

**SWINDON AREA CHILD PROTECTION COMMITTEE**

**SERIOUS CASE REVIEW**

**'B' FAMILY**

**EXECUTIVE SUMMARY**

**September 2004**

## **Background**

- 1.1** Three generations of the 'B' family lived together in the same family home, which they had occupied since the grandparents had married. It was very overcrowded and there were fluctuating concerns about the poor physical state of the house and how this impacted on the care of the children. All the first generation of children moved out one by one as they got older but the eldest daughter remained at home and went on to have six children, who lived with her and her parents.
- 1.2** There was increasing professional suspicion over through the 1990s that Mr 'B' might be the father of his eldest daughter's six children. Three of the children were diagnosed with the same rare genetic disorder, which it was known could only occur when both parents are carriers. This, together with Mr 'B's' efforts (often aggressive and threatening) to keep professionals at a distance and to retain control of the situation, fuelled the belief that incest offered a possible explanation and there were also anonymous allegations received that suggested that this might be the case. However, the professionals believed that, as there was no evidence to prove this, there was nothing that they could do. It was not until the Police were given a clear Statement alleging sexual abuse and incest in 2002 that steps were taken to arrest Mr 'B'. He was subsequently convicted of incest and is currently serving a fifteen year term of imprisonment.
- 1.3** The children in this family with the genetic disorder required regular medical assessments and ongoing treatment to diminish the impact on their immediate health and their longer term developmental prospects. Professionals were very aware that the demands on the family of caring for all the children were very high and considerable emphasis was placed on supporting them and trying to ensure that the children with disabilities received the medical care and educational resources that they needed. The family were often reluctant to accept professional advice about services and this was seen as an understandable anxiety about the ability of other people to care for the children adequately in view of the life threatening nature of their problems. However, in practice, it meant that important medical appointments to monitor their health and to provide essential treatment were often missed, resulting in a need for emergency hospital admissions in crisis. It also meant that the children did not attend school and their education was compromised.

## **2. Criteria for undertaking a Serious Case Review**

- 2.1** When there are concerns about inter-agency working to protect children then the Area Child Protection Committee must consider holding a Serious Case Review. The purpose of such a review is to consider whether there are any lessons to be learned from an analysis of the way in which the professionals delivered their services to the family and how the agencies worked together.
- 2.2** Following Mr 'B's' conviction and imprisonment, an Independent Review was immediately commissioned. This review was based on an examination of records from 1997/98 held by Swindon Social Services Department, Swindon Borough Education Department, Wiltshire and Swindon Healthcare Trust (and its successor organisation Swindon Primary Care Trust), Wiltshire

Police and Swindon and Marlborough NHS Trust. The Law and Corporate Governance Section of Swindon Borough Council also provided notes of their involvement. This Independent Review was presented to the Area Child Protection Committee in November 2003.

- 2.3 A special meeting of the Area Child Protection Committee considered the Independent Review Report on 12 December 2003 and took the decision that a full Serious Case Review should be commissioned under the stewardship of an independent chairperson. It was felt that this would facilitate a more robust examination of the way in which services were provided for the 'B' family, given the large number of professionals and different agencies involved over a lengthy period.
- 2.4 Sylvia Duncan, Consultant Clinical Psychologist, was appointed as the Independent Chairperson for the Serious Case Review in light of her extensive published research on Public Inquiries and 'Part Eight' Reviews. It was hoped that her expertise would assist the Overview Panel in its analysis of this complex case.

### **3. Scope of the Review**

- 3.1 It was agreed that the Serious Case Review should examine the way in which all statutory agencies within Swindon (and earlier Wiltshire) discharged their functions in relation to the policies and procedures of the time in respect of the 'B' family and any children of the 'B' family whom the perpetrator could have had an abusive relationship with.
- 3.2 The Review spanned a period of thirty years, starting with the birth of the eldest child of Mr and Mrs 'B' who, as an adult, went on to give birth to six children by her father. It was considered relevant to consider whether there had been missed opportunities during the childhood of this young woman to protect her from the abuse by her father. However, the Review has considered in more depth the period beginning with the birth of the first child of Mr 'B' and his daughter in 1991 up to the time of his arrest in 2002 and whether professionals could have intervened earlier to protect the children and prevent further incestuous births.
- 3.3 A further area for consideration was whether professionals should have intervened sooner to promote the health and developmental prospects for the children by taking legal steps to ensure that they received the necessary services.
- 3.4 Lastly, there were questions as to whether steps should have been taken sooner to address the impact on the children (of both generations) of the poor physical state of the home, where the family lived until the end of 2001.

### **4. Contributions to the Review**

- 4.1 Management Reviews based on the preparation of a chronology of involvement were undertaken by the following agencies:

- Swindon Social Services Department

- Swindon and Marlborough NHS Trust (Great Western Hospital)
- Swindon Education Department
- Swindon Housing Department
- Wiltshire Constabulary
- National Probation Service
- School Nursing Service
- Swindon Primary Care Trust
- Sure Start

## **5. Summary of Conclusions**

- 5.1** An analysis of the pattern of relationships that existed between the ‘B’ family and the professional network during the 70s and 80s revealed a number of repeating themes that continued to dominate the family / professional interface during the next eleven years and inhibited an effective professional response. In particular, a tendency was noted whereby the family appeared to use various ploys to ‘close off’ from professional efforts to intervene and it could be seen how Mr ‘B’ worked very hard throughout the thirty year period to remain in control of the family / professional relationships.
- 5.2** Professionals worked hard to be accepted by Mr ‘B’ and to stay on the right side of him in the belief that only by doing so would they gain access to the children to be able to provide the necessary services to them. They did not appear to take into account the fact that, as a grandfather, he had no authority to make decisions on behalf of the children as he did not have Parental Responsibility. What they also failed to recognise was that they were being encouraged to believe that they had a reasonable relationship with the family and could deliver an effective service. With hindsight it is apparent that those professionals allowed into the home were only accepted on the family’s terms and would not always gain full access. They often did not get into the home and were never allowed beyond the sitting room. They never had access to the children alone or to their mother. Mr ‘B’ was always present and dominated any encounter. Those who challenged Mr ‘B’ and tried to assert their views were overtly excluded with threats of violence and blatant non-cooperation, leading them to work even harder to gain acceptance by demanding less and trying to do more themselves to compensate for missed appointments etc.
- 5.3** Looking back retrospectively it can be seen that Mr ‘B’ divided professionals into those he seemingly accepted and those he did not and this created splits in the professional network and different views about how best to intervene when concerns increased. At times, some professionals wanted to assert more control, whilst others were keen to protect their ‘special’ relationship with the family in the belief that this was the only way to provide services for the children and they were reluctant to participate in any plan for authoritative action. It is evident over the years how repeatedly, when the professional network geared itself up to use statutory authority to intervene, Mr ‘B’ was allowed to dominate and control by mounting counter-strategies and demands that resulted in the professionals abandoning their efforts to be in charge and agreeing a low key approach time and time again. Invariably, this involved the use of ‘concrete solutions’ in the form of more equipment or of more services

on the family's terms, which almost inevitably they did not take up. Professionals also appear to have felt sorry for Mr 'B' when he was upset by the plight of the children and this added to a sense of professional paralysis and helplessness.

- 5.4** It is apparent that occasionally some of the professionals did have an awareness that they were caught up in a repeating pattern of interaction that disabled them. However, it is not clear that this was understood nor that any consideration was given as to how to escape from this 'paralysis' to do something different. There was a resigned acceptance of the situation and the need to 'try and work with it'.
- 5.5** Where there are splits in a professional network, there is a potential for sub-groups to develop, which start to operate independently of each other. There are indications that this happened in this case with the result that information was not shared. Throughout the period under consideration, there were also repeated examples of information being dealt with in isolation without it being integrated into the wider body of information available. As a result, interventions tended to be based only on the immediate information available and a threshold of concern that should have indicated the need to investigate or take protective action was often not reached. Consequently, these children appear to have been categorised as being in need of support rather than protection. During the late 1990s, when concerns arose about possible incest within the family, these were often considered in isolation from the existing concerns about the physical state of the home and neglect of their health needs. This led to a 'flip flop' approach, whereby there were attempts to either address the neglect issues or the paternity issues but not both together. In summary, there was a tendency to work with a narrow focus in the 'here and now' rather than considering the wider picture and interventions were developed on the basis of limited information without undertaking a proper assessment.
- 5.6** It is also evident that there were repeated failures to integrate concurrent information available within and between the agencies. For example, there was a considerable amount of important and relevant information being held within different parts of the health service but there was no effective system for coordinating and sharing this. It appears there was no centralised system that would have allowed all the different parts of the service to be kept informed about missed appointments and the uptake of services. If this information had been shared more effectively then a threshold of concern for action might have been reached sooner with regard to the issue of the neglect of the children's health needs. Concerns held by the medical professionals about the paternity of the children, as a result of an increased understanding of the genetic basis of their disabilities, were not linked to the anonymous allegations regarding the possibility of incest held within the Social Services until after the birth of the third child with a disability. If this information had been linked sooner then an earlier intervention might have been initiated.
- 5.7** Professionals worked hard to try and provide the necessary services for the current generation of children and yet it is clear that at times they lived in poor conditions, their health needs were not adequately met, their developmental needs were neglected. There is no doubt that a more effective and earlier professional intervention was required. This Serious Case Review has identified factors which appear to have inhibited an appropriate and effective

professional response to the needs of the children in this family and there will be action taken to reduce the chance of similar problems arising in the future.

## 6. Recommendations

- 6.1** Each agency contributing to a Serious Case Review makes recommendations for improving practice within their own agency. The Overview Panel then makes recommendations from an inter-agency perspective, based on an analysis of a combined chronology and all the Management Review Reports.
- 6.2** Overview studies of inquiries at a national level demonstrate that very similar deficiencies have run through cases subjected to review over the last thirty years with the commonest practice themes clustering around: communication (e.g. record keeping, inter-agency coordination and information sharing); assessment (e.g. integration of available information, recognition of warning signs, basis of decision taking); resources (e.g. staffing levels, availability of supervision); and policies and procedures (e.g. compliance with them and how they were interpreted). **This case is no exception and the recurrence of similar problems from year to year must mean that crucial lessons are not being learned and /or that effective solutions have not been implemented.**
- 6.3** There is often a preoccupation in many reviews with the need for procedural adjustments and / or policy changes, although there is little evidence that the problems lay with the policies and procedures themselves. There is a growing body of opinion that the more important lessons from inquiries lie elsewhere than policy modifications or exhortations to practitioners to change their behaviour and that attention can more usefully be focused on the more ‘thinking’ aspects of professional practice. The personal characteristics of staff, the quality of their training and skills acquisition and the nature of their working environment are all relevant factors that become manifest in various psychological and interpersonal processes that unfold during work on a case and are a crucial determinant of whether policies and procedures will succeed.
- 6.4** There were some failures to follow procedures in this case, which are being addressed by the agencies concerned. In addition, some minor changes to the procedural guidelines have been suggested to try to address what we consider to be the omission of some important information regarding legal orders. However, the main thrust of the recommendations of the Overview Panel is to seek to provide relevance for the procedures and to facilitate ‘thoughtful practice’.

### Procedures

1. The Child Protection Procedures should be reviewed with particular attention to:
  - The need for an up to date definition of Parental Responsibility, with a clear guideline about who can make decisions in relation to a child with regard to such things as medical treatment, educational choice etc.

- The need for a glossary of legal terms, to include a list of the various legal orders and when / how they can be used to protect children.
- The need for a definition of the various types of professional network meetings with clear guidelines regarding the remit, authority and structure of each, the expectations on those attending and the approved method for recording the proceedings.
- The need for a protocol on how to respond to anonymous allegations.

## **Practice**

2. When a professional receives a referral on a family they should immediately identify who else is involved and make contact with the rest of the network (according to Information Sharing Protocol – see Item 3 below). No professional should be working in isolation without a full understanding of the involvement of other agencies. For multi-problem complex families, where large numbers of professionals are involved, there should be a ‘keyworker’ appointed to coordinate the input and organise regular core group meetings. A ‘map’ of the network with contact details for each member and information about the purpose of their involvement should be held in the file for the client within each agency.
3. Consideration should be given to setting up a Working Party with representatives from the many services providing services to children and families within Swindon & Marlborough Health Trust and Swindon PCT to develop a strategy for implementing the ‘Information Sharing Protocol for Children and Young Persons’ that has already been developed. The purpose of this would be to promote the delivery of a coordinated service to families with complex needs and effectively monitor their up-take of services.

The Panel would recommend that the involvement of a General Practitioner in any such Working Party would be crucial, as they are ideally placed to adopt a central role in any professional network.

The Panel would also recommend the inclusion of representatives from the Adult Mental Health Service, the Drug and Alcohol Service and Accident and Emergency Department. There is currently insufficient liaison between adult focused and child focused services and the Panel would like to recommend a policy of ‘think family’. A strategy should be developed to promote the use of the ‘See the Adult / See the Child’ protocol that has recently been developed.

4. Each agency file should contain a genogram (family tree) of the family and a running chronology of significant events, to include all identified concerns.

An awareness of the make-up of the family and easy access to historical concerns should enable current information to be considered in context

rather than in isolation and thus allow for any intervention to be based on a full consideration of all the concerns and not just the immediate information.

5. Practitioners need to develop an ‘assessment mindset’ so that every encounter with a family is conceptualised as an opportunity to re-evaluate their intervention strategy in the light of new information. Lord Laming has referred to the need for practitioners to adopt a position of ‘respectful uncertainty’, which leads to a constant reappraisal of the information available with an accompanying modification to intervention strategies as appropriate. Assessment should be understood to be a continuous process and never complete.
6. The availability of well informed supervision should be the right of all practitioners and ideally supervision would be compulsory across all professional groups. This should have clear objectives to:
  - provide emotional support;
  - enable the practitioner to stand back and recognise how they might be being manipulated or drawn into family dynamics;
  - direct the practitioner to locate appropriate information to guide their work;
  - assist in the identification of concerns that need to be addressed through protective action;
  - assist the worker to formulate their views in a precise way that can be clearly communicated to other relevant professionals in writing.

Accurate notes should be recorded in the agency file regarding the issues discussed and any decisions taken.

7. Newly appointed or inexperienced practitioners or managers should be given an effective induction programme and provided with a mentor for up to six months as well as a clear competency based training programme.
8. In line with the current availability of ‘Named Professionals’ within the Health Service, the Panel would recommend that similar roles should be developed within all agencies to provide consultation to professionals with child protection concerns. The Overview Panel consider that it would be best to develop these roles amongst a small number of professionals within each agency, rather than appointing a single professional, in order to allow for continuity of provision and a sharing of responsibility. It is important that these professionals remain ‘off-line’ and do not get drawn into delivering services personally but, at the same time, they must operate within a clearly defined managerial structure and be provided with supervision.
9. When a practitioner feels that the network is ‘stuck’ and that there is a failure to take the necessary action to protect a child then there is already an option for this to be dealt with at a managerial level between agencies. This option was not used as much as it probably should have been in this

case and all too often practitioners failed to challenge their colleagues. Practitioners need to be made aware of the necessity of using this facility. However, the Overview Panel believe that there should also be a provision for independent consultation for 'stuck' professional networks from an external consultant with expertise in child protection and working systemically for those rare occasions when a network cannot reach agreement.

10. The ACPC should consider developing a Working Party to draw together the collective findings from recent Serious Case Reviews to identify common themes and consider how to disseminate this information in order to improve practice and implement any recommendations. The ACPC Serious Case Review Panel could fulfil this function and the Children's Board would be well placed to monitor the implementation of any strategies developed.

### **Training**

11. Only well informed practitioners who have undergone rigorous training, which is regularly updated, will operate an appropriate 'threshold of concern' to alert them as to when there is a need to share information with other colleagues and consider taking protective action. The ACPC already organises a rolling programme of multi-disciplinary training. However, the Overview Panel would like to recommend that there is an audit of training needs for all professionals working with children, which allows for identification of professional specific training needs in addition to the multi-disciplinary component. Some of the apparent gaps in training identified by the Overview Panel in this Review included topics such as:

- The development of core competencies
- Creating chronologies
- Record keeping
- Working in partnership
- Recognising unhelpful or stuck patterns of family / professional interaction
- Assessment of parenting / needs / risk
- Formulating and sharing information and opinions –making yourself heard in the network
- Challenging colleagues
- Communicating with children
- Protecting children with disabilities
- Working with violent or threatening clients / patients
- Incest / sexual abuse
- Child protection and the law
- Learning from Serious Case Review
- Recognising 'closure'
- The significance of concealed pregnancies

### **The Review Process**

- 12.** Staff within agencies should be given the opportunity to discuss the Management Report relating to their own agency to facilitate an honest exchange of ideas and to promote learning. The option for an independent external consultant to facilitate this process would be helpful.
- 13.** To reflect the enormous amount of resources that are currently being invested in conducting Serious Case Reviews, every effort should be made to find a way of sharing the knowledge gained through the detailed re-examination of cases with all professionals concerned with protecting children by disseminating the information and using it as a basis for training initiatives.

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