DORSET SAFEGUARDING CHILDREN BOARD
SYNOPSIS OF LEARNING FROM A SERIOUS CASE REVIEW
August 2015

Family S15

Introduction

The S15 Serious Case Review took place through the autumn of 2014 in to early 2015. It concerned multi-agency practice between October 2012 and March 2014. The findings of the Serious Case Review were accepted by Dorset Safeguarding Children Board in February 2015.

This Synopsis of Learning will be used to disseminate the findings from the Serious Case Review as widely as possible. However this will be an unusual synopsis in that an overview of the case will not be included because the SCR has not been published and the DSCB is in fact recommending to the DfE that publication will harm the two children involved.

Background

Briefly, this case involved a barely 14 year old girl who became pregnant while agencies were assessing risks from an adult male who was living in the household and allegedly posed a sexual risk to children. Her carer had failed to protect previous children from child sexual abuse. The girl was already pregnant when she was made subject to a Child Protection Plan; however, this did not come to light until a few weeks before the baby's birth. The perpetrator was eventually arrested and served a prison sentence for the crime.

All the agencies involved accept that work could and should have been done differently to protect the girl. In this case it is important to note that most processes were followed to the letter, timescales were met and the number of practitioners and managers involved put a lot of effort into working with the child and family. Learning from this case goes beyond these issues and really goes to the heart of progressing effective work with families where child sexual abuse is known or suspected. The DSCB will be working on certain procedures as a result of the findings from this Serious Case Review and the Serious Case Review update training in the summer of 2015 will tackle some of the complex learning. However we want to encourage all practitioners to reflect on the findings and think about how they may change their own practice as a result.

Findings

Investigative mindset

The Police and Social Care need to re-visit the threshold for Joint Agency Section 47 enquiries. However, it is the responsibility of all practitioners involved to question, check out and triangulate information where children are at risk, particularly in the area of child sexual abuse. Just accepting that carers say that they will protect a child is not good enough. As part of making these enquiries, social workers should be prepared to speak to alleged perpetrators, either with guidance from the police when they are involved or because they want to know what is happening when the police are not involved.

Professional Curiosity and Challenge within the Multi Agency Network

Most cases that involve Child Protection Procedures with the child subject to a plan are complex. Practitioners may feel that they cannot voice their concerns and worries in front of family members, particularly children. They must have the confidence to call a professionals' meeting outside of the Child Protection Conference process where appropriate and use this to share concerns and worries and reflect on the case jointly with colleagues from other agencies. This will need to be chaired by the most appropriate manager

Some families may show disguised compliance and the inter-agency procedures for working with Hard to Reach Families were published in 2015 and this is the framework within which these professionals meeting can be called.

The DSCB is also working on a process whereby all children who remain subject to a Child Protection Plan after the 3rd Review Child Protection Conference are automatically reviewed. A similar process will be put in place for all children who are further abused when subject to a Child Protection Plan. This will give the opportunity for the practitioners involved to jointly reflect on the case.

Medical Assessments

The new Inter-agency Child Protection Procedures published in February 2015 about investigating child protection concerns encourage social workers to think about whether a medical assessment would be useful when child sexual abuse is suspected. This would not be a forensic medical if the police were not involved, but would enable issues around sexual health to be explored sensitively with the child. This medical assessment would be seen as potentially investigative but also therapeutic. Taking a child for such a medical can take place at any point in the process where child sexual abuse is suspected and social workers are required to consider this as part of their input to help a child.

The Voice of the Child

There are complex reasons why many children will not tell us that they are being abused. Teenagers who are subject to child sexual abuse may believe that they are in a loving relationship with the perpetrator and can be made to feel special. There is a risk that the real consideration of what it is like to be a child in a family gets lost and there can be over-reliance on what they tell practitioners. There can also be helplessness as to what to do when the child is not disclosing abuse even though it is suspected. It is important that practitioners share information and record their concerns and consider this in ongoing work with children. Practitioners who work with children should have the confidence to use a range of skills and techniques to communicate with children to identify their fears, worries and issues.

Supervision

Those who supervise practitioners working in complex family situations must use supervision as an opportunity to stretch and help the workers challenge their own thinking around the family situation. It is not acceptable to allow practitioners to assess cases without supporting them to tease apart the reasons for the outcome of their assessment. In addition, supervisors should be aware of the safeguarding procedures and support practitioners in implementing new ways of working that are supported by these procedures.

Supervision should be a robust opportunity to consider much of what has come out of the findings from this Serious Case Review.

Conclusion

We acknowledge that there is much good practice in Dorset and many children are protected through the inter-agency working that is established. Also a number of agencies have improvement plans that will already be addressing some of the issues identified in this SCR.

Learning from this SCR is all about professional practice and practitioners and managers using their skills to really consider each child's situation and to understand how intervention should be targeted to make a very real difference.

What next?

Please think about these findings; discuss them in your teams and take forward this learning. If you want an opportunity to explore these issues in more depth, please look out for training opportunities on the DSCB Website