Serious Case Reviews in Oxfordshire

A Summary

Oxfordshire Safeguarding Children Board

AB Reported 2007

Key Facts

AB was an eighteen month old boy who died accidentally in July 2006 after falling into his grandparents' garden pond. The family had been known to Oxfordshire Children's Services for several years; AB and his sister were on Oxfordshire's Child Protection Register from September 2004 to September 2005 under the category of neglect. The case was characterised by domestic violence; poor safety in the home, including poor supervision; mother's depression; and hostility towards professional intervention. From February to July 2006 the two children and their mother lived in refuge accommodation in Hampshire, Portsmouth and East Sussex, returning to Oxfordshire three days before AB died.

The mother had been known to Social Workers prior to August 2004. She had four previous children, one living with her father (i.e. Maternal Grandfather), one placed for adoption and two living with their father.

Analysis

There was no evidence to suggest that different decisions and actions by individual professionals at any one time would have resulted in a different outcome. At no time could any one person have been expected to predict that AB would drown. However, what emerges from the analysis is the challenge of working with complex family situations where risks may be fluctuating on an almost daily basis. Also that as the family moved around, professionals failed to effectively link – an example of the 'start again syndrome' highlighted in the findings from SCRs nationally.

Key Learning and Action

The case would have benefitted from a sharper, more outcome focused plan and work was undertaken with Conference chairs to achieve a better outcomes focus in child protection planning. Liaison between agencies across LA and Health boundaries and acceptance of one another's assessments was addressed by changes to procedures. The role of Women's Refuge staff in child protection was addressed through changes to the service level agreement. The danger posed by garden ponds to young children needed a higher profile and a publicity campaign was undertaken to address this.

CD Reported 2007

Key Facts

In December 2006 CD fell to her death fell from the balcony of her tower block home (later recorded by the coroner with an open verdict) following an evening of drinking and emotional confrontation with her father. In her 16 years, she had multiple changes of school and address and was part of a large chaotic family. She was the subject of child protection procedures on five separate occasions, four times because of concerns about sexual abuse, and the fifth because of concerns about the risk of physical abuse and neglect connected with domestic violence. Care proceedings resulted in supervision orders, not care orders due to parenting improvements. At fourteen years old CD started self-harming and her school attendance became a cause for concern. At several points she was offered counselling and following the pattern set within her family CD rarely attended more than an initial session. At 15 CD 'voted with her feet' and went to live with her father, against professionals and her mother's wishes.

Analysis

This was a complex, complicated and chaotic family who did not engage with professionals, seeking help only under the duress and pressure of crisis and then withdrawing from any ongoing involvement. There did not appear to be any single action, by any agency, that would definitely have resulted in a different outcome. Significantly all agencies worked hard with this family and there was evidence of good inter-agency communication and adherence to agreed protocols and procedures. However there was little evidence over the years of real, outcome focused joined up work or planning, and a lack of multi-agency meetings.

Key Learning and Action

The inter agency work with CD and her family could have been better planned and focussed; improvements which followed included multi-agency early intervention work. One major contributing factor seemed to be the family's reluctance to engage with professionals, which it was thought might have benefitted from family based decision making rather than the conventional approach which failed here; as a consequence investment in the Family Group Conference Service increased ten-fold. Issues highlighted around engaging reluctant families resulted in changes to CAMHS procedure and practice.

EF Reported 2009

Key Facts

EF was a 15 year-old girl looked after by Oxfordshire County Council. She was living in a small, independent children's home when, on 17 November 2008, she was found dead in her bedroom, An inquest recorded an open verdict, but it is believed that she killed herself. EF had been in the care of Oxfordshire County Council, on a full-time basis, since early 2007. Support for the family had been provided over many years, and EF's first experience of the care system was in 2005. Her placement history included spells in in-county residential care and in secure care. Her last move to an independent children's home in Hampshire was triggered by the closure of the independent home in which she had been living. EF had four sisters: two now adult, living independently; one older living with her father (having spent considerable time in care herself) and a younger sister living with her mother.

Analysis

EF was very difficult to help and at the same time her behaviour put her at very significant risk of serious harm. Agencies worked hard to support her and her family, and shared information well but their efforts were not well enough jointly planned or coordinated. EF's self harming behaviours were not holistically assessed nor effectively addressed by all agencies. It is not possible to say that the eventual tragic outcome could have been avoided but improved assessment, information sharing, care planning and decision making could have served to reduce the likelihood of that outcome occurring.

Key Learning and Action

The need for a more strategic, integrated multi agency approach for such complex cases was highlighted – including self-harming behaviour - which resulted in the development of a new multi-agency complex case planning process. A clear understanding of thresholds for taking court action has been addressed by the provision of additional training and guidance. Understanding by partner agencies of shared obligations towards Looked After Children has been improved through a community health review, the virtual school and improved scrutiny and monitoring through the Trust and LSCB quality assurance groups.

G-H Children x 4 Reported 09

Key Facts

The mother of these children (born in '91, '93, '96 and '02) was abused as a child herself; had been in care as a young girl; married young and had a child but subsequently divorced and had 3 further children from other partners. She began to take illegal drugs, then developed an alcohol problem. She moved frequently. She suffered violence from each of her partners to varying degrees. Social Workers and Health Visitors made enormous efforts to encourage the mother to seek help and assistance for her drug and alcohol problems, but many appointments were not kept and often excuses made as to why she could not or would not take drug urine tests. Often the children would attend school hungry, filthy and wearing dirty clothes. Home visits found the house in a totally unacceptable state for children. The children's situation was further aggravated by a totally chance meeting with a known sex offender IJ - see below - as they moved into one of their houses that adjoined his garden. He soon ingratiated himself with the family, paying for holidays, gifts and hotel accommodation. The offender was subsequently arrested and convicted for Child Abuse and is now serving life imprisonment.

Analysis

Numerous agencies were involved with the family over the years. Child Protection Review Conferences were held but often the focus was about how to reduce, monitor and treat the mother's drug and alcohol problems. This was a very difficult case, aggravated by the unwillingness of the mother to heed advice and protect her children, her unwillingness to seek help with drug and alcohol problems and her often aggressive responses to professionals.

The needs of the children seemed to diminish into the background. Agencies appeared to act individually rather than working together. There was an absence of Core Group working, to 'pull things together' and develop a more strategic view of the whole of the professional contact with, and input into, this family, and of the impact of that involvement. There were numerous missed opportunities for the children to have been removed and placed in care. Instead they suffered further, preventable neglect and abuse.

Key Learning

The highlighted need to adopt a coherent approach to working with neglect has resulted in the development of a multi-agency neglect strategy which is being implemented. Core Group working was a weakness in this case and monitoring training and guidance have addressed this. Steps have been taken to improve attendance at and participation in child protection conferences. The problems in working with difficult and deceptive people was a feature and this has been addressed though training.

Adult IJ and his involvement with 9 children Reported 09

Key Facts

This case has a convicted sex offender at its centre, his 2 disabled daughters for whom he had sole care, together with 7 other young males, all of whom he groomed and/or sexually abused. IJ was subject to Probation and MAPPA (Multi Agency Public Protection Arrangements) supervision during the period when he abused the boys and there was significant, ongoing health and children's social care involvement relating to the care of his daughters. The trigger for the abuse being uncovered was a paedophile investigation in the USA, which alerted Thames Valley Police. IJ is now serving a life sentence for sexual offences against these boys.

Analysis

Concerns about the risk posed by IJ in caring for his daughters were sometimes overshadowed by the overwhelming physical needs of the children. In addition IJ's predatory abuse of boys outside the family went unhindered by lack of information sharing between certain agencies; inconsistent attendance at child protection conferences; over dependence on expert opinions; inadequate recourse to robust consequences when breaches of agreements occurred; and reliance on fixed assessments even in the light of changing circumstances. However, IJ was/is a very intelligent, deceptive, charismatic individual who was able to manipulate a variety of practitioners, parents, and agencies, at times despite evidence to the contrary.

Key Learning

For some whose primary clients are adults, the boundaries between inter-agency information sharing to safeguard children and confidentiality became blurred – new guidance has been issued. There was a lack of assertive action by MAPPA and poor collaboration between it and the LSCB; information sharing and collaboration issues have now been addressed. Written agreements were used inappropriately in the case which prompted a review and new guidance is being issued.

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