SERIOUS CASE REVIEW OVERVIEW REPORT – CHARLIE AND CHARLOTTE

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Contents

Introduction

1. The Durham Safeguarding Children Board (LSCB) agreed on 15th June 2016 to commission a Serious Case Review (SCR) into the neglect of Charlie aged 10 and Charlotte aged 7.
2. Regulation 5 of the Local Safeguarding Children Board Regulations 2006 sets out the requirement for Local Safeguarding Children Boards to undertake reviews of serious cases where:

   (a) Abuse or neglect of a child is known or suspected; and

   (b) Either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board Partners or other relevant persons have worked together to safeguard the child.

Background

3. The parents had five children previously removed from their care by another Local Authority because of concerns regarding severe neglect. This was in 2001.
4. Parents went on to have 2 further children; Charlie in 2007 and Charlotte in 2010 both of whom remained in their care from birth.
5. There has been extensive multi- agency involvement with the family since 2006 concerning the parents' ability to meet the children's needs specifically;
   - Both Charlie and Charlotte have suffered severe dental decay and parents have failed to ensure appropriate treatment for both children.
   - Both children have suffered permanent visual impairment as a result of parental failure to seek treatment.
   - Throughout the period of time considered by this serious case review there have been variable home conditions from very poor and unsafe to acceptable.

6. An assessment concluded in March 2016 that the parents were unable to meet the children's basic needs.
7. There were also underlying periodic concerns about possible sexual abuse based on children's behaviour and who the children have had contact with.

The SCR: Process and Methodology

8. The Local Safeguarding Children's Board (LSCB) agreed on the 15th June 2016 to commission an SCR. The scope of this SCR was to cover the timeframe from 2006 until April 2016.
9. The SCR Sub-Committee recommended that the LSCB should conduct a proportionate, appropriate and participative SCR with the emphasis upon professional involvement, to address how agencies had worked together in this case, identify any learning, aggregate lessons from individual organisations and ensure that an improvement action plan was put in place.
10. Working Together to Safeguard Children (2013) also provided new guidance for undertaking a Serious Case Review which requires that they should be conducted in a way which:
    - Recognises the complex circumstances in which professionals work together to safeguard children;
    - Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
    - Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
    - Is transparent about the way data is collected and analysed; and
    - Makes use of relevant research and case evidence to inform the findings.
11. The SCR was designed and led by Clare Hyde MBE, independent reviewer, from The Foundation for Families (a not for profit Community Interest Company). Ms. Hyde developed

a review model that would enable participants to consider the events and circumstances, which occurred during the timeframe. Ms. Hyde also authored this report.

12. The methodology used was the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).

13. This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead it is an effective learning tool for Local Safeguarding Children Boards to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken of the case is not the focus of the reports which are succinct and centre on learning and improving practice. However, because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of Safeguarding Boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Board may identify additional learning issues or actions of strategic importance. These may be included in the final SCR report or in the action plan as appropriate.

14. This approach also takes account of work that suggests that developing over prescriptive recommendations has limited impact and value in complex work such as safeguarding children. For example, a 2011 study of recommendations arising from SCRs 2009 -2010, (Brandon, M et al), calls for a limiting of 'self-perpetuating and proliferation' of recommendations. Current thinking about how the learning from SCRs can be most effectively achieved is encouraging a lighter touch on making recommendations for implementation rather than over complex action plans.

15. A Serious Case Review Panel was convened of senior and specialist representatives from agencies involved with the family in the time covered, to oversee the conduct and outcomes of the review. All panel members were independent of the family and casework. The role of the panel was to assist the Lead Reviewer in considering the evidence, formulating the recommendations and quality assuring this report.
16. There was considerable agency involvement with the family and the following agencies were asked to provide a chronology and these were integrated into a combined chronology.
    - Durham Constabulary
    - GP Medical Practice
    - County Durham & Darlington NHS Foundation Trust
    - Harrogate & District NHS Foundation Trust
    - Tees, Esk & Wear Valleys NHS Foundation Trust
    - Durham Children & Young People's Services
    - Durham & Adult Health Services
    - Housing Provider
    - School 1
17. The Lead Reviewer considered the combined chronology in order to consider in detail the sequence of events and any key practice episodes that underpinned those events.
18. The LSCB SCR Sub Group agreed draft terms of reference for the SCR in addition to the terms of reference described in national guidance.
19. The SCR panel also considered further key lines of enquiry which were then included in the terms of reference. The key lines of enquiry were:
    A. What was professional's understanding of the missed medical appointments?
    B. What was professional's understanding of mother's learning difficulties, her functioning and her ability to parent?

C. What was professional's understanding of father's mental and physical health and his ability to parent?

D. Were the children's voices heard and how did they contribute to assessments of risk, planning and decision making

E. What difference did the interventions and the repeat interventions make to the children and the adults in the family? How much did professionals know about previous interventions?

F. How much did professionals know about the indicators of sexual abuse e.g. sexualised behaviour and the family history and how much was this information considered during the different periods of intervention?

G. Consideration of managerial oversight and decision making.

H. When there were no safeguarding arrangements in place in respect of the children what was going well for the family?

I. Consider whether disguised compliance was an issue in this case.

20. The SCR aimed to provide an innovative 'whole system' approach involving key front line practitioners who worked with the family in a Learning Event held in December 2016. Every effort was made to ensure that Charlie and Charlotte's experience were central to the Learning Event.

Independence

21. The Lead Reviewer, Clare Hyde, was CEO of Calderdale Women Centre for 14 years (between 1994 and 2009) and developed nationally acclaimed, high quality services and support for at risk women and families. Ms Hyde contributed to Baroness Corston's review of women with vulnerabilities in the criminal justice system which was commissioned by the Government following the deaths of several women in custody.

22. Ms Hyde is currently working with Local Safeguarding Children Boards and their partners to improve safeguarding outcomes for children and young people living with domestic abuse, substance misuse and parental mental illness and to support the development of a multi-agency response to children and young people at risk of sexual exploitation.
23. Ms Hyde also designed and facilitated a multi-agency review of child sexual exploitation in Rochdale in 2012 and is currently the Independent Chair of several SCRs and a Domestic Homicide Review and has designed and led several Learning Reviews on behalf of Local Safeguarding Children and Adults Boards.

Serious Case Review Panel

24. The SCR Panel met on a number of occasions between August 2016 and March 2017. The overview report was ratified at the Local Safeguarding Children Board meeting on 15 March 2017.
25. The Panel comprised of:

Title	Organisation
Independent Consultant	Chair & Reviewer
Business Manager	Durham LSCB
Admin Co-ordinator	Durham LSCB
Detective Inspector	Durham Constabulary Safeguarding Units
Designated Nurse Safeguarding Children	Durham Dales, Easington & Sedgefield CCG
Associate Director of Patient Experience & Safeguarding	County Durham & Darlington NHS Foundation Trust
Strategic Manager – First Contact & Intervention	Durham Children & Young People's Services
Business Contract Manager	Stonham Group
Named Nurse Safeguarding Children	Harrogate & District NHS Foundation Trust
Principal Support Officer	Durham Adult & Health Services
Associate Director of Nursing (Safeguarding)	Tees, Esk & Wear Valleys NHS Foundation Trust
Lead for Health & Wellbeing	Durham Education

Confidentiality

26. Working Together to Safeguard Children 2015 clearly sets out a requirement for the publication in full of the overview report from SCRs:
27. "All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report may be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case."

Family involvement

28. The parents were made aware that a Serious Case Review was being undertaken and were invited to contribute. They engaged with the process at the point the Serious Case Review report was completed and subsequently met with the LSCB Business Manager, LSCB Admin Co-ordinator and Social Worker and read the report and commented upon the findings.
29. In terms of professional concerns regarding neglect, parents felt that they had not harmed the children and had sought support for their needs as well as their children's when required, however they felt that they were not given the right support. Parents explained that the reasons why the children were not brought to a number of medical appointments was due to father's ill-health and they had no means to transport the children to the appointments which varied in distance and location. At the time, they had a lot going on and had struggled on occasion to keep on top of things. With regards to concerns around the children's dental issues, parents advised that they had taken the children to the dentist and had been reassured that they were no concerns and that they would continue to routinely monitor.

30. Parents confirmed that there were a number of professionals involved and that their involvement was sporadic and they were assured that they were doing everything appropriately. In terms of learning, parents felt that professionals needed to consider the whole family's needs as opposed to focussing on the children only and that professionals need to build relationships with the family and needed to be open and honest. They acknowledged that mother's learning disabilities and father's ill-health had an impact on meeting the children's needs, however, they felt that they received no support.

Staff involvement

31. The staff who were involved with Charlie and Charlotte participated in a Learning Event in December 2016. The Learning Event was attended by 28 professionals in addition to the Lead Reviewer who facilitated the event, the LSCB Business Manager and the LSCB Administrative Co-ordinator. The Learning Event was organised in line with Welsh Government guidance (Child Practice Reviews: Organising and Facilitating Learning Events, December 2012) and minutes were recorded of the event.
32. Following the Learning Event, the Lead Reviewer collated the outputs from the Learning Event and from the agency chronologies and began her analysis. In reviewing the findings, the panel gave consideration to what could be done differently to further improve future practice.

Race, Religion, Language and Culture

33. Charlie and Charlotte's family were English White British. Religion is not considered to be a feature of their lives.

Summary of Family history

34. The timescale considered during this review is unusually long as the SCR Panel believed that events which took place prior to the birth of Charlie in 2007 were significant to the learning to be gained from the review.
35. Father and his ex-wife had five children. The couple separated in 1993.
36. Father was medically discharged from the army after he sustained a head injury.
37. Father has severe and enduring mental health problems.
38. Father's physical health is also poor and he has chronic and long term disabling illnesses.
39. Both he and his ex-wife said they could not cope with the children and there were concerns about how well the children were cared for.
40. In 1988 one of Charlie and Charlotte's father and ex-wife's children died following an illness whilst still a baby.
41. In 1989 they had another child. They struggled to cope and he went to live with a family member at 4 months old.
42. In 1989 one of their children reported domestic abuse.
43. Throughout 1989 and 1990 father's mental health was unstable and he stated that he wanted to kill himself.
44. In August 1990 Charlie and Charlotte's mother gave birth to a child. She was living with her mother at the time and was 15 years of age.
45. At some point around this time Charlie and Charlotte's mother began to babysit for father and his ex-wife.
46. Throughout the children had various injuries including a cigarette burn to the foot of one child all of which raised concerns.
47. In November 1990 one of the children disclosed sexual abuse by one of his siblings. The sibling admitted adding that he did this to his sisters and to his mother.

48. Throughout poverty was an issue for the family and they were served with an eviction notice in 1991.
49. The 5 children led a very unsettled life and were separated and sent to live with family members or accommodated by the local authority before returning home for periods of time.
50. In 1991 Charlie and Charlotte's father's ex-wife became pregnant again.
51. During 1991 and 1992 Charlie and Charlotte's father stated that he could not cope with the children. On one occasion in 1992 he hit one of his children and his ex-wife could not get him to stop.
52. During 1992 one of the siblings instigated explicitly sexualised behaviour with other children including his sister
53. Also in 1992 father disclosed that he had been sexually abused by a member of the extended family when he was 4 years old.
54. Father was cutting himself and said he could not cope with the children.
55. The couple both admitted to hitting the children
56. In April 1993 the 5 children are made subject of Child Protection Plan for neglect.
57. In June 1994 the Child Protection Plan ended.
58. Between 1994 and 1996 there continued to be concerns about the children including injuries. Father's mental health was still unstable and poverty was a constant added stress.
59. In 1996 the father of Charlie and Charlotte's mother's second child contacted CSC and reported that she had been sexually assaulted by one of Charlie and Charlotte's child who was then aged 13.
60. Also in 1996 a child was born to Charlie and Charlotte's parents. Mother had been the babysitter for the family and was residing with Charlie and Charlotte's father and ex-wife.
61. Between 1996 and 1998 concerns continued about school attendance, neglect and father's alcohol consumption.

62. In 1997 Father was involved in an assault on a man who had allegedly sexually assaulted one of his and his ex-wife's children.
63. Father was also arrested for drunk driving.
64. In 1998 the family were living in a homeless unit following a fire at their rented house.
65. In June 1998 another child was born to Charlie and Charlotte's parents.
66. Between 1998 and 2000 concerns continued about the children's attendance at school, that they were dirty, infested with lice, hungry and had twice arrived at school unaccompanied at 6.30am
67. The family's life was characterised by very frequent house moves and the children staying with various relatives and then returning to parents.
68. In April 2000 a further child was born and went to live with her paternal aunt from birth. She was Charlie and Charlotte's parents' 3rd child.
69. In 2001 CSC were contacted by a member of the extended family who informed them that one of Charlie and Charlotte's father and his ex-wife's children was in a relationship with her former husband. She was aged 15 and was pregnant.
70. In November 2001 five children were removed from the care of Charlie and Charlotte's parents. One of the children then aged 15 refused to be accommodated and stayed with her parents.
71. The reasons for the removal of the children included chronic neglect, physical and sexual abuse and the unwillingness of the parents to accept and engage help and support. Damage had been caused to one of the children's eyesight due to neglect. An assessment of the parents carried out at the time concluded that, "Given the couple's unwillingness to accept any of the concerns, it was impossible to affect any change".
72. In 2006 mother became pregnant with Charlie and by the time he was born in 2007 it was six years since the couple had had any children living with them.

73. From 2007 onwards (Charlotte was born in 2010) there were professional concerns about parents' parenting and the neglect of the children. These concerns included

- Missed medical appointments
- Missed dental appointments
- Poor home conditions
- Mother's possible learning difficulties
- Father's mental and physical health
- Charlie and Charlotte's deteriorating dental health
- Charlotte's emotional distress, aggressive and sexualised behaviour
- The possible sexual assault by mother on a vulnerable young person

Overview of the integrated chronology of events and agency involvement: 2006 to 2016

74. This section does not reproduce the full integrated chronology but highlights the significant practice events which occurred from 2006 onwards.
75. In August 2006 mother presented for ante natal care. An initial assessment was carried out by CSC.
76. In March 2007 Charlie was born. It was, by then, six years since parents' other children had been removed from their care.
77. In September 2007 the CIN arrangements in respect of Charlie ended.
78. In October 2007 a HV referred Charlie to the orthoptic service.
79. Two appointments were made for Charlie during November 2007 but he did not attend either and was discharged.
80. During 2008 allegations were made by one of Charlie and Charlotte's half-sibling and full sibling stating that they had been sexually abused by both parents.
81. In late May 2008 the case was allocated to a Social Worker to review historical information and determine if a Core assessment was needed.
82. Because of the significant information held on record by another Local Authority about the family the initial assessment took several weeks to complete.
83. No criminal proceedings resulted from Charlie and Charlotte's half-sibling and full siblings' allegations.
84. In June 2009 HV1 completed a CAF in order to put TAC in place. The case was allocated to the 'Pathfinders Team' to complete an assessment and undertake direct work with parents.
85. In December 2009 mother became pregnant with Charlotte and a Safeguarding concern form was completed by a community midwife and shared with the Senior Nurse; Child

Protection. Concerns were noted as maternal learning needs, paternal illness, previous children removed and no attendance at Consultant appointment.

86. Also in January 2010 the Family Worker (Pathfinder Team) was informed that mother was pregnant.

87. In March 2010 the Pathfinder Team worker noted that the house was dirty and unsafe and made a 'referral for CIN'. The case was allocated to a Social Worker to undertake a core assessment in respect of Charlie and the unborn baby.

88. Mother did not attend any further ante natal appointments until April 2010 when she was 21 weeks pregnant. The midwife at this ante natal appointment made a referral to CSC.

89. A multi-agency meeting was held at the beginning of April 2010. CSC were reported to initiate Child in Need status for Charlie due to father's chronic health needs and mother's pregnancy. Charlie was reported to sleep in his own bed then join his father to sleep in the chair during the night. Mother was reported to be sleeping on couch, as she had no bed. The new home required carpets, but was otherwise clean and tidy. Charlie was reported to have squint. The Midwife reported that mother had missed appointments. It was agreed that HV1 would refer Charlie to the orthoptist.

90. In early April 2010 HV1 conducted a further visit and carried out a health needs assessment. Father's health was described as poor and he was in a wheelchair. Mother was reported to describe herself as lacking confidence. HV1 records that mother appears to lack problem solving ability and requires father to lead her and that his capacity to do this is compromised due to his health. Charlie was reported to be clean, wearing appropriate clothing and his development is equal to his age.

91. In May CSC completed an assessment and recorded "Home conditions acceptable in terms of meeting the needs of Charlie and the unborn child, in particular a baby. Parents have co-operated fully with the assessment process and continue to be willing to work with the Department. No particular service provision has been identified to date as so far, the family

are being visited regularly by health professionals and are engaging with the Sure Start Service in respect of Charlie. Although advice and guidance have been given to parents regarding issues of Charlie having a bedtime routine there have been no significant concerns raised".

92. On the same day Charlie was seen by an Orthoptist as a new referral and referred to a Consultant Ophthalmologist.
93. In June Charlie was diagnosed with a "Left convergent squint, Left amblyopia Hypermetropic astigmatism and was prescribed glasses for full time wear. Charlie was then 15 months old.
94. In July 2010 Charlotte was born. Charlotte required resuscitation on delivery. An antenatal scan showed possible problems with her kidneys and possible dislocation of the hip. A follow up ultrasound scan was arranged.
95. Throughout July and August 2010 HV1 visited the family home frequently and gave advice on ensuring that Charlie was wearing his glasses all the time, obtaining a second pair of glasses, the temperature of the home which was too warm for the baby Charlotte, and feeding following a comment by father that 'all Charlotte does is feed, we should be cutting down her food.'
96. In August Charlotte was taken for the scan of her hips and kidneys which were normal. The first appointment had been missed.
97. In early September 2010 HV1 repeated the advice she had given on 29/07/10 and 12/08/10 regarding to property being too warm.
98. At the end of September 2010 Charlie failed to attend an appointment with the orthoptist.
99. In December 2010 HV1 provided an opportunistic home visit. Charlie was not wearing his glasses. The family reported that SW1 had contacted them in respect of an anonymous allegation of father abusing Charlie. HV1 advised that Charlie was to wear glasses and reminded his parents that Charlie had an appointment with the Consultant Ophthalmologist in mid-December.

100. In early March 2011 Charlie was seen for the 3rd time by the Orthoptist.

101. In mid-March 2011 HV1 provided a home visit. Charlie reported not to be wearing glasses and nursery reported to HV1 that he had not worn them since Christmas. The nursery also reported to HV1 that Charlie had become quieter and was not joining in as much and staff felt it was due to difficulty with his vision. Parents reported that Charlie had been sleeping badly. HV1 reinforced their responsibility to ensure that Charlie wears his glasses and that he has two pairs. Mother reported that his glasses would be ready in two days but HV1 recorded pointing out that Charlie's Ophthalmology appointment had taken place several weeks ago.

102. In May 2011 Charlie did not attend an appointment at the Ophthalmology Department.

103. In mid-July 2011 liaison took place between the Health Visitor and Social worker following an anonymous referral made reporting poor home conditions and reporting that the children were dirty and neglected.

104. The next day HV1 provided a home visit. It was Charlotte's first birthday. No cards were seen in the living area. Parents reported that they planned to go to the shop when they get transport to buy a gift and cake. Charlotte was in a nappy full of excrement and wearing only a vest. Father was reported to have to prompt mother to change the baby's nappy.

105. In September 2011 the Ophthalmology Department wrote to parents and to Charlie's GP to inform them that following five failures to attend appointments Charlie was being discharged.

106. In January 2012 HV2 gained access to the family home after several ineffective visits. Charlotte was reported to have walked at 1 year of age and say several words. Mother was reported to be the main carer for the children's father and found it difficult to socialise as she could not push a wheelchair and push chair simultaneously. Father was unable to use electronic chair due to it being stored in an area with steps.

107. In April 2012 HCSW1 saw Charlie, as health screening letter sent to parents in mid-April (not returned so HCSW undertook screen, as it had not been declined). Only a distance vision test was given as Charlie did not have his glasses in school. A teacher confirmed that Charlie never wore glasses at school. HCSW1 recommended an Ophthalmology referral and planned to liaise with School Nurse regarding the outcome of the screening. HCSW1 also sent the health screening results to parents.

108. In July 2012 HV2 provided a home visit for Charlotte's 2 year developmental assessment. The house was warm. No evidence of toys was seen. Charlotte was reportedly not interested in HV2's toys or books but wanted to roll around and hit HV2. Single words only were heard from Charlotte. Mother said they don't go out anywhere and Charlotte likes to play on her mobile phone. Charlotte was drinking juice from a bottle and was reported to be picky eater. HV2 again recommended a toddler group as Charlotte has lack of stimulation and play. Parents agreed to Charlotte going to nursery. HV2 recommended Charlotte drink from a cup. HV2 established that there was no social care involvement at present. Father could now access a mobility scooter and reported picking Charlie up from school. Father's social worker from Adult Services was reported not to have engaged.

109. In August 2012 HV2 provided a home visit to establish nursery consent. Charlotte was wearing very dirty clothes and had healing cut on her forehead a graze to her chin and an infected lesion on her lower right leg. Mother reported that she had not brought Charlotte to clinic because of the 'scrapes' on Charlotte's body due to accidents in garden. The house was reported to be dirty and warm. Mother reported that she went to A&E with Charlotte's injuries. HV2 advised Mother to change Charlotte's clothing and make a GP appointment to look at Charlotte's leg. HV2 advised supervision when Charlotte was playing in the garden. HV2 recorded giving mother a careful explanation as she has a 'degree of learning difficulty'. HV2 noted that family have had social service's input by another Local Authority. HV2 rang

the GP and made an appointment for Charlotte that day and requested that the GP ring her so that she could share relevant information about the family.

110. In mid-November 2012 HV3 attended a TAC meeting to discuss a nursery placement for Charlotte. Mother reported that Charlotte's behaviour was challenging, Charlotte was reported to nip and struggle to share. Charlotte's speech; sounds were heard but could not be deciphered.

111. CSC records show that an anonymous referral at the end of November 2012 had been received by the NSPCC. Concerns that both children are being neglected, physical and sexual abused by their parents and others in the community and exposed to inappropriate adult sexual behaviour. The case was passed to the Initial Response Team to make further enquiries with professionals involved with the family.

112. Four days later HV3 recorded contact from an IRT worker to inform her that there had been a referral regarding Charlie and Charlotte being physically and sexually abused by their parents, that they were not being fed and that food was being used as a punishment allegedly not allowing them food and making them watch their parents eat. It was also alleged that the couple moved house frequently and put the children in their rooms when social workers attended and that the children watched inappropriate videos. Father was reported to misuse drugs and alcohol. Abuse by parents to another person was also alleged by the referrer.

113. The initial assessment was concluded in January 2013 following an investigation into the information provided by the anonymous referrer. Parents were visited and told of the allegations. They felt the allegations were malicious and denied all of the concerns that were raised. No major concerns regarding home conditions or the presentation of the children were noted. Charlie's school and the health visitor involved expressed no concerns regarding the children. SW visited Charlie in school the day before the Initial Assessment was concluded and Charlie raised no major concerns that would warrant further involvement

from DCS. School agreed to monitor Charlie and will make a referral if they have any concerns.

114. In May 2013 HV5 provided a home visit, as the family had moved to another area. Father was walking independently at visit. Charlotte was playing in garden. Charlotte reported to be saying 'Can I have.' Reported to be attending nursery. Mother disclosed having previous children removed. HV5 obtained permission to receive information from Nursery and Social Care. HV5 arranged a 2 years of age developmental check for Charlotte for mid-June.

115. In early June 2013 HV5 received information from nursery relaying concerns that father was controlling and verbally abusive to mother and concerns about Charlotte's development. Charlotte was reported to fall asleep on her feet at nursery, was difficult to engage, reluctant to socialise, was a poor eater and had a lack of dental hygiene.

116. In mid-June 2013 HV5 provided a home visit to complete 2.5 years of age review. Father's son. Charlotte was wearing only a nappy. Mother reported that Charlotte liked to dress like that if it is warm. Toys were seen in the home. Mother reported Charlotte to be poor eater but ate family meals. Weight 11.18kg (between 2nd and 9th percentile). Charlotte was still having a bottle with juice/pop and HV5 noticed discoloured teeth. Mother reported that she cleans Charlotte's teeth twice daily and she has been to visit the dentist.

117. In early December 2013 Charlie's GP records a request from the Optometrist for a referral to the Opticians which stated 'Mother reported that Charlie had been under the hospital 3 years ago for an eye condition but he had not been back since. Charlie presented with a high prescription but vision in left eye remains poor. Referral to hospital requested.'

118. In mid-December 2013 mother took Charlotte to see GP14 with an upper respiratory infection. The GP shared information with HV6 that Charlotte was 'grubby' and poor dental hygiene was noted and cat scratches to arms. Mother told the GP that she had taken Charlotte to the dentists.

119. In early February 2014 Charlie failed to attend an appointment at the Ophthalmology Department. A letter was sent to parents and to the School Nurse and the GP. The GP re-referred Charlie in mid-March.

120. In May and June 2014 Charlie was seen for the fourth and fifth time by the Ophthalmology Department however he failed to attend two further appointments in July and August 2014. Charlie was aged 7 at this point.

121. In August 2014 DCS received information from father's son's probation officer. She had been informed by father that his son had been staying with him. His son is a sex offender and was a risk to children. Parents said they were not aware of his father's son's convictions and had removed him from the family home.

122. In August Charlie failed to attend an appointment with the Ophthalmology Department. This was the 9th missed appointment.

123. In early September 2014 Charlotte started at primary school.

124. In mid-September 2014 SN2 contacted mother and reiterated the importance of Charlie attending his hospital appointments. SN2 re-referred Charlie the same day. There was an unexplained delay in the appointment being made and the next appointment was not until November 2014 which was attended.

125. In October 2014 school raised concerns about Charlotte's escalating behaviour and a referral was made to the PSA.

126. In January 2015 the PSA records Charlotte's behaviour and presentation; regularly sleepy and tired, hitting teachers and children and biting. Discussion took place with parents around need for referrals and possibly PSA support. Charlotte could end up excluded for assaults.

127. There were two incidents in mid-January involving Charlotte assaulting other pupils, members of staff, attempting to run away from school and presented angry and distressed.

128. Charlotte was referred to CAMHS by her GP two days later.

129. CAMHS attempted to contact parents by telephone but could not do so.

130. In early February 2015 Charlie failed to attend an appointment at the Ophthalmology Department (10th DNA)

131. The same day CAMHS wrote to parents with an 'opt-in' letter for Charlotte.

132. Throughout February Charlotte's behaviour at school included hitting, biting and kicking staff and pupils.

133. Also in early February 2015 a young male disclosed to a worker that he had been sexually assaulted by Charlie and Charlotte's mother. The worker shared this information with the police who made an urgent referral to DCS/ Health and CAIT. However, the young male did not wish to report an assault, therefore, no further action was taken.

134. In mid-February 2015 the PSA attempted to contact mother to discuss Charlotte's worsening behaviour.

135. At the end of February the PSA recorded that mother was to attend a course of parenting classes and attend regular meetings with the school.

136. In early March 2015 SN2 and PSA1 undertake a joint home visit. The room was reported to be tidy. It was also recorded that PSA1 was planning to commence a CAF. Behaviour routines and boundaries were discussed and mother was recorded to be keener to take advice. Father agreed to complete a diary of behaviour concerns.

137. Eight days later a TAF meeting was held. Actions which were agreed included

- Identified need for routine, support with discipline and structure for bedtime and meal time.
- PSA to chase CAMHS referral
- SW – to refer to Young Carers
- Parents to register with dentist
- Referral to OT and Educational Psychology.
- Charlie's missed hospital appointments were discussed.

138. On the same day Charlie did not attend an appointment with the Ophthalmology Department and HCSW2 recorded that Charlotte required a referral to the Orthoptist.

139. Throughout March Charlotte's behaviour continued to be extremely difficult at school.

140. In mid-March Charlotte disclosed that saw her father watching an inappropriate video on the laptop.

141. At the end of March 2015 Charlotte was seen by a Nurse Practitioner (NP) at the GP Surgery. The NP noted Charlotte's very poor dentition. Mother told the NP that Charlotte had seen a dentist.

142. In early April 2015 Charlie did not attend an appointment with the Ophthalmology Department.

143. At a TAF meeting in mid-April 2015 parents reported that they were worried about Charlie being bullied. They felt that Charlie was self-conscious about his weight. Major concerns about Charlotte's behaviour were also noted. Charlotte's comments about the laptop were also discussed. Actions taken included

- PSA rang CAMHS – they said appointment sent to family in February but no response so have been discharged
- Given information about Sponsor a Grown-up – physical activity and family activity free of charge
- PSA suggested taking advice from FISCH re weight
- Given information about Charlie joining multi-skills each week
- Given information about Family Learning with PSA – in school

144. Throughout April Charlotte's behaviour continued to be of concern and included hitting or throwing things at other pupils.

145. At the end of April mother took Charlotte to the GP surgery and was seen by GP5. GP5 noted significant dental decay. Mother told the GP that this was being treated by a dentist.

146. On the same day the GP practice received a copy of a letter from CAMHS offering an appointment.
147. At the end of April 2015 Charlie was taken by mother for an appointment with the Ophthalmology department.
148. In early May 2015 a single agency assessment was completed by DCS the outcome was to put in place CIN arrangements.
149. On the same day Charlotte was taken to her first appointment with at the Ophthalmology Department. She was prescribed glasses for constant wear.
150. Throughout May Charlotte's behaviour continued to be very difficult. PSA1 carried out 2 home visits and also observed Charlotte whilst she was at school.
151. In mid-May Charlotte told a teacher that her mother had pushed her down the stairs and was nasty to her. The school telephoned DCS and DCS records state that "Charlotte was visited. There was no evidence to suggest that an incident had happened over the weekend nor was Charlotte's disclosures consistent in her reporting". Following a strategy meeting no further action was taken.
152. Three days later a TAF meeting took place at which information was shared about the children's behaviour.
153. In early June 2015 PCMHW contacted PSA1 to share her safeguarding concerns from initial meeting. PSA1 informed her that mother had five previous children removed due to neglect. Reported Social Worker involved due to mother's drinking and incident involving a young male. Charlotte had made sexualised comments in school which they had reported to the Social Worker. PCMHW discussed her concerns in clinical supervision. Supervisor advised her to:

    - Discuss child protection history with Social Worker and to question if Charlotte's attachment behaviour is due to on-going abuse that has/should be investigated and be escalated to a strategy meeting.

- PCMHW to refer to ‘Full Circle’ as no current role for CAMHS.

  *Social Worker on annual leave so message left asking her to return the call urgently on her return.

154. In mid-June the Social Worker returned call to PCMHW and stated that as the family were working with social services there was no need to upgrade to child protection. The Social Worker questioned whether Charlotte had ADHD. PCMHW advised the Social Worker that her presentation was not indicative of this and was more likely due to parenting, trauma, attachment and neglect and that intensive parenting support was required and ‘full circle’ for attachment assessment and intervention.
155. A day later CAMHS attended a TAF meeting and advised that parental and environmental issues need resolving and recommended Full Circle for therapeutic work.
156. In early July 2015 Charlie and Charlotte failed to attend a dental appointment.
157. Two days later GP7 received a letter from CAMHS. It was noted that “Mother reported longstanding behavioural difficulties at home and at school and day time enuresis and encopresis. There had been an episode of sexualised language in school and when this was raised with Mother she felt it was because Charlotte had watched her brother Charlie playing ‘Grand Theft Auto’ (a game for 18+). Mother was advised this was not acceptable for either child. Charlotte was reported to frequently sleep downstairs with her father. Charlotte’s presentation could be due to attachment difficulties, learning difficulties and complicated by environmental factors. Advised that parenting and environmental situation needs to be addressed prior to any intervention. The appropriate intervention service would be Full Circle. Family discharged by CAMHS. It was noted that family were being supported by Social Worker”.
158. In mid-July 2015 Charlie and Charlotte failed to attend a dental appointment.
159. Seven days later DCS made a referral to the Community Support Service and support commenced on 28th July 2015. The remit of the service was to ‘support parents in providing

consistent routines and boundaries for their children that they attend school ready to work and are not fatigued. Build confidence in parents for positive parenting. Work with the children on their behaviours and liaise with professionals'.

160. At the end of July Charlotte was taken by mother for her second appointment with the Orthoptist.

161. On the same day a dentist examined the children. The dentist reported giving advice to mother about the children's diet which should change immediately to drastically reduce their intake of sugars. Advice was given on oral hygiene, especially in the case of Charlie. The dentist discussed treatment options and referred Charlie to another Dental Department and applied topical fluoride to Charlie's teeth.

162. In respect of Charlotte's teeth mother reported that Charlotte had no symptoms from the multiple carious roots and therefore dental extraction was not pursued. The dentist gave detailed diet and oral health care advice and applied topical fluoride to Charlotte's teeth. The dentist requested to see Charlotte in 3 months, or sooner if her teeth became symptomatic.

163. In August mother took Charlotte to her third appointment with the Orthoptist.

164. In September Charlie did not attend his appointment with the Orthoptist.

165. Four days later a TAF meeting led by school was held. It was noted that:

- Community support – seeing the family including through holidays.
- Charlotte starting gymnastics – Charlie also wants to start gymnastics.
- Charlotte kicking Mother, shouts, up at 1am– this is why she is always tired.
- Every night out of bed so Charlie woken up.
- Still bedwetting (both children)
- Charlotte's eating is poor – school concerned.

166. In mid-September Charlie failed to attend an appointment with the Orthoptist and was discharged. A letter was sent by the department to Charlie's GP. This was the 13th missed appointment.

167. Throughout September Charlotte's behaviour continued to be of concern.

168. In early October 2015 Charlotte was assessed by the Speech and Language Therapy service. Who record that Charlotte's "language skills are age appropriate but with mild difficulty in understanding and following multi-step instructions. Advice provided to parents and review to be arranged in the New Year".

169. In mid-October SW3 contacted the dental service with mother's permission to share information about Charlotte's dental health. The dentist conveyed concern for Charlie and Charlotte's teeth.

170. A further TAF meeting was held five days later. Mother did not attend as she was unwell.

171. Throughout October Charlotte's behaviour was of concern. She was aggressive and very tired at school.

172. At the end of November 2015 Charlotte did not attend an appointment with the Ophthalmology Department.

173. In early December a TAF meeting was held at which mother was not present. It was recorded that:

- Charlotte very tired. Falling asleep. Eating continues to be a problem. Defiant.
- Charlie no glasses – struggling. He has been unwell
- Housing options completed.
- Father advises that mother had been seeing another man and was talking about moving him in after Christmas – sorted now. Discussed mother not knowing how to parent.
- Charlotte talking about Mum and Dad fighting "Mum and Dad argue. Mum sneaks out. It makes me cry"

- Concerns about awareness of relationship issues – impact of parental discord needs to be addressed. SW recommends re-assessment once a new worker is identified – she says we should hear who new worker is before next meeting.
- Children mentioning playing on Grand Theft Auto.

174. On the same day a referral to Home Support was made by Adult Social Care in respect of father's needs.
175. Seven days later Charlotte was not taken to an appointment at the Ophthalmology Department and was discharged. A letter was sent to her GP to notify them.
176. In mid-December the Community Support Service worker who had visited the family 26 times between July and December 2015 carried out a final visit. Work was completed and repeated on boundaries and routines using not only written and oral language but also pictorial in creating charts and rules.
177. In late December DCS transferred the family to the Pathfinder Team.
178. On the same day Charlie failed to attend a dental appointment.
179. During January Charlotte's fell asleep in school, was brought into school whilst asleep, and was distressed and disruptive. It was also noted that she was not wearing her glasses.
180. In mid-January a TAF meeting was held an Assertive Keyworker & Family Worker were present. The following were discussed: Charlotte's behaviour a concern, Charlie not reading at home, Charlotte often hungry, Concerns raised about father transporting children alone, issues with parents arguing.
181. Four days later a DCS Family Worker undertook an observation of Charlotte in school. "Charlotte appeared 'feral', was extremely defiant, disruptive and fell asleep on top of another pupil during the observation. Informed Charlotte cannot conform to rules and this is regular pattern of behaviour. Children informed that they do not have toothbrushes at home". Toothbrushes and toothpaste were provided by the worker and given to the parents.

182. Three days later Charlotte used sexually explicit language at school. Her parents were informed.

183. Four days later during a School session with the Family Worker; Charlotte disclosed her Mum has a boyfriend who stops over and that her Mum and Dad fight over this. Also that her mum will smack Charlotte on the 'bum' and makes her cry when she is naughty. This was put to mother who confirmed that she has relationships with other males but does not have them stay overnight. Parents denied physically disciplining children and state they do not argue and fight in front of the children.

184. Three days later the DCS Family Worker (FW) carried out a home visit and noted that home conditions were not appropriate. The children said they did not eat breakfast and they went to school hungry. The Family Worker checked and there was no milk, bread or cereal in the house. The FW informed parents that this was not appropriate will return unplanned to ensure food items have been purchased. The FW telephoned the Head Teacher and was informed that the children often came into school hungry and are given food.

185. In early February a DCS Pathfinder Team worker, PW2, telephoned SN1 and shared information about missed hospital and dental appointments and also requested a FISCH referral for Charlie as he was overweight. It was noted that PW2 was taking Charlie and Charlotte to the dentist.

186. Two days later Charlie and Charlotte attended the dentist who again gave detailed advice on diet and oral hygiene. Charlie was to be referred to Community Dental Health for treatment possibly under sedation. The Dentist was to review Charlie and Charlotte in May 2016.

187. In late February 2015 a TAF meeting was held. Discussion included:

- Charlotte falling asleep and lack of routine
- Discussion regarding Charlie's weight and activity
- Continued concerns about the children's teeth
- Missed appointments for eyes – re-referral

- Refer to FISCH
- Concerns as Dad has fallen out of chair and he continues to be main one who transports children and he is unwell.
- Discussion about moving house, management of Charlotte's behaviour, need to be able to contact by phone

188. Two days later Charlie's primary school telephoned DCS to report that Charlie was very tired at school and had stated that his Mum had been drinking last night and he had been up all night because of this. A home visit was carried out and mother confirmed that she had stayed up late drinking and that Charlie had slept on the sofa.
189. At the beginning of March 2016 Charlotte was reported as being exhausted at school and falling asleep.
190. A day later Charlotte told a member of staff at school that her Mum and Dad had been drunk and that her mum's boyfriend had been there. Dad was so drunk he fell out of his chair and some skin came off. They were locked (in/out?) so her mum's boyfriend kicked the door in.
191. The next day a home visit was carried out by Home visit by the FW and Senior Lead Professional from Families First Team. Parents were informed of the disclosure made by Charlotte. They stated that Charlotte must have been mixed up and was referring to last week when mother was drunk. Father stated that he does not drink alcohol at all and that he is on a lot of medication. The adults stated that the male Charlotte was referring to was not "mother's boyfriend" but a friend of both of them. They denied that any arguing had taken place and said that the door had been smashed by youths the previous week.
192. The following day Charlotte fell asleep in school. She was seen by SN2 on the same day and was reported to be clean, tidy and appropriately dressed. Dental decay was evident and Charlotte was not wearing glasses, reporting them lost.

193. In mid-March SN1 saw Charlie in school for growth measurement. Charlie was recorded to be tidy, appropriately dressed in school uniform and wearing glasses.

194. On the same day Charlotte fell asleep at school and was very badly behaved and exhausted. She was sent to the classroom and fell asleep across table. It was noted that father was bringing and collecting the children to and from school on his own again.

195. Four days later the school telephoned DCS to report their concerns that Charlotte was falling asleep at school on a regular basis.

196. The following day the FW carried out a home visit and home conditions were not appropriate. There were faeces on the bathroom floor, general presentation was unclean and there were other health and safety risks.

197. The next two days March Charlotte's behaviour at school was very disruptive.

198. Five days later a Housing Provider Support Worker who had been attempting to meet with parents to discuss their support needs met with them at their home. The HGSC informed the Family Worker of her involvement and asked to be included in the TAF arrangements.

199. On the same day Charlotte fell asleep in school again. Neither Charlie nor Charlotte had their spectacles.

200. Seven days later the FW alongside mother, accompanied Charlie and Charlotte to their Orthoptist appointments. It was found that both children's eyesight had deteriorated. One of Charlie's eyes was now shaped like a rugby ball. The doctor felt being overweight may be linked to this. Charlotte has not been wearing glasses as she should resulting in the decline, new prescriptions for both were given.

201. At the end of March the family were allocated a social worker and an unplanned home visit was carried out to inform the family. During the home visit it was apparent that conditions were not appropriate and tasks were given. Parents were told that workers would revisit the same evening to check that health, safety and cleanliness standards were met. Parents were informed of ongoing concerns that they are not meeting the needs of the children

consistently. They were also informed that professionals will be holding Strategy meeting after School holidays.

202. The next day mother returned a telephone call from SN1 (this was 2 weeks after SN1's original call) to ask about SN1's offer of support regarding Charlie's weight.

203. SN1 provided a home visit on the following day and gave advice on portion control, diet and exercise.

204. Three days later the new social worker carried out an unplanned home visit. Conditions were much improved, the bathroom and kitchen were clean and the stairway clutter free. Mother's bedroom was tidy but had sick and urine from Charlotte present in the bedding whilst Charlotte was sleeping in it. Mother was asked to clean this and was told that a worker would return to check that this had happened. A follow up home visit was undertaken by the Social Worker later that day where it was noted that a new mattress had been put in place and the duvet, pillows, etc. were in the washing machine. Mother was advised to take Charlotte to the Urgent Care Centre or GP as Charlotte had been reportedly unwell for two weeks.

205. The next day a worker from a Housing Provider carried out a home visit and recorded that "both children were present and were being sick. Mother said they had a vomit bug and said Charlotte was being sick on her pillow just before we came in. Charlie was watching TV wrapped in a blanket wearing only trousers he was topless. There was a bottle of urine sitting on the bottom of the fireplace. The house was dirty and had a foul smell.

206. A Strategy Meeting was held the following week. Concerns about neglect, physical and emotional care, missed Dental and Orthoptist appointments were discussed. It was noted that Charlie's sight has deteriorated and school staff report Charlie frequently does not have his glasses at school. Further issues of Charlie not sleeping as reportedly disturbed by Charlotte, lack of routines, small number of friends and parents alleged alcohol misuse – children reported to witness mother drunk and falling into walls. Mother reported to be in a

relationship with a man and children witnessed her arguing with him. Parents reported to be difficult to engage and do not answer telephone.

207. It was recorded that decision was made to undertake Section47 enquiries and progress to an Initial Child Protection Conference.

The SCR Key Lines of Enquiry: Analysis

208. This section sets out an analysis of key findings and associated recommendations that are designed to offer challenge and reflection for the LSCB and partners.

209. The key lines of enquiry for the SCR were explored through the process of the Learning Event and considered together with the details submitted in individual agency chronologies.

210. The analysis also draws upon relevant research and upon findings from other serious case reviews.

211. **What was professional's understanding of the missed medical appointments?**

212. Charlie and Charlotte were not taken to the majority of appointments (detailed in the summary chronology above) in respect of their eyesight and dental care. The missed medical appointments were not always recognised as a serious symptom of chronic neglect by professionals and the various professional responses included reminders, information being provided on dental care, practical help including buying toothbrushes and toothpaste for the family and transporting mother and the children to medical and dental appointments.

213. There was a lack of professional curiosity (and subsequent challenge) about whether or not the children had been taken to their various appointments.

214. The British Society of Paediatric Dentistry define dental neglect as being the wilful or persistent failure to meet a child's basic oral health needs by not seeking or following through with necessary treatment to ensure a level of oral health that allows function and oral health (freedom from pain and infection).

215. The damage to the children's teeth was visible and commented upon by practitioners who attended the Learning Event who had worked with the family. Nobody appears to have asked the children if their dental decay was causing them pain.

216. The family's history was the single most important indicator that parents were highly unlikely to ensure that the children's health needs were met. In 2001 another Local Authority commenced care proceedings and was granted a Care order due to severe neglect, unattended health appointments, unkempt, dirty presentation, home conditions, poor attendance at school, routine checks and immunisations missed were all listed as issues. ***One child had severe dental decay through missed appointments and another child had problems with his vision due to lack of care by parents.***

217. This historical information does not appear to have been seen by all professionals specifically school staff and the PSA and was not therefore taken into account when assessing risk and need. However; the significant number of missed medical appointments plus the visible extent of the children's extreme dental decay was ongoing over a period of several years.

218. In a study completed in 2011/12; 16 health visitors indicated that dental neglect is rarely an isolated issue that leads on its own to child protection referral however poor dental health in children is a marker of broader neglect

219. Abused and neglected children have been found to have higher levels of tooth decay than the general population (Valencia-Rojas et al. 2008) therefore when primary health care workers such as health visitors are aware of the presence of dental neglect it should alert them to the potential for broader neglect and subsequent child protection and particularly in families that are resistant to professional advice.

220. In summary the missed medical appointments were not recognised and responded to as a serious safeguarding concern by professionals despite the visible evidence of dental decay in both children and the visible absence of glasses.

221. **What was professional's understanding of mother's learning difficulties, her functioning and her ability to parent?**

222. There was much discussion amongst the professionals who attended the Learning Event about the nature and extent of mother's learning difficulties. Mother had not (up until 2016) undergone an assessment for cognitive or learning disabilities. She was described by professionals as being articulate with 'normal' verbal reasoning. Mother gave the impression of having heard and understood what professionals were discussing with her and of their expectations of her. It was apparent however that mother's verbal skills masked her inability to remember or be capable of carrying out what was required of her.

223. A further consideration when assessing mother's ability to parent should have been her own history of possible sexual exploitation and abuse.

224. Mother was pregnant with her first child at the age of 15. Mother lived with her grandmother at this point. The father of this child is unknown. Also at around the age of 15 or 16 mother was babysitting for Charlie's father and his former wife. Parents began a sexual relationship at some point whilst she was still a teenager. Father is 18 years her senior.

225. It does not appear that mother was ever recognised as a potential victim of sexual exploitation or abuse and this may have been an important indicator of risk and need for mother's children. For instance researchers have found that a maternal history of childhood sexual abuse is the single strongest predictor of sexual abuse in the next generation, with a daughter's risk of abuse being nearly four times greater when their mother reports a history of sexual abuse (McCloskey & Bailey, 2000; Oates et al., 1998).

226. There was a lack of professional curiosity regarding Mother's history including the possibility that she had a learning or cognitive difficulty. It was known, for example, that the local authority completed assessments as part of the care proceedings regarding the older children who were subsequently removed from her care. Following this assessment, the Social Worker stated that given the parents' unwillingness to accept any of the concerns,

they did not have the capacity to change; this was a static risk factor. Had any professional been sufficiently curious and examined her records they would have 'discovered' this significant information which would then have been considered in further assessments and decision making. This was a missed opportunity at the point of the pre-birth referral in respect of Charlie and would have warranted progression to an Initial Child Protection Conference. It was also a missed opportunity at any point thereafter had any professional been sufficiently concerned or curious enough to examine mother's history in an attempt to ascertain whether or not an assessment of her cognitive functioning had ever been considered or carried out.

227. **What was professional's understanding of father's mental and physical health and his ability to parent?**

228. Father's physical and mental health needs were significant. He had long term severe mental health issues and increasingly severe chronic physical health needs. A multi-agency/ multi-disciplinary assessment of the impact of these needs on father's parenting was not undertaken.

229. The direct impact of father's mental and physical health needs upon the children's daily lives was also not assessed although a referral to a Young Carer's Service was recorded as an action at the TAF meeting in March 2015. It is not clear if this in respect of one or both children or what happened as an outcome of this referral.

230. Father also reported (in 1992) that he had been sexually abused as a child by a paternal uncle. Father did not want to press charges at that time. Research indicates that there is a link between being a male victim of childhood sexual abuse and/ or incest and becoming a perpetrator of such abuse. In the 2009 Kolvin et al study of 135 male victims of childhood sexual abuse 59% were also perpetrators. The rate varied according to the victim's experience:

- 51% of reported incest victims were perpetrators (24 of 47);

- 61% of reported paedophile victims were also perpetrators (46 of 76);
- 75% of those who reported that they were victims of both incest and paedophilia were also perpetrators (9 of 12).

231. In other words father's own history of as a possible victim of incest was an important indicator of risk to his own and other children.

232. **Were the children's voices heard and how did they contribute to assessments of risk, planning and decision making**

233. There is no information to suggest that Charlie and Charlotte were seen on a regular basis independently of their parents.

234. There is no information to suggest that their views, wishes and feelings were sought and it therefore follows that they were unable to contribute to assessments of risk, planning and decision making. However it is important to note that the children had on occasion made disclosures of domestic abuse, alcohol misuse by their parents and of being hungry, however. This information did not contribute to assessment and decision making and the parents were able to deflect this.

235. Charlie and Charlotte demonstrated very different signs of children who are experiencing severe neglect and possibly other abuse. This highlights the need for sensitive trauma and gender informed approaches when working with children and young people who have experienced neglect and other forms of abuse.

236. These manifestations of neglect were not responded to as such and were, in Charlotte's case, treated as behavioural difficulties which school staff attempted (with much compassion) to manage.

237. In infancy and preschool, neglected children are more likely to show inadequate growth and failure to thrive, ***more extreme mood swings, non-compliance and less positive affect*** (Howe, 2005). At primary school age, they are more likely to be ***socially isolated, lack social skills and appear withdrawn*** (Hildyard and Wolfe, 2002). They may show other signs of

neglect such as consistent hunger and fatigue, apathy, poor hygiene, inadequate clothing, and bald patches on the scalp or other skin afflictions, and achieve less well educationally (Berry et al, 2003).

238. An analysis of 67 serious case reviews evaluated by Ofsted between 1 April and 30 September 2010 identified key themes in relation to the voice of the child. These themes included:

- the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings
- agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute
- parents and carers prevented professionals from seeing and listening to the child practitioners focused too much on the needs of the parents, especially vulnerable parents, and overlooked the implications for the child
- Agencies did not interpret their findings well enough to protect the child.

239. It is not clear –because no one appears to have asked them- what daily life was like for Charlie and Charlotte but it is unlikely that either child felt entirely safe, secure and cared for and they may have experienced pain from untreated dental decay. It is clear however that Charlie and Charlotte each in their own way articulated their distress but this was not always understood as symptomatic of severe and chronic neglect.

240. **What difference did the interventions and the repeat interventions make to the children and the adults in the family? How much did professionals know about previous interventions?**

241. The interventions and repeat interventions from the birth of Charlie (he was initially subject to a Child in Need plan which ended when he was 6 months old) onwards made little difference to the children and adults in the family as any change was not sustained and the children's dental and eye health deteriorated over a period of several years. Charlie's first

missed appointment in respect of his eyesight for instance, occurred when he was just 8 months old.

242. Throughout home conditions fluctuated from being only just good enough to being unsafe and unhygienic.

243. It was apparent from the contributions made by practitioners attending the Learning Event and from agency chronologies that there had been no multi-agency oversight or review of the interventions which had taken place which should have included an assessment of how effective the interventions were and a continued re-appraisal of risk and need based on agreed, time limited outcomes e.g. Charlie and Charlotte's improved dental health and attendance at medical appointments.

244. When Team around the Family (TAF) arrangements were put into place there was no agreement with the adults and with other agencies about what success would look like and crucially what steps should be taken if no sustained change was achieved.

245. Each intervention presented an opportunity to carry out a holistic review of this case but one which stands out as having had particular potential was the assessment of Charlotte carried out by the CAMHS Primary Care Mental Health Worker (PCMHW) on 9th June 2015. Following this assessment the PCMHW telephoned the PSA and relayed her safeguarding concerns from her initial meeting with Charlotte. The PSA informed the PCMHW that Charlotte's parents had five previous children removed due to neglect and reported that a Social Worker was involved due to mother's drinking and an incident involving 16 year old boy. The PSA also reported that Charlotte had made sexualised comments in school which they had reported to Social Worker.

246. On the same day the PCMHW discussed her concerns in clinical supervision and her Clinical Supervisor advised her to discuss the child protection history with the Social Worker and to question if Charlotte's attachment behaviour was due to on-going abuse that should be

investigated and be escalated to a strategy meeting. The PCMHW left a message for the Social Worker to contact her urgently.

247. The Social Worker returned the PCMHW's call on 14th June 2015 and the PCMHW recorded that the Social Worker stated that as the family were working with social services there was no need to 'upgrade to child protection'. The Social Worker questioned whether Charlotte had ADHD. The PCMHW advised Social Worker that her presentation was not indicative of this and more likely due to parenting, trauma, attachment and neglect and that intensive parenting support is required and 'full circle' for attachment assessment and intervention.

248. This episode of intervention by the PCMHW was brief but insightful and offered a 'fresh pair of eyes' to a long standing case. This conversation with the Social Worker did not prompt reconsideration of the root cause of Charlotte's behaviour specifically the possibility of other forms of abuse.

249. The PCMHW subsequently attended a TAF meeting and repeated her concerns and opinion. This did not prompt a multi-agency re-consideration of the case and it is not clear what the PCMHW's own response to this was e.g. did she consider using an escalation process or further discuss the case in supervision? It is of note that issues of professional hierarchy were identified as an issue in a previous Durham serious case review.

250. **How much did professionals know about the indicators of sexual abuse e.g. sexualised behaviour and the family history and how much was this information considered during the different periods of intervention?**

251. An unborn baby assessment was carried out in respect of Charlie during 2006. This included information about the severe neglect of parents' other children but did not include information about historical concerns of sexual abuse (including the origins of parents' own relationship).

252. The CIN plan in respect of Charlie ended before full historical information about the family had been gathered from the Local Authority in which the family lived when their previous children were removed.

253. During 2008 allegations were made by two of parents' older children that they had been sexually abused by both parents and as a result of the allegations a strategy meeting was held (the outcome of the meeting was not recorded) and information sought from their previous local authority.

254. The allegations made by the older children led to a criminal investigation and as no offences were revealed there was no further action taken by Durham agencies in respect of the allegations.

255. In November 2012 an anonymous referral was made to CSC relaying concerns that both children were being neglected and physically and sexually abused by their parents and others in the community and exposed to inappropriate adult sexual behaviour. By January 2013 CSC completed their assessment concluding that the allegations were unfounded.

256. During this period of time concerns were emerging about Charlotte's behaviour which was challenging.

257. When Charlotte was aged 35 months a HV carried out her delayed 2.5 year assessment. The HV noted that father's son was present at the family home. In August 2014 contact was made by probation officer contacted CSC as she has been informed by father that his son had been staying with him. His son is a sex offender and a risk to children and it appears he has been in contact with several children because he lied to family about his offences. It is not known if he had unsupervised access to the children. Father reported that he had told his son to leave the family home immediately. Charlie and Charlotte were not spoken to in respect of any harm they may have suffered whilst he was staying in their home.

258. By November 2014 Charlotte's primary school reported that her behaviour was deteriorating including acts of aggression and defiance and that her levels of distress were increasing.

259. In early 2015 a worker contacted CYPS as a young person had made a disclosure that he had had sex with mother. This incident did not result in a criminal charge against mother as the young person did not wish to make an allegation of sexual assault. The SCR panel members noted that had the young person in question been a girl that the professional perspective and response may have been different i.e. a 16 year old girl and a 39 year old male involved in a potential sexual assault / rape (violence and alcohol were featured) and it may have led to the immediate removal of Charlie and Charlotte from their home environment.

260. In March 2015 Charlotte disclosed that she had saw her father watching an inappropriate video on the laptop. The issue was raised during a TAF meeting held in April 2015 but it is not clear what action was taken or agreed as a result of this.

261. At the end of April Charlotte's school reported to father that Charlotte was 'wetting herself' whilst at school which was unusual and advised father to ensure that Charlotte was 'checked out'. Both Charlie and Charlotte had night time enuresis.

262. Despite these ongoing indicators of potential sexual abuse it is apparent from the agency chronologies that this was not specifically considered as an ongoing and longstanding concern and that no overview of the incidents listed above was used to inform risk assessments.

263. In addition both parents were possibly themselves victims of childhood sexual abuse and exploitation and, as described above this can also be an indicator that their own children were more vulnerable to sexual abuse.

264. The different thresholds for criminal and other proceedings e.g. Family Court in cases of child abuse were discussed by the SCR panel members and the participants who attended the Learning Event. The fact that no criminal proceedings against parents took place as a

result of the various allegations and investigations may have influenced decision making and practice. In cases where the evidential threshold for criminal proceedings is not met but the probability of abuse taking place is high; this has significant implications for practice and decision making.

265. When mother became pregnant with Charlie the following year key historical information was not readily available or visible anywhere in her medical records. This issue in information recording could potentially re-occur and is reflected in the SCR recommendations.

266. **Consideration of managerial oversight and decision making.**

267. Agency involvement with the family was significant with professionals having contact with the adults and children over a period of several years.

268. The information held by another local authority and the information held by the police in relation to the allegations of sexual abuse was substantial but did not become 'fixed' in the family's records in Durham. This information was reviewed on more than one occasion by more than one professional but was not consistently shared or used to inform decision making.

269. There were opportunities to assess the case holistically taking into account the family's long history of involvement with agencies, the pattern of severe neglect and removal of 5 previous children, the concerns about sexual abuse and the capacity of the parents to sustain any change. These opportunities were missed however as the focus remained, on the whole, on the particular incident which led to the assessment.

270. There was also a need in this case for managerial oversight and challenge specifically around the possibility of the parents achieving and sustaining change. The children were suffering ongoing harm and practitioners were too optimistic and too willing to trust the adults' accounts of visits to the dentist, accounts of missing or broken glasses and that the allegations made by members of the community were malicious.

271. Practitioners who participated in the learning event described the parents' behaviour as manipulative. Father in particular seemed able to deflect and confuse practitioners causing them to lose focus. In cases where there are long standing concerns and issues of neglect and disguised or non-compliance supervision should include specific guidance and challenge to ensure that practitioners remain focused and are able to identify when this is happening. This will help to ensure that focus on improved outcomes for children and young people is not diluted or lost completely.

272. **When there were no safeguarding arrangements in place in respect of the children what was going well for the family?**

273. Improved home conditions were the main indicator that things were going well for the family although conditions had fluctuated from unsafe and unhygienic to acceptable within short periods of time this appears to have reassured professionals that the adults were able to meet the children's other needs.

274. However the missed medical appointments were ongoing even when home conditions had improved temporarily.

275. **Consider whether disguised compliance was an issue in this case.**

276. There was an element of disguised compliance identifiable in parents' engagement with services. Disguised compliance involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions and allay concerns. Other published serious case reviews highlight that professionals sometimes delay or avoid interventions due to parental disguised compliance.

277. Families who display evasive or resistant behaviour can be challenging to work with. Examples of such behaviour include:

- avoiding home visits (often cancelling at the last minute) or not appearing to be home (curtains drawn and not responding to telephone calls or knocks on the door);
- children failing to attend school or child care

- parents not attending appointments, prearranged meetings that involve the assessment of themselves or the children or are in denial about issues such as use of drugs /alcohol

278. Any persistent displays of avoidant or resistant behaviour should be taken very seriously because of the association with fatal child abuse and neglect.
279. Non-compliance and disguised compliance by parents were common features in serious cases reviewed by Ofsted in their national report on professional responses to neglect. The report found that although some multi-agency groups adopted clear strategies to manage such behaviour, this was not evident in all cases. Where parents were not engaging with plans, and outcomes for children were not improving, professionals did not consistently challenge parents.
280. It appears from the accounts of the professionals who attended the learning event that parents were adept at managing professionals and father in particular was able to deflect challenge. Mother provided reassurance on more than one occasion that the children had been taken or were about to attend dental appointments when this was not the case.

Summary Analysis

281. The adults in this family had complex histories, ongoing complex physical and mental health needs and an unassessed cognitive difficulty. The origins of their own relationship are unknown but are highly suggestive of having been exploitative. As previously described there was no multi-agency management plan that did not include key historical information and this information did not 'follow' the adults.
282. This complexity was exacerbated by the interactions between multiple professionals working with the family, often in isolation from one another and information was not always shared between adults and children's services or between different elements of children's services.

283. Much of the discussion between the SCR Panel Members and professionals who attended the Learning Event focused on the 'clean slate' approach taken when mother became pregnant with Charlie in 2006. At that point in time the couple had not had any children living with them for 6 years.

284. Brandon et al 2007 describe this as 'The 'start again syndrome'' and go on to say that this 'has proved a helpful way of conceptualising practice and decision making especially in cases of neglect. In these circumstances knowledge of the past is put aside with a focus on the present and on short term thinking. There may, for example, be an unfounded assumption that a new baby, or a different partner, presents an opportunity for the family to embark on a more successful period of parenting, without adequate professional reflection about whether the parental capacity to care for the child has in reality changed. This way of thinking and behaving tends to happen when workers are overwhelmed. 'Starting again' is a way of dealing not only with overwhelming amounts of information but also the feelings of helplessness generated by families, especially in long term neglect cases. This strategy prevents workers from having a clear and systematic understanding of a case. Starting with a clean slate can be prompted by a worker leaving (or being away on sick leave) or a new practitioner starting afresh to form an 'unprejudiced' view of the case. It can also be prompted by the courts rejecting applications for care orders and instructing workers to give families another chance to demonstrate successful parenting'.

285. An initial assessment was triggered by a referral from the midwife in October 2006 when mother became pregnant with Charlie. Concerns were identified as the family history of child protection issues, which culminated in the removal of five previous children, and the subsequent granting of a Care Order to another Local Authority in November 2001 on the grounds of severe neglect.

286. The initial assessment was completed on 31 October 2006 concluding that "parents' capacity to respond to the new baby will have to be further assessed at a multi-agency meeting with

health and other professionals, which will provide past and present information they have about the unborn baby and parents and contribute specialist knowledge or advice to determine future plans".

287. An assessment was carried out in respect of the unborn baby and the case was assessed as high risk. The recommendation was to proceed to a core assessment via a strategy meeting, which eventually took place in early February 2007, more than 3 months after the initial assessment was completed. Charlie was born early March 2007.

288. In mid-March 2007 when Charlie was just 10 days old an assessment concluded that 'the current situation has been assessed and found to be acceptable in terms of meeting the needs of a child'. Given what is known about neglect and what was known about parents' history this was an overly optimistic, simplistic and unsafe assessment carried out over a very short time period. (A decision was made at some point following the assessment to manage the case at Child in Need level).

289. Given what was known at the time of the core assessment, the serious and longstanding concerns about parents' ability to parent (including a psychological assessment of mother) which resulted in the permanent removal of 5 of their children for severe neglect and the suspicions of their involvement in child sex abuse this should have warranted a strategy meeting, an ICPC, pre-birth legal advice regarding the need to consider issuing Care proceedings, and the commissioning of a specialist parenting assessment.

290. In early September 2007 the CIN was closed although it is not clear from the records made available during the course of this SCR how many CIN meetings (if any) took place and what the outcome / actions of the meetings were.

291. Within 2 months of the closure of the CIN Charlie had missed his first eye care appointment.

292. Following the allegations of sexual abuse made by 2 of parents' older children in May 2008 Children's Social Care carried out an in-depth review of the information held by the local

authority where parents had previously lived. A strategy meeting was also held (although the outcome of this is not recorded).

293. No criminal investigation resulted from the allegations and the family were allocated to the Pathfinder Team for direct work to be carried out with parents. The Pathfinder team provided support and practical assistance but there was no sustained change or improvement in the care of Charlie for example during this entire period Charlie was not attending medical and dental appointments. The Pathfinder team were not specifically briefed to consider the risk of sexual abuse as an ongoing possibility.

294. In January 2010 mother became pregnant with Charlotte. The family were allocated a social worker in March 2010 and parents were assessed as meeting the needs of the children and the family were reallocated to the Pathfinder Team in October 2010.

295. In November 2010 an anonymous referral was made to the NSPCC alleging that Charlie was being hurt by his parents. Parents denied the allegations and again were believed.

296. A further anonymous referrals was made in July 2011 alleging poor home conditions and neglect and in November 2012 a fourth anonymous referral alleged that the children were being neglected and physically and sexually abused by their parents and others. An initial assessment was completed following a home visit. Parents denied all allegations which they felt were malicious. A social worker who completed the initial assessment visited Charlie at school and spoke to him alone. No concerns were raised by the school at the time, and home conditions and the children's presentation were considered acceptable.

297. This 4th anonymous referral does not appear to have been reviewed alongside historical and current information (at this point Charlie's teeth were visibly decayed and he had missed a number of appointments in respect of his eyesight) in other words there was an incident focused response.

298. A reassessment of this case at any time from Charlie's birth onwards should have alerted professionals to the high levels of risk of harm to Charlie and Charlotte which had not reduced and in fact were increasing.

299. These risks included:

- Father allegedly sexually abused as a child.
- Father's ongoing severe mental illness.
- Father's deteriorating physical ill health and disabilities.
- Mother possible history of sexual exploitation and abuse.
- Mother's involved in a possible sexual assault against a young person
- The children's behaviour and allegations
- Fluctuating /poor home conditions
- Mother's possible learning disability
- History of severe neglect leading to 5 children being removed
- Domestic abuse
- Multiple house moves/ poverty
- Missed medical appointments
- Missed dental appointments
- Exposure to a Registered Sex Offender
- Allegations by older siblings and others of sexual abuse

300. The compounding nature of risk in this case was not recognised, assessed or responded to appropriately. The single biggest indicator that parents would not be able to meet Charlie's needs was their history and there were very early signs in Charlie's life that history was repeating itself.

301. There were, undoubtedly missed opportunities (outlined above) to intervene earlier in Charlie and Charlotte's lives in order to safeguard them and halt or prevent damage to their eyesight and visible damage to their teeth.

302. There is also an unknown and unquantified damage that the children have suffered as it is highly unlikely that they have had their emotional and psychological needs met as a result of severe neglect.
303. There is also the possibility that Charlie and Charlotte have experienced sexual abuse and they were certainly living with a registered sex offender for a period of time.

Lessons Learned

304. The lessons learned from this SCR focus in particular on the 'start again' approach taken when mother became pregnant with Charlie which led to an over optimistic and unrealistic assessment of parents' capacity to care for their children.
305. The learning from this review should be used to influence practice and policy where families have previously had children removed from their care.
306. Additional learning comes from how professionals recognise, assess and respond to risk when sexual / abuse allegations are made by children and young people but do not proceed to criminal proceedings specifically the difference between evidential thresholds and actual/ probable risk.
307. Further learning comes from how practitioners recognise, understand, assess and respond to cases of chronic neglect. Definitions of neglect vary in the extent to which they describe neglect as chronic, episodic or as involving one-off incidents. Typically, definitions emphasise the chronic or ongoing nature of neglect. The point at which recurrences of neglectful events, even when minor, can be said to constitute chronic neglect is relevant in this case (as in many others within the County and nationally) and if not recognised and understood can lead to inconsistencies in the way neglect is assessed and to differences of judgement about what constitutes 'good enough parenting' amongst professionals.

Multi Agency Recommendations

308. The LSCB should ensure that current policy and practice ensures that when any parent/s becomes pregnant and there has been a history of care proceedings that an initial child protection conference (ICPC) is automatically convened regardless of current family circumstances, or provide a clear rationale, with legal advice, if this is not considered necessary.
309. The LSCB and partners should prepare a briefing and other learning opportunities for practitioners to outline the difference between evidential thresholds in criminal and civil proceedings and what this means for children where physical and/or sexual abuse is alleged or suspected. Specifically there should be a focus on those cases where the evidential threshold for criminal proceedings is not met but the probability of abuse having taken place is high and what this means for decision making and practice.
310. The LSCB should ensure that partners develop a working protocol to highlight and provide guidance for instances when children and young people miss or are not brought to medical appointments. Consideration should be given to parents/ carers opting out from the sharing of records, i.e. unless it is stipulated that parents do not want information to be shared consent to share information is assumed. The protocol should be developed within 12 months of the completion of this Serious Case Review and should be evaluate/ reviewed within 3 months of becoming operational.
311. The LSCB and partners should ensure that practitioners and line managers are able to evidence that children and young people have been listened to and their wishes and feelings have been understood, respected and taken into account in decision making, risk assessment and planning. This should be a core (and clearly recorded) element of all work at Child in Need or Child Protection levels.

312. The LSCB and partners should ensure that their policy and practice positively supports and encourages professional challenge within single and multi-agency forums. This could be evidenced through supervision records and review of multi-agency meeting minutes.
313. The LSCB and partners should ensure that neglect policy and practice recognises the danger of 'fresh start' thinking and provide assurance in long standing or chronic cases of neglect that professionals have reappraised risk and need on a regular basis. For example case notes/ multi-agency minutes should evidence that re-assessment has taken place on at least a monthly basis.
314. The LSCB and partners should review practice and policy in chronic cases such as this and ensure that for any intervention or support provided clear, time limited targets are set for professionals and for the families. Specifically evidence should be recorded that improvement or reduction in risk / need has or has not been achieved and clear recording of decision making thereafter.
315. The LSCB and partners should review what currently happens when adults who have no children living with them where there have been significant safeguarding concerns. In particular partners should seek assurance about that information is stored and shared in a way that it can be reviewed if the adult/s do at any point in the future have contact with children or become parents themselves.

Actions for Single Agencies

1. The agencies involved in the Learning Event which took place as part of the serious case review process each developed an individual agency action plan to deliver improvements identified at the Learning Event. The delivery of the improvement plans will be monitored through the Serious Case Review Thematic Tool maintained by the LSCB Business Unit.

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