Adam & Anna Serious Case Review
6 Step Briefing

The Background

In September 2017 the LSCB received a referral regarding the sexual abuse of two children by a family member. Adam and Anna's paternal uncle was convicted in July 2017 for multiple counts of abuse against the children which took place from around December 2015 until his arrest. The abuse took place within the family home and at the same uncle's home where the children had also lived.

The purpose of this Serious Case Review was to understand the barriers to safeguarding Adam and Anna from sexual abuse and to better understand the correlation between neglect and child sexual abuse within the family. The review also explored how effectively agencies worked together to identify and address the risk posed to the children, what the barriers were and what can be learned to improve future professional practice.

The Review

The review was conducted by an independent reviewer and covers the period from October 2013 (when concerns regarding neglect triggered child protection concerns) to July 2017 (when the children were received into the Local Authority's care following confirmation they had been subject to sexual abuse). The review covers issues of child sexual abuse within the family alongside neglect, isolation and poor home conditions, and provides key learning for agencies working with children. The review makes a number of recommendations to improve the safeguarding of children, shown overleaf.

The Safeguarding Concerns

Practitioners involved in protecting Adam and Anna had identified the risk of child sexual abuse as early as September 2014, but there was inconsistency in how to articulate the risk, and how to gather and apply evidence on a consistent basis to ensure that risk assessment informed the child protection and PLO processes. Whilst there was insufficient evidence available to unequivocally prove that Adam and Anna were being sexually abused until July 2017, practitioners had requested and received assurance from the parents that contact between the children and the family member suspected of posing a risk would be supervised. Practitioners worked well together to ensure unsupervised contact didn't take place outside of the family home, but were frustrated in attempts to protect Adam and Anna by the lack of legal powers to explore or monitor contact with external family members within private settings, such as the family home.

Key Learning Points

Identifying and Investigating: CP plans must convey a common understanding of all types of harm and the level of risk for each, the legal powers to prevent sexual abuse by mitigating risk and the expectations for recording and reporting information so it is shared in a way that facilitates swift, effective interventions. The PLO and CP processes aren't linear, rather they require dynamic risk assessment and evaluation of thresholds. A 'reasonable cause to suspect' a child is at risk of significant harm justifies s.47 investigations.
Voice of the child: The voice of the child must always be actively sought by practitioners. Observations on the child's presentation, developmental progress and environmental or risk factors must be considered.
Preventative advice and direct work with child at risk of IFCSA: If necessary and proportionate parental consent should be sought for direct work with children to help them recognise, resist and report sexual abuse.
Role of the responsible parent: Parents/carers must engage fully to detect and disrupt sexual abuse. Where parents are skeptical of risk, practitioners should justify decisions and make clear to parents that failing to adhere to the protection plan will almost always require escalation into civil and possibly criminal proceedings.

The Recommendations

Training:

1. The LSCB set up a task and finish group and/or host a practitioners' workshop to explore whether protocols for increased inter-agency work or joint training could be developed to respond to a perceived risk of inter familial child sexual abuse. The focus should be to develop a shared understanding of the legal framework and empower practitioners across partner agencies by providing clarity on:
   - The full victimisation profiles of children at risk of neglect and IFCSA in order to address the cumulative impacts of harm;
   - The legal powers that could be employed when support families to ensure that perpetrators find fewer opportunities to target and abuse children. [pg1.13 and 5.34]
   - The services available locally to support children, families and practitioners (including school and health staff) working with children who are at risk of IFSCA recognise and report such abuse [pg5.22];
   - the role of parents in protecting children at risk of IFSCA [pg5.50]
   - Legal powers and expectations when collating and sharing information so as to assist lead agencies (social care, the police and CPS) progress matters into Court in a timely manner. [pg5.4]
   - The evidential burden required to arrest for offences that might arise where there is neglect and a risk of IFSCA, including complicity offences, so that a child is supported through specialist interview techniques and any criminal investigation can commence at the earliest opportunity. [pg5.34]
2. The LSCB seeks assurance that staff from relevant agencies, including designated safeguarding leads within schools, school nursing staff and health visitors, receive learning from this review and the LSCB give consideration to how to measure the impact of that training, e.g. review of referral data, audit or professional surveys. Any training offer should include guidance on retention of records, compliant with GDPR, Data Protection and Freedom of Information obligations. [pg4.11]

Pathways and Processes:

3. Where there is reasonable cause to suspect IFCSA may occur, this must be recorded as the principle category of risk and evidence of other types of abuse carefully considered against the Finkelhor's four preconditions model so that plans and contingency plans adequately reduce risk through early detection or disruption as with other forms of child sexual exploitation. [pg5.15]
4. LSCB to explore opportunities for Child Protection Conference Chairs to secure advice from agencies with expertise in management of offending behaviours on the possible risk reduction measures they can lawfully employ as part of a CP plan and when failure to comply with any protective measures could indication reasonable grounds to believe a child may be experiencing significant harm. [pg4.27]
5. LSCB give consideration to reviewing multi-agency guidance so as to clearly indicate that CP and PLO processes are not linear, but require exercise of professional judgment having regard to the thresholds set out in legislation. This should also make explicit that it is expected practice that a RCPC is held whenever there is a significant change in the protection plan, including a conclusion by the lead practitioners that proceedings should commence. [pg5.36]

Quality Assurance

6. LSCB review mechanisms used for securing assurance from all member agencies that they:
   - Actively implemented supervision within practice including how the escalation policy works within agencies. [pg4.12]
   - Effective processes of case reallocation / handover when active risks are being managed [pg4.25] or when the child[ren] have been subject to a CiN or Child Protection process previously [pg4.9].
   - Pathways are widely understood and that any practitioner who believes there is reasonable cause to suspect a child could be at risk of IFCSA raises this in line with the referral mechanism through MASH
7. LSCB to seek information on commissioned therapeutic support/services locally to work with perpetrators and cascade details of referral pathways to the multi agency. [pg5.12]
8. LSCB to seek assurance from NHS England and/or the CCG re support services for children and YP who have experienced IFCSA. LSCB to seek assurance that the access to therapeutic services is included and monitored as part of the children's LAC planning. [p5.53]

Supervision and management oversight

9. The relevant lead person from CSC provide assurance that oversight of assessment process and decision making is robustly monitored by team managers. Also that service managers have oversight of decision making trends and that decisions are 'dip sampled' as part of the service Quality Assurance processes. [pg4.9] Focus must be given to:
   - Those child/ren who have been subject to a CiN or Child Protection process previously.
   - There is reasonable cause to suspect IFCSA is a risk; or
   - Continuity of practice- especially when an outgoing lead professional believes there are reasonable grounds to believe a child is at risk of significant harm to ensure managerial oversight is consistent. [pg4.25]