Surrey Safeguarding Children Board

Report of the Serious Case Review regarding Child G

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1 INTRODUCTION

1.1 This Serious Case Review (SCR) was commissioned by Surrey Safeguarding Children Board to review and learn from the practice which related to Child G. Child G was placed under Special Guardianship Order[1] (SGO) with her maternal great aunt and uncle (referred to in the report as Mr and Ms A). During the latter period when she was living with Mr and Mrs A, Child G was observed to be demonstrating behaviours that could indicate that she had been sexually abused. In November 2018, Child G made allegations of sexual abuse by Mr A and a full ABE (Achieving Best Evidence)[2] interview was completed. There had been a previous allegation against Mr A of indecent assault on a minor. There had been sufficient evidence to charge Mr A of this offence, however, he was found not guilty at court. The police investigation which occurred regarding Child G's allegations concluded that there was not sufficient evidence to proceed with a prosecution.

1.2 In light of this, a referral to Surrey Safeguarding Children's Board occurred on 13th December 2018. A rapid review took place on the 21st December 2018 and a decision was made that the criteria for a Serious Case Review had been met as abuse of a child was known or suspected and the child was seriously harmed; and there are concerns about how organisations or professionals worked together to safeguard the child[3]. In April 2019 Rhian Taylor was appointed as an independent lead reviewer and is completely independent of all agencies involved in the review. Rhian's experience is set out in Appendix two.

1.3 Surrey Safeguarding Children Board appointed a chair and Review Panel to oversee the review. The membership is outlined below.

Agency	Representative
Surrey Clinical Commissioning Group	Chair of the Panel: Designated Nurse Looked After Children. Deputy Designated Nurse Safeguarding Children Safeguarding Nurse Advisor for Children and Adults

[1] Special Guardianship is an order made by the Family Court under the Adoption and Children Act 2002 that places a child or young person to live with someone other than their parent(s) on a long-term basis. http://www.legislation.gov.uk/ukpga/2002/38/section/115

[2] An A.B.E. interview refers to the guidance for interviewing children specified in 'Achieving Best Evidence (ABE) in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses' (2011) available at https://www.cps.gov.uk/sites/default/files/documents/legal_guidance/best_evidence_in_criminal_proceedings.pdf

[3] H.M. Government (2015) Working Together to Safeguard Children, Online, Available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf
Working together to Safeguard Children is the government's overarching guidance on safeguarding.

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Surrey County Council Children's Social Care	Team Manager
Surrey County Council Legal Services	Principal Solicitor
Surrey and Boarders Partnership	Consultant Nurse Safeguarding
Children and Families Courts and Advisory Support Services (CAFCASS)	Service Manager
Surrey Police	Force Advisor Child Exploitation and Abuse
Surrey County Council Education Authority	Area Schools Officer

1.4 There were a number of delays to completing this Serious Case Review, primarily as a result of restructuring in the safeguarding partnership, which caused a delay in organising panel meetings and making sure that chronologies were completed.

1.5 In September 2019, the new requirements for multi-agency safeguarding arrangements outlined in Working Together to Safeguard Children (2018)[4] meant that the Surrey Safeguarding Children Partnership replaced Surrey Safeguarding Children Board. The panel, therefore, transitioned to reporting to the Partnership.

1.6 The methodology of the review was designed to focus on not only *what* happened, but also *why* practice decisions were made, and to use this understanding to make recommendations for practice improvements. The following agencies were asked to submit a detailed chronology in line with the dates identified in the Terms of Reference (Appendix one), 1st February 2014 to 28th February 2019. They were also asked to comment on their practice alongside the identified timescales in the chronology. During a series of panel meetings, agency representatives were able to analyse these reports in their consideration of learning and recommendations.

1.7 Organisations who supplied information included:

- Ashford and St Peters Hospitals
- Cafcass (Child and Family Court Advisory and Support Service)
- Children and Family Health Surrey
- General Practitioner
- Independent Social Work Agency
- National Probation Service and Kent, Surrey and Sussex CRC (Community Rehabilitation Company)

[4] H.M. Government (2018) Working Together to Safeguard Children, Online, Available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf
Working together to Safeguard Children is the government's overarching guidance on safeguarding.

- Surrey and Borders Partnership
- Surrey Children's Social Care
- Surrey Police
- Surrey Schools and Learning.

1.8 The panel has had access to a number of relevant court reports and statements from the care proceedings made available with judicial permission in order to provide fuller material and balance of opinion within the Serious Case Review process.

1.9 Practitioners contributed to the learning and analysis of practice through a group event early in the process, individual discussions, and a later event that allowed practitioners to comment on a draft version of the final report.

1.10 In line with Working Together to Safeguard Children (2015) guidelines, family members were advised that the review was underway. Child G's mother was informed about the Serious Case Review process but stated she did not want involvement. Child G's father was informed and chose to be involved. He was visited by the lead reviewer and a panel member so that his perspectives could be ascertained. His views are included in the report. Mr and Mrs A were notified the review was taking place and invited to participate. They chose to be involved and met with the lead reviewer and a panel member. Their views and perspectives are included in the report. Due to Child G's age, she was not interviewed as part of the report process. Although the panel has focussed on her lived experience and considered her perspective where possible, without direct contact there are limits to the ability of the report to capture Child G's voice and individual experience.

2 CASE BACKGROUND

2.1 Family Composition –

Names	Year of birth	Gender	Relationship	Ethnic origin
Child G	2011	F	Subject	White British
Mother		F	Mother	White British
Father		M	Father	White British
Older sibling - known in the report as Sibling 1.		M	Half Brother on Mother's side	White British
Older sibling- known in the report as Sibling 2.		F	Half-sister on mother's side	White British

Younger sibling – known in the report as Sibling 3.		F	Half-sister on Mother's side	White British

2.2 Other significant adults: Mr and Mrs A are Child G's great aunt and uncle on the maternal side. They became Special Guardians for Child G. Child G's grandmother on the maternal side had an important role in caring for Child G and is currently the carer for Sibling 3.

2.3 In terms of early history, Child G's mother and father split up during the pregnancy of Child G. Her father has been in contact at various points during her childhood but in interview he explained his involvement had been limited due to serving several prison sentences. He expressed sadness about this limited contact and stated that in retrospect he would have sought to have been more involved with his daughter. He said he always felt confident Child G's mother would provide adequate care for Child G. Child G's father has two other children from a previous relationship. They live with their mother and have limited contact with their father.

2.4 Sibling 1 did not live with the family during the main period of this chronology, although visited the family home and occasionally stayed with the family. Until Child G became subject to an Interim Care Order in August 2017, Child G lived with her mother, Sibling 2, and Sibling 3.

2.5 Records indicate that Child G's mother had ongoing and significant mental health needs. The police chronology reports a number of incidents of domestic abuse within the home. Children's Social Care have been involved with the family since 1995 with regard to Child G's older siblings as well as Child G and Sibling 3. The identified concerns were in relation to neglect and parental failure to protect the children from harm and meet their basic needs. Child G's mother had an inconsistent history of engaging with professionals. Although there was some engagement, the concerns regarding the family were significant, ongoing and are outlined in greater detail below.

3 CASE NARRATIVE AND EVALUATION OF AGENCY PRACTICE

Early intervention with the family (February 2014 - October 2015)

3.1 During the period February 2014 - November 2014 there were ongoing concerns about neglect within the family and referrals to Children's Social Care from the police and the school. There was a particular focus on the needs of Sibling 2. In March 2014 there was a Children and Families Assessment with a recommendation for case closure. In November 2014 there was a Section 47 enquiry[5] regarding allegations of physical abuse on Sibling 1 by mother. The younger children were not seen or spoken to. There was no health visitor involvement despite the family having a number of identified needs. This would have been available if Mother had requested it, but as a universal service it was reliant on Mother requesting health visitor input.

3.2 In March 2015 there was a referral from the school regarding the attendance of Sibling 2. The referral highlighted the impact of mother's poor mental health on the children. There was a Children and Families Assessment, but the children were not spoken to or seen in a home visit. The case was then closed.

3.3 In June 2015 a social worker was allocated due to concerns of neglect. A Child in Need (CIN) plan was put in place but there was a lack of follow up on recommended actions. Mother was not attending her own health appointments.

Summary evaluation: Early intervention with the family

During this phase of intervention with the family, there was evidence of a lack of listening to, and hearing the lived experience of the younger children in the family, who were often not seen. Their needs were not being made visible, nor were there sufficient links being made between the experience of the older sibling and the likely parallels for the younger children. The children were not receiving the support of a health visitor, as Mother had not requested involvement. However, this could have been a beneficial service in terms of the children's needs and raises the issue of children missing out on services if parents are struggling to engage or reluctant to ask for support. Whilst different agencies were working with the family and offering some intervention, there was a lack of joined up support and the wider picture of issues that the family was facing, was not addressed.

[5] A section 47 enquiry occurs when Children's Social Care have reasonable cause to suspect that a child in their area 'is suffering or is likely to suffer, significant harm.' The aim of the assessment is whether any action should be taken to safeguard the child. HM Government (1989) Children Act, (Online), Available from: https://www.legislation.gov.uk/ukpga/1989/41/data.pdf,

The Child in Need plan was not sufficiently effective in bringing together multi-agency involvement. The context for this practice extends beyond this specific case, with similar issues relating to concerns about cases being closed prematurely and poor multi-agency planning, particularly in relation to neglect, being highlighted in the 2015 Ofsted report [6]. Ofsted questioned the effectiveness of the system of early help (page 48) and the service has since been restructured. With the benefit of hindsight, it seems that a more effective early intervention would have been useful in addressing the family's needs as they presented during this period.

Child G subject to Child Protection Plan (October 2015 - July 2017)

3.4 In October 2015 a further Section 47 enquiry occurred following an incident of domestic abuse, and the threshold was met for an Initial Child Protection Conference (ICPC). The conference made Child G, Sibling 2 and Sibling 3 subject to a Child Protection Plan under the category of neglect. The Initial Child Protection Conference report outlined numerous concerns regarding Child G, including reports of iron burns to her face and body whilst under her mother's care. There was a recommendation for parallel legal planning.

3.5 Between November 2015 and January 2016, the subsequent core group met and included the health visitor, who began to build a relationship with the family. There was ongoing difficulty in engaging Mother, who was struggling with her mental health. Records indicated a change of social worker. There was positive engagement with a family support worker who was helping Mother attend appointments.

3.6 In January, the chronology identified Mr and Mrs A as involved in supporting Mother with the children. During February, it was indicated that Child G was staying over with Mr and Mrs A. No risk assessment or further checks were made regarding this.

3.7 On 2nd February 2016, Child G's primary school informed Children's Services that a parent had come to see them informing them that Mr A, who was supporting Child G with school attendance, had historical allegations of sexual abuse made against him. This was noted in the subsequent Review Child Protection Conference minutes, indicating a discussion with a family member who had said that he had been found not guilty, but there was no indication that this information was pursued by Children's Services following the conference. The outcome of the conference was that all three children remained on a Child Protection Plan under the category of neglect, with the chair highlighting that due to the lack of progress there needed to be parallel legal proceedings. This had not been progressed following the first conference.

[6] Ofsted (2015) Surrey County Council: Inspection of services for children in need of help and protection, children looked after and care leavers. https://files.api.ofsted.gov.uk/v1/file/50004296

3.8 Child G made an allegation of her mum hurting her. This was not addressed until over a month later. Child G was visited at school by her social worker where she told the social worker different ways she was being hurt, including her older sister holding her face under water. Records indicate that this was seen by the social worker as over chastisement rather than harm.

3.9 In May 2016, Mrs A asked if her and her husband could be considered as carers for Child G. Child G was spending an increasing amount of time with Mr and Mrs A, and they were positive about their relationship with her and their ability to offer support.

3.10 During the June to October 2016 period there was no legal planning despite the earlier direction. The suggested Family Group Conference did not take place. Mother was cancelling appointments with professionals and despite numerous attempts the health visitor did not see Child G for several months. Child G was handed over to the school nursing team. Mother was also not attending her own health appointments.

3.11 The subsequent Review Child Protection Conference highlighted the lack of progress regarding the Child Protection Plan. As a consequence of this, the local authority initiated the pre-proceedings Public Law Outline process. There was no follow up on the noted concerns of sexual abuse allegations regarding Mr A.

3.12 A further Review Child Protection Conference was held in January 2017 with Child G remaining on a Child Protection Plan under the category of neglect. At the conference, the school expressed concern about Child G's ongoing behaviour deterioration. It was noted that Mrs A was bringing Child G to school on a regular basis.

3.13 In March 2017 there are records of incidents of domestic abuse, and Mother's mental health was deteriorating to the point it was agreed she would not be on her own with the children. Her mother stayed with the family to assist in supporting the family. Support to Child G was being offered through one to one support at school. There continued to be consistent support and involvement from the family support worker.

3.14 An audit of the case by Children's Social Care occurred which identified issues of drift and delay. The chronology does not indicate the response to the audit, and whether the tasks set by the audit were completed within the identified timescales.

3.15 In May 2017, Child G's father was released from prison and began to stay with the family. The social worker identified the need for a risk assessment but there was no follow up on this. From discussion with Child's G's Father, he describes himself as being keen to get know Child G within this period, although he felt he could not be consistent because of instability in his life and police involvement.

3.16 In June 2017 Child G and Sibling 3 were found almost naked at the local shops. Child G had climbed out of a first-floor window. A single agency Section 47 enquiry was initiated leading to a safety plan.

3.17 At the Review Child Protection Conference, the accumulation of incidents and the lack of progress in meeting the children's needs for safety and stability was identified. Following the review conference, Children's Social Care made the decision to initiate care proceedings.

Summary evaluation: Child G subject to a Child Protection Plan

There was evidence of delays and drift during this period. Allegations made by Child G were not followed up promptly and there were missed opportunities to consider whether Child G was experiencing harm. Records indicate that supervision was still focussing on the older children. The school were passing on allegations but there was not a feedback loop in them knowing how these issues were progressed. Discussion at the practitioner event highlighted confusing messages over what information they were entitled to request following the passing on of allegations, and the school did not feel confident in asking about the outcome of the information they had referred. This lack of information contributed to their ability to effectively use the escalation procedures.

There were a number of changes in the professionals working with the family during this period. One of these was that health responsibility for Child G moved from the health visitor to the school nursing team. Whilst these professionals work closely together and shared information effectively, this was still a change in worker for Child G at a point when she had developed a good relationship with the health visitor. Within the service specification there is flexibility in the age children are transferred to the school nursing service (they can be maintained by health visitors until the age of 7). This flexibility in case transfer is important in promoting the building of trust and sustained professional relationships. This is particularly important when parents are engaging inconsistently as Mother was during this period. There was also a change in social worker during this time. Mother was frequently cancelling appointments, leading to the children not being seen. It is likely that frequent changes in professionals made eluding ongoing engagement (if this was what the Mother was doing) more feasible, as if a professional has a sustained relationship with a parent they are in a better

position to challenge their behaviour and understand patterns of compliance and disengagement. Professionals with sustained relationships are also in a better position to note and respond to indications of trauma in children. This should be prioritised by agencies and noted as an important part of developing trauma-informed practice in organisations.

The social worker was not completing actions and procedural requirements within the correct timescales and the proposed Family Group Conference was not held. Feedback from practitioners indicates that this was a time of high caseloads in the team. There was also a lack of supervision and management oversight to pick up on uncompleted actions and planning. There were no records of audits during this period, which would have provided an organisational oversight of uncompleted tasks. The Ofsted report (2015) highlighted the issues of drift[7] (page 15, point 54) and the length of time children were subject to Child Protection Plans, over a year before this point in the chronology. It is concerning that there was still evidence in Children's Social Care of this issue despite it being highlighted by Ofsted.

Despite the deterioration in Mother's mental health there was a lack of a co-ordinated response. Responses seemed to be crisis driven without sufficient attention to the accumulating concerns. There was not adequate risk assessment on a range of issues, including Child G's contact with Mr and Mrs A. There was a lack of challenge in the system. The tasks identified by the audit were not followed up and there was insufficient evidence of curiosity and challenge in terms of the children's experience and their safety.

Care planning processes and assessment for Special Guardianship Order (August 2017 - February 2018)

3.18 In August 2017, Mr and Mrs A contacted Children's Social Care to put themselves forward as carers for Child G, who had been staying with them for the previous three weeks and with whom they felt they had a strong connection. The child's mother was not aware of this request. In the social worker's initial meeting Mr A disclosed previous police involvement from 2006 and 2007 where he was arrested and taken to court for an offence of indecent assault on a minor, his ex-partner's teenage daughter. There was sufficient evidence to charge, however Mr A was found not guilty at court. Criminal courts use 'Beyond all reasonable doubt' as their legal standard of proof. A referral for a Regulation 24 assessment[8] was sent to the fostering team.

[7] Ofsted (2015) Surrey County Council: Inspection of services for children in need of help and protection, children looked after and care leavers. https://files.api.ofsted.gov.uk/v1/file/50004296

[8] A Regulation 24 assessment occurs when a relative, friend or other connected person is being considered as a carer for a Looked After Child. The carers are assessed as temporary foster carers under the Care Planning, Placement and Case Review (England) Regulations 2010.

3.19 On 31st August 2017 an Interim Care Order was made. Child G and Sibling 3 were placed together out of county, in a foster placement.

3.20 A Regulation 24 assessment was completed stating that the social worker was unable to recommend Mr and Mrs A for a temporary Connected Persons fostering placement. Records in the chronology state that the social worker was unable to recommend Mr and Mrs A due to a number of concerns. Mr A had disclosed mental health issues which could have affected his emotional availability to care for a child. Mrs A had physical health difficulties which could have impacted on her ability to deal with the emotional challenges of caring for a young child and meet their needs. The social worker also stated that bearing in mind the historical accusations of abuse, they were not able to sufficiently assess the risk in the timescale provided, so could not eliminate potential risks relating to this. A Police National Computer (PNC) check was completed but this came back clear with no trace for either applicant. Having discussed this assessment with Mr and Mrs A, they disagreed with the social workers response to their health concerns and told the lead reviewer that these were past problems and would not have affected their care of Child G.

3.21 In September 2017, when at a contact meeting, Child G made an allegation of physical harm by her mother when she was in her mother's care. She also made an allegation of possible sexual abuse by her mother's ex-partner. The record of this supervised contact was not responded to, and there was no indication in the chronology of these concerns being followed up.

3.22 During this period, Child G was showing distressed behaviour in foster care, hitting animals and becoming destructive and aggressive in the home. She was subsequently moved to a new foster placement. A handwritten note attached to the Looked After Children (LAC) review in September identified concerns around Child G demonstrating behaviour which had a sexual content. The Independent Reviewing Officer confirmed that whilst this note is no longer available, there was discussion about Child G's sexualised behaviour at this review.

3.23 A referral for an assessment of Mr and Mrs A as potential alternative carers (Special Guardians) was sent to the Fostering (Friends and Families) Team. The referral did not provide information about the historic allegations, nor the other concerns that led to the negative Regulation 24 assessment. There is mention of a positive viability assessment, but this cannot be sourced from the records. There is no indication in the records or chronology that information was sought from historic Children's Social Care records of the Section 47 enquiry that would have related to the historic allegations made against Mr A. Children's services records could have provided relevant information regarding background information on Mr A, and the alleged incident. This social services check should have been completed and would have assisted in

providing more evidence for decision making. In the management discussion regarding the referral for the Special Guardianship assessment for Mr and Mrs A, there is no record of consideration of the issues raised in the negative Regulation 24 assessment or the historic allegations.

3.24 Due to capacity issues in the Family and Friends Fostering Team, the Special Guardianship Order (SGO) assessment was outsourced to an Independent Social Work agency.

3.25 In November 2017 the completed SGO assessment was returned. It identified positives in Mr and Mrs A's relationship and said that the child's mother supported this prospective placement. The social worker identified vulnerabilities in Mr and Mrs A's lack of knowledge of attachment and children's difficulties, Mr A's mental health and the proximity of the family home to Child G's Mother. In her report, the assessor acknowledged there were gaps in the information at the time of finalising her report and making her recommendation, stating she had not had sight of the either carers' Disclosure and Barring Service checks, the medicals, the written references or any other background checks. She had not spoken to Mr A's previous partner, or Mr A's daughter or stepdaughter. In the report she acknowledged she only had Mr and Mrs A's account of the historical allegations. The recorded discussion with Mr A in the SGO report regarding the offence was not supplemented by Police or Crown Prosecution Service documents, and therefore relied on Mr A's narrative of what happened. In discussions with the reviewer, the report writer said that she only had Mr A's account of what happened and didn't have alternative information which could have potentially allowed her to provide a challenge to this narrative. With the benefit of hindsight this was an inadequate response to making a risk assessment which was critical for Child G's ongoing safety. The report author also identified that access to past Children's Social Care records and past files would assist Independent Social Workers in having further information and evidence to draw on, enabling a more thorough assessment. This happens in some independent social work agencies but was not a requirement in this particular agency. The SGO report author recommended that a Special Guardianship Order should be made in respect of one child, Child G, given her pre-existing relationship to the family.

3.26 The local authority supported the recommendation of the SGO author for Child G to be placed with Mr and Mrs A. Although questions were raised about the deficits of information during the care planning processes, there seemed to be limited scrutiny regarding the report recommendation. The Independent Reviewing Officer also supported the recommendation. The local authority did not recommend a Supervision Order as it was thought that the support Child G required could be given under a Child in Need Plan. However, Child in Need plans, whilst effective in lots of situations, do not have strong statutory duties.

3.27 The Children's Guardian met with Mr and Mrs A. It is recorded that she was aware of the historical allegations. She noted that Mr and Mrs A wanted a Supervision Order as they thought it would provide an increased level of support. The Guardian raised the issue of the lack of returned Disclosure and Barring Service (DBS) check and contact with Mr A's daughter in her report, and she clarified that CAFCASS could not recommend an SGO without these being in place. However, she continued to support the care plan, subject to these issues.

3.28 On 30th January 2018, a Special Guardianship Order was granted for Child G to Mr and Mrs A. Sibling 3 was placed separately with her maternal grandparents. A 12-month Supervision Order was also granted. The Court, in making the SGO, made directions in respect of the outstanding DBS checks and the need for the matter to be returned to the Court should there be concerns arising upon receipt. The medical reports had been returned by the time of the court hearing, but the delay meant that they had not been returned in time for consideration within the SGO report recommendation. Child G was moved to live with Mr and Mrs A under the Special Guardianship Order.

Summary evaluation: Care planning processes and Special Guardianship Order assessment

There were a number of opportunities during this period of practice to recognise potential concerns and provide a more robust approach to assessing the risks that Child G might be subject to. The local authority failed to seek potentially significant information from their own records, and from the Police and Crown Prosecution Service. The SGO assessment was completed and a recommendation made without key checks and significant information. In discussions with the lead reviewer, the SGO report writer said that with the benefit of hindsight, she should have delayed making the recommendation until she had access to the checks and could more fully consider the issues in her recommendation.

There was a lack of oversight of this report within the independent social work agency, and by Surrey Children's Social Care who received the report. There is no evidence of management oversight regarding the quality of this report and the significance of the missing checks. The now adult children of Mr A were not successfully contacted, and the recommendations were made without sight of the DBS check or medical checks. There was a lack of forensic scrutiny regarding the narrative of the allegations of historical abuse told by Mr and Mrs A. This should have been a particular focus, as research indicates that sexual offenders can frequently minimise their offences. Hypothetically, if Mr A had been a perpetrator of sexual abuse, it is possible that he would minimise the seriousness of what happened. No past agency records were sought on Children's Social Care's involvement with Mr A at the time of the historic in

2006, and no requests were made to the Police or CPS for further allegations information and documentation. Having acknowledged the above lack of scrutiny it is also important to note that Mr A was found not guilty of the allegations in a court of law.

The recommendation for an SGO was made and supported without important information, and professionals should have had a more cautious approach in ensuring they had the required information before making care plan recommendations to ensure they have fully analysed every aspect of a situation. The Independent Reviewing Officer supported the recommendation, and whilst the Children's Guardian raised the issue of the lack of checks, she supported the care plan.

Child G is moved to live with special guardians and is subject to a supervision order. (February 2018 - October 2018)

3.29 During the early period when living with her carers, Child G was reported to be demonstrating challenging behaviour at school and at home. There were delays in accessing services, exacerbated by the fact that health services were not informed for two months that Child G had moved back to Surrey. The school reported they were not prepared for the level of need demonstrated by Child G, and in the practitioner event, educational professionals said that they thought insufficient information was shared. Mr and Mrs A reported in interview that the responsibility for sharing information was left to them rather than Children's Social Care.

3.30 In June 2018, Mr and Mrs A moved to a new home, and it was at this point that they reported that Child G's behaviour dramatically deteriorated. Child G was excluded from school due to physical outbursts and aggression. She was given a place at a special support unit, whilst staying on role at her current school. Mrs A described G's behaviour as unmanageable.

3.31 With regard to the Supervision Order in place, an initial Child in Need meeting was held, however there was no health and school involvement in the meeting, and there is no record of minutes being shared with colleagues. The case holding social worker was not visiting Child G regularly, and most support was being given by the family support worker. The family support worker had a very good relationship with Child G, which is a strength, however the lack of recorded visits by her allocated social workers indicate that practice requirements were not met and the lack of qualified worker means that there was an increased risk of safeguarding concerns not being addressed.

3.32 In July 2018 a Child in Need meeting identified the urgent need for therapeutic support for Child G, as well as support for Mr and Mrs A as the Special Guardians. Education staff report that support was being offered to Mr and Mrs A from the school and wasn't always taken up. Mr and Mrs A stated in interview that they would have benefitted from a worker from the Friends and Families service in Children's Social Care who would have had a specific role in providing independent support for them as carers, and was not directly involved in supporting Child G.

3.33 In August 2018, the GP made an urgent CAMHS (Child and Adolescent Mental Health Services)[9] referral, due to Child G demonstrating extremely distressed behaviour, including biting and hitting. The chronology reports increasing sexualised behaviour. Child G was also reported to be having visual and auditory disturbances. Child G was assessed by CAMHS, but not seen as high risk as Child G had adults involved who were perceived as supportive. In discussion with the lead reviewer, the CAMHS worker explained she had referred Child G to an art therapist, however the art therapist had said that the placement needed to stabilise before work could begin. CAMHS therefore felt that working with the carers and professionals involved would be the best way of supporting Child G. This is common practice for children under ten, as parents/carers are key people in the child's life and therefore providing support for them indirectly works to improve the situation for the child. A meeting was suggested with Mr and Mrs A and Child G's social worker, and the CAMHS workers wrote to the social worker requesting attendance at the meeting. The social worker didn't respond, and despite CAMHS leaving messages for the worker and asking for a response by a particular date, the social worker failed to get in contact. She received no response and it was decided to close the case. The CAMHS worker felt that without the social worker's involvement she couldn't meaningfully continue with the plan to support the carers. With the benefit of hindsight, the CAMHS worker felt that she should have used escalation procedures to make sure she got a response from Children's Social Care, rather than closing the case.

3.34 In terms of education provision, during this period Mr and Mrs A report that Child G settled well at the alternative provision she was offered. They feel she found it more difficult when she was returned to mainstream schooling as she was on a restricted timetable, which limited her opportunities her opportunities to be involved in class activities. Education colleagues report that this strategy was agreed by those involved including her carers, to help Child G with the process of settling back in school.

[9] CAMHS is the Child and Adolescent Mental Health Services.

Summary evaluation - Child G is moved to live with special guardians and is subject to a supervision order.

In terms of support and monitoring for Child G, the Child in Need plans did not provide a comprehensive multi-agency response to Child G's needs and there was unreliability in social worker visits. Consequently, the Supervision Order was not being effectively implemented, as the Child in Need plans were the processes through which the Supervision Order was intended to have effect.

The levels of support for Special Guardians is also of note and has been identified nationally as a concern. As children are no longer 'Looked After', statutory responsibilities are reduced, however children have often experienced similar issues to those who remain looked after and the support needs of carers can be equivalent.

There were a number of delays to Child G accessing therapeutic support. An example of this is the art therapist only taking referrals once the home situation had been stabilised. It seems it is difficult for children who are in a current state of distress to access therapy. This raises the concern of how these children are not getting specialist support and restricts how effectively their voice is being heard. This is a particular concern as these distressed children might be experiencing current harm, as well as past trauma.

There was a lack of response from the social worker by a set deadline, which led to CAMHS closing the case, despite Child G still having significant needs. This raises the issue of the impact of poor multi-agency communication from Children's Social Care. There was a change of social worker during this key period and it was thought that this inconsistency contributed to the lack of response. Children's Social Care should ensure that worker transitions are managed smoothly without affecting the child. Use of escalation procedures from CAMHS could have meant that a response from Children's Services was achieved and the case kept open.

Child G makes allegations of sexual abuse (November 2018 - February 2019)

3.35 In November 2018, Child G made allegations about Mrs A hitting her with a hairbrush and with her hand, and a joint section 47 enquiry was initiated. Child G was observed by the family support worker to be demonstrating sexualised behaviour. There was an increasingly robust social services response to the support needs, but no revisiting of the allegations within Mr A's history and the overall placement safety.

On 19th November 2018, Child G alleged sexual abuse by Mr A and was moved to a new foster placement under Section 20 of the Children Act 1989[10]. In interview with the lead reviewer, Mr and Mrs A reported that the reason for Child G's move was not made clear to them. They stated that they were asked to sign the Section 20 consent for Child G to be accommodated but were told there was not time to explain what it meant.

3.36 Child G did not make any disclosures in the first Achieving Best Evidence interview.[11] As soon as this finished, Child G then made disclosures and was re-interviewed under ABE conditions. In this second interview Child G made clear allegations of sexual abuse by Mr A.

3.37 Mr A was interviewed and denied sexually abusing Child G. He said that the explanation for Child G's allegations and her sexualised behaviour was that Child G had witnessed sexual activity whilst living with her mother.

3.38 In January 2019 Child G was moved to a new foster placement. A Child Protection medical occurred at the Sexual Abuse Referral Centre. No injuries were identified in the medical, nor were there physical indications of sexual abuse. The medical did not provide any additional evidence of abuse, however, this would be consistent with Child G's allegations that the abuse that took place involved 'touching' and therefore would be unlikely to result in physical indications of harm.

3.39 Professionals were seeking therapy for Child G during this period. A referral was made to Surrey Sexual Trauma Recovery and Support Service (STARS) on January 17th 2019, and a professionals meetings was held on February 1st, with Child G being offered immediate individual emotional support from the Surrey 3 C's service (CAMHS Children in Care), alongside support to her foster carers. More specific therapeutic services were then to be offered when her placement needs were clearer. Children's Social Care, however, decided to seek another provider, and notified 3 C's that they would not be requiring the services specified. Children's Social Care then pursued therapeutic services for Child G with the organisation Family Futures.

3.40 Following two further foster placement disruptions a positive Regulation 24 assessment was made on Child G's Great Aunt. Child G moved to live with this great aunt in a new area on 15th February 2019, being subject to an Interim Care Order.

[10] Section 20 is a section of the Children Act 1989, where the local authority can provide accommodation for a Child In Need in their area. If the child is not abandoned or lost, consent from those with parental responsibility is necessary for Section 20 accommodation.

[11] An A.B.E. interview refers to the guidance for interviewing children specified in 'Achieving Best Evidence (ABE) in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses' (2011) available at https://www.cps.gov.uk/sites/default/files/documents/legal_guidance/best_evidence_in_criminal_proceedings.pdf

3.41 There was a review of the police case and it was decided there was not enough evidence to support a prosecution. The investigation was closed on 27th February 2019.

Summary evaluation. Child G makes allegations of sexual abuse.

The panel considered the police intervention and practice and identified that an area that could have been improved was the preparation for the interview process with Child G. There is little evidence of planning and preparation for the interview and in particular, no consideration was given to whether Child G should have had an intermediary. Given Child G's vulnerability and the distress she was presenting with, consideration should have been given to the use of an intermediary.

Whilst acknowledging how difficult it is to find emergency placements for a child in clear distress, and with the behaviours Child G was demonstrating, Child G had three placements that broke down, following her move from Mr and Mrs A. Although a professionals meeting took place and individual emotional support was offered, this was not pursued by Children's Social Care and Child G did not receive specific therapeutic support during this period. Whilst not suggesting there are easy solutions to the issue of accessing therapeutic support for children in crisis and experiencing placement breakdowns, it is important to acknowledge the highly destabilising and distressing impact of such instability on a child, who has already been through a high level of trauma and has potentially experienced ongoing sexual abuse.

4 SUMMARY OF FINDINGS & RECOMMENDATIONS

Finding One

Despite evidence of much good practice within the individual agencies there were challenges in communicating across the multi-agency partnership when working with a complex family with multi-faceted needs. When communication does not work well, the provision of services may not be effective.

4.1 The early periods within this chronology indicate that despite concerns from the school and the police and several referrals being made, Children's Services closed the case on a number of occasions. There was a long history of trauma and mental health problems from Mother, but there was not a coordinated response from social services and health with regard to how that was likely to affect Mother's parenting and consequently the needs of the children. As identified in the 2015 Ofsted inspection,

the Surrey restructure that led to the establishment of RAIS (Referral Assessment and Intervention Service) teams had contributed to a situation where Children in Need cases were not receiving an adequate service, with the impact of potential risk to their safety not being properly considered' (p. 39)[12].

4.2 This situation has now changed in the county as since the Ofsted report, there has been a significant restructure to a Family Resilience and Safeguarding model, based on the Family Safeguarding Model pioneered by Hertfordshire since 2015. The Hertfordshire model received a positive evaluation in a 2017 government commissioned evaluation of the service[13]. The aim of this model is to recognise that adult problems cause children to be in need or at risk, and Children's Social Care practitioners work alongside adult-focussed professions in a joint team. The Surrey implementation of this model has not been evaluated, however the implementation documentation indicated that each pair of family safeguarding teams (there are 22 across the country) will share an adult mental health worker, two domestic abuse workers and a substance abuse worker[14]. The Early Help provision, will co-locate both CAMHS and SEND (Special Educational Needs and Disability) in a multi-agency hub. These are promising moves and could work to address the lack of a joined-up approach to need identified in this report, whilst acknowledging that the early stages of this chronology are now over five years ago. What is key, however, is ensuring that services are sufficiently resourced so that threshold levels can be consistently maintained and that families are not stepped down to lower tiers of support, if this is not in line with their needs. Surrey Children's Social Care should make certain that there is clarity over the threshold levels, and provide ongoing monitoring to consider whether there is consistency of interpretation across the county. They need to ensure the thresholds are not reduced in periods where demand for services rises, or funding is reduced.

4.3 In terms of multi-agency communication, practitioners from outside of Children's Social Care identified that they felt it was difficult to be heard by social workers. When concerns were passed on, they did not receive feedback on what had happened regarding their concerns. There was a sense that when referrals were made, they had to trust that it was being pursued appropriately, but as in this case, this did not always happen. With regard to the initial referral that the school made of the information they had received regarding the allegations of Mr A's historic sexual offending, the school

[12] Ofsted (2015) Surrey County Council : Inspection of services for children in need of help and protection, children looked after and care leavers. https://files.api.ofsted.gov.uk/v1/file/50004296 page 13 and page 39

[13] Forrester et al. (2017) *Family Safeguarding Hertfordshire.* Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625400/Family_Safeguarding_Hertfordshire.pdf

[14] Surrey Safeguarding Children Partnership (2019*) Surrey Family Resilience and Safeguarding . How our approach is changing.* https://www.surreyscp.org.uk/wp-content/uploads/2019/05/How-our-approach-is-changing-May-2019.pdf

made a referral and raised it at the Initial Child Protection Conference. Yet this information was not pursued by Children's Social Care. In discussion about this with education practitioners at the practitioner's event, they identified a hierarchy with regards to safeguarding, where they perceive education professionals' views to be considered as less important than social workers. This leads to lack of confidence in asking for follow up information and challenging social workers. Children's Social Care should ensure they listen to their education colleagues and provide feedback to referring professionals. Education professionals at the practitioner event expressed a lack of confidence in the escalation procedures. Surrey Safeguarding Children Partnership needs to ensure that escalation procedures are widely circulated and known, with professionals having clear and regularly updated contact information. The system for recording alerts, challenge, difference of opinions and the resolution of differences should also be clear to staff across the Partnership.

4.4 With regard to the issues of professional confidence, it is important that all practitioners involved with children feel listened to and their significance is valued with regard to safeguarding. Educational professionals are of key importance here as they are often the people closest to the child and often are the people to whom children disclose child sexual abuse[15]. Practitioners also raised the importance of strong relationships between police and health workers with social workers. In terms of addressing this, multi-agency training, which stresses the value of all participants in safeguarding would be of value, for information-giving as well as for network building and professional liaison. Joint A.B.E. training was additionally identified as an important potential mechanism in building police and social worker relationships.

4.5 Practitioners raised the issue of school staff not receiving safeguarding supervision. Reflection on practice can occur in a number of different ways, and it was positive to hear that educational professionals have a number of spaces they use for reflection. However, supervision has a particular role in providing emotional support for staff, and a place for professional challenge and feedback. New Ofsted guidance for safeguarding recommends that all Designated Safeguarding Leads have regular supervision[16]. Supervision provides a context where staff are assisted in following up safeguarding concerns with the local authority and challenged to use escalation processes if necessary.

[15] Allnock, D (2019) *Key messages from research on identifying and responding to disclosures of child sexual abuse* Child Centre for Expertise on Sexual Abuse.

[16] Ofsted (2019) Guidance for Inspectors carrying out inspections under the education inspection framework. https://www.gov.uk/government/publications/education-inspection-framework

Recommendations

1. Surrey Safeguarding Children Partnership (SSCP) needs to be reassured that the identified threshold levels of the Family Resilience and Safeguarding Model are being consistently applied across the county and families are not being stepped back to lower tiers of support due to resource pressures.

2. For the SSCP to review the effectiveness of escalation procedures ensuring it is fit for purpose and being effectively used.

3. For partner agencies to expedite the implementation of supervision for Designated Safeguarding Leads in line with Ofsted guidance.

Finding Two
Maintaining expected practice standards is a fundamental aspect of safeguarding practice, and management systems should provide the necessary supervision and oversight.

4.6 Earlier sections of the report detail how practice standards were not met within Children's Social Care. Plans were not sufficiently robust and targets remained unmet. Some safeguarding concerns were not followed up, as in the case of the first reports of Mr A's historic abuse. The proposed Family Group Conference did not occur. This is of particular note as the family member with whom Child G is now settled well with had not been considered as a potential carer at an early stage in the proceedings. During the Supervision Order the qualified social worker's visits were irregular and not recorded. Multi-agency communication was not always effective. There was a lack of effective management and oversight. In considering these issues the reviewer is mindful of the importance of looking through a systemic lens and considering organisational issues.

4.7 In reflecting on the overall themes, it seems that there is a reactive rather than pro-active response to events, leading to a lack of focus on the child and her lived experience. There was a lack of analysis regarding the reasons for Child G's behaviour and what might be happening to her in the present. Child G had a number of social workers and these trends were present in the work of a number of the qualified social workers who were responsible for her case. In discussing the reasons for these responses with practitioners, it is clear that capacity issues were pertinent. Social workers were described as having caseloads of 28 when the recommended number was 15. Whilst acknowledging there are national issues regarding the social care workforce and the increase in care proceedings which was occurring during a key part of this chronology, contextual information highlights particular workforce issues in this area due to its proximity to London, and some geographical issues

regarding travelling. In practitioner discussions the reviewer has been told that during the period of the chronology the area struggled to recruit staff, leading to high turnover of social workers and a shortage of permanent workers. Managers were described as having to 'act down' to fill the gaps caused by a lack of staff, which would have restricted their ability to provide adequate oversight.

4.8 Being extremely busy is known to impact on social worker's critical thinking skills and the work of Ferguson (2017)[17] on 'Invisible Children' in the child protection system, highlights how social workers are often overwhelmed by the emotional intensity of the work and the complex interaction with often resistant parents. He cites time, insufficient support, and organisational pressures as contributing to anxiety for social workers and the lack of ability to think clearly and 'hold' an individual child in their mind. When people are experiencing active anxiety, it is very difficult to 'think straight'. To address these issues, it is important to look systemically at the organisation, and Ferguson highlights the need for an organisational culture where staff receive opportunities to critically reflect on their experience (p 1021). Supervision is part of an ongoing suite of reflective abilities within a local authority which can provide space for critical thinking, and consideration should be given to providing a culture within teams which supports this. For this critical thinking to occur supervision needs to be more than a bureaucratic exercise in case management, but to have a genuinely reflective content. It is of note that during the most recent months in the chronology there was a significant improvement in the overall standard of practice, so it is likely that progress has been made in these areas during the last year, however an overall picture of staff wellbeing needs is important to ascertain how current these issues are, and for the Surrey Safeguarding Children Partnership to reduce future risks.

4.9 As well as supervision, management audits are also an important part of practice oversight. There was a lack of effective audits in the early part of this chronology. Where issues were picked up by auditors there was not follow up and therefore no feedback loop to ensure identified actions were completed. More recent audits indicate a better system of feedback. It is understood from practitioner conversations that historically the management structure lacked capacity and the more recently configured management structure has delivered more managers at Area Director level based in the different quadrants. This increase in management numbers and capacity should mean that a more robust approach to quality assurance can be maintained.

4.10 Tracking systems also provide monitoring that children are being visited and having their cases reviewed at the appropriate intervals. Whilst tracking systems have limitations in terms of quality of practice, an effective monitoring system would have

[17] Ferguson, H. (2017) How Children Become Invisible in Child Protection Work: Findings from Research into Day-to-Day Social Work Practice, *The British Journal of Social Work*, Volume 47, Issue 4, June 2017, Pages 1007–1023, https://doi.org/10.1093/bjsw/bcw065

picked up that Child G was not being visited at the appropriate intervals by her social worker. It is understood that a tracking and monitoring system is now in place in Children's Social Care. However, it is important that the alerts from this system are appropriately monitored by managers so there can be a swift response when deficits are identified.

4.11 There is a consistent theme across the professional groups that everyone was working at capacity. Practitioners described how people were doing their jobs and passing on relevant concerns when necessary, but they had little extra space to reflect on issues and provide extra follow up. A number of professionals in the practitioner event said that in retrospect there were some instances when they should have followed up on issues but did not have time. It seems that across the professional networks there is an issue of people working at full capacity, which leaves very limited space for critical questioning and 'holding a child in mind'. It is worth noting that these are concerns across the public sector workforce and are not necessarily specific to Surrey. However, if each agency is working at full capacity this impacts the whole system, meaning it is entirely overstretched. In terms of safeguarding in Surrey, this creates a level of risk in the system and agencies and SSCP needs to reflect on this and its implications for keeping children safe.

Recommendations

4. A new supervision policy is in place in Surrey Children's Social Care, however, this should be evaluated to ensure that the case management elements of supervision are not so dominant that there is no space for reflective analysis and critical thinking. Surrey should promote a high challenge/high support approach to supervision so that there is time in supervision for professional curiosity and challenge over decision making and problem solving.

5. Surrey Safeguarding Children Partnership needs to ensure that there are mechanisms to regularly review caseload size, and social work shortages. This should include reviewing staffing at the managerial level, so that quality assurance processes, including audit feedback follow up, are completed.

6. Surrey Safeguarding Children's Partnership should ensure the effective implementation of the plans for Family Group Conferences so that the whole range of family networks can be considered in the care planning process. The Board (now Partnership) should review that Family Group Conferences are occurring under the new structure.

7. With regard to the finding of a lack of capacity across the partner agencies, Surrey Children's Safeguarding Partnership should seek assurance from partners that practitioners are not so overloaded that they are unable to focus on the experience of the child, due to issues of workload. If the ability to effectively safeguard children is being compromised because of resource limitations in the agencies, then the Partnership should name this situation and work with partners to mitigate risks.

Finding Three

The Special Guardianship Order report and recommendation was not subject to sufficient scrutiny within the care planning processes. There is a risk that reports commissioned by independent agencies may fall through the quality assurance net. There is a need for clear expectations to be identified at the point of commissioning independent agencies and relevant information sharing. There should be ongoing challenge within the professional network, and the quality of practice monitored throughout the care planning process.

4.12 The Special Guardianship Order report request was commissioned by Surrey Children's Social Care to an independent social work agency. This is not current practice but was occurring frequently at the point in time due to the high volume of care proceedings being dealt with in the department and internal capacity issues. The referral to the independent agency lacked vital details. The section on the Police National Computer check was not filled in, and whilst there was reference to the negative Regulation 24 assessment, no details were provided as to the reasons for this. There was no information provided about the historical allegations re Mr A.

4.13 The Special Guardianship Report (SGO) was not sufficiently thorough in assessing potential risks to Child G. In particular, more information should have been sought with regard to the historic allegations of abuse, so this information could have been analysed more thoroughly. The SGO report recommendation was made without the writer having sight of the Disclosure and Barring Service report. The recommendation for the SGO was also made without reference to the medical checks or without speaking to Mr A's daughter and stepdaughter. These were necessary checks as part of the Special Guardianship Order assessment process.

4.14 The 2015 ADCS/Cafcass guidance on the assessment of Special Guardians as the preferred permanence option for children in care proceedings applications, state that 'No child should be placed in the case of a Special Guardian without DBS and other necessary checks being carried out.' The recommendations for the SGO were made without the DBS check being returned. When the DBS check was returned it came back as clear, as did the earlier PNC check. This raises the issue of what is included in PNC and DBS checks regarding police investigations that have not progressed, or not guilty verdicts. This has been raised as a learning point in Lewisham and Harrow Serious Case Review Child LH[18], which highlighted that DBS staff have to make complex decisions about the threshold for including so called 'soft information' or unproven allegations. This report concludes that there are lessons for agencies and practitioners on an over reliance on DBS checks and, if relevant, it is important that

[18] Lewisham Safeguarding Children Partnership (2019) Joint Serious Case Review Lewisham Safeguarding Children's Partnership and Harrow Safeguarding Children's Board: Child LH. https://www.safeguardinglewisham.org.uk/assets/1/harrow_and_lewisham_scr_overview_report_in_respect_of_child_lh.pdf

practitioners request specific information from the police from the Police National Database (PND) and the Crown Prosecution Service (CPS). In this case, practitioners were aware of the historic allegations regarding Mr A, and he brought them up early in the SGO assessment process. Therefore, in relation to this review the 'no trace' checks did not mean that the allegations did not come to light. However, it is significant to note that if professionals were relying on the PNC and DBS checks the historic allegations regarding Mr A would not have been identified. It is also of note that medical checks were not returned prior to the recommendation being made. Both Mr and Mrs A identified medical issues, which could have impacted on their ability to care for a child with emotional and behaviour needs. Medical checks should have been seen as an important part of the assessment process.

4.15 With regard to the allegations of sexual abuse, further information from the police and CPS regarding the allegations of historic abuse should have been sought so that a robust assessment of risk could have occurred. The lack of a robust risk assessment was highlighted in my discussions with Child G's Father who found this aspect of practice, and how it put his child at risk, particularly concerning. Mr A's account of what happened could have been discussed in a comparative way alongside considering police information, Crown Prosecution Service documentation and historic social care records which could have been accessed. Comments from practitioner conversations noted that the lack of robustness came from professionals being convinced by an overall narrative that living with Mr and Mrs A was the best course of action for Child G, and a way of keeping her with family members. The fact that 'everyone' seemed to support this course of action, meant there was little questioning of it as the preferred course action. It also seems that there was little consideration to the fact that if Mr A was a perpetrator of sexual abuse, and this is being considered hypothetically as we are considering allegations about Mr A rather than convictions, then he might have adept strategies of convincing others of his point of view. Whilst recognising that this review is looking at events with hindsight, it is clear that this lack of analysis was a key factor in the failure to properly asses the risk of Child G experiencing sexual abuse. During the process of writing the review, the independent agency has confirmed that they have produced new guidance for the writing of Special Guardianship Reports to respond to the learning from this review. They have confirmed that Independent Social Workers will not be able to make recommendations until outstanding issues are resolved, and these issues will be clearly listed in the report. Where there has been a prior criminal court case, report writers will be required to assess and investigate factual records, where available, and clarify any missing information as a caveat to the report.

4.16 The deficits of information in the Special Guardianship Order assessment report were not identified when the quality assurance of the report occurred with the independent agency, nor was it questioned by the commissioning Local Authority on receipt of the report. This raises significant issues around the processes for quality assurance in the

independent agency and the Local Authority. It is understood from practitioner comments that the procedure in the independent agency is that the report is quality assured by a case manager and this process is separate from any regular supervisory relationship. When Children's Social Care received the report there was insufficient questioning of the recommendation. Comments from the practitioner event highlight that there was confusion over the route for quality assurance within the local authority and whether the referring team, or the Friends and Family fostering team held responsibility for this. This line of accountability has since been clarified and all reports are now quality assured by the Friends and Family team.

4.17 Surrey Children's Social Care has informed this review that it no longer uses this independent agency and is now completing SGO assessments internally. Whilst this finding does not necessarily mean that the use of independent agencies is by nature problematic, it does highlight how contracting to independent agencies creates a risk in that the Local Authority does not have control over their quality assurance process, supervisory arrangements and ensuring that the appointed worker has appropriate training. Although the social work regulator[19] requires social workers to maintain their continued professional development, there are no specified requirements regarding independent social workers' supervision and professional support. Therefore, there is likely to be significant variation in supervisory arrangements and quality assurance. In view of this it seems that in order to reduce risks, the Local Authority should view the use of independent social workers as a less favourable option than using internal staff, for whom they can exercise control over supervisory and quality assurance processes. If contracting out to independent agencies on future occasions, Surrey should request information regarding supervision and quality assurance, considering the quality of these in their contracting decisions.

4.18 In comments from the practitioner events as to the reasons why the report was submitted without reference to Mr A's daughter and stepdaughter and completed checks, one of the issues raised was the pressure of timescales. It seems that independent agencies feel these particularly acutely, as they are commissioned due to capacity issues on the understanding that the assessment can be completed to time. This could mean that independent workers feel less confident in asking for extra time. Local Authorities need to ensure that they support independent report writers with requests for extra time if it is required to complete a full assessment and analyse fully the potential risks to a child. Recent interim guidance from the Family Justice Council[20] states that an extension to the timetable should be considered by the court when necessary to ensure the stability of the placement.

[19] At the time this practice took place, the social work regulator was the Health and Care Professionals Council (HCPC). On 2nd December 2019, Social Work England took over the role of regulating social workers.

[20] Family Justice Council (2019) *Interim Guidance on Special Guardians.* Available at https://www.judiciary.uk/wp-content/uploads/2019/05/fjc-sg-interim-guidance-pfd-approved-draft-21-may-2019-1.pdf

4.19 There was a lack of effective challenge within the professional network during the care planning process. Although the lack of DBS check was identified and questioned by a number of professionals, there didn't seem to be challenge over the recommendation itself. When discussed at the practitioner event, explanations about this referred to workers 'overlooking' things which with the benefit of hindsight seem more significant. Practitioners from Cafcass as well as Children's social care were reporting issues with workload and staff retention. It was thought that this was likely to have affected the ability to have the time to analyse decisions and follow up on issues.

Recommendations

8. Surrey's Safeguarding Children's Partnership should ask Children's Social Care to review its processes for undertaking Special Guardianship assessments, considering how the results of checks are logged and conveyed, clarifying the accountability structures, and how the care planning processes ensure sufficient scrutiny and quality assurance of decision making.

9. Surrey Safeguarding Children Partnership should write to the new regulator, Social Work England, bringing to their attention the finding of this review regarding the lack of regulation of independent social workers in relation to their supervision and the quality assurance of their work.

Finding Four

It is important that all professionals are attuned to the possibility of present trauma and current abuse, including sexual abuse, in children presenting distress and high levels of disturbance. As part of this process, Supervision Orders should be actively worked by qualified workers, and should monitor the child's wellbeing, ensuring that any risks are identified and responded to.

4.20 In the period after which Child G had moved to live with her Special Guardians her behaviour changed. Child G's behaviour displayed considerable anger and aggression, and she also demonstrated sexualised behaviour. She was very difficult to manage both in the home and the school setting and both her Special Guardians and the school were raising how concerned they were and how difficult it was for them to manage her behaviour. This is not to say that there were no earlier incidents of aggression and sexualised behaviour, but there was an increase in them during this period.

4.21 In terms of the professional response there was a lot of concern for Child G, but potentially a misinterpretation of the behaviour she was presenting. The chronology indicates she was often described as aggressive and difficult to manage, and the family thought that she might have had Attention Deficit and Hyperactivity Disorder

(ADHD). Without excluding the possibility that this could have been a possibility, it is worth noting that there is increasing interest and research into how ADHD and the consequences of neglect and trauma in children might have similar external symptoms and signs.[21] Whilst acknowledging that children's behaviour is often very difficult to unpick and information is often ambiguous, there should have been greater curiosity as to what Child G might have been trying to communicate via her behaviour about her life in the present. It seems there was an assumption that Child G's behaviour was a result of past trauma due to her previous experiences of neglect, rather than professionals considering the possibility that this was a child currently being harmed. Education professionals are often the people in the professional network who know the child best and whom they are most likely to talk to[22]. It is therefore very important that professionals in the partner agencies, particularly schools, have enough training in sexual abuse and the different signs and ways children might communicate over this. At the practitioner's event professionals from a range of partner agencies said that they would benefit from training on the signs, symptoms and effects of sexual abuse. This is a national issue and a 2015 report by the Children's Commissioner[23] found that professionals often lacked knowledge and confidence in identifying child sexual abuse and in supporting children where there are concerns but no clear disclosure. In terms of the SSCP's response, it would be important to offer training across the partnership, not just for staff within Children's Social Care.

4.22 In terms of intervention from Children's Social Care during this period, despite the Supervision Order and Child in Need plan, visits by Child G's qualified social worker were irregular. This did not meet procedural guidelines and limited the opportunity for Child G to have talked to her social worker and potentially disclosed her allegations at an earlier stage. The Child in Need plan associated with the Supervision Order was not reviewed according to timescales, nor did it provide the kind of coordinated response which facilitated good multi-agency communication and support during this critical period in Child G's life. Child G's school was extremely concerned about her and in the practitioner event said that did not feel they got an adequate response to their escalating concerns. Mr and Mrs A were also asking for support as they felt G's behaviour was unmanageable. As identified earlier in this report Special Guardians frequently report a lack of support, despite caring for children with very significant needs.

[21] An example of this research can be found at: Brown, N et al. (2017), 'Associations Between Adverse Childhood Experiences and ADHD Diagnosis and Severity', *Academic Paediatrics*, vol. 17, no. 4, pp. 349-355. https://doi.org/10.1016/j.acap.2016.08.013

[22] Allnock, D (2019) *Key messages from research on identifying and responding to disclosures of child sexual abuse* Child Centre for Expertise on Sexual Abuse. https://www.csacentre.org.uk/index.cfm/_api/render/file/?method=inline&fileID=7C7BB562-DB13-4C7E-B8C21D04920D6AEF

[23] Children's Commissioner (2015) *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action*. https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Protecting-children-from-harm-full-report.pdf

4.23 During this period Child G's case was closed to CAMHS due to the fact that the social worker did not respond to the CAMHS worker's offer of support and request for a meeting. In finding 2 of this report, consideration has already been given to why some Children's Social Care staff were not meeting procedural requirements or exercising sufficient professional curiosity about their caseload. An additional comment was made at the practitioner event which said that workers were asked to 'prioritise the more urgent cases', and the Supervision Order and it's ensuing Child in Need plan was seen as 'low priority'. This reinforces the identified learning that social workers should have appropriate caseload sizes but it also raises the issue of the potential for Supervision Orders not to be given the weight and significance intended by the court when the Order is granted.

4.24 When Child G made the allegations of sexual abuse by Mr A, she made this disclosure to the family support worker who had worked with the family for some years. This worker had been a regular and long-term visitor to the family and a consistent figure for Child G and was someone she trusted. This is a positive and an important reminder of the importance of continuity of professional relationships, as this worker had been with the family much longer than the qualified workers who changed on a number of occasions throughout the period of the chronology. This effect of this lack of consistency of social workers on children is well documented and this is a reminder of how children are more likely to disclose if there is a context of trust. Comments at the practitioner event indicate that staff who are not in qualified roles often feel that they are not listened to even though they know families best, yet this review highlights their importance in facilitating children speaking about their experience, and consequently in overall safeguarding. Surrey Children's Social Care is engaged in training staff on trauma informed approaches. Trust is central to responding to children's trauma as it is recognised that relational disruption and trauma require relational healing. It is therefore important that trauma informed practice training within Children's Social Care is completed alongside supporting practitioners to develop trusting and consistent relationships.

Recommendations

10. For Surrey Safeguarding Children Partnership to review its training on both trauma informed practice and sexual abuse. The review should ensure that training is available to staff across the agencies, and that training on child sexual abuse should include indicators of sexual abuse and how this might impact on children's behaviour.

11. For Surrey Safeguarding Children Partnership to seek reassurance from Children's Social Care that supervision orders are being actively worked by qualified workers and that the tracking systems now in place would identify gaps in visits to children and lapses in reviewing of Child in Need plans.

Finding Five

There were significant delays to the accessing of therapeutic support for Child G, during the time when her emotional distress and needs seemed most urgent.

4.25 Chronology reports from Child G's schools, family members and subsequent foster carers describe Child G's distressed behaviour. As part of the post-Order support available to Child G on the conclusion of the care proceedings where the Special Guardianship Order was granted, funding was allocated from the Adoption Support Fund so that Child G could receive play therapy. There were a number of delays that affected the play therapy starting. A CAMHS referral for art therapy was also postponed as the therapist thought the home situation should be stabilised before therapy could begin. There was a plan to start the therapy during November 2018, which was then affected by the breakdown in the placement.

4.26 As documented earlier in the report, a referral was made to Surrey STARS service and a multi-professionals meeting swiftly held. Whilst relevant services were offered Children's Social Care pursued an alternative provider. At the end of February 2019, records indicate that Family Futures would be visiting Child G in her new home to agree ongoing support. Although it is positive that this Family Futures support was initiated, the lead reviewer is concerned by the number of delays to the processes here and the lack of therapeutic support for Child G during such a critical period.

4.27 The reasons for these delays to therapeutic support to child G are multi-faceted and they come from understandable clinical positions. It is difficult to provide a safe therapeutic space when there is instability in a child's placement, and offering support to the carers is often the most effective option. However, if a child is trying to communicate distress about their placement, then the lack of therapy could restrict their ability to voice what is happening for them. This raises questions over whether a better multi-agency response could be developed. In particular this review highlights the importance of services that can respond to the needs of children who are in crisis in the present. When discussing multi-agency responses to Child G's therapeutic needs, comments from practitioners included expressions of concern from schools that they are left having to deal with very serious emotional and behavioural difficulties, without adequate support. In addition, Children's Social Care staff who were experienced, but not specifically therapeutically trained, were often dealing with very complicated needs. Ideas from practitioners as to how things could be done differently included the possibility of drop in CAMHS support. This occurs in Surrey for children aged 10 and above, but at present this is not available to children under ten.

A further suggestion was making the Hope service available to children under eleven. The Hope Service is a Surrey multi-agency service for children experiencing mental health, emotional, social or behavioural needs and works with children when there is potential placement breakdown or hospital admission. This is currently only available to children over eleven, however this review highlights the needs of younger children in crisis. Practitioners also thought that embedding CAMHS practitioners in the early help local hubs, as is proposed in the Surrey Family Resilience and Safeguarding structure, would assist in providing a faster response to children. In conclusion, practitioners expressed the view that Trauma Informed Practice training, if complemented by supervision and ongoing training updates, could assist in equipping carers and professionals to respond more effectively to a child's presenting distress.

Recommendations

12. For Surrey Safeguarding Children Partnership to review the therapeutic support available to children under eleven who are displaying significant emotional distress or are in crisis. This review should include consideration of how effectively information about available services is disseminated to multi-agency professionals, parents and carers.

5 APPENDIX 1 – Terms of Reference

5.1 Initial considerations of case materials identified that it would be most appropriate to focus on the period 1st February 2014 to 28th February 2019. Agencies who had been involved with Child G were asked to provide a chronology as well as a narrative record of their involvement which highlighted any emerging practice issues. The terms of reference which were considered during the review process were:

1. *How effective was the assessment and Early Help response to emerging concerns of neglect? How effectively had the long-term issues of neglect affecting the family been addressed?*

2. *Given the significant history of domestic abuse over a protracted number of years involving the mother and a number of associates males / fathers of siblings and concerns about mother's mental wellbeing: How did agencies work together to understand the lived experience of Child G and her siblings? What steps were taken to protect them from significant harm and what more should have been done to safeguard them? Consider how delays and drift affected safeguarding process.*

3. *Explore at what point which people knew of the allegations of sexual abuse against Mr A. How far did professionals work together to share information and consider the previous allegations of sexual abuse made against Mr A as part of the assessment process? How robust was the investigation in the Regulation 24 assessment?*

4. *The SGO assessment was outsourced to an independent agency. Consider the effectiveness of outsourcing of SGO assessments. Who retained ultimate authority? Was there appropriate management oversight and quality assurance?*

5. *Explore the LA's thought process that led to the decision to recommend an SGO for Child G to Mr & Mrs A given the concerns raised? Expanding on how professionals worked together and the process of querying the decision making based on information available?*

6. *When Child G was showing indicators of increasingly sexualised behaviours – what steps did agencies take to explore and address these increasingly concerning behaviours?*

7. *Consider the effectiveness of the Supervision Order? What steps did agencies take to safeguard Child G? Who was monitoring her wellbeing and safety? What missed opportunities were there to protect and safeguard Child G from harm and abuse?*

8. *What evidence is there that professionals that knew Child G well, listened to her and took her concerns seriously? Were professionals curious to understand her lived experience and the presenting risks following the ABE in 2018? Explore further the police's activity in response to Child G's allegation*

9. *What level of management oversight took place and was there effective communication with other agencies? What organisational QA processes were in place to pick up that management oversight was not taking place frequently enough?*

6 APPENDIX 2 – The Review Process

6.1 In considering the process for this review, account was taken of the principles set out within Working Together to Safeguard Children (2015)[24] which specifies that:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works to promote good practice.
- The approach taken to reviews should be proportionate to the scale and complexity of the issues being examined.
- Reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Families including surviving children should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring the child is at the centre of the process.
- The final report must be published, including the LSCBs response to the review findings.
- Improvement must be sustained through regular monitoring and follow up.

6.2 Rhian Taylor was appointed lead reviewer. Rhian trained in social work at the London School of Economics qualifying in 1996. She has an MSc in Social Policy and Research and the Post Qualifying Child Care Award. She has over twenty years' experience as a social worker and manager in statutory children's services. She is currently an academic at the University of Kent as well as an Associate for In-Trac Training and Consultancy. She writes about, and researches social work supervision.

6.3 Further information was gathered through discussions with practitioners who had worked with the family in order to confirm the detail of what had happened and explore the context within which practice took place and reasons for the decisions that had been made. Practitioners from the following agencies contributed to the review either through group discussion or individual conversations:

[24] H.M. Government (2015) Working Together to Safeguard Children, Online, Available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf
Working together to Safeguard Children is the government's overarching guidance on safeguarding.

- Surrey Children's Social Care
- Independent Reviewing Officer
- CAFCASS
- Surrey - Community Health Services
- Surrey and Borders Partnership
- Surrey Police
- The Independent Social Work agency
- Surrey Primary Schools
- Lumen Learning Trust
- Probation (Kent, Surrey and Sussex Community Rehabilitation Company).