Cheshire East Local
Safeguarding Children Board

CHESHIRE EAST SAFEGARDING CHILDREN'S BOARD

SERIOUS CASE REVIEW CE001

CHILD B
CHILD C
CHILD D

EXECUTIVE SUMMARY

FEBRUARY 2011

Independent Overview Report Author

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CONTENTS

1. INTRODUCTION

1.1 This Serious Case Review (SCR) was established to review the circumstances, and actions by agencies, relating to the abuse by M and F, the adoptive parents of:-

Child B	born 1996
Child C	born 1997
Child D	born 1999

1.2 The overall purpose of the SCR is set out in paragraph 8.5 of "Working Together to Safeguard Children 2010".

- To establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of Children;

- Identify clearly what those lessons are both within and between agencies, how and within what timescale they will be acted on and what is expected to change as a result;

- improve intra and inter-agency working and better safeguard and promote the welfare of Children.

2. CIRCUMSTANCES THAT LED TO THE SCR BEING UNDERTAKEN

2.1 Disclosures were made within video interviews by Child B in September 2009, and Child C and Child D in November 2009, regarding the serious abuse they had suffered from M and F their adoptive parents. The abuse started in 2000 soon after they were placed and continued over the next 9 years. The abuse was of a severe and recurring nature and included frequent episodes of physical abuse, neglect and emotional abuse. These were said to have been mainly carried out by M but also F to some limited extent.

2.2 Child B made the first of a series of allegations that he was being abused in March 2009. In September 2009 a full investigation of his allegations was carried out, and he was protected. Child C and Child D were made subject to Interim care Orders but returned home after 1 week as they did not corroborate Child B's accounts. They subsequently disclosed the abuse and were removed from home in November 2009.

Criminal Proceedings

2.3 On 14 April 2010 M was charged with 88 counts of child cruelty. F was charged with 14 counts of child cruelty and one of perverting the course of justice. Both appeared in court on 6th May 2010 where not guilty pleas were entered. Subsequently, M and F pleaded guilty to 14 and 3 charges respectively. On 18th October 2010, M was given a 4 years prison sentence and F received a 2 year suspended sentence.

3. SERIOUS CASE REVIEW PROCESS

Decision to Commission the SCR

3.1 The case was referred to the Standing Serious Case Review Sub Group by the Police in April 2010 when charges were brought against M and F. A recommendation to establish the Serious Case Review made by the sub group on 27th May 2010 was approved by David Mellor, the Independent Chair of Cheshire East LSCB on 4th June 2010. Ofsted were notified of this decision the same day.

SCR Panel Arrangements

3.2 Following the formal decision to establish the SCR, a case specific SCR Panel was established with an Independent Chair, Linda Harmer-Jones, who had not had any previous involvement with any of the agencies involved in this case. The full membership of the Panel comprised:-.

- Linda Harmer Jones - SCR Panel Independent Chair
- Principal Safeguarding manager – Cheshire East Council
- Services Manager Improvement & Achievement – Cheshire East Children's Services
- Designated Nurse - Central and Eastern Cheshire PCT
- Director of Governance and Strategic Planning – Central and Eastern Cheshire PCT
- Deputy Director of Nursing Therapies and Director of Infection Prevention and Control - Cheshire & Wirral Partnership NHS Foundation Trust
- Detective Inspector – Major Crime Review Team - Cheshire Constabulary
- Strategic Manager - Corporate Parenting – Stoke-on-Trent Children's Services
- Deputy Corporate Director - Education Transformation – Staffordshire Children's Services

<u>Also in Attendance</u>

- LSCB Business Manager – Cheshire East
- LSCB Administrator – Cheshire East
- Communications and Media Relations Advisor – Cheshire East

The Overview Report Author, Chris Brabbs, was not a member of the Panel but attended most meetings to observe proceedings and offer professional advice as required.

3.3 Arrangements were made to secure advice as necessary from the legal advisor to the Board. The SCR Panel did not identify a need for other specialist advice during the conduct of the Review.

Agencies Contributing to the SCR

3.4 The following agencies completed Individual Management Reviews (IMRs)

- Cheshire East Children's Services *(Social Care and Education)*
- Cheshire Constabulary
- Central & Eastern Cheshire PCT *(Health Overview Report)*
- Cheshire East Community Health *(Health Visiting and School Nursing)*
- Cheshire & Wirral Partnership NHS Foundation *(Child and Adolescent Mental Health Services) (CAMHS)*
- East Cheshire NHS Trust *(Acute and Paediatric Hospital Services)*
- Stoke-on-Trent Children's Services *(Social Work and Adoption Services)*
- Staffordshire County Council *(School and Education Welfare Services)*

"Single Issue" Information reports were commissioned from

- CAFCASS
- Cheshire East Legal Services

3.5 The scoping of the SCR, was comprehensive and covered all the elements set out in "Working Together to Safeguard Children 2010". The initial information gathered from agencies identified the following key areas:-

- Adoption Assessment, Matching and Support
- Cross Boundary Information Sharing and Work
- Identification of signs and symptoms of abuse within universal services
- Conduct of Section 47 investigations
- Disclosure work with children
- Challenges for professionals in working with assertive, high status parents.

3.6 The Terms of Reference (ToR) included the 12 standard questions to be covered by a Serious Case Review as set out in "Working Together to Safeguard Children 2010" and the following specific questions:-

- The process and quality of the assessment and approval of M and F as adoptive parents having regard to statutory requirements and guidance in force at that time. Given what is now known, did any information emerge or were there any indications, within the assessment process, relating to the abuse M previously experienced and /or her mental health? *(ToR 13)*

- The children's history and progress through the care system up to the point of the making of the Adoption Orders, including the assessed needs of each child when the adoption agency decided that adoption was in the children's best interests. To what extent were these were taken into consideration in the subsequent adoption matching decision to place the children with M and F? *(ToR 14)*

- Were appropriate placement support arrangements provided, and statutory reviews carried out, prior to the making of the adoption orders, and did these identify any issues relating to the care provided to the children by M and F? *(ToR 15)*

- What continuing post adoption support arrangements were made and were these appropriate? *(ToR 16)*

- Were the schools' arrangements for pastoral care and assessment of special educational needs (e.g. school action /school action plus) sufficiently responsive to the children's emerging needs. *(ToR 17)*

    - were the needs of each child assessed appropriately?
    - were interventions, recorded, monitored and evaluated systematically?
    - were interventions escalated or de-escalated appropriately?

- Were the arrangements and conduct of the Section 47 investigation appropriate? *(ToR 18)*

- How effective was the cross boundary information sharing and inter-agency working across the various LSCB areas involved in this case? *(ToR 19)*

- Were there any significant issues in terms of the approach adopted by professionals in their work arising from the parents' social class, perceived professional standing, attitude and behaviour. *(ToR 20)*

3.7 The Terms of Reference also included the standard questions to be covered by a Serious Case Review set out in paragraph 8.37 of "Working Together to Safeguard Children 2010. The Terms of Reference emphasised the importance of all relevant issues being covered relating to age, ethnicity, cultural or religious needs, and how these were taken into consideration in assessments and service delivery.

Time period over which events should be reviewed

3.8 The time period covered by the review was from 5th May 1998 to 13th November 2009 when Interim Care Orders were made following the children's disclosures. The start date was selected to ensure full coverage of:-

(i) the application by M and F to be approved as adoptive parents;

(ii) the adoption plan for the 3 children and the decision made by the adoption agency that adoption was in the children's' best interests;

(iii) decisions to "match" the children with the adoptive parents and the placement process.

3.9 In addition, agencies were asked to include within their IMRs relevant background information prior to the SCR start date including a summary of:-

- the children's previous "care" history and reasons for the formulation of the adoption plan;

- any significant family and health information relating to the adoptive parents.

Contribution of Family Members to the Serious Case Review

3.10 The Panel made strenuous efforts to secure the contribution of family members and full information was provided to Child B and the parents. In consultation with the Police and Crown Prosecution Service, a decision was made that interviews should not be carried out until the conclusion of the criminal process to avoid adding to the stress being experienced by the children, who might be required to give evidence at the trial, and to avoid any risk of the criminal proceedings being compromised.

3.11 Child B met with the Overview Author on the understanding that he would not have to talk about the details of the abuse or his family life. Child B provided important insights into what he experienced, as to the inadequate responses of agencies on the several occasions he disclosed abuse, and to the anxieties he expressed for the safety of his younger siblings after he had become looked after by the local authority. Child B expressed his hope that his contribution would result in children in similar circumstances being protected better in the future. The Overview Author later shared the findings of the Review and passed onto him a personal letter of thanks signed by all Panel Members and the Independent Chair of the LSCB.

3.12 In consultation with the children's social worker, it was agreed that it would not be in Child C's and Child D's interests to involve them at this stage of their recovery from the abuse.

3.13 Several approaches were made to M and F to see if they wished to contribute to the Review and these continued right up to the last moment. M's position changed at various points including just before the review was completed. Concerns around her health appeared to be a factor influencing M and F's views about her participation. In the light of this, the Panel concluded that it might not be helpful to proceed with attempts to meet with her within the serious case review framework but that dialogue would continue with her through the support services being provided to her, and that the LSCB would take into account within the action plan, any information that might be subsequently provided by M.

3.14 It was also felt that further delay to completing the review would not be beneficial in achieving the main objective of drawing out, and implementing the learning as quickly as possible. The view was that although M's contribution might provide useful additional insights, these were unlikely to add significantly to the learning through what had been a comprehensive and robust serious case review process.

3.15 F declined the invitation to meet with the Overview Author partly because of work commitments but also because he was "still finding the whole situation extremely upsetting". F provided a short written contribution that in his view, they, and the children, had been badly let down by Stoke-on-Trent Social Services. His view was that they were negligent in placing 3 young children with two parents with almost no experience of looking after children, and for not providing sufficient practical and emotional support. The Panel were disappointed that F felt unable to meet with the Overview Author to explore his perceptions further, but respected his feelings. The Panel noted that work commitments were frequently offered by M and F as reasons for not being able to meet with professionals over the years, or take up some of the support services offered.

3.16 The Panel explored whether there were members of the extended family who should be approached to make a contribution. However, as the Serious Case Review progressed, it became clear that there were no other family members who had developed a significant relationship with the children, and that they had been quite isolated within the family and had few social contacts outside of school.

SCR Timetable

3.17 Two extensions to the timetable were approved during the completion of the Review. A 2 month extension was approved by the Safeguarding Advisor, Government Office North West on 30th September 2009 to take account of the complexity of the case, the challenges in gathering full information covering the 11 year time period across 3 local authority areas and the unavoidable delay in engaging with family members until the completion of the criminal trial. This resulted in a revised completion date of 3rd February 2011.

3.18 In December 2010, the need for a further short 3 week extension was identified in order to overcome practical problems encountered in securing the contribution of Child B and the parents. This extension was approved under the revised arrangements within "Working Together 2010" which came into effect from 1st October 2010.

Panel Meetings

3.19 The Panel met on 7 occasions. These were between 3 and 5 hours duration which allowed the panel to give in depth consideration to the findings from the IMRs, draw out the learning, and work through the multi agency and single agency action plans.

4. BRIEF FACTS OF THE CASE

The Children's Early History and Plan for Adoption

4.1 In 1999, agencies in Stoke-on-Trent were involved with the family because of domestic violence and the birth parents' substance misuse and mental health problems – often referred to in research as the "toxic trio". Child B and Child C were placed on the Child Protection Register in the category of neglect. Child D was then born opiate dependent. Care proceedings were commenced in July 1999. In October 1999, the Director of Social Services approved the recommendation from the Adoption Panel that adoption was in the children's best interests, and that they should be placed as a sibling group of three – a plan supported by the Children's Guardian within the care proceedings.

Approval of M and F as Adopters

4.2 In May 1998, M and F applied to Stoke-on-Trent to become adoptive parents. They only started to live together full time during the assessment and had no experience of looking after children. There were some problems arranging appointments due to the couple's work commitments. M and F were approved to take a sibling group of 3 which was their preference expressing their view that offering a home to a sibling group would avoid the children having the difficulties M and F had experienced as only children.

The Adoption Match and Placement

4.3 In November 1999, the Adoption Panel matched the children with M and F recording that "this was an excellent piece of work". The period of introductory visits was short with Child B and Child C being placed after 6 days, and Child D 6 days later. He had never lived with his siblings previously. Child B was aged 3, Child C aged 2, and Child D. aged 6 months.

Post Placement Support

4.4 Stoke-on-Trent continued to supervise the placement but did not provide the statutory notification of the placement to agencies within Cheshire where they lived. There were delays in organising the agreed extra support which placed extra strains on the family.

4.5 Initially, the placement was judged to be progressing well but from June 2000, M started to report difficulties in her relationship with Child C and by December these had become quite acute with M stating that she was unable to bond with Child C. M complained about the lack of support and requested more help stating that they would not submit the adoption application to court until the situation with Child C improved. M and F were said to be hostile, and resistant to advice, when social workers raised concerns about their parenting style and overly high standards. Primary School 1 also had concerns about M's attitude towards staff and her unrealistic expectations of Child B's behaviour.

4.6 In early 2001, M and F were described as continuing to be struggling in their care of the children. In March, the health visitor became aware of, but did not share information about 2 injuries which might have been sustained accidentally and that M and F had chosen to change the children's first names.

4.7 The statutory review scheduled for April 2001 was cancelled because M and F had submitted their application to court to adopt. There had been no re-evaluation of whether the placement was viable and still in the children's best interests. The Adoption Orders were made in June 2001.

Abuse during the Adoption Placement

4.8 During the final investigation in 2009, it became clear that that the abuse started soon after the placement was made.

Agency Involvement after the Adoption Orders

4.9 The parents did not request post adoption support and there is no record of further social work visits. Stoke-on-Trent Social Services formally closed the case in November 2001. Following the adoption, there was little agency involvement other than the schools. The family rarely came into contact with primary health care professionals prior to 2009 and the only significant involvement was a referral made by the GP to the Child and Adolescent Mental Health Service in late 2003.

Concerns noted by the Primary Schools

4.10 The children attended 3 primary schools from January 2001 – the first in Staffordshire, and two in Cheshire. During the 2009 investigation, 16 staff from these schools gave statements to the Police about their observations of possible neglect and emotional abuse, and concerns about M's parenting style, her

treatment of the children, and her aggressive attitude towards professionals. The main incidents and concerns are summarised below.

4.11 In September 2001 at Primary 1, Child B disclosed that M had pushed him resulting in a bruise to his forehead – 3 days after the head teacher had raised concerns with M about her treatment of Child B and Child C. Later the head teacher contacted Staffordshire Education Welfare who advised that the situation should be monitored. Despite further concerns about M's attitude towards the children and staff, no further advice was sought. However, the head teacher and class teacher alerted their counterparts when the children were moved to Primary School 2.

4.12 At both Primary Schools 2 and 3, there were recurring concerns that the children were being sent to school with insufficient food in their lunch boxes, and there were observations made by teachers that the children appeared quite thin.

4.13 Staff recalled many incidents where they were concerned about what they perceived as M's harsh and unfair treatment of Child B and Child C, and their shock at the aggressive and humiliating way in which M sometimes spoke to the children. Teachers themselves found it difficult to deal with M's hostile and aggressive attitude. The schools never witnessed M showing any warmth towards Child B. The children frequently appeared sad, worried, frightened and exhibited very controlled behaviour. The children resisted all attempts by staff to get them to talk about what was troubling them, and on occasions admitted they were anxious that M would be angry if she found out that they had said anything or had been comforted at school.

4.14 None of the Primary Schools made an official record of any of the incidents or concerns within the school files. No external advice was sought, and no referrals were made to Children's Social Care.

GP Referral to CAMHS – December 2003

4.15 The GP and Practice staff had serious concerns about M's unfeeling and punitive attitude towards Child D when he attended for his immunisations. The referral was made to the Child and Adolescent Mental Health Service after advice from the Consultant Paediatrician (Designated Doctor), and in the light of Social Care's view that the threshold was not met for them to become involved.

4.16 At the first appointment in March 2004, M explained how her behaviour at the GP surgery was related to her inappropriate fears that Child D might grow up to abuse substances because he was born drug dependent. M was not seen again for 6 months as she failed to attend the next 3 appointments. At the second meeting, M described improvements and CAMHS ended its involvement without seeing Child D and observing his relationship with M. Although the GP was notified of this, other agencies remained unaware there had been CAMHS involvement.

Disclosures of Abuse between March and October 2009

4.17 Disclosures were made on 9 occasions during this 6 month period – 8 by Child B and 1 by Child C. Section 47 enquiries were only commenced in response to 3 of these. The circumstances and outcomes are summarised below.

1st March 2009 No Section 47 Investigation

4.18 Child B went to the local Residential Children's Unit and alleged that he was being abused by both parents. He alleged that the slight red mark around his eye was caused by F. A social worker from the Emergency Duty Team (EDT) took Child B home where F denied the allegation but stated that M had hit Child B. EDT decided not to seek a medical assessment but referred the case for urgent follow up. This was provided by the adoption team rather than the area social work team but no investigation was carried out after Child B stated that he had exaggerated his allegations. The Police were not informed of this incident.

17th March 2009 Section 47 Investigation Commenced

4.19 Child B again went to the local Residential Children's Unit and had 2 red marks under his eye and alleged that F had hit him, but also that both parents frequently punched him. Police and EDT were involved and Child B was accommodated by the local authority, and placed in foster care, to enable further investigation and a video interview to be carried out. Paediatric assessment the following day was unable to establish if the injuries were non accidental. Child B was returned home at M's request before the video interview had been carried out – M giving assurances that Child B would be kept safe from F. That decision overlooked the fact that Child B had disclosed that M was also abusing him, and F had identified M as having hit Child B. Child B was extremely distressed when told of the decision and stated he did not want M to take him home. After Child B had left with M, the foster care informed her supervising social worker of Child B's reactions and fears, but there was no follow up to visit to explore these with Child B and to check that he was safe. M transported Child B to the video interview where he declined to proceed. (In his 2009 video interview Child B stated that during the journey, M had threatened him with further abuse).

30th March 2009 No Section 47 Investigation

4.20 Child B went to the local Children's Unit for the third time alleging he had been assaulted by F, and stating that he did not want to return home. The Emergency Duty Team arranged for M and F to collect him without interviewing Child B. A Police Officer visited the family home the next morning but only M was seen as Child B was at school. The outcome was no further action when M said Child B was seeing his social worker later that day and would be going into care. This was not true.

3rd June 2009 No Section 47 Investigation

4.21 A teacher from Primary 3, whose son was a close friend of Child B, made a referral to Social Care reporting their worries about Child B and his claim that he would not self refer because he had not been believed previously. No investigation or initial assessment was initiated

6th June 2009 No Section 47 Investigation

4.22 Child B approached a stranger for help and was brought to the Accident and Emergency Unit with injuries caused by jumping out of the bedroom window at the family home. Child B said that he did this to escape the abuse he was experiencing. He was admitted onto the paediatric ward for observation in the context of possible child protection issues. The following day, the Emergency Duty Team decided that he should return home after telephone calls with M and Child B. No face to face interview was held with Child B. On arrival, M was verbally aggressive to the staff nurse who felt intimidated but did not escalate her concerns. The Police were not informed of this disclosure.

4.23 The following day, Child B was accommodated for 2 weeks at M and F's request because they were unable to keep him safe as he was regularly running away from home. He was also presenting behaviour difficulties at school. Child B returned home on 26th June.

29th June 2009 No Section 47 Investigation

4.24 After sleeping rough overnight, Child B was located by police officers who were told by a man that was with him at the time, that Child B was running away because he was being hit by his parents and being bullied at school. Child B would not confirm this despite persistent efforts made by police officers to explore this allegation. He was returned home.

2nd July 2009

4.25 A friend of Child B contacted the police to say Child B was scared to go home because his 'adoptive parents' had been hitting him, but that he was reluctant to disclose this himself. At the police station, Child B remained adamant that he would not return home but the Emergency Duty Team, without visiting the station, decided that M and F could collect him. There was no follow up of Child B's allegations.

22nd July 2009 Section 47 Enquiries Commenced

4.26 Child C disclosed to a school friend, the daughter of a teacher at Primary 3, that M had assaulted her and showed her the bruises. Child C did not want to report this as M would get angry and deny it. The teacher asked her daughter to write everything down and make a sketch of the shape and size of the marks, and made a referral to Social Care who commenced Section 47 enquiries. Child C appeared "fragile and distressed" throughout and refused to be medically examined only allowing F to look at the marks. He said there was only a mark on her back – at odds with the marks seen at school. The investigation was deemed to be "inconclusive" as it could not be progressed due to Child C refusing a medical examination, and not being willing to make a statement. The Police were not informed of this disclosure. The teacher later destroyed the notes when informed that they would not be required.

8th September 2009 No investigation

4.27 On 8th September 2009, Child B attended the local Hospital Accident and Emergency Unit after being assaulted by another young person. Child B made allegations of verbal and physical abuse by both parents but mainly by M and he was found to have bruising to his arm. Child B was admitted onto the paediatric ward and was adamant that he would not see M nor return home. The social worker's plan was to return Child B because there had been no evidence to support Child B's previous allegations, and because her assessment was that Child B's problems were linked to school. The Consultant Paediatrician challenged the plan stating that he would not allow Child B to be discharged to M's care against his strong wishes. Child B was accommodated by the local authority when M discovered that Child B did not want to see her.

23rd September 2009 Section 47 Investigation and Video Interview

4.28 Prior to the first Looked After Children's Review, Child B made detailed disclosures to the Independent Reviewing Officer of the serious physical and emotional abuse. These were said to have been mainly carried out by M but also by F to some limited extent. Child B subsequently gave a detailed account in a video interview on 25th September 2009 of the abuse stretching back over the previous 9 years.

Actions following Child B's Full Disclosures

4.29 A strategy meeting the same day resulted in a decision to apply for Interim Care Orders in respect of all 3 children to allow the Police and Social Care to carry out video interviews with Child C and Child D. However, because of continuing Police concerns that the children might be placed at additional risk once M and F were informed of the application, Child C and Child D were separately interviewed at school by a police officer and social worker but did not corroborate Child B's allegations. Had they made disclosures, applications would have been made to make the children subject to Police protection Orders.

4.30 Interim Care Orders were made on 29th September 2009 to run until a further hearing on 20th October 2009. The court had appointed a solicitor to represent the children's interests but Cafcass did not allocate a Children's Guardian because of excessive demand on the service. Child C and Child D were placed together but had to be moved after 3 days because of a pre-existing commitment of the first foster carers over the weekend. They were then moved back again to the first carers for 1 night. During that week, Primary School 3 noted a marked change in Child D who seemed more relaxed and chattier.

4.31 On 2nd October, M and F were arrested on suspicion of abusing all three Children. Both denied the allegations and were released on Police bail.

4.32 On 5th October, at very short notice, the local authority solicitor wrote to all parties, including Cafcass, the children's solicitor, and the parents' solicitor seeking views the same day on the proposal to ask the court to revoke the interim care orders the following day and return Child C and Child D home because they had been no disclosures. The children's solicitor accepted the plan but did not speak to the children.

4.33 Neither the Independent Reviewing Officer (IRO) nor the Police were consulted about this plan. The video interviews originally planned had not been carried out. Instead direct work had been undertaken by a Family Support Worker with Child C and Child D on successive days 2 days after their admission into foster care, but they made no disclosures.

4.34 On 6th October, with the consent of "all parties", the Court revoked the interim care orders in respect of Child C and Child D who returned home. The children were to later disclose that they were subsequently abused by M on several occasions including the day they returned home.

4.35 On 10th November 2009, Child B told his foster carer that Child C had told him at school that Child D intended to disclose the abuse. The foster carer informed the Police who arranged with Social Care to interview the children at school the following day without M and F's consent so that the children could not be coerced into staying silent. Child C and Child D corroborated Child B's disclosures and later in video interviews, gave full details of the abuse they had experienced. M and F were rearrested the same day.

4.36 Child C and Child D were immediately made subjects of Police Protection Orders. On 13th November 2009, all 3 children were made subjects of Interim Care Orders. The final court hearing on the local authority's application for full care orders is scheduled for April 2011.

5. SUMMARY OF REVIEW FINDINGS

5.1 The children went from being "rescued" from the exposure to significant harm within their birth family only to end up being placed in another abusive situation where they were subjected to repeated and systematic physical abuse, emotional harm and neglect. The specific nature of the abuse, and the manner in which it was carried out, by adults who chose to adopt vulnerable children, is hard to comprehend.

5.2 The conclusion of this Serious Case Review was that at various stages over the 10 years, the abuse was both predictable and preventable. Had the appropriate actions been taken, the abuse may have been detected, and the children helped to disclose, much earlier. The Review has identified the many missed opportunities to pick up on the indicators of abuse, or to investigate disclosures made by Child B in particular, but also by Child C.

5.3 The children should never have found themselves placed in that situation. The assessment of M and F as adoptive parents was flawed and at the very least should have been suspended in view of the following factors:-

- the inappropriateness of embarking of an adoption application at a time of major life change – the couple had never lived together full time

- their almost complete lack of any experience around, or caring for children.

- questions about their level of commitment– given the missed appointments

5.4 The adoption assessment was too reliant on self assessment from M and F that was not probed sufficiently. The encouragement to M and F to provide information in a way that would maximise their attractiveness to placing social workers was a major contributory factor, and explains the over positive tone of the assessment presented to the Adoption Panel. The focus was too much on what would meet the applicants' needs, with insufficient consideration of the needs of children who might be placed with them. The checks and balances that Regulations and Guidance built in to the approval of adoption applications through the role of the Adoption Panel did not work in this case. On the limited documentary evidence available, the Adoption Panel did not provide the required level of probing and challenge. The Panel too allowed itself to be sucked into the attractiveness of the fact that these applicants were offering a rare and highly sought after commodity – a willingness to take a sibling group of 3

5.5 The decision that adoption was in each child's best interests was correct. However, a wish to achieve the "ideal" placement of all 3 children together meant that insufficient consideration was given to each child's individual needs in considering the merits of whether they should be placed as a sibling group. The assessed priority was to keep Child B and Child C together, and if a decision had been made to place them as a sibling group of 2, more placement options may have been available – although this would still have been difficult. The

implications of placing Child D with them - a child who had never lived with his 2 siblings – was not thought through in terms of the potential impact on achieving a successful placement, or in terms of the potential impact on all 3 children.

5.6 The placement introductions were carried out with indecent haste and were not child focused, and not evaluated sufficiently. The placement of Child D just 6 days after the other 2 children moved in was a tipping point and set off pressures and changes in the relationships between the children, and each child with the adoptive parents, that never recovered. The timing of the introductions could barely have been more ill-conceived - just prior to Christmas and the Millennium New Year which left the children and the adopters with no access to professional support. This again appears to have been driven by putting the adopters' wishes and interests ahead of the children's needs.

5.7 At several points, the placement should have been subject to a full review of its appropriateness and viability, and that review should have resulted in a decision to end it because of the increasing evidence of:-

- Attachment problems between Child C and M
- M and F's unrealistic expectation of the children's behaviour;
- F opting out of his parenting responsibilities
- Difficulties in the previously close relationship between Child B and Child C
- M and F's hostility towards social workers and rejection of advice
- M and F's ambivalence shown by the delay in lodging their court application.

5.8 The supervision during the placement was inadequate and showed insufficient child focus. There were too few visits, and insufficient direct observation of the children, and of the children with M and F. While social workers did challenge M and F, they did not follow through their concerns. The statutory review arrangements that should have built in some independent checking were not robust, and were not given sufficient importance with the decision to cancel the final review. That was the last chance to draw back from the situation.

5.9 Following the making of the adoption orders, and the ending of social work involvement by Stoke-on-Trent, the children were largely reliant on professionals working within universal services being willing and able to recognise and act on indicators of possible abuse, or direct disclosures made by the children. On one of the few occasions when any of the children were seen by health professionals, prompt action was taken by the GP to follow up serious concerns about M's treatment of Child D. However, the subsequent work by CAMHS was not child focused and the involvement ended without Child D being seen. Inadequate information sharing meant that primary health care professionals other than the GP were unaware of this, and had no reason to consider making any change to the universal level of service they were providing.

5.10 Given the lack of contact with health professionals, the role of school in protecting the children became more crucial. Although there is evidence of staff showing concern for the children, and trying to mitigate against the excess of M's parenting style, the inescapable conclusion is that the children were badly let down by all 4 schools who failed to record, or act on, their direct observations of a number of indicators of possible physical neglect and / or emotional abuse.

5.11 School staff became too focused on their relationship with the parents, particularly M, and were not sufficiently child focused and responsive to their needs. It appears that over time, the children's demeanour and M's treatment of them became accepted as the "norm" and staff did not compare these to what would be considered the "norm" or acceptable in relation to other pupils.

5.12 Throughout, the children displayed enormous resilience and they developed their own survival strategies aimed at not making things worse. Unfortunately their resilience had the effect of sowing seeds of doubt in teachers' minds as to whether the children were at risk of significant harm. School staff struggled to make sense of the contradictory evidence of the children doing well at school alongside the possible indicators of abuse.

Response to Disclosures of Abuse

5.13 There were 10 missed opportunities to carry out investigations of the many occasions when Child B in particular disclosed abuse, and on some occasions the Police were not contacted to hold a strategy discussion. On many occasions Child B was returned home against his wishes and without being interviewed by a social worker. Prime responsibility for those oversights and decisions rests with Cheshire East Social Care and its Emergency Duty Team but there were occasions when the Police should have been more challenging of Social Care's plans and escalated their concerns for resolution at a more senior level.

5.14 Once Child B began to disclose, too often the response was not child focused. There were several examples of conscientious and responsive work by practitioners within all agencies. The consistent child focus of the hospital staff is to be commended. However, too often, procedures, and basic sound professional practice, were not applied, and there was insufficient information sharing and assessment to build up a full picture of concerns and previous incidents.

5.15 With regard to Child B, too many professionals misread the signals and thought Child B was running away as part of normal teenage rebellion against the parents' discipline. In this they were lulled by M and F's disguised compliance. They presented as being concerned for Child B's welfare – which to an extent they may have been. They usually reported him missing, and often made efforts themselves to locate him. In addition they were active in supporting the High School's efforts to deal with his challenging behaviour and running away from school. Professionals throughout this period failed to remain centred on the

needs of the children, and dealt with each 'event' in isolation rather than building a picture of the experience of these children over time.

5.16 While some conscientious attempts were made by different professionals to encourage the children to talk, it is perhaps not surprising that the children were cautious, and reticent, because they would not feel confident in professionals' willingness and ability to protect them. This would only happen if they were removed from their parents' care. Based on the outcome of professionals' responses to Child B's disclosures in March 2009, the children's perception must have been that disclosing what was happening to them would make no difference – as Child B was always returned home, even when he was accommodated in the first instance. The risk therefore was that if they talked, and they were not removed, M and F would know, and might result in the abuse being taken into unknown and even more dangerous territory. Therefore it is possible that the children thought it better to endure the abuse they knew.

5.17 As time went on, and the occasions mounted up where Child B felt he was not listened to, not protected and returned into the abusive home situation, he lost confidence in professionals' ability to protect him. Fortunately, for all the children, Child B never gave up and found the confidence one more time to tell the Independent Reviewing Officer the specifics of the abuse he and his siblings had been suffering. In contrast to some of the earlier work, the response was immediate and responsive to the children's needs. The final investigatory work was of a high standard resulting in their removal from M and F who were brought to justice and convicted.

5.18 Credit is also due to non professionals who tried to secure help for the children at an earlier stage – most especially their school friends, and other adults and young people who encountered Child B, and were advocates for his welfare when he had run away from home. Their actions reinforce a key message that friends, family, and members of the public have a vital role to play in helping professionals to keep children safe. However, in this case professionals did not give sufficient weight to the information they provided.

6. LEARNING FROM THIS SCR

6.1 Given the above findings, the learning from this Serious Case Review covers a wide number of areas.

Recognition of Signs and Symptoms of Abuse / Referral of Concerns

6.2 The fact that the abuse went undetected and unchecked over a 10 year period underlines the importance of training being provided at regular intervals to ensure that all professionals, regardless of their work setting:-

- are clear about their roles and responsibilities as laid down in national guidance "What to do if you are worried a child is being abused"

- are knowledgeable about how to identify possible signs and symptoms of all categories of abuse.

- are confident about their role in recording their observations and concerns, and how to refer these in line with the national guidance.

- seek guidance from specialist safeguarding advisors at an early stage

- give the necessary consideration to the test as to whether the abuse is 'likely to cause significant harm' not just whether significant harm has been caused.

Safeguarding Arrangements within Schools

6.3 The case points to the need for an urgent review and audit of safeguarding arrangements across all schools to ensure that each has appropriate procedures in place and these are being applied. It is essential that concerns are brought to the attention of the designated teacher quickly, and the recording of concerns and actions become part of the child's safeguarding school record. The Panel identified that particular focus may be required on schools which encounter fewer cases of abuse.

Assessments

6.4 The Review highlights the importance of:-

- reviewing the level of understanding of professionals working in universal services regarding their role and responsibility for initiating action within the Common Assessment Framework where they have concerns about a child.

- the maintenance of up to date chronologies in building up a picture of events and concerns over time to inform assessments and decisions

- professionals applying a systematic evidence—based approach to information gathering and assessment to check out their "professional instincts". This applies to all types and levels of assessment.

- gathering information within the 3 assessment domains of the Framework for Assessment of Children in Need and their Families.

- using information gathered within the "parenting capacity domain" to identify the style of parenting are being exercised:-

  Authoritative – high control, high warmth
  Authoritarian – high control, low warmth
  Permissive – low control, high warmth
  Neglectful – low control, low warmth

It should have been clear to the professionals involved, particularly in the schools, that these parents were authoritarian and as such showed very little warmth towards the children which would have resulted in the children's emotional needs not being met at the very least, but may have been indicative of other forms of abuse taking place.

- direct observation of the child, and the child's relationship with the parents, particularly when the child is too young to express verbally his / her experiences, wishes and feelings. It is important that practitioners create opportunities to compare observations of the child's demeanour and behaviour within the home environment with that in other settings such as school and foster placements.

Working with "Hard to Change" / "Highly Resistant" Families

6.5 In this case, many professionals struggled to maintain a child focus when faced with M and F's aggressive behaviour and their "disguised compliance", and that their approach was affected by perceptions and assumptions made regarding the parents' social class, professional status, and high academic qualifications, and the attitude of M and F towards them. A priority will be to help build professionals' confidence around the need for greater challenge to parents, carers and other professionals in order to safeguard children effectively. In addition to additional training, the use of single and multi agency forums will be important in allowing staff to reflect, and share experiences and solutions, in working with "hard to change" or "highly resistant" families. There is a need for practitioners to develop confidence in differentiating between families genuinely engaged with services and those who are displaying "false compliance".

Supervision / Use of Specialist Advisors

6.6 Good supervision is always important, but never more so than when working with the most complex family situations. Maximum use must be made of the expertise provided by specialist safeguarding advisors within agencies, and within the Local Safeguarding Children Board. Practitioners should be encouraged to seek advice as appropriate from specialist advisors across all agencies. This, and regular meetings of all Specialist Advisors will help to maximise effective cross agency working.

Section 47 Investigations

6.7 The weaknesses in the conduct of some of the Section 47 investigations, and subsequent decisions which resulted in one or more of the children being left at risk of further abuse, emphasises the importance of :-

- Strategy discussions to agree and plan the investigations;

- Importance of approaching investigations with an open mind in considering disclosures made by a child, or information provided by a friend, relative or member of the public;

- considering the risks to other children in the family early on, and maintaining a focus on their safety throughout the investigation;

- gathering information from other agencies, and referrers, in order to build up a full picture.

- seeing paediatric assessment of injuries or indicators of neglect as just one important component of Section 47 enquiries, which needs to be considered alongside all other relevant information and assessments in reaching conclusions and decisions.

- encouraging the child to talk to a paediatrician who may be able to provide the necessary reassurance and overcome the child's fears of undergoing a medical examination.

The Use of Legal Remedies

6.8 A crucial lesson from this case is the need to avoid the inappropriate use of Section 20 of the Children Act 1989 to provide immediate protection by seeking to gain parental agreement to the child being accommodated by the local authority on a "voluntary" basis. This solution does not guarantee the child's safety if the parents decide to exercise their right to request the child's return, and it can also be unfair to parents who can be denied their legal right to challenge the basis of the local authority's view of the situation.

6.9 In this case, Section 20 was used more than once when Child B disclosed abuse and the immediate view was that it would not be safe for him to return home. This had far reaching consequences on the occasion when M discharged him from Section 20 accommodation prior to the planned video interview being carried out. It is vital that where the statutory investigating agencies, Police and Children's Social Care Services, believe the child will not be safe if allowed to remain in the care of his / her parents, or that the conduct of the investigation may be impeded, that they are prepared to make the necessary application to use the emergency powers that exist – an Emergency Protection Order or Police Protection Order.

6.10 The Panel heard a view that evidentially it was unlikely that the threshold for an emergency order would have been met in this case. That view is entirely speculative because the evidence was never tested. A key lesson is that practitioners must avoid making decisions based on "second guessing" what the legal advice may be, or the chances of a successful application, based on anecdotal information about the outcome of previous cases. In such situations, legal advice should be sought. Even then, legal advice is just that – it is advice. While legal advice should clearly be given due weight, the final decision on whether to seek the order rests with the practitioners and managers responsible for the investigation and the safety of the child.

6.11 Appropriate decision-making will be enhanced by such cases being brought within the child protection framework and an Initial Child Protection Case Conference being held.

6.12 **Information Sharing**

This case underlines the importance of prompt and full information sharing in contributing to effective safeguarding work. In this case, there were many different instances where this did not happen both within, and between agencies. There was inadequate information sharing for example:-

- by social workers regarding the children's placements;
- between primary care health professionals
- within the primary schools
- between social workers and the schools
- between social workers and the Police

Improved information sharing might have contributed to the abuse being detected earlier and investigated more thoroughly.

Helping Children to Disclose

6.13 There are a number of important learning points from both the good practice in the final disclosure work with the children, but also the weaknesses in some of the earlier work:-

- Good preparation for video interviews is essential and that all available information is shared with the interviewing officers. Care needs to be taken in balancing the need for good preparation with the need to act quickly to secure evidence to protect the child, and not to miss the most opportune moment in helping the child to disclose.

- Arrangements for disclosure interviews must minimise the risk of pressure being placed on the child by the parents not to proceed or disclose;

- Disclosure work must be carried out by appropriately trained staff, and always planned in consultation with the Police.

6.14 It is important that the Local Safeguarding Children Board's guidance and public awareness work, build on the learning from this case, and messages from research on how children disclose, the barriers they encounter, and who they feel most able to trust when considering making disclosures. As in this case, children often tell their friends, and some professionals are not seen as people they can disclose to, or having the powers to keep them safe.

6.15 Therefore it will be important for the LSCB to develop the information that is directed at children and young people, to include more information to explain and reassure how they can disclose what is happening to them, their siblings or friends. This information should also provide clear explanations of the role that

different professionals can play in helping to keep them safe, and what action they can expect to be taken to protect them if they do seek help or disclose abuse. This awareness raising must take place in parallel with the additional awareness raising and training for professionals on their responsibilities otherwise children may not receive the response they are being led to expect.

Adoption Practice

6.16 While acknowledging that there have been major changes to adoption law, and improvements in practice, since the adoption work in this case some 10 years ago, it will be important to check that these have been embedded in practice around the following issues.

Adoption Assessments

6.17 In carrying out assessments, there needs to be rigorous verification of information and self assessment provided by the adoptive applicants.

Adoption Planning for Sibling Groups

6.18 In reaching decisions on the placement of sibling groups, it is important to retain a focus on how the needs of each child can best be met, and ensure that these are not compromised by the pursuit of what might be seen as the "ideal" placement objective of keeping all the siblings together. It is essential therefore to draw up a hierarchy of preferred placement options that offers the most chance of meeting the assessed needs of each individual child.

Adoption Placements – Support and Supervision

6.19 It is essential that a written plan is drawn up prior to the placement being made and shared with the adoptive parents and other agencies. This must specify the role of each professional in delivering the plan, the support to be provided, and arrangements for monitoring the child's progress and welfare – including the completion of health assessments. The Plan should specify the frequency of visits and the arrangements for the statutory Looked After Children's Reviews. These reviews must continue to be held at a frequency that is appropriate to the children's needs, and as a minimum in line with statutory timescales, up to the making of the adoption order. Similarly, a clear Post Adoption Support Plan should be considered at the final Looked After Children's Review before the making of the Adoption Order.

Missed Appointments Policy and Practice

6.20 It is essential that each agency has in place a policy covering action to be taken when children / parents miss appointments in cases involving known, or potential, safeguarding issues. These policies should be based on a common set of standards agreed by the LSCB. The policies must be applied in a timely fashion and include notification to all other professionals involved with the family.

Decisions to End Involvement

6.21 There should be prior consultation with all other agencies involved with the family when consideration is being given to ending involvement - followed by immediate formal notification if the case is closed. This will ensure full information sharing to inform decisions to close the case, and enable other agencies to adjust its service appropriately. If an agency ends its involvement without seeing the child, the reasons for this must be recorded, and other agencies made aware of this.

Hospital Admissions where there are safeguarding concerns

6.22 Where a child is admitted to hospital, and there are safeguarding concerns, the child should be admitted under the care of both the Consultant Paediatrician and the Specialist Consultant for the presenting medical condition. This will ensure that the arrangements during the child's stay in hospital, and plans for the child's discharge, take account of any safeguarding concerns.

Protection of Looked After Children Placed Out of Area

6.23 This case highlights the potential vulnerability of children and young people living away from their families and placed out of area, and underlines the importance of strict application of the legislative and regulatory framework for the care and protection of all children living away from home. It is essential that the local authority placing the child provides full information promptly to all relevant agencies within the area where the child is to be placed. This information sharing must include clarification and agreement on the type and level of service to be provided from agencies within the "receiving" area.

6.24 Given the problems that occurred in this case, it will be important for the 3 LSCBs in this case, to raise awareness of this issue, and satisfy itself that agencies have effective protocols and arrangements in place both in respect of children moving into their area, and equally when placing its own Looked After Children out of area. These arrangements must be robust enough to ensure that information is shared promptly about all significant events such as changes in placement and legal status. A key issue which is addressed within the recommendations within the Health Overview IMR is to ensure clarity and timely delivery of arrangements for the completion of health assessments, and the speedy transfer of health records.

Diversity and Culture Issues

6.25 This case contained many ingredients relating to culture and diversity issues which were not picked up sufficiently by practitioners at the time. These gaps were not always explored sufficiently in some of the Agency IMRs to draw out the key issues that should have been taken into account. Therefore, it will be important for the LSCB and member agencies to raise awareness and provide the necessary guidance and training to ensure these are taken into account and recorded fully. It is also essential that the child's ethnicity is recorded accurately and consistently on all occasions using the current approved national descriptors.

Change Management / Risk Assessment

6.26 This case has shown the significant impact of major organisational change on the capacity and quality of work of the Social Care agencies in Stoke-on-Trent and Cheshire East brought about by national decisions on changes to local government structures. While such changes were beyond the control of those authorities, the key learning is the need for organisations to carry out robust risk assessments of the possible impact on services to protect children, and to share these with partner agencies at all stages.

7. ACTION ALREADY TAKEN

7.1 The Individual Management Reviews completed by agencies involved in this Serious Case Review, and their Action Plans, show that some of the failures cited in this SCR echo concerns already understood in respect of practice at that time. Therefore, considerable action has been taken to implement improvements required from the learning from this case. The following paragraphs summarise some of the most significant developments.

7.2 In recent years, Stoke-on-Trent have been implementing a wide-ranging action plan to address shortfalls in practice identified through national inspections, and have overhauled their fostering and adoption services. These services have received more positive results in subsequent inspections.

7.3 Similarly, Cheshire East Children's Services established a wide ranging Improvement Plan after the establishment of the new Unitary Authority in April 2009 and the appointment of a Director of Children's Services. This was already addressing weaknesses in service organisation and practice that featured in this case, but has now been updated to reflect the specific learning from this Serious Case Review. One important change is that the inherited Emergency Duty Team arrangements, currently shared with the other new unitary authority, will be replaced from 1st April 2011 with a new Cheshire East service.

7.4 During the period that this Review was being carried out, the Police have issued hand held computers to all officers which will enable them to retrieve all relevant information held within Police intelligence systems to inform risk assessments and decisions when dealing with incidents.

7.5 There have also been changes implemented by the various Health agencies. For example, the East Cheshire NHS Trust has already implemented its recommendation that where a child is admitted to hospital, and there are possible safeguarding issues, a child should come under the joint care of the Specialist Consultant for the presenting health condition, and the Consultant Paediatrician. This will ensure a continuing focus on any child protection issues and that discharge arrangements will promote the child's safety. The Central and East Cheshire Primary Care Trust is involved in regional initiatives to develop agreed protocols for commissioning health services for Looked After Children who are placed in other local authority areas. There have also been significant changes in

the policy and practice of the Child and Adolescent Mental Health Services which ensures greater focus on potential safeguarding issues, which will ensure full information gathering and liaison with other agencies involved with the family, and the child being seen during the service's involvement.

7.6 The Cheshire East LSCB is already revising its multi-agency training programme to implement the recommendations from this review, and this is also reflected in the plans that are well advanced to change the content of all levels of Safeguarding Training for schools

8 RECOMMENDATIONS AND ACTION PLAN

Overview Report Recommendations

1. In view of the Serious Case Review findings and recommendations relating to historical shortfalls in adoption practice in Stoke-on-Trent, Cheshire East LSCB, Stoke-on-Trent LSCB and Staffordshire LSCB request the respective Directors of Children' Services to carry out a check of adoption arrangements to ensure that practice is consistent with current national standards.

2 Cheshire East LSCB should update its policies, procedures and practice guidance to include the learning from this Serious Case Review and national research, and deliver a programme of refresher training during 2011 on:-

- roles and responsibilities of professionals set down in ""What to do if you are worried a child is being abused"

- the recognition, assessment and management of cases involving possible neglect and emotional harm,

- assessment and engagement strategies when working with "hard to change" or "highly resistant" families.

- the use of chronologies to build up a full picture of key events to inform assessments and decisions on action to be taken

3. Cheshire East LSCB should commission a report on both multi-agency, and single agency, arrangements for:-

- to enable staff to reflect on the challenges of working with "hard to change", hostile, and / or "highly resistant" families to improve their confidence and skills in maintaining a child centred approach and "assertive" practice.

- care and support for staff encountering challenging behaviours when working with complex family situations

4. Cheshire East LSCB should satisfy itself that all agencies are taking the necessary action to ensure that their managers and practitioners:-

   - place increased reliance on direct observation of the child, and parents / child relationship, when carrying out assessments of parenting style and capacity, to avoid an over –reliance on parents' un-evidenced accounts

   - compile full and accurate records of potential safeguarding concerns, including the maintenance of an up to date chronology of key events to inform assessment and decisions.

   - share information with all relevant agencies when parents and / or children fail to attend appointments, and consult with other agencies regarding any plans to end involvement because of non-attendance.

   - give greater focus to issues of race, culture, class or economic status, language and religious identity within their work, and the need to evidence in their records how these have been taken into account.

5. Where a child discloses abuse, the statutory investigating agencies, Police and Social Care, must:-

   - agree through a Strategy Meeting, which involves other relevant agencies, particularly Health Service agencies, how the necessary enquiries will be carried out - Initial Assessment or Section 47 investigation - and ensure that the child is seen on their own within 24 hours. If it is not possible, or appropriate, to see the child alone, the reasons for this must be recorded;

   - ensure that staff adopt an open-minded approach to the child's disclosures in planning how to carry out further enquiries and evaluate the results;

   - consider the possible risks to other children in the family, and maintain a focus on the safety of all children within the family throughout the investigation

   - gather information early from other agencies that may have knowledge of the child to inform planning and risk assessments during the investigation.

   - ensure that all disclosure work with a child is carried out by appropriately trained practitioners, and always in consultation with the Police

6. Cheshire East LSCB should request the Cheshire East Children's Trust Board to provide a report which evaluates the use and effectiveness of multi-agency work within the Common Assessment Framework, and the extent to which each agency is discharging its role and responsibilities within that framework.

7. Cheshire East LSCB, Stoke-on-Trent LSCB, and Staffordshire LSCB should request a joint report from their respective Directors of Children's Services, and the Chief Executive of the Primary Care Trust which evaluates the effectiveness of arrangements for the statutory notification of placements of Looked After Children who they place out of area, and the arrangements made by other authorities placing children within their area. This report should identify any steps being taken to improve compliance with the statutory requirements, reciprocal arrangements with other authorities, and include reference to any current regional initiatives.

8. Cheshire East LSCB should request joint reports from the Director of Children's Services and the Cheshire Constabulary on:-

   - the effectiveness of the arrangements for the out of hours social work service in dealing with referrals where there are child safeguarding issues, with regular updated assessments of the effectiveness of the service changes that are planned to come into operation from 1st April 2011;

   - current practice and trends in the use of Police Protection Orders, Emergency Protection Orders and Section 20 of the Children Act 1989. That report should include detailed statistical information from 1st April 2009 when Cheshire East became a unitary authority.

9. Cheshire East LSCB should request a report from the Cheshire Constabulary which describes and evaluates the effectiveness of "Return Home" interviews with children and young persons who go missing from home or local authority care. The report should include information as to how decisions take account of the history, and intelligence held within police systems, of previous incidents where the child went missing, the reasons established, and any information about previous or possible safeguarding concerns.

10. Cheshire East LSCB requests all agencies to submit reports to the Board when organisational change, or changes in the use of resources or capacity, are planned that have an impact on the delivery of services to children and their families, either directly or indirectly. The reports should evidence that risk assessments have been carried out on how children will be kept safe during the change process, and partner agencies have been informed of the revised arrangements.

11. The Chair of Cheshire East LSCB and Director of Children's Services write to Central Government to suggest that the next annual review of serious case reviews includes analysis of the risks to, and impact on, safeguarding practice arising from the implementation of major national organisational changes such as the establishment of new unitary authorities and changes to NHS structures.

12. Cheshire East LSCB uses the learning from this case to expand the range of public information made available to children and young people on how they can disclose abuse. This should include clear explanations of the role that different professionals can play in helping to keep them safe, and what action they can expect to be taken to protect them if they do disclose abuse.

13. Cheshire East LSCB and Stoke-on-Trent LSCB should provide the children with an apology on behalf of all agencies for the shortfalls in the services they received and an acknowledgement of the impact of the abuse they suffered.

14. Cheshire East LSCB commissions a report that assesses the effectiveness of local arrangements and practice within public law proceedings for safeguarding the interests of children to ensure these are child focused. The arrangements should allow the child's views to be heard, and be taken into account, in case planning and decisions. The report should include some perspectives from children on their experiences of the legal process. The Cheshire LSCB should include further evaluation within its standard audit programme.

SINGLE AGENCY RECOMMENDATIONS

Staffordshire Education

15 Education services will seek to ensure that all schools are compliant with legislation regarding record management and transfer of a child's school record between schools, as this is a recurrent theme in local serious case reviews.

16 The Education Welfare Service will review the content of the 'Level 1 Child Protection Training' delivered to education staff to ensure that a greater emphasis is placed on the recognition of potential indicators of emotional abuse and on how practitioners need to appropriately respond to concerns.

17 Education Services will actively support the development of the work being coordinated by Staffordshire Safeguarding Children Board on how to recognise and work effectively with difficult or 'highly resistant' families.

Stoke-on-Trent Children's Services

18. We need to ensure that each adopters' assessment has a plan which includes a formal opportunity for the supervisor to review progress and to highlight any areas of concern and agree how to address them. This should be at a midway point when all checks and references have been received. It should include a clear procedure to follow if there are any concerns about suitability so that it is possible to suspend an assessment in order for a decision to be made about continuing.

19. Where a sibling group is being placed for adoption, there needs to be a good quality assessment of each child's individual needs, especially if they have been separated in care, before making a decision that adoption with siblings is in each

child's best interests. It should never just be an assumption that it is best. If assessments are to have credibility, workers need to be confident in assessing bonding as well as attachment and need access to psychological expertise.

20 Adoption introductions are an opportunity for both the authority and the adopters to explore the reality of adoption. They are also another opportunity to observe behaviour and assess the potential for future bonding and attachment. The plans in respect of sibling groups, separated in care and to be re-united in adoption are complex when they have to address different needs and the meetings to plan introductions need skilful chairing to keep them child focused. Although practice has improved in this area, an audit of introduction plans for recently placed sibling groups is undertaken to identify whether any concerns were identified and acted upon.

21. We need to focus on how we improve social workers' skills in assessing wishes and feelings, especially with children who are young and have a limited ability to express themselves. This must involve using visits to adoption placements to observe the way that children and parent figures interact, in order to pick up on behaviour which is concerning and requires further exploration.

22. Where there are concerns about bonding issues, there needs to be a pathway to explore these which is child focused, but which recognises the fragility of bonds between adopters and children in the early stages of placement and allows for honesty and openness about problems, so that support as well as ending a placement can be considered. The procedures to investigate child protection concerns and serious causes for concern should be broadened to include a category of concern in respect of bonding.

23. The role of the IRO is crucial to ensure that the child's best interests are served rather than the adoptive parents. With new statutory responsibilities to oversee a child's care planning as well as review process, there is the opportunity to independently assess a child's wishes and feelings in order to highlight concerns and challenge care plans. This is especially the case where the child is considered too young to consult with and IROs will need to be trained to assess best interests in these situations.

Cheshire East Education

24. Review Safeguarding Training (Levels 1-3) for School and Settings during the summer term 2011 and implement in autumn 2011 to provide a greater focus on the following themes:

- The impact of emotional abuse on children and young people's well-being and emotional health.

- Raise awareness of challenging behaviours as potential indication of abuse.

- The importance of maintaining up-to-date pupil records which detailed events and record interventions, outcomes and next steps.

- Raise awareness of appropriate trigger points for referral to Children's Social Care

- Working with challenging parents/carers.

- Establish a learning network of designated teachers to develop practice.

25. Further consideration of the CAF Training Modules to include advice when:

- Appropriate implementation of the CAF process where social and educational issues need to be considered

- Appropriate implementation of the CAF process where there is evidence of suspected emotional harm

26. Record keeping by School Staff:

- Guidance issued via the School Bulletin fao Safeguarding, Pastoral and SEN Leads

27. To review the Safeguarding Audit tool to include case work recording.

Cheshire East Community Health

28. There needs to be a review of the current notification process for notifying health partners when a child / children are received into the cared for system or when placements are changed.

29. There needs to be raising of awareness across the workforce regarding the legislative and regulatory framework for the care and protection of all children living away from home. The role of NHS bodies and the responsibilities of lead health professionals need to be clearly understood.

30. Communication pathways between health visitors, school nurses, general practitioners need to be reviewed and formalised.

31. Children and young people living away from home should always be considered potentially vulnerable and practitioners should receive regular supervision on all such cases.

32. There needs to be a review of health visitor / school nurse records in order to ensure that information with regard to the family is part of the main file.

33. There needs to be a review of the current arrangements for transferring records between services and out of area for children living away from home and when they have been formally adopted.

34. There needs to be a review of the child health surveillance policy to ensure that children living away from home and those that have been adopted receive age appropriate assessments at key stages of the Healthy Child Programme.

35 There needs to be a review of the supervision arrangements currently provided to newly qualified practitioners.

East Cheshire NHS Trust (Hospital)

36. Where there are Safeguarding Concerns about a child the child should be admitted both under the Consultant Paediatrician and the Specialist Consultant for the presenting problem.

37. This case will be anonymised and included as a scenario in safeguarding training. In order to promote good practice and to increase staffs confidence to challenge decision making. .

Cheshire and Wirral Partnership NHS Foundation Trust

38. Where there are safeguarding concerns for a child at the point of referral or initial assessment with the parents, then every effort should be made to see the Child individually.

39 Through training, staff are reminded of the need to check with other professionals involved with the family, parent's or guardian's self reporting of their children's progress, when abuse or neglect is a feature of the case.

40. A specific audit tool is to be developed for CAMHS to implement in relevant safeguarding cases to ensure processes/procedures have been followed.

41. All missed appointments are clearly documented and followed up, they are notified appropriately to all relevant professionals involved with the family in a timely manner.

42. When there are safeguarding concerns for children that all the relevant professionals such as Social Workers, Health Visitors or School Nurses should be informed of the closure of the case to service as the result of non engagement.

43. The issue of the availability of Post Adoption support is taken for discussion at CWP's CAMHS Safeguarding Group.

44. The learning from this Serious Case Review when complete is presented as an agenda Item on the Annual CAMHS training day in 2011.

Cheshire East GP Services

45. Better communication pathways need to be in place between Social Services and GP's to provide timely notification when a child has been placed in foster care.

Central and East Cheshire Primary Care Trust (Health Overview Report)

46. CECPCT must have clear guidelines on how services are commissioned for their Looked after Children who are placed outside of the PCT. There should be a review of the commissioning pathways and arrangements currently in place to ensure that the health needs of the PCT's out of area Looked after Children are met in a timely manner.

47. There should be a greater emphasis on the 'power to challenge' parents, carers and other professionals within safeguarding children training across all health providers. .

48. There should be a further review of storage of child health records in respect of school nurse base 1, in order to explore how more immediate access to records can be obtained.

49. There should be a greater emphasis on culture and diversity within safeguarding children training across all health providers.

Cheshire Constabulary

50. The Review Team recommends that visibility of the MFHLO involvement in supporting missing from home enquiries is captured on the front page of a CAVA record. This could be achieved by amending the information field to include a section which would allow the MFHLO to endorse recognition of the referral.

Cheshire East Social Care

51. There needs to be greater clarity about the role of the Intake/Duty service about assessments with regards to support to adoptive families (to include those working within and those accessing the service).

52. To ensure greater accuracy and depth of Assessments; clear analysis and decisions recorded; focus on the disguised compliance of families.

53. Senior managers, where appropriate, need to be more visible in the decision making process.

54. Organisation needs to provide cover for long term absences.

55. Supervision of social care staff must be prioritised; this needs to be recorded accurately with ongoing enhanced training to include Professional Development of staff case loads.

56. There needs to be a whole family focus in the course of Core Assessments, including members who are not the named in referrals.

57. That training is provided into the issues around disclosure of abuse and the barriers to this will incorporate the issues at also.

APPENDIX 1 – MULTI-AGECNY ACTION PLAN

	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
1.	In view of the Serious Case Review findings and recommendations relating to historical shortfalls in adoption practice in Stoke-on-Trent, Cheshire East and Staffordshire LSCBs request the respective Directors of Children' Services to carry out a check of **adoption arrangements** to ensure that practice is consistent with current national standards.	New and existing evidence (e.g. recent audits or inspection) is collated to assess current practice.	Report back to CE LSCB with evidence of confirmation or development action plan.	CE LSCB is assured that current adoption practices are in line with national standards and reduce risk to positive outcomes for adoption.	Directors of Children' Services Cheshire East, Stoke-on-Trent, and Staffordshire	30/9/11
2	Cheshire East LSCB should update its **policies, procedures and practice guidance** to include the learning from this Serious Case Review and national research, and deliver a programme of refresher training during 2011 on:- • roles and responsibilities of professionals set down in ""What to do if you are worried a child is being abused" • the recognition, assessment and management of cases involving possible neglect and emotional harm, • assessment and engagement strategies when working with "hard to change" or "highly resistant" families. • the use of chronologies to build up a full picture of key events to inform assessments and decisions on action to be taken	Review of policy & procedures, and of CE LSCB training programme to assess changes needed to address these issues. Policies updated following consultation with stakeholder expertise, published and implemented. Training programme sources new research, materials or external trainers to update training content, trainers briefed and new materials are integrated into the training programme. Inclusion of these issues in multi-agency audits.	Report to CE LSCB confirms policy and procedures updated. Report to CE LSCB confirms that training programme updated.	Practitioners and frontline managers have greater confidence in dealing with the signs of abuse including neglect and emotional harm, and with resistant families	CE LSCB Policy & Procedures Sub-Group CE LSCB Training Sub-Group LSCB Performance Management sub-group	30/9/11 30/9/11

	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
3	Cheshire East LSCB should commission a report on both multi-agency, and single agency, arrangements for:- • to enable staff to reflect on the challenges of working with "hard to change", hostile, and / or "highly resistant" families to improve their confidence and skills in maintaining a child centred approach and "assertive" practice. • care and support for staff encountering challenging behaviours when working with complex family situations	CE LSCB Chair to send template across agencies for completion that evidences their arrangements. Returns reviewed by Performance Management sub-group for report to the Board.	Report with action plan received and signed off by CE LSCB.	In work with "hard to change", hostile, and / or "highly resistant" families, practitioners are given the opportunity through supervision and planning meetings to review, plan, and discuss the personal impact. Practice improves, children's outcomes are better assured	CE LSCB partners – for single agency reports. Performance Management sub-group for report to the Board	30/9/11
4	Cheshire East LSCB should satisfy itself that all agencies are taking the necessary action to ensure that their managers and practitioners:- • place increased reliance on **direct observation of the child**, and parents / child relationship, when carrying out assessments of parenting style and capacity, to avoid an over –reliance on parents' un-evidenced accounts • compile full and accurate **records of potential safeguarding concerns,** including the maintenance of an up to date chronology of key events to inform assessment and decisions. • share information with all relevant	These messages are included in dissemination of findings from this SCR. Performance Management and Quality sub-group requests a 'health check' against these recommendations and an action plan for improvement where required from CE LSCB partners that these areas of practice are in place or developing.	Report with action plan from the Performance Management and Quality sub-group received and signed off by CE LSCB.	Changes in practice reduce risk to the child.	CE LSCB partners Performance Management and Quality sub-group	30/9/11

	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
	agencies when **parents and / or children fail to attend appointments**, and consult with other agencies regarding any plans to end involvement because of non-attendance.					
5	Where a **child discloses abuse**, the statutory investigating agencies, Police and Social Care, must:- • agree through a Strategy Meeting, which involves other relevant agencies, particularly Health Service agencies, how the necessary enquiries will be carried out - Initial Assessment or Section 47 investigation - and ensure that the child is seen on their own within 24 hours. If it is not possible, or appropriate, to see the child alone, the reasons for this must be recorded; • ensure that staff adopt an open-minded approach to the child's disclosures in planning how to carry out further enquiries and evaluate the results; • consider the possible risks to other children in the family, and maintain a focus on the safety of all children within the family throughout the investigation; • gather information early from other agencies that may have knowledge of the child to inform	These messages are included in dissemination of findings from this SCR. Police and Social Care evidence practice in these areas and develop improvement plans where necessary. Performance Management & Quality sub-group includes these issues within multi-agency case auditing. LSCB training materials reviewed to ensure the inclusion of these messages.	Communication materials on lessons from SCRs include these issues. Police, Social Care and Safeguarding Unit provide reports to the Performance Management & Quality sub-group	service is consistent with good practice expectations and children and young people are better safeguarded	Police and Social Care Performance Management & Quality sub-group	31/7/11

	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
	planning and risk assessments during the investigation. • ensure that all disclosure work with a child is carried out by appropriately trained practitioners, and always in consultation with the Police.					
6	Cheshire East LSCB should request the Cheshire East Children's Trust Board to provide a report which evaluates the use and effectiveness of multi-agency work within the **Common Assessment Framework**, and the extent to which each agency is discharging its role and responsibilities within that framework.	CE LSCB provide Children's Trust with outline Terms of Reference for a CAF report. Children's Trust considers whether existing monitoring systems can provide this information, and what additional research might be needed.	Report with action plan received and signed off by CE LSCB.	CE LSCB is assured that CAF will play an increasing role in the safeguarding of children.	Cheshire East Children's Trust Board	30/6/11
7	Cheshire East LSCB and Stoke-on-Trent LSCB should request a joint report from their respective Directors of Children's Services, and the Chief Executive of the Primary Care Trust which evaluates the effectiveness of arrangements for the statutory **notification of placements of Looked After Children who they place out of area**, and the arrangements made by other authorities placing children within their area. This report should identify any steps being taken to improve compliance with the statutory requirements, reciprocal arrangements with other authorities, and include reference to any current regional initiatives	CE LSCB provides Children's Services and PCT with outline Terms of Reference for a report.	Report with action plan received and signed off by CE LSCB.	Improved compliance with the statutory requirements, and reciprocal arrangements with other authorities.	Directors of Children' Services Cheshire East and Stoke-on-Trent, and the Chief Executives of the Central and Eastern Cheshire PCT and Stoke-on-Trent PCT.	30/8/11

	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
8	Cheshire East LSCB should request joint reports from the Director of Children's Services and the Cheshire Constabulary on:- • the effectiveness of the arrangements for the **out of hours social work service** in dealing with referrals where there are child safeguarding issues, with regular updated assessments of the effectiveness of the service changes that are planned to come into operation from 1st April 2011; • current practice and trends in the use of **Police Protection Orders, Emergency Protection Orders and Section 20** of the Children Act 1989. That report should include detailed statistical information from 1st April 2009 when Cheshire East became a unitary authority.	CE LSCB provide Children's Services and Police with outline Terms of Reference for a report.	Report with action plan received and signed off by CE LSCB.	CE LSCB is assured that Out of Hours service and use of Police Protection Orders, Emergency Protection Orders and Section 20 reduces risk to children in safeguarding situations.	Director of Children's Services and the Cheshire Constabulary	31/7/11
9	Cheshire East LSCB should request a report from the Cheshire Constabulary which describes and evaluates the **effectiveness of "Return Home" interviews** with children and young persons who go missing from home or local authority care. The report should include information as to how decisions take account of the history, and intelligence held within police systems, of previous incidents where the child went missing, the reasons established, and any information about previous or possible safeguarding concerns.	CE LSCB provides Police with outline Terms of Reference for a report.	Report with action plan received and signed off by CE LSCB.	CE LSCB is assured that an effective system is in place for "Return Home" interviews that reduces risks faced by children in safeguarding situations.	Cheshire Constabulary	30/9/11

	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
10	Cheshire LSCB requests all agencies to submit reports to the Board when **organisational change**, or changes in the use of resources or capacity, are planned that have an impact on the delivery of services to children and their families, either directly or indirectly. The reports should evidence that risk assessments have been carried out on how children will be kept safe during the change process, and partner agencies have been informed of the revised arrangements.	CE LSCB provides a framework of questions for partner agencies to report on when assessing the impact of organisational change. Each agency conducts it's own review and reports back.	Report with action plan received and signed off by CE LSCB.	Potential risks to safeguarding systems are identified as early as possible and steps are identified to mitigate them.	Chair of Cheshire East LSCB	30/9/11
11	The Chair of Cheshire East LSCB and Director of Children's Services write to **Central Government** to suggest that the next annual review of serious case reviews includes analysis of the risks to, and impact on, safeguarding practice arising from the implementation of major national organisational changes such as the establishment of new unitary authorities and changes to NHS structures.	Identification of key recipients. Draft and agree letter.	Final draft presented to Cheshire East LSCB.	Government Department preparing for next annual review of SCRs is able to access advice from Cheshire East LSCB.	Chair of Cheshire East LSCB and Director of Children's Services	30/4/11
12	Cheshire East LSCB uses the learning from this case to expand the range of **public information made available to children and young people** on how they can disclose abuse. This should include clear explanations of the role that different professionals can play in helping to keep them safe, and what action they can expect to be taken to protect them if they do disclose abuse.	Identify appropriate materials Consult children & young people on appropriateness of materials and ease of access. Develop web materials and hard copy	User reports on children & young people's LSCB web pages. Distribution of hard copy materials through event and channels engaging children & young people.	Children & young people, particularly those who may be at risk, are better informed about the choices and opportunities to disclose abuse (their own or others).	Cheshire East LSCB Communications sub-Group	30/9/11

	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
13	Cheshire East LSCB and Stoke-on-Trent LSCB should provide the children with an apology on behalf of all agencies for the **shortfalls in the services** they received and an acknowledgement of the impact of the abuse they suffered.	Consult children's current cares and social workers to consider best approach. Draft and agree letter.	Final draft presented to Cheshire East LSCB.	Children are able to recognise the meaning of the message to them from Cheshire East LSCB and Stoke-on-Trent LSCB.	Chair of Cheshire East LSCB and Stoke-on-Trent LSCB	30/4/11