# THE VALE OF GLAMORGAN LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW: CHILDREN 'C' and 'D':
THE EXECUTIVE SUMMARY

**22 SEPTEMBER 2011** 

CONFIDENTIAL

## 1.0 CIRCUMSTANCES LEADING TO THIS SERIOUS CASE REVIEW

- 1.1 This Serious Case Review involves two children both aged less than 10 years old, C and D. Both children were members of the B family. Prior to the events set out in this Serious Case Review there had been no previous concerns about the welfare of either C or D. In order to protect the welfare of both children this summary has sought to minimise the information it reveals about their circumstances.
- 1.2 Mr and Mrs B had been approved by the Vale of Glamorgan Social Services Department's adult placement service as a host family to provide supported accommodation for vulnerable adults who are unable to live independently and who want to live in a family environment.
- 1.3 A, aged 19 years, had been accommodated by the local authority since he was 11 years old and qualified for advice and assistance from the local authority until the age of 21 years and, as his welfare required it, the provision of accommodation. A was the subject of a pathway plan prepared in accordance with the Children (Leaving Care) (Wales) Regulations 2001. A has learning disabilities. There was a history of professional concern that A may have both suffered and perpetrated sexual abuse.
- 1.4 In 2008 A was placed with the B family by the Vale of Glamorgan's adult placement service. About seven weeks later the local authority removed A from the placement as a consequence of having been told that he had sexually abused child D. Shortly afterwards child C reported having also been sexually abused by A, and A was arrested.
- 1.5 In 2009, A was convicted of the rape of a child aged under 13 by a male and sexual assault on three occasions of another child also aged under 13. Shortly after this the Vale of Glamorgan Council published its own case management enquiry, which made a number of recommendations in the form of an action plan, the implementation of which has been the subject of inspection by Care and Social Services Inspectorate, Wales (CSSIW).

#### 2.0 TERMS OF REFERENCE

2.1 The Chair of Serious Case Review Standing Group is Ms Victoria Warner, Divisional Nurse, Primary Community and Intermediate Care Division, Cardiff and Vale UHB<sup>1</sup>. These terms of reference were completed on 23 October 2009 and updated on 7<sup>th</sup> January 2011. They are as follows:

"The Vale of Glamorgan Local Safeguarding Children Board has confirmed that there will be a Serious Case Review in relation to the above children [C and D].

These children were the subject of sexual assaults by a young adult male ('A').

At the time of Ms Warner's appointment to chair of the SCR she held the post of Nurse Director, Torfaen Local Health Board.

The initial Terms of Reference for this Serious Case Review were identified by the Serious Case Review Standing Group. They will be reviewed by the Serious Case Review Panel that will manage the specific processes in relation to this Serious Case Review. These Terms of Reference are as follows:

This Review is being commissioned by the Chair of the Vale of Glamorgan Local Safeguarding Children Board in accordance with 'Safeguarding Children; Working Together under the Children Act 2004'.<sup>2</sup>

# 2.1.1 The purpose of the review is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children.
- Identify clearly what those lessons are, how they can be acted upon, and what is expected to change as a result.
- As a consequence, improve inter agency working and better safeguard children.
- Identify examples of good practice.
- Attempt to make contact with the parents and take into account their comments.

# 2.1.2 The key issues this review will seek to clarify:

- Whether there was evidence that the children were at risk of harm that was not recognised by agencies at the time of the incidents
- Whether information was shared and acted upon appropriately in relation to risk of harm to these children
- Whether the Vale of Glamorgan Local Safeguarding Children Board Child Protection Procedures (All Wales Child Protection Procedures) were adhered to by agencies.
- Whether the relevant agencies assessments of the children's needs were accurate and comprehensive.
- Whether case planning and review was adequate.
- Whether plans were implemented and monitored.
- 2.1.3 As a result, the review should focus on the time period from the date of placement with the Host family to the date of A's second court appearance.
- 2.1.4 Agencies, identified as having information to share, have permission to include a 'context' section in their Management Reviews relating to any information held on 'A' outside the agreed time period of the review that they feel is significant to be included.
- 2.1.5 The management reviews will be received and considered by the Serious Case Review Panel as the primary means of fulfilling the purpose of this review.

<sup>&</sup>lt;sup>2</sup> Welsh Assembly Government (2006) Safeguarding Children; Working Together under the Children Act 2004. Cardiff

- 2.1.6 The decision on how and when to engage with the family will be a matter for the panel to consider on an ongoing basis.
- 2.1.7 The Chair<sup>3</sup> of the Vale of Glamorgan Local Safeguarding Children Board will be responsible for making all public comment, and responses to media interest concerning the review until the process is complete.
- 2.1.8 It is anticipated there will be no public disclosure of information other than the Executive Summary of the Overview Report which will be available as required. The family of children C and D will be given sight of the Executive Summary of the Report when this has been completed.
- 2.1.9 Consideration will also need to be given to the need to share appropriate information with 'A'.
- 2.1.10 The Serious Case Review Panel considered the role of any experts or independent persons in the review process and agreed that there was no specific need for this involvement at this stage.
- 2.1.11 The findings of the Serious Case Review will be shared with any relevant Local Safeguarding Children Board within which area the perpetrator has been or is currently resident.
- 2.1.12 There are no parallel investigations of practice being undertaken that are ongoing in relation to the children who are the subject of this Serious Case Review.
- 2.1.13 The following organisations have been identified as contributors to the Review:

Vale of Glamorgan Social Services – Mr Gareth Jenkins, Head of Children and Young People Services, Ms Julie Clark, Principal Officer Policy and Protection, and Ms Julia Ross independent author of the Individual Management Review (IMR) for Social Services.

**Public Health Wales NHS Trust** – Dr Hywel Williams, Designated Doctor Safeguarding Children /Mrs Caroline Jones Designated Nurse Safeguarding Children,

Vale of Glamorgan Education – Mr Bob Grover, Designated Education Officer for Child Protection and Safeguarding

South Wales Police – Detective Inspector Gary Bohun, Public Protection Unit and Ms Linda Wood, Policy Research and Development Officer, Public Protection Department, author of the chronology and IMR.

Vale of Glamorgan Legal Services – Mr John Lewis, Senior Lawyer. Llamau – Mrs Sam Austin, Operational Director.

2.1.14 The Terms of Reference of the Serious Case Review to be reviewed regularly by the Serious Case Review Panel."

<sup>&</sup>lt;sup>3</sup> The Chair in relation to this SCR is the Vice Chair of the LSCB

2.2 Mr Stephen Pizzey, social work consultant was appointed as the independent Overview Report Writer on 2 September 2009. The Chair of the Serious Case Review Standing Group and the Overview Report Writer, met with Mr and Mrs B to discuss the questions they would like the Serious Case Review to cover. The overview report was accepted by the Vale of Glamorgan Local Safeguarding Children Board on 4 April 2011.

#### 3.0 CONCLUSIONS

- 3.1 Prior to the local authority arranging to place A in the B family there had been no previous concerns about the welfare of either C or D.
- 3.2 A's history was well known to the children and young people's division of the social services department of the Vale of Glamorgan: there were extensive case files on him, which documented his background, including his history of sexualised behaviour. There was a repeated failure to incorporate this knowledge into transfer summaries, chronologies or the second pathway plan made as he approached the age of 18 years. There was also a failure to review new information about A's behaviour in the light of what was already known and therefore its significance was not appreciated.
- 3.3 There was a systemic failure to appreciate the significance of the pattern of sexualised behaviour identified in A's adolescence and that it would be likely to persist into adulthood with implications both for A's future care arrangements as a young adult and for those with whom he might have contact in any care setting. Based on what was known to the local authority about A, the pathway plan should have concluded that it was not in his interests to be placed in settings where there were children so as to avoid the likelihood of him engaging in further sexually abusive behaviour in any placement.
- 3.4 There was a failure by the social services department to use the Assessment Framework<sup>4</sup> as a basis for systematically gathering and updating the available information about A's behaviour and analysing the likelihood that C and D might suffer harm if A was placed in the B family.
- 3.5 Other professionals failed to refer to A's history of sexualised behaviour when preparing reports or letters of referral. The general practitioner's (GP) records contained documentation about A's history of sexualised behaviour. The GP referred A to the community mental health team (CMHT) for a re-assessment of an earlier diagnosis and a review of his medication but did not include any information about A's history of sexualised behaviour. The CMHT records contained A's child and adolescent mental health (CAMHS) file which included information about his history of sexualised behaviour. This information was not referred to in the background section of the consultant psychiatrist's report or in a subsequent referral letter to a clinical psychologist for a cognitive assessment (level of functioning).
- 3.6 The clinical psychologist's report was seen by Mr and Mrs B when A was placed with their family and by the adult placement service workers all of whom were unaware of A's history. Had the clinical psychologist been made aware of A's history of sexualised behaviour it is likely that it would have been referred to in the background section of

<sup>&</sup>lt;sup>4</sup> National Assembly for Wales and Home Office (2001) Framework for the Assessment of Children in Need and their Families, London: The Stationary Office.

their report thus serving to alert the adult placement service workers and Mr and Mrs B to A's history of sexualised behaviour (in the absence of the children and young people's division of the social services department having done so hitherto).

- 3.7 If any of the actions referred to in the previous paragraphs above had been taken into account it is likely that either:
  - the placement of A with the B family would not have gone ahead; or
  - Mr and Mrs B, in the unlikely event that it was decided to progress with the placement, would have been in a position to ensure the protection of their children by virtue of them being aware of the possible risks of harm A posed to their children.
- 3.8 The Vale of Glamorgan social services department failed to respond to and manage the initial allegation by one of the children of sexual abuse by A in accordance with the All Wales Child Protection Procedures 2008. Three sections of the local authority social services department were involved in the management of this referral. None appeared to be clear about the requirements of the child protection procedures suggesting a systemic problem of compliance within the local authority at that time. This resulted in:
  - a failure to hold a strategy discussion and commence section 47 enquiries immediately;
  - a delay of five days before the police were informed of the allegations, potentially prejudicing their criminal investigation; and
  - Mr and Mrs B having to take responsibility for making a referral to the police.

#### 4.0 RECOMMENDATIONS

### Vale of Glamorgan Local Safeguarding Children Board should:

- 4.1 Ensure there is a programme of dissemination of the All Wales Child Protection Procedures.
- 4.2 Ensure that there is a programme of continuing multi-disciplinary training on the All Wales Child Protection Procedures, which is made available to all relevant staff from both the statutory and non-statutory sectors.
- 4.3 Promote understanding amongst relevant professionals from adult and children's services of the impact that sexual abuse suffered or perpetrated in adolescence has upon the development and behaviour of young adults and the implications for planning the future care needs of this group of young people.
- 4.4 Promote understanding amongst all relevant staff through multi-disciplinary training and supervision of the significance of historical information contained in agency records and the importance of considering its relevance for all referrals and reports.

#### Vale of Glamorgan Social Services Department should:

4.5 Ensure that all relevant members of staff understand the principles underpinning the Assessment Framework and its relevance for analysis and assessment of risk and likelihood of harm.

- 4.6 Ensure that all relevant social work staff receive regular supervision that is based on the principles underpinning the Assessment Framework.
- 4.7 Promote understanding amongst all relevant staff through training and supervision of the importance of reading the history set out in case files and considering its significance.
- 4.8 Establish a procedure for preparing all transfer summaries according to the Assessment Framework.
- 4.9 Establish a procedure for preparing chronologies of significant events that can be quickly accessed and understood.
- 4.10 Ensure independent reviewing officers and all participants in reviews of pathway plans read and take account of current and historical information and consider its significance for future care planning decisions.
- 4.11 Ensure the participation of all relevant staff in the programme of dissemination of, and the continuing multi-disciplinary training on, the All Wales Child Protection Procedures.
- 4.12 Ensure that the first contact team is available throughout council opening hours.

## Cardiff and Vale University Health Board should:

- 4.13 Remind relevant staff of the importance of reading the history set out in their records and considering its significance when requesting or providing an opinion.
- 4.14 Ensure the participation of all relevant staff in the programme of dissemination of, and the continuing multi-disciplinary training on, the All Wales Child Protection Procedures.

#### Llamau should:

4.15 Ensure the participation of all relevant staff in the programme of dissemination of, and the continuing multi-disciplinary training on, the All Wales Child Protection Procedures.

STEPHEN PIZZEY