013 concluded that she should be supported as a long term carer for Child B. However a further assessment, carried out to meet the requirements of Regulation 24, 2010 Care Planning Regulations[8] recommended only the following month, November 2013, that PGM should not continue to care for Child B in the long term. That position was supported by a Fostering Panel in December 2013 which confirmed that she should not care for Child B. Nonetheless the child did remain with PGM until moving to live with Mr K and Ms L in April 2014.

6.2.7 It is always necessary in these exercises to keep in mind the clarity that hindsight brings. It is also right to acknowledge the hard work of the staff involved in trying to work out the best options for these children from a range of more or less unsatisfactory choices, in what can be a confusing legal context. But, standing back now, one is struck by the extent to which care planning was reactive rather than driven by a dispassionate assessment of what these children really needed most. They do not live with their birth family now and it may be that the option of removing them from their birth family should have been given greater weight at a much earlier stage.

6.2.8 The weaknesses in proactive planning are further illustrated in the decision whether the two children should be placed together. These were very young siblings who had never lived together for very long. Yet one cannot see evidence of any measured, structured consideration of the potential benefits of placing them separately. This had appropriately been raised as a concern with the local authority by the Children's Guardian. The local authority has now reflected on this and accepts that there was a "*lack of rigour*" in their approach to this issue.

Key Issue
Finding a permanent home outside the children's birth family, and placing them separately, should have been given greater thought.

6.2.9 Two further issues arise from the local authority's response to the two incidents, in late 2014 and early 2015, when the children had facial bruising. The various accounts of these incidents are not consistent but the crux of the

[8] Regulation 24 of the 2010 Care Planning Regulations sets out arrangements for the temporary approval of a "connected person" as a foster carer in exceptional circumstances for up to 16 weeks.

matter is that on both occasions, when the day care provider informed CSC of the bruising they were advised that Mr K's account of accidental causation was reasonable and no further investigations were necessary.

6.2.10 There was clearly a possibility in both instances that these were inflicted injuries – the day care providers were sufficiently concerned to report them. But the social worker failed to initiate child protection enquiries and failed to consult anyone else about what had been reported. The local authority has now agreed that
"…our response was not adequate and that procedures and protocols for responding to such concerns were not followed".

6.2.11 There is a clear picture throughout these events of staff working hard for these children in the face of a series of challenges and obstacles. But that picture also includes elements of an approach which follows events rather than leads, underpinned by an insufficiently questioning optimism.

6.2.12 The second concern is that these two incidents were not reported by the local authority to this SCR. They came to light only as a result of the contact between the author of this report and Ms L. I do not think the local authority deliberately sought to conceal these matters but this does indicate a lack of thoroughness in the authority's approach to this aspect of the Review: any incidents suggestive of inflicted injury during the relevant period should have been identified and analysed in the report received from CSC.

6.3 Thames Valley Police

6.3.1 TVP has had relatively little involvement with this family. There have been three key contacts in respect of the children. The first of these contacts arose from the allegations in October 2013 that Child A's foster-carer was rough and unkind to him. From a police perspective
"A police investigation … found this case to be one word against the other without any corroborative evidence".

6.3.2 The second contact relates to the concerns in July 2014 that Child B may have been physically abused. The immediate operational response from police, in conjunction with the local authority's EDT, was prompt and thorough. However this thoroughness is not entirely reflected in the subsequent follow up from police. The IMR notes that police did not interview Mr K or Ms L and withdrew from the enquiries prematurely, at a point when it had not been demonstrated or concluded that no crime had been committed. The IMR illustrates how, across the agencies, the emphasis drifted away from the protection of the children from harm, and towards the need to support the carers in the difficult task they had taken on.

6.3.3 Finally police were of course involved in responding to the abuse that has led to this review. They were the first agency to be involved and went on to pursue a very efficient, comprehensive investigation, while giving an appropriate weight to the needs of the children throughout.

6.4 Oxford University Hospitals NHS Foundation Trust

6.4.1 OUH was principally involved as a result of the special health and developmental needs of the children. The Trust's IMR describes the process of assessment, provision of services and review which was systematic and thorough, appropriately involving the range of other agencies that could contribute. The Trust was also involved in the multi-agency response to the injuries to Child B in July 2014, discussed below.

6.4.2 The IMR highlights two key themes emerging across the agencies:

- that children with special needs can display similar behaviour to children who are distressed as a result of abuse, and that
- the issue of Special Guardianship in this case illustrates the diverse and complex range of ways in which the courts can become involved in the lives of children. Non-specialist agencies may sometimes need assistance in understanding that complexity, for example in respect of determining who has parental responsibility.

6.5 Oxford Health NHS Foundation Trust

6.5.1 This Trust provided health visiting services and a range of specialist therapy services for both children. Some of this provision was unavoidably disrupted when, for various reasons, the children's addresses changed, so that a large number of professionals saw the children. During the periods when the children were in the care of the local authority the Trust also provided services through its Looked After Children team.

6.5.2 The Management Report demonstrates good, well co-ordinated professional involvement across this range of services, and with the other agencies:
"both children received a high level of input from both the health visiting and the children's integrated therapy services in order to ensure their development progressed and their needs were met".

6.5.3 There are some learning points and instances when best practice was not maintained – for example, not submitting a written report to the Child Protection Conference on Child B in July 2014 – but, again, the overall standard of work, and the commitment of practitioners to these children is clearly evidenced.

6.6 Oxfordshire Clinical Commissioning Group

6.6.1 The CCG has reviewed the involvement of the children's General Practitioners during the period under review. Because of changes of placement a number of GP practices were involved but this did not lead to any significant difficulties. The GP was central to the events leading to the Child Protection Conference in July 2014, which is discussed separately. The overall level and quality of service from all GPs was good apart from some issues relating to documentation.

6.7 Children And Family Court Advisory And Support Service (CAFCASS)

6.7.1 Cafcass became involved when the local authority initiated care proceedings in the Family Court in the summer of 2013. This prompted the appointment of a Children's Guardian by Cafcass. Their Management Report explains that
"The core functions of a Children's Guardian are to provide the court with an independent overview of the child's situation and of options available to the court; to critically appraise the work of other agencies; and to make recommendations to safeguard and promote the welfare of the child. Ensuring that the 'voice of the child' is represented during the proceedings is another key role of the Children's Guardian".

6.7.2 The Children's Guardian (the guardian) was fully and appropriately involved throughout the journey of the children through the legal proceedings. There were a number of points at which issues arose between the guardian and the local authority in relation to the care planning for the children. Ultimately an overall consensus was reached and the guardian supported the placement of the children with Mr K and Ms L.

6.7.3 However the guardian remained concerned about the use of SGOs in this situation, particularly in view of the young age of the children and the inexperience as carers of Mr K and Ms L. Issues related to the legal management of the case and the use of SGOs are considered separately below.

6.8 Oxfordshire County Council, Legal Services

6.8.1 Legal Services' role was to give advice to inform the key decisions to be made in planning the long term care of the children. Their involvement is also considered below in relation to the relevant terms of reference.

7. THE KEY ISSUES

7.1. A focus on the child
How were the children's wishes and feelings assessed and considered? Were services sensitive to the possible causes of evidence of unhappiness and disturbance after the placement which has led to this

review? Were specialist services, such as the ATTACH team, appropriately and productively involved?

7.1.1 It was difficult for all the agencies to assess the wishes and feelings of these children because of their young ages, disabilities and communication difficulties. There was always good reason to believe that disturbed behaviour was a consequence of early neglect. OUH reports, in respect of Child A, that *"Behaviour such as head banging, biting the tongue and grinding the teeth were noted in the records (and)… the Clinical Psychologist confirmed that, given the previous social history, this would not be unusual behaviour for a child with attachment difficulties".*

7.1.2 The guardian has reflected on whether she might have done more, perhaps by arranging an observation while Child A was getting to know the Special Guardians. The IMR from Cafcass accepts that this might have been helpful, but only to a limited extent:
"there were limitations, in that Child A was getting to know both adults through weekly visits whilst the primary carer remained his foster carer. The weekly meetings were activity based and would not, I believe, have provided robust evidence as to how Child A would relate to the Special Guardians once placed full time in their care".

7.1.3 The IMR from CSC also identifies how behaviour can be interpreted so as to fit with assumptions made about the children:
"If they appear to be comforted then this is viewed, understandably, as a sign of positive attachment. If Child B is observed crying and head banging and unable to be comforted by Ms L, then this is interpreted as due to previous experiences with the parents and paternal grandmother".

7.1.4 The prevailing specialist advice was that the reported disturbed behaviour of the children could be explained as a consequence of early neglect and attachment issues. This was the view taken by ATTACH, a local authority specialist team of professionals with backgrounds in clinical psychology and therapy. They provide assistance and support in a range of situations where children are living away from their birth parents, and overall the team's involvement was helpful. However, as the IMR comments
"there should have been more critical reflection between professionals as to the likelihood of other causes of this disturbed behaviour".

7.1.5 The IMR from CSC appropriately concludes that
"some of Child B's behaviours can also be viewed as classical signs of abuse. Very calm behaviour with a new carer was perhaps an indicator of a missed opportunity to spot this earlier".
The advantage of hindsight bias is accepted but, ultimately, SCRs do have that benefit. No criticism of those involved at the time necessarily arises from the opportunity to view these events in the light of what we know now.

Key issue
The children's distress was too easily ascribed to negative experiences in their earlier lives. Professionals might have been more alert to the possibility of other causes.

7.2 Were agencies sensitive to any significant issues of diversity in their involvement in this case? Did interventions take full and proper account of the disabilities and disadvantages which these children had?

7.2.1 Both of these children had very significant disadvantages. They were not always well cared for by their birth parents, nor by some subsequent carers. They both have global developmental delay. Child B has a degree of physical disability. Both have needed a range of therapeutic services. Their ethnicity is also complex.

7.2.2 All of the participating agencies have been able to demonstrate that they took account of the children's special needs, and those of their birth parents, in their delivery of specialised services to the family.

7.2.3 Research[9] tells us that disabled children are three times more likely to be abused than non-disabled children. The agencies, and particularly CSC with its lead responsibilities for the children, have recognised that they could have been more alert to the possibility of abuse of these children. Again, this is not a conclusion solely informed by hindsight. Closer observation and analysis of Child B's reported behaviour – screaming in distress for long periods when in the care of the Special Guardians but not doing so when going to the foster carers for "respite" – might have suggested cause for concern. The inexperience of the Special Guardians as parents might also have been kept more closely in sight.

Key issue
The vulnerabilities of the children, and particularly their disabilities, did not always prompt the level of professional watchfulness that they might have done.

7.3 Were assessments carried out and decisions taken and followed up in an appropriate way? In particular were child protection concerns identified in July 2014 appropriately assessed and followed up?

[9] See, for example, Jones, L., Bellis, M.A., Wood, S., Hughes, K., et al. (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. The Lancet July 2012

7.3.1 Because of their special needs, and the requirements of child care planning, there were very many assessments carried out by the agencies. Generally there are no concerns about the quality of those assessments and how they were followed up and reviewed. However a number of issues arise from the agencies' response to the child protection concerns in July 2014.

7.3.2 Mr K took Child B to the GP on a Friday evening. Child B had bruising to the forehead which Mr K said he had noticed a couple of days previously and could not explain. The GP assessed Child B carefully and found further bruising to the legs. He judged that the possibility that these were inflicted injuries, particularly the bruising to the legs which was unusual, needed to be assessed. He allowed Mr K to take the child home judging, appropriately, that there were no acute concerns. After some difficulty in making contact the GP spoke to an "out of hours" social worker from the Emergency Duty Team (EDT) who agreed to follow up.

7.3.3 The social worker contacted the family and secured an agreement that another adult (Mr K's sister) would stay with them overnight to provide a degree of supervision. The social worker then referred the matter to police, for information at that stage. The following day social workers arranged for Child B to be seen at hospital. Child B was admitted for observation and Mr K remained on the ward throughout. The social worker and uniformed police went to Mr K and Ms L's home and satisfied themselves that there was no cause for concern for Child A.

7.3.4 A Strategy Meeting under child protection arrangements was convened at the hospital on the Monday. The results of some medical tests were still awaited but the Paediatric Consultant raised concerns at the meeting. The number and nature of the bruises and the lack of any adequate explanation for them was of concern.

7.3.5 The consultant and nursing staff, and the EDT social worker, had also been concerned about Mr K's attitude and presentation: he seemed nonchalant and distant from Child B and at one point had complained to staff that Child B had
"been more trouble than they knew".

7.3.6 The Consultant was also surprised that apparently no-one caring for the child had heard any cry of pain, which he would have expected, given the nature of some of the bruising.

7.3.7 Police decided at that stage to take no further investigative action unless it were demonstrated more clearly that there were non-accidental injuries. A second Strategy Meeting was held the following day. Results of a full skeletal survey did not reveal any further concerns, nor any underlying organic cause for the marks and bruises. Child B was discharged although it was judged that Mr K should not have unsupervised care of Child B until the matters were concluded (though he could have unsupervised care of Child A).

7.3.8 It was decided that there should be a Case Conference under child protection procedures. CSC had initially felt this was unnecessary but the Independent Chair for the meeting, having discussed the situation with the Consultant Paediatrician, decided that there should be a conference.

7.3.9 That meeting now received information from Child A's nursery. Staff there had seen a lump on Child A's thigh during the week before the admission to hospital and had noted this on a body map. The body map did not show subsequent bruising though it was later confirmed that nursery staff had seen bruising to the head and had not felt that these injuries were of concern.

7.3.10 Mr K had by this time suggested that the bruising to the legs was probably caused when Child A had been sitting in a shopping trolley during a recent trip to a supermarket. The social worker for the children accepted this as a possible explanation, as did the Consultant, with some reluctance.

7.3.11 The conference concluded, unanimously, that there should be no further child protection action. Key factors in that decision were that

- The injuries had not been conclusively demonstrated to have been inflicted.
- A wide range of services was already involved with the family and would be continuing to see the children.

7.3.12 When these events were considered during the SCR, the significance of hindsight bias was acknowledged: it was important to assess what had happened with the perspective of what was known by the staff dealing at that time, before the perverse cruelty of Mr K had come to light. In that context the SCR judged that, overall, the decision not to pursue these matters further under child protection arrangements was reasonable. There had also been some good and thorough practice by the GP and EDT in responding to the initial concerns, and by the Independent Chair in challenging the CSC reluctance to pursue the matter under child protection arrangements.

7.3.13 However some concerning learning points were identified. Agencies need to keep sight of the well-evidenced high frequency of non-accidental injury in children with disabilities, who are often least able to explain or demonstrate what had happened to them. Police too quickly came to the conclusion that they could withdraw from the enquiries: there was still a clear possibility that the injuries were non-accidental and relevant further enquiries should have been made – interviewing Mr K and Ms L, for example. The unusual, disaffected behaviour demonstrated by Mr K on the ward was too easily set aside. The medical opinion of the paediatrician, indicating non-accidental causation, was also too easily set aside – by all concerned, including the paediatrician himself. The GP did not attend or report to the meetings held, and the Health Visitors did not submit a written report.

7.3.14 The review has identified some factors which may have affected the outcomes of the conference. There were so many attendees at the meeting - twenty-two - that it was difficult to have a sufficiently full discussion. The

carers were in attendance throughout which may also have inhibited discussion. Overall the desire for the placement to be successful, especially for staff with a continuing relationship with the children, may have obscured their judgment.

Key issue
Formal child protection procedures were not followed with sufficient rigour. Further investigative steps should have been taken and fewer people should have attended the Child Protection Conference.

7.4 How were Family Group Conferences used? Was this helpful?

7.4.1 A Family Group Conference is a process led by family members which can plan and make decisions for a child who is at risk. In Oxfordshire they are facilitated by a dedicated service located within CSC.

7.4.2 Most of the agencies involved in the SCR were unable to comment on this issue as they played no part in two FGC's which were held in March and June, 2013, and which led to the initiative to place the children with Mr K and Ms L. These conferences arose from a request by the MGM of the children. The report from CSC judges that they were
"useful in galvanising the role of the wider family in working together to support the children (and considering)… viable long term solutions".

7.4.3 It was through the FGCs then that Mr K and Ms L almost drifted into the lives of these children. They were brought to the meetings by a distant relative. As discussed below there are a number of factors that might lead one to question whether they were properly equipped to become their parents. Their lack of any experience of bringing up children is the most obvious one.

7.4.4 It was not the role of the FGC to assess them as parents – that came later. But that FGC process must own some of the responsibility for the initial suggestion that they could and should look after two exceptionally needy children. Once an idea like that is mooted it can take on its own momentum. The FGC process may have given it a degree of legitimacy it would not have owned, had they come forward in different circumstances. The IMR from CSC appropriately raises the question:
"Should there be some safeguards as to who is invited to FGCs and the role they can assume based upon these meetings?"

Key issue
The FGC could have been facilitated in a way that enabled a more robust challenge to a proposal that adults with no experience of parenting and some problems of their own could offer a permanent home to two children with very special needs.

7.5 Are there any lessons to be learned from the conduct of the overall legal proceedings throughout the period under review?

7.5.1 The legal proceedings were complex and changing. There are a number of detailed matters and considerations which consumed time and energy, but do not need to be set out in this report. The following summary of the process and progress of the legal proceedings is drawn from the submission to this review from Legal Services.

7.5.2 Following the initiation of proceedings in August 2013, Interim Care Orders (ICO) were made (unopposed) at the first hearing in September 2013 together with various directions involving a comprehensive timetable up to a final hearing. The final hearing was originally listed for five days commencing in February 2014.

7.5.3 There were a number of matters that arose following the issue of proceedings:

- The birth of a third child, Child P
- The capacity of both birth parents
- The paternity of birth father
- The care of Child B by the paternal grandmother

7.5.4 Proceedings were also issued and consolidated with the proceedings concerning Child A and Child B following the birth of Child P in September 2013. There was a contested ICO hearing with an ICO being made in favour of the Local Authority. Arrangements were made for Child P to be cared for by the maternal grandparents. These arrangements were made permanent following the final hearing.

7.5.5 In October 2013 the Local Authority had adopted a position that

- Child P remain in the care of the maternal grandparents
- Child A move to the care of the newly proposed special guardians in a planned way within four weeks
- Child B remain in the care of the paternal grandmother

7.5.6 The case summary submitted by Legal Services to the Court indicates that the IRO was content with this plan but the Guardian had some concerns and needed further time to consider the SGO.

7.5.7 Concerns then arose about the care afforded to Child B by the paternal grandmother and the local authority became unwilling to approve Child B's continuing placement with her. In December there was a contested ICO regarding Child B. The matter was adjourned to January 2014 and an Interim Supervision Order granted in respect of Child B. In addition, there were further directions for the Local Authority to file and serve final evidence, care plans and SGO assessments by the end of January 2014. The final hearing was also moved to the end of March/beginning of April 2014.

7.5.8 In mid-January the Local Authority's adjourned application for an ICO in respect of Child B was refused, the test for interim removal having not been met – essentially that at an interim stage the removal of children from their carers is not to be sanctioned unless the child's safety requires interim protection.

7.5.9 At a further hearing in March 2014 the Local Authority was directed to provide an addendum SGO Support Plan, together with the Support Plan in relation to Child B in the event that the child remained with PGM. The Special Guardians were requested to set out their position as to whether they put themselves forward as carers for Child B and alternative proposals in relation to contact should both children not be placed with them.

7.5.10 Following a final hearing that concluded at the beginning of April 2014 SGO's were made in relation to Child A and Child B, together with Supervision Orders for twelve months.

7.5.11 There was some delay as a result principally of the challenges arising from the learning difficulties of the birth parents, the birth of Child P and the decision to be reached as to whether Child B should remain with PGM. The Court acknowledged these issues and sanctioned the delay in the proceedings.

7.5.12 As indicated above there remained some areas of disagreement between the Guardian and the local authority as to the most appropriate order to be made by the court. The sad events leading to this review could not have been foreseen but the Guardian's caution is understandable, particularly given the inexperience as parents of Mr K and Ms L. Ultimately, as Legal Services now advise in their report to this review
"These matters were then considered fully before the Court and the competing arguments assessed and determined in (the local authority's) favour".

Key issue
The legal proceedings were particularly complex but their overall conduct was satisfactory. Differences of opinion between agencies were resolved as they should have been.

7.6 Were the relevant agencies clear about when and how Special Guardianship should be considered, what enquiries should be made and what assessments should be carried out? Are there satisfactory arrangements for following up children who have been made subject to Special Guardianship Orders? Is the guidance provided to staff adequate?

7.6.1 Special guardianship was introduced in 2005. It could be seen to fit broadly between a residence order and an adoption order in terms of the new carers' responsibility for the child. Special guardianship offers greater security

than long-term fostering but does not require the absolute legal severance from the birth family that can stem from an adoption order.

7.6.2 It was introduced to some extent in the light of research indicating that a significant group of older children do not wish to make such a complete break from their birth family. The introduction of the new order also recognised some special circumstances such as the situation of prospective carers from some minority ethnic groups who may have religious and cultural difficulties with adoption as it is set out in law. Similarly, unaccompanied asylum-seeking children who need secure, permanent homes may have strong attachments to their birth families.

7.6.3 A fundamental aim of special guardianship is to meet the child's need for a legally secure relationship with their carer. An SGO gives the special guardian parental responsibility for the child, with some limitations and, unlike adoption, the birth parents also retain parental responsibility.

7.6.4 Where an SGO is made in respect of a looked after child, the child will no longer be considered to be in the care of the local authority. A Supervision Order to the local authority may be made. There is a requirement to undertake an assessment for a Special Guardian Support Plan. That support may include some or all of the following provisions:

- Counselling, advice and information
- Financial assistance
- Mediation with parents in respect of, for example, contact arrangements
- Therapeutic provision
- Training for Special Guardians to meet the child's needs

7.6.5 So, these children became subject to SGOs. The court made a Supervision Order, to provide oversight by the local authority for one year. This was part of the local authority's plan submitted to court. There was a Special Guardianship Support plan in place. The Special Guardians subsequently complained (to the Children's Guardian) that they had not been provided with enough information about what they were committing to and, particularly, the differences between being an approved Kinship Carer and a Special Guardian. CSC point out that, as is required, they had ensured that independent legal advice was provided to the Special Guardians but have accepted this as a learning point. In future they will ensure that the advice provided does clearly explain the differences between different sorts of legal order and status.

7.6.6 There is no other indication that the local authority failed to meet any statutory or good practice requirements in respect of the decision to place these children under Special Guardianship arrangements with Mr K and Ms L. Our Terms of Reference query whether the guidance to staff about when and how to use Special Guardianship arrangements is adequate. The local authority has reviewed this and confirms that

"The online procedures are easily accessible to staff and outline the 'Special Guardianship process and Tracking' process and provides links to supporting procedures and information".

7.6.7 However, the very fact that this review is specifically tasked with considering the use of Special Guardianship indicates a degree of concern. That concern arises from the fact that these were two very needy young children and their placement was with two people who had no experience at all of being parents. They did not know the children before becoming involved, through the Family Group Conference, in making arrangements for their future. Any family connection was tenuous. There were criminal records for offences of dishonesty. The assessment process used was not as rigorous as the arrangements for permanence through adoption – there is no requirement that a proposed Special Guardianship arrangement be considered by the Permanence Panel. Special Guardianship did not guarantee that the local authority had a continuing significant role in supervising and planning the care of these young children, for whom the local authority had some parental responsibility.

7.6.8 While plans were being made for these children the government was also reviewing the use of Special Guardianship. That review was prompted by widespread concerns about, to quote the final report from the government's review[10]

- *"Rushed or poor quality assessments of prospective special guardians, for example, where family members come forward late in care proceedings; where there has been inadequate consideration early on of who might be assessed; when assessments have been carried out very quickly to meet court timelines; or when the quality of an initial assessment is challenged, requiring the reassessment of a special guardian.*
- *Potentially risky placements being made, for example, where the SGO is awarded with a supervision order (SO) because there remains some doubt about the special guardian's ability to care for the child long-term. In the …case file analysis (which informed the report), almost half of the 51 cases considered had a SO attached to the SGO. This is particularly concerning where the child is not already living with the guardian, or where there is no or little pre-existing relationship*
- *Inadequate support for special guardians, both before placements are finalised, and when needs emerge during the placement, for example, where the special guardian has not received the information or advice to make an informed choice about becoming a special guardian, or where they receive little or inadequate support post order to ensure they can support the child's needs"*

7.6.9 The correspondences between these national concerns and some features of the case under review are self-evident. The government has made a number of changes to the arrangements for Special Guardianship which will address some of these issues, and they are detailed in the national review.

[10] SGR_Final_Combined_Report.pdf

7.6.10 This report has stressed that we have the advantage of hindsight. Those repeated references are made because it is very important to be clear that the grotesque abuse of these children could not have been foreseen. However, judgments about the overall placement decision, the choice of new carers and the legal arrangements used, do not rely on hindsight. This was a risky placement choice which, in my view, was more likely than most to fail. It is not clear that placement options outside the birth families of the children were given enough consideration.

Key issue
There are clear correspondences between features of this case and the concerns which have led to a national review of Special Guardianship.

7.7 Were there any organisational difficulties within or between agencies? If so, how were these tackled? Has this review found evidence of good practice?

7.7.1 The report from community health services describes the challenges arising when dealing with children who have a diverse range of disadvantages and who move relatively frequently so that "new" professionals inevitably become involved.
"Frequent changes in professionals can prompt a 'start again process', in other words the children are re-assessed by every new professional and former behaviours and adaptation to different environments can be missed. The loss of this vital information with regards to behavioural changes may prevent deeper analysis of the case".

7.7.2 In fact the agencies generally responded well to this challenge and their reports do not indicate any unusual problems of communication or collaboration. Indeed, there is quite a lot of evidence of productive working across agencies. This can be found both in the ongoing work with the children and in the agencies' responses to the significant events which arose during the period under review. As the report from CSC judges:
"There was good multi-agency working and co-operation during the period in question".

7.7.3 There are two well evidenced examples of good practice emerging from this review. The first is the response across all the agencies to the evidence of the abuse which has led to the review. That response was swift and well thought through. Police and CSC were decisive and thorough in balancing their safeguarding responsibilities with the requirements of the criminal investigation. They were supported in that by the other relevant agencies.

7.7.4 The second body of evidence of good practice lies in the agencies' ongoing work. The special needs of these children, social, medical and developmental, constituted a significant challenge to the agencies. For the most part those agencies worked together well.

8. SUMMARY OF CONCLUSIONS

8.1 A number of learning points and concerns about practice within and between agencies are identified in the SCR. However it is right to say at the outset that there was no indication that the children might be abused, so seriously and extensively, within the Special Guardianship placement. It is also right to note that the SCR recognised that many individual staff across the agencies had displayed great commitment and compassion in their work with these children.

8.2 The SCR identified an overall concern about the way in which the local authority approached the task of planning the care of the children. There was an unevidenced optimism that various arrangements within the children's family would meet the children's long term needs, which were special and demanding. The review found that the possibility of seeking to remove them from their birth family should have been given greater weight at a much earlier stage. There was also a lack of rigour in the Council's approach to determining whether the children should be placed together, when they had spent little time together before living with the Special Guardians.

8.3 Neither of the Special Guardians had any experience of parenting, nor any experience of looking after children with substantial disabilities and disadvantages. They almost drifted into the children's lives yet became their legal parents. The SCR expressed some concerns about how this had happened, firstly in respect of the FGC. The FGC process may not have adequately challenged that plan and in fact may have provided an unwarranted degree of legitimacy to the proposed arrangements.

8.4 The legal proceedings which culminated in the Special Guardianship Orders were complex. This was related to associated developments across the extended family, and some disagreements between the Council and the Children's Guardian. Ultimately however it is agreed that all matters were considered fully and properly by the Court before making those orders. There is no indication that the local authority failed to meet any significant statutory or good practice requirements.

8.5 However, while plans were being made for these children the government was also reviewing the use of Special Guardianship. That review was prompted by a range of factors including evidence of some matters identified in this review

- insufficient assessments of prospective Special Guardians
- SGOs being awarded along with a Supervision Order, suggesting a degree of ambiguity about a permanent placement
- inadequate support / intervention from agencies post-placement, particularly when new needs or concerns emerge

The government has made a number of changes to the arrangements for Special Guardianship to address these issues.

8.6 The particular vulnerabilities arising from these children's disabilities should have been given greater weight. Children with disabilities are known to

be much more likely to be abused than non-disabled children. There were concerning aspects of the children's' presentation after the placement with the Special Guardians which might have given greater cause for concern. There was a tendency too readily to conclude that distressed behaviour was an inevitable consequence of early neglect and then the changes in the arrangements for the children's care. Agencies need constantly to remind staff that children with special needs can display similar behaviour to children who are distressed as a result of abuse.

8.7 There was a specific missed opportunity across the agencies, when one of the children was found to have suspicious bruising and formal child protection procedures were initiated. Aspects of those events, including medical evidence and concerns about the presentation of the male Special Guardian, might have prompted more thorough investigation. Police too quickly withdrew from the investigation when there was still a clear possibility that the injuries were non-accidental and further enquiries could have been made. There was a Child Protection conference where there were so many attendees at the meeting, including the carers, that it was difficult to have a sufficiently full discussion.

8.8 There were other occasions when a day care provider reported bruising but the local authority made no enquiries about this. Overall the desire for the placement to be successful inappropriately affected child protection processes.

9. RECOMMENDATIONS TO THE OXFORDSHIRE SAFEGUARDING CHILDREN BOARD

9.1 The Board should use its arrangements for disseminating the learning arising from Serious Case Reviews to highlight the particular vulnerability to abuse of children with disabilities and special needs.

9.2 The Board should require the local authority to demonstrate that it has used the findings of this review to inform its arrangements for care planning for “looked after” children with particular reference to:

- Working with families where there have been long standing child care concerns
- Responding to new child protection concerns
- The use of Special Guardianship, with particular reference to the involvement of the Permanent Placements Panel
- The use of Family Group Conferences
- The arrangements for assessing whether siblings in care should be placed together or separately

APPENDIX A THE LEAD REVIEWER

Kevin Harrington

Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on some 50 Serious Case Reviews in respect of children and vulnerable adults. He has a particular interest in the requirement to write SCRs for publication and has been engaged by the Department for Education to re-draft high profile Serious Case Review reports so that they can be more effectively published.

Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He served as a magistrate in the criminal courts in East London for 15 years.