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Cruelty to children must stop. **FULL STOP.**



**Kevin  
Harrington  
Associates  
Limited**



# **SERIOUS CASE REVIEW**

## **FAMILY A**

### **Report Author**

**Kevin Harrington JP, BA, MSc, CQSW**

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## 1. INTRODUCTION

1.1 Family A, a family of seven children between the ages (now) of 14 and 6, was originally known to agencies in Norfolk between 2004 and 2011. The children lived with both of their parents, firstly on a travellers'<sup>1</sup> site and then in settled social housing. There were recurring concerns about neglect and physical abuse of the children. Some of the children had Statements of Special Educational Needs. The father was known to have mental health problems and there was evidence of domestic abuse. There were a number of referrals and assessments but no substantial, continuing involvement by the local authority in Norfolk.

1.2 In 2011 the parents separated and the father, with all the children, moved to a travellers' site in the Southampton area. The father had grown up in a traveller family, and some of his relatives lived on that site. All the children were now said to be educated at home by the father, although he himself was unable to read or write.

1.3 There were some continuing concerns for the general welfare and safety of the children. Evidence then emerged that the children had been neglected, and abused by their father over many years. After this the children were initially cared for within the travelling community by relatives of the father but these arrangements were not successful.

1.4 Eventually all the children were brought into the care of the local authority through the courts. The father admitted numerous charges of neglect, physical and sexual abuse and received a long custodial sentence.

1.5 These events were considered by the Southampton Local Safeguarding Children Board (SSCB) and it was decided that the Serious Case Review (SCR) should be carried out. The purposes of SCRs are set out in "Working Together"<sup>2</sup>. They are to

- *establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;*
- *identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and*
- *improve intra- and inter-agency working and better safeguard and promote the welfare of children.*

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<sup>1</sup> This family are referred to as "travellers" throughout this report. Section 8.1 of the report considers issues relating to Gypsies and Travellers in more detail.

<sup>2</sup> Working Together to Safeguard Children (2013) – referred to in this report as "Working Together" – is a government publication containing statutory guidance on how organisations and individuals should safeguard and promote the welfare of children and young people, in accordance with the Children Act 1989 and the Children Act 2004.

## **2. FAMILY COMPOSITION**

2.1 The father, Mr A, is some seven years older than Ms B, the mother of the children. She was 17 years old when the first of the children was born, and had all seven children by the time she was 27 years old. The children are referred to throughout this report, in descending order of age, as Child 1 through to Child 7.

2.2 The maternal grandmother, who lives in Norfolk, did have some contact with the children when the family was in that area. Ms B is known to have lived with her mother after separating from Mr A but there is no information about any contact between the children and their maternal grandmother in the period under review. There is no information to suggest that any other grandparent had any contact with the children.

2.3 Mr A's brother, Mr D, and one of his sisters, Ms C, lived on the travellers' site in Southampton during the period under review. Ms C cared for the children after the first evidence of abuse emerged in January 2013. Mr D and another sister, Ms F, did have some continuing involvement with the children and were involved in discussions with agencies about them and their father.

## **3. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW**

3.1 There were a number of changes to the senior management team in Southampton City Council (SCC) from the autumn of 2012. Incoming managers found that there were several cases, dealt with during the same period of time, which met or might meet the criteria for conducting an SCR, but where no review had been initiated.

3.2 Five independent people with experience in the conduct of SCRs were drawn together by SSCB and appointed to carry out, eventually, five SCRs. In each case two Lead Reviewers were appointed from this group, one responsible for chairing the Review, the other to draw up an Overview Report. For this review Jane Wonnacott and Kevin Harrington, respectively, were appointed in these roles. Further details are at Appendix A.

3.3 The independent reviewers have met on two occasions with the Chair of SSCB in order to identify emerging themes relevant to all the reviews, which might indicate deep rooted issues within the safeguarding system. Two of the independent reviewers have been commissioned to undertake an analysis of the overall context for the safeguarding of children in Southampton during the period under examination in these reviews. That analysis will be presented separately to the SSCB when all the reviews have been completed.

3.4 The SSCB constituted a panel (the Panel) to manage and oversee the conduct of each review. The membership of the Panel for this review is set out at Appendix B.

3.5 It was determined that the agencies listed in the table below should contribute to the review. Agencies with substantial contact were required to submit full Individual Management Reviews (IMR) whereas agencies with less significant or less recent involvement provided reports for background information.

<b>AGENCY</b>	<b>NATURE OF CONTRIBUTION</b>
Southampton City Council, Children's Social Care Services	Individual Management Review
Southampton City Council, Prevention and Inclusion (Education) Services	Individual Management Review
Southampton City Council, Housing Services	Individual Management Review
Southampton City Council, Legal Services	Individual Management Review
Hampshire Constabulary	Individual Management Review
Solent NHS Trust	Individual Management Review
Southern Health NHS Foundation Trust	Individual Management Review
NHS England, Wessex Area Team – the General Practitioners	Individual Management Review
Norfolk Safeguarding Children Board	Report for information
South Central Ambulance Service NHS Foundation Trust	Report for information
Southampton City Council, Adult Social Care Services	Report for information
University Hospital Southampton NHS Foundation Trust	Report for information

3.6 The government has introduced arrangements for the publication<sup>3</sup> in full of Overview Reports from Serious Case Reviews, unless there are particular reasons why this would not be appropriate. This report has been written in the anticipation that it will be published but it is necessary that some confidential information is not disclosed. Consequently the information in the report is limited so as to:

- 1) take reasonable precautions not to disclose the identity of the children or family.
- 2) protect the right to an appropriate degree of privacy of family members.
- 3) avoid the possibility of heightening any risk of harm to these children or others.

3.7 Anonymised Terms of Reference for this SCR are attached at Appendix C. They are drawn from the statutory guidance contained in Working Together, amended to highlight specific issues relevant to the circumstances of this case.

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<sup>3</sup> See Working Together 2013

## 4. METHODOLOGY USED TO DRAW UP THIS REPORT

4.1 This Overview Report is based principally on the agency IMRs, background information submitted and subsequent Panel discussions and dialogue with IMR authors. Family involvement is discussed at section 6.

4.2 This report consists of

- A factual context and brief narrative chronology.
- Commentary on the family situation and their input to the SCR.
- Analysis of the part played by of each agency, and of their IMR – in those sections quotations are from the relevant IMR unless otherwise specified.
- Closer analysis of key issues arising from the review.
- Conclusions and recommendations.

4.3 The conduct of the review has not been determined by any particular theoretical model. However the review has been carried out in keeping with the underlying principles of the statutory guidance, set out in Working Together 2013, detailed below: The review

- *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<sup>4</sup>;*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings.*

## 5. SUMMARY CHRONOLOGY

### 5.1 Introduction

5.1.1 This section of the report firstly contains background information about the family and their contact with services in Norfolk before the move to Southampton in June 2011. This is followed by a brief summary of their contact with services in Southampton. More detailed information about this is then contained in the body of the report.

5.1.2 For the purposes of this report a decision has been made to restrict individual description of the children to specifically relevant issues, such as educational special needs. It is not necessary to say any more than that all of them have been seriously abused over many years and are receiving a range of therapeutic and supportive services to address the consequences of their experiences.

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<sup>4</sup> This review does not rely on hindsight, and tries not to use hindsight in a way that is unfair. It does use hindsight where that promotes a fuller understanding of the events and their causation.

## 5.2 Background

5.2.1 Mr A is known to have a Romany or traveller<sup>5</sup> heritage and to have grown up in a travelling community. There is evidence that he was seriously harmed within his family as a child.

5.2.2 Mr A had a long psychiatric history with multiple diagnoses. He was also at times assessed and found to be in good mental health. He was prescribed various medications but his compliance with medication was erratic.

5.2.3 Ms B is believed to have grown up in Norfolk in an isolated, rural location. She has reported an unhappy childhood. She is not known to have had any connection with the travelling community before meeting Mr A when she was in her early teenage years. There is evidence that she was the subject of serious and sustained domestic abuse during their relationship and there are allegations also that she was violent to Mr A.

5.2.4 The family was known to agencies in Norfolk between 2004 and 2011, having apparently returned to Norfolk after spending time in Suffolk and Wales. While in Wales, in 2003, the local authority in that area received a report raising concerns about poor home conditions and domestic abuse in the family but that referral does not appear to have led to any engagement between the family and agencies with safeguarding responsibilities.

## 5.3 Norfolk

5.3.1 Between 2004 and 2007 the family lived on a travellers' site in Norfolk. During that time safeguarding concerns were raised twice. These related to allegations of neglect and cruelty towards some of the children. Neither referral led to any continuing child protection action. During this time Mr A is known to have been involved with mental health services in Norfolk after he had jumped from a bridge and sustained multiple fractures.

5.3.2 During 2007 the family moved from the travellers' site to live in a rented house in Norfolk. This was the children's home until they moved to Southampton.

5.3.3 A statutory assessment of Special Educational Needs (SEN) in respect of Child 1 was initiated in 2008. During 2009 assessments of SEN were also commenced in respect of Child 2 and Child 4. The parents did not engage with the process but all three children were eventually made subjects of Statements<sup>6</sup> of SEN by Norfolk County Council.

5.3.4 Safeguarding concerns were raised by neighbours, the children's school and by health professionals on eight further occasions between 2007 and

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<sup>5</sup> The description of the family as "travellers" is discussed further at section 6 of this report

<sup>6</sup> When a child has been statutorily assessed as having special educational needs, a legal document called a statement of special educational needs may be drawn up – a formal record of needs and services to be provided. This process is widely referred to, by families and professionals, as "statementing".

2011. The concerns again related to maltreatment and neglect of the children, who were said to be poorly clothed, hungry in school and living in squalid overcrowded conditions. They were described as being uncontrolled by their parents, who did not recognise the causes for concern. The mother was said to be fearful of the father and is known to have left the family home for some four months on one occasion.

5.3.5 These referrals were all considered by the local authority but led to no substantial, continuing involvement. On one occasion the father asked that the children be accommodated by the local authority but this was refused. Instead it was suggested that NCSC would provide continuing support to the family. The parents were resistant to this but it was agreed that a social worker would visit once each month.

5.3.6 In fact only two successful visits were made, in February and March 2011. On the final visit the social worker judged that home conditions were satisfactory and the presentation of the children gave no cause for concern, but noted that there were no toys anywhere in the house. Mr A spoke of the children being bullied and there was evidence of bad feeling towards the family from other local residents.

5.3.7 In June 2011 the social worker was told by the Head Teacher that Ms B had again left the family and Mr A and the children had moved to a travellers' site in Southampton. The Head Teacher was particularly concerned that the special educational needs of the three "statemented" children should be met. By this time one had a place at a special school and another child was being considered for placement in a special school. There is a record of a failed telephone call from the social worker to Ms B but no further action by the local authority until the events described below.

5.3.8 When Southampton children's social care services (CSC) were first aware of the family NCSC were asked to provide details of their previous contact with them. NCSC advised, incorrectly, that this should be pursued through "Access to Records" arrangements. CSC did not follow this up and full details of the family's contact with NCSC were only clearly established after the children came into local authority care in Southampton.

## **5.4 Southampton**

5.4.1 From May 2011 services in Southampton became involved with the family when they were allocated accommodation on a travellers' site.

5.4.2 There was some liaison and sharing of information between services in Norfolk and Southampton. Information was shared between the services for "Children Missing from Education" (CME) in the two localities. Community Paediatric services and Speech and Language Therapy services sent information about their involvement. There was some liaison between the Norfolk Early Intervention in Psychosis (EIP) Team, which had treated Mr A, and their counterparts in Southampton .

5.4.3 A Health Visitor (HV), who routinely visited the site, saw the family in August and was told by Mr A that the children were all healthy and he had no concerns for them. He had registered with a local GP and intended to educate all the children at home. The HV contacted NCSC and was given a brief oral outline of the family background, summarised as *“on going neglect of the children (which) never reached the criteria for protection planning”*.

The HV was told that the three oldest children were subject to statements of SEN and that Mr A had a history of mental ill health.

5.4.4 The Health Visitor contacted Southampton CSC but they decided the situation did not meet the threshold for their involvement. Two Education officers visited the family and completed documentation relating to home education.

5.4.5 Over the following months the family had occasional contact with a number of services before moving in August 2012 to a larger plot on the same site.

5.4.6 In September of that year the council's education services visited the family again to establish whether Child 7 was also to be home educated, which Mr A confirmed. The officers were concerned about a range of aspects of the family's presentation and made a referral to CSC. CSC had also just received a referral from a warden on the travellers' site. She had been approached by a number of female residents expressing concern for the general welfare of the children and making comments which indicated concerns about sexual abuse. This did not trigger the initiation of formal child protection arrangements. Visits were made by CSC and a Core Assessment completed but the case was closed after one contact.

5.4.7 In mid-December two of the children came to police attention when they were suspected of stealing food and drink from a local supermarket. Information was shared between agencies and a CSC manager decided that their involvement was not necessary because of the recent Core Assessment.

5.4.8 Concerns persisted with evidence that the children were unclean, out of control and dependent on neighbours for food. Mr A was described as increasingly unkempt and his sister and brother told the warden on the travellers' site that they were becoming more concerned. They said they had contacted the children's mother to ask that she intervene but she had not responded. The HV tried to speak to Mr A but he refused. Both the HV and the warden then made referrals to CSC.

5.4.9 Police and CSC tried to assess the situation. Their intervention was not well planned and led to a serious disturbance on the travellers' site. Mr A asked that the children be taken into care but it was eventually agreed that the children be cared for by their aunt in a neighbouring caravan. The legal basis for this arrangement was confused and remained so for some time.

5.4.10 Some days later the first clear disclosures of sexual abuse were made and reported by the aunt to police. Mr A was arrested. The children remained initially with their aunt and all were seen by the Community Paediatricians. Over the following weeks evidence emerged, in respect of all of the children, of severe physical abuse and sexual abuse and extreme neglect with enduring consequences for their health.

5.4.11 The children said that they had been abused and neglected over many years, both in Southampton and previously in Norfolk. Some of the children reported that their mother had both been aware of the abuse and physically abused them herself. The children's mother denied any knowledge of any abuse or neglect of the children but did not wish to have any continuing contact with them.

5.4.12 The arrangement with the aunt could not be sustained and all the children eventually moved to new placements. They were made the subjects of Care Orders and it is not anticipated that they will return to the care of their family. Criminal charges were considered, but not pursued, against the mother. The father admitted many charges of abuse of the children and received a long custodial sentence.

## **6. INVOLVEMENT OF THE FAMILY IN THIS SCR**

6.1 Efforts to involve the children's parents in this review have been unsuccessful. The children's mother was invited to meet the author of this report at a location convenient to her but did not respond. The father was contacted in prison but did not respond to an invitation to meet the author of this report. The children's aunt, Ms A, was invited to contact the author of this report but also did not respond. Consequently it has not been possible to reflect a consideration of these events from their perspective.

6.2 None of the children has at this point had any direct involvement in this review. Some of them have expressly said that they do not wish to be involved. Some have indicated an interest but any such involvement will need to be linked in to the arrangements for their care and support. There are continuing discussions with social workers and carers on how best to involve the children and prepare them for the potential publication of this report.

## **7. THE AGENCIES**

### **7.1 Agencies in Norfolk**

7.1.1 Norfolk Safeguarding Children Board (NSCB) was made aware that this SCR was being conducted, and that the SSCB had decided that the period under detailed review would be restricted to the time the family lived in Southampton.

7.1.2 It was agreed that the NSCB would not initiate any sort of review themselves until this work in Southampton was able to deliver a better informed account of the family's history and circumstances. As this report has

been developed it has become clear that there is evidence of serious and sustained abuse and neglect of these children while the family lived in Norfolk. The NSCB is now considering the involvement of agencies in their area between 2004 and 2011 in the light of the matters arising from this review.

7.1.3 There have been discussions between the two localities about the transfer of information when the family moved and subsequently. Although a Norfolk social worker was involved with the family when they moved to Southampton, no information was passed to Southampton CSC when the social worker learned of the move. The involvement by NCSC had not identified the serious concerns which have now come to light but it would still have been appropriate for NCSC to ensure that colleagues in Southampton were as fully informed as possible. The fact that no such referral was made may have influenced the judgment of the Southampton senior practitioner who decided to take no action when contacted by the Health Visitor about the family.

7.1.4 The Education service in Norfolk did not alert their counterparts in Southampton to the fact that three of the children had Statements of Special Educational Needs. They were clearly required to do so under the national arrangements relating to statements of SEN. The special educational needs of these children were therefore not addressed in any way until they left the care of their family.

7.1.5 Some agencies – mental health services and speech and language therapy services – passed very timely and / or full information to their counterparts in Southampton. However much of the information transferred was incomplete, even in basic detail about the numbers of children and their names. Nonetheless a comprehensive multi-agency assessment in Southampton would have identified the inaccuracies and inconsistencies in the information received.

7.1.6 It is appropriate to note here the evidence of domestic abuse in the family before the parents separated. By some accounts the parents were violent to each other. There are graphic accounts of Mr A's violence to the children's mother. There is a deep and enduring link between domestic abuse and the need to protect children:

*"The link between domestic violence and child abuse is such that, where one is present, questions should always be asked about the other as a means of creating safer, more sensitive assessments and intervention strategies."*<sup>7</sup>

The children were no longer directly exposed to domestic abuse when they moved to Southampton but their previous experience will have contributed to their overall vulnerability.

## **7.2 Southampton City Council – Children's Social Care Services**

7.2.1 This section of the report addresses in some detail the way in which CSC were involved in the case. This level of detail is required because the

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<sup>7</sup> Humphreys & Mullender – Children & Domestic Violence (2005)

weaknesses identified are significant and recurring. It is recognised that there were unusual staffing problems and stresses which must have affected the strength and capacity of the service. It is positive that, after the children left the care of family members, there was eventually a more sensitive and efficient response.

7.2.2 Nonetheless the Board will want to be satisfied that the concerns identified have been addressed across the service. The content of this report has been accepted by senior managers. However, as described below, the work done to inform the review has included interviewing officers who remain unable to recognise causes for concern that have been identified. The relevant agencies and the Board will be concerned about that. There is accordingly a recommendation from this report.

7.2.3 When contacted by the HV who had become aware of their arrival in Southampton a social worker decided that the case did not reach the threshold for CSC involvement. This was despite being told that

- Mr A was a single parent of seven children
- Mr A was illiterate but intended to home educate the children, some of whom were known to have special needs, because he wanted to avoid contact with statutory services
- Mr A had a history of mental ill-health for which he continued to be prescribed medication, though he might not be compliant with this regime
- The children had been known to Norfolk CSC because of concerns that they were neglected
- The whereabouts of their mother was unknown
- Mr A was unwilling to co-operate with the HV in a CAF process

7.2.4 The social worker did make contact with Norfolk CSC to request information and was advised in error to send a written request to the “Access to Records” department. The social worker did not then take any further action to follow this up. It was left that the HV should conduct the CAF even though she had indicated that Mr A would not comply. The social worker then wrote to Mr A (despite being told of his illiteracy) to advise of the referral and that no further action was to be taken. The issue of the children’s special educational needs was not clearly specified or followed up in any way.

7.2.5 This was an inappropriate decision. It was not challenged by anyone because social workers at that level (designated as Senior Practitioners) were authorised to make such decisions without reference to anyone more senior, or to a peer. The IMR advises that *“There is no evidence that this decision was scrutinised by a team manager. At this time and currently senior practitioners would have unilaterally made this threshold decision as part of their designated responsibility”*. That is an unusual arrangement in children’s social care services and in most professions and should be reviewed.

7.2.6 CSC then had no contact for just over a year until September 2012. They then received the referral from the housing warden which included information that

- one of the children was displaying a sexual interest in younger children
- Mr A was locking himself in the caravan with his daughters who could then be heard screaming
- the home conditions were poor

It was made clear that this information had come from other travellers on the site, an unusual and aggravating feature of the concerns. As the IMR says *“This information should have resulted in an immediate investigation under Section 47 of the Children Act 1989; this should have included a strategy meeting with the Police”*.

There are further examples, as the events unfolded, of social workers and police not working well together and not following procedural requirements. This is fundamental to effective safeguarding and the Board will want to be satisfied that it is not a continuing problem.

7.2.7 CSC had not yet responded to this referral when, six days later, officers from the Education service visited the site to enquire about the plans for Child 7, who was approaching the age for admission to school. They confirmed with Mr A that he was to be home educated but were concerned by the presentation of the children who were

*“dirty, smelly and unkempt”*

They also heard from other residents that Mr A used drugs and that the children were often left alone and were always hungry. These officers then made a written referral to CSC (described in more detail in section 7.3 below).

7.2.8 Two days after that a social worker went to the site alone, charged with conducting an Initial Assessment, but was intimidated by men with dogs, who chased her from the site. Five days later a manager in CSC decided that there should be a Core Assessment and ten days after that a social worker again went alone to the site. She was also approached by men with dogs, feared for her safety and left the site. On the same day the housing warden who had made the original referral called CSC again to express her continuing concerns. Four days later Mr A was sent a letter advising that social workers would visit later in the week. Almost exactly a month after receiving an explicit child protection referral a social worker visited and saw Mr A – but not the children. Mr A denied any cause for concern. By this time the nature of the first referral, which clearly indicated concerns about sexual abuse, had been lost.

7.2.9 It is difficult to understand how CSC could have responded so inappropriately to a referral of this nature. The failure to focus on the real causes for concern, the delay, the absence of any structured approach, the lack of effective managerial involvement all indicate a service in disarray. However, and again perhaps this is of even greater concern, one of the managers involved, when interviewed for this review, said that she stood by her judgment at the time.

7.2.10 It was now decided by a Senior Practitioner that there should be a meeting with Mr A, his sister Ms C and other agencies to agree a way forward. That meeting was held at the end of October but the Senior Practitioner was unwell and it fell to a more junior social worker to chair the meeting. The minutes of the meeting state that the meeting was called to discuss the fact that the children were 'unsupervised'. In fact the focus of the meeting was almost entirely on the arrangements for the children's education.

7.2.11 The IMR advises that

*"All the other key issues were not addressed, including seeing inside the caravan, finding out about the girls screaming, clarifying issues of possible sexual risk posed by one of the older children, the whereabouts of the mother and finding out about Mr A's mental health".*

It is as if the situation had been re-defined into something that was easier to deal with. The children themselves were still not seen. Yet, again, when interviewed for this review, the Senior Practitioner

*"believed that this meeting was satisfactory. She said that she felt the priority was to engage Mr A and enable him to work with agencies rather than confront him and have a further risk of disengagement and possible flight".*

7.2.12 The meeting was followed up by a planned visit to the site by two social workers. They did see the children though there is recording only of them speaking to the two girls. Following that meeting the Senior Practitioner decided to terminate CSC involvement. The IMR details the causes for concern raised by this decision:

- The assessment was based on this one contact
- Not all the children were spoken to
- None of the children was spoken to privately
- The issue of sexual abuse was not explored at all
- The children presented as clean and tidy – in contrast to all previous reports – but this did not raise suspicions
- The home conditions were not investigated –they were seen in the site "office".
- No attempt was made to contact their mother or to verify an (untrue) account of her visiting every three weeks
- Mr A spoke of being supported by his family but this was not explored in any detail or verified
- The assertion that the children had been home educated was accepted at face value and not explored further
- There was an assumption that the home education of the children would lead to some continuing monitoring by Education staff – although education officers swiftly wrote to explain that this was not the case.
- There is no evidence that the likelihood that this was a demonstration of "feigned compliance" was considered
- There is no evidence that the possibility of false optimism was evaluated

7.2.13 Overall,

*“The fact that the children’s presentation was at such odds to every other previous report available should have led to suspicions”.*

Yet again, when interviewed for this SCR, the officer responsible for the decision that CSC should withdraw felt this was a reasonable decision. That officer was able to identify some stresses in the service at that time. They were generally struggling to cope with the level of incoming work. A new system of allocating work had been introduced which in effect led to staff being given new and pressing assessments before they could finish tasks they were already involved in. Tellingly

*“She also said that the senior practitioners in the Integrated Assessment Team ‘did not work together to support the system that was in place’”.*

7.2.14 The next opportunity for intervention by CSC came three months later when two of the boys were arrested following an attempt to steal goods from the storage premises of a local supermarket. Police noted that the boys were hungry and poorly dressed – they were given a shower and a change of clothes. Police were concerned for the children and CSC – via the Out of Hours (OOH) Service – were contacted. Police were told that there had been a recent assessment and no continuing concerns were known.

7.2.15 The OOH officer could only reflect what was in the family’s records. However when the information that they had been arrested was then routinely reported to CSC, and considered by the same Senior Practitioner who had recently been involved, she decided to take no further action. We should be mindful of the benefits of hindsight when evaluating that decision – from her viewpoint there had been what was judged to be a satisfactory recent assessment and an appropriate decision to close the case. But it is also right to say that some aspects of the encounter- particularly the boys’ presentation and the degree of concern felt by police, who were worried enough to contact OOH – should have led to further enquiries by CSC.

7.2.16 The most explicit indications of the nature and extent of the abuse of these children emerged first in January 2013.

*“the housing warden on the traveller site telephoned CSC to report that... there were lots of complaints from the residents. Concerns included: the children smelling of urine and left unsupervised: the children tried to cook food for themselves as they were hungry and set the cooker on fire in the caravan: Mr A was reported as looking disheveled and unwell and not coping. The children are hungry and are dirty: the caravan has holes in the floor and there is evidence of mice and cat faeces on the floor and there is no bedding on the beds”.*

7.2.17 On the same day a written report was received from the HV stating that, the IMR reports,

*“the children have no shoes and are dressed inappropriately for the weather, other residents are feeding the children, Mr A is refusing to come out of the caravan and is not engaging with mental health services, the van has no electricity and the toilet is unusable so the children are using the site to go to the toilet. The children are bored and are damaging the site. They are not being home educated and no one has gained access to their trailer. All*

*contact with the children is via the site office and the assessment visit completed a month previously was set up and perfectly presented to ensure that social workers went away satisfied that everything was ok”.*

7.2.18 These were reliable informants, particularly the HV because of her professional background and experience. The fact that the warden was reporting concerns raised by other residents was telling, given the closed nature of the community. There could hardly be a clearer indication of a need for an immediate response under child protection procedures to these reports. Yet no action was taken, that day or the following day. Two days after receiving the referrals a Senior Practitioner was asked to review the case and determine a course of action. She sent two social workers to the site. Police were also asked to attend and did so.

7.2.19 A group of residents of the site gathered around Family A’s caravan and some of them, particularly some male residents, became increasingly hostile towards the social workers. The caravan was, like the others on the site, in an enclosed compound behind fences and a locked gate. After negotiations it was agreed that the social workers could enter the compound – but only by climbing the fence, not through the gate. Residents did not want police to enter and the officers present agreed not to do so. Essentially the community members were demonstrating that they were “in charge” of the situation and there is a recurring theme of staff feeling intimidated and consequently ineffective.

7.2.20 The social workers, to their credit, did make their way into the caravan. *“It was chaotic and dirty... There was no bedding, no clothes and no toys... The walls were covered in faeces and urine”.*

There was no food until Mr A’s sisters also entered the caravan and put packets of food around, apparently so as to try to deceive the social workers. Some of the children were seen but the social workers could not determine which ones. The situation outside was becoming increasingly volatile, with residents threatening to start fires and, in any way they could, prevent the removal of the children – even though Mr A asked the social workers to take them into care.

7.2.21 One of the social workers asked a police officer to exercise powers of police protection to remove the children but the officer felt this was inappropriate. After “negotiations” with the family and telephoning managers for advice, it was agreed that the children should remain on the site in the care of Ms C and another resident.

7.2.22 Neither police nor CSC could be satisfied with their management of these events, and both agencies accept this. There was no planning for how they would approach what was clearly a complex and potentially dangerous situation. The social workers felt increasingly threatened but unsupported by the police officers in attendance. The “compromise” that was agreed was not in the best interests of the children and an opportunity to protect them was lost.

7.2.23 The following day CSC convened a meeting designated as a Strategy Meeting<sup>8</sup> under formal child protection arrangements. The upshot of this was a conclusion that all seven children remain in the care of Ms C (as well as her own two children). None of the children was seen or interviewed. The accommodation in which they were to live was not seen.

7.2.24 The basis for this arrangement was confused. Staff have advised that they felt the threshold for enforced removal of the children had been met but accepted that they should not be removed. Despite the overwhelming evidence of neglect, such that the threshold criteria for judging that the children were likely to be suffering “significant harm”<sup>9</sup> were clearly met, the children would no longer be dealt with under child protection arrangements (section 47, Children Act, 1989) but would instead be seen as falling into the much broader category of “children in need” (section 17, Children Act, 1989). All those at the Strategy Meeting agreed with this course of action.

7.2.25 The IMR closely analyses this turn of events and identifies a number of factors which were significant in the decision to move away from an immediate child protection approach. Ms C was described by some of those in attendance as co-operative (despite her involvement in attempts to deceive the officers the previous day). There was of course a reluctance to disturb arrangements under which the children could remain in the care of their family and community. There was an assumption that this would be what the children – none of whom had been interviewed – would want. However a number of other factors were in play.

7.2.26 It was appropriate to think about finding a solution that would retain the children within their cultural and family network, but this assumed inappropriate proportions:

*“Engagement with the community became the ...imperative rather than safeguarding the children”.*

This seems to have led to an untested assumption that Ms C would automatically be able to care for and protect the children.

7.2.27 There was confusion about the wishes of Mr A. He had repeated his request that the children come into care but this had effectively been set aside – in fact the person managing the meeting reports that she was unaware of this. No attempt was made to contact the children’s mother until after the decision to leave them with Ms C. Their mother then reported that she was not in agreement with that arrangement but her view was disregarded. It was not until over a month after these events that she agreed to the children being “in care”.

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<sup>8</sup> A formal meeting of agency representatives to consider concerns that a child may need to be protected

<sup>9</sup> “the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child” (working Together 2013)

7.2.28 No attempt was made to explore and take account of the long history of concerns in Norfolk. Similarly the undercurrent of concerns about sexual abuse was set aside. The judgment in the service's IMR is blunt *"The ... lack of curiosity and failure to respond to this critical information with more robust investigation demonstrated either naivety or negligence"*. Overall the situation was re-defined into a need to respond to a single father who was struggling to cope with a large number of children, perhaps because he himself was ill.

7.2.29 Even now it has not been possible to establish clearly the detail and the extent of any senior management involvement. Some managers interviewed reported that they were unable to remember the detail of events or to indicate why actions were taken. The Strategy Meeting was chaired by a Team Manager, when one would expect a more senior officer to become directly involved in such an unusually difficult situation. What should have been the principal focus of the meeting – how to move on from the temporary arrangements agreed the previous night and make arrangements for individual assessments of the children's wellbeing – became overtaken by *"a drive to find a solution and resolve this issue before fully considering all the relevant information"*.

7.2.30 There was a basic confusion about whether or not the children were "in care" at their parents' request. They were treated as such even though both parents had objected to the arrangements for them to live with Ms C. There was then a decision formally to assess Ms C as a foster-carer, on the basis that the children would be placed with her under Regulation 24 of the Care Planning, Placement and Case Review (England) Regulations 2010 – the statutory arrangement for children in care to live in an emergency with a family member or friend pending that person's assessment as a foster-carer. In sum, as the IMR reports *"The confusion about whether the children were accommodated and formally placed with Ms C... started a train of events which resulted in confusion, frustration and polarisation of views within CSC which led to delay and (errors in) subsequent decisions about planning and placement"*.

7.2.31 The next significant development was three days later, a Sunday, when Ms C contacted police to report the first disclosures by the children that their father had sexually abused them. Police attended the travellers' site and saw Ms C with five of the children. Mr A was elsewhere with the other two children. Police decided to transport Ms C and the five children to police premises and to place the five children under "police protection"<sup>10</sup>. One of the children confirmed the disclosure of sexual abuse of more than one child by the father. Police subsequently returned to the site, found the other two children and placed them also in police protection. One of them had

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<sup>10</sup> The police have powers under Section 46 of the Children Act 1989 to protect children. If a police constable believes that a child is at risk of suffering significant harm in a particular situation then he may exercise powers under this Act to remove the child to suitable accommodation and kept in police protection for more than 72 hours.

significant facial injuries which he said had been inflicted by his father. They also found Mr A who was arrested.

7.2.32 Exploratory interviews were conducted by police and confirmed that the children would need support and preparation before they could be formally interviewed under Achieving Best Evidence<sup>11</sup> (ABE) arrangements. These were planned for the following week and after discussions with the Out of Hours (OOH) service the children were returned to the care of Ms C. There was no dispute between the agencies in concluding that the children should stay with Ms C overnight – their father was now in custody and police also maintained a presence on the site overnight.

7.2.33 The report from CSC expresses some concerns at the extent to which their OOH service was consulted and involved by police, although, equally, police note that the OOH service did not initially attend and participate in the management of the situation. The police decision to terminate powers of police protection is discussed in section 7.4. Overall it should be acknowledged that this must have been a very challenging situation for all those involved in managing it. There are graphic descriptions in the IMRs of the extent to which the children were out of control, ravenously hungry and fearful that food would be taken from them.

7.2.34 After the weekend the management of the case by CSC became disorganised. A Strategy Meeting was held, chaired not by a middle-level or senior manager, despite the complexity of the situation, but by a senior practitioner – the fourth person in five days to chair a meeting about these children. That meeting focussed on the “new” disclosures of sexual abuse but failed to get a grip on the overall planning and management of the case. The IMR sums up:

*“There is not a logical flow from identified need, to plan, review of action and activity to outcome from one meeting to the next and each meeting deals with the presenting issue at the time”.*

7.2.35 The new facial injuries to one of the children were not followed up at all and, subsequently as new evidence of abuse of all the children increasingly emerged, no action under formal child protection arrangements was taken at any point. This position seems to have arisen from a mistaken view that there was no need for child protection planning as the children were “in care”.

7.2.36 Meanwhile the confusion about the legal status of the children continued and was in a sense compounded by legal advice that the children should be seen as being in “voluntary care” under section 20, Children Act 1989. Although that advice was essentially correct, as explained in section 8.3 below, the legal advisor did not know, and did not establish, that both parents at that time had refused consent to this arrangement.

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<sup>11</sup> Achieving Best Evidence in Criminal Proceedings - Guidance on interviewing victims and witnesses, and guidance on using special measures (MoJ 2011)

7.2.37 By now the responsibility for dealing with all aspects of this unusually complex and demanding case had been given to one social worker, who was largely left without adequate supervision or management direction. She was described by a colleague as *“anxious and lost”*.

7.2.38 The council’s fostering service was similarly confused by the part they were being asked to play in these events. There was a fundamental dilemma – not unusual in situations where family members may become foster-carers – as to whether the fostering assessment was almost expected to be a rubber-stamping of the situation that had developed, or whether, as should be the case, it was indeed a thorough assessment of Ms C’s ability and capacity to care for these children. Managers needed to identify that challenge and help staff to tackle it in the assessment process. There is no indication of any proactive management of the situation, while there is evidence of tension and strained relationships between the staff groups trying to work through it: *“staff groups operated in isolation and were often working at cross purposes again resulting in delay, poor assessments and flawed decision making”*.

7.2.39 The management of this difficult situation was to deteriorate further. Over the course of two weeks all the children made disclosures of extensive physical and sexual abuse and neglect by their father, with indications that their mother had been at times complicit, or aware of what was happening. Then, at an internal CSC meeting, it was decided by a service manager that the local authority should not seek to retain the children in care but should support a plan for Ms C to care for all of them under a Special Guardianship Order<sup>12</sup>.

7.2.40 This was an insupportable decision. As the IMR outlines *“The assessment of Ms C has not properly commenced, the legal status of the children is still confused and technically the local authority has no mandate to make this level of decision. No assessment of either parent with parental responsibility has been started”*.

This decision was led by an inexperienced manager who now accepts that it was wrong and poorly evidenced – it was a conclusion reached without even reading the case files. This manager recalls discussing the situation informally with her manager, who was also inexperienced – but he told this review that *“he had little knowledge or recollection of the case”*.

That also seems extraordinary – this was not an everyday set of circumstances. In any event it is clear that there was no formal process of recorded supervision of the managers involved.

7.2.41 Around this time arrangements were being made for an internal transfer of case responsibility from the social work team responsible for incoming work to the team responsible for longer term work. The “long term” team was concerned at the confused planning in the complex case they were being asked to take on and requested a formal legal planning meeting. This

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<sup>12</sup> Special Guardianship is a court order that places a child to live with someone permanently and gives legal status for non parents who wish to care for that child in a long term secure placement.

resulted in comprehensive written advice, endorsed by the Head of Children's Services, that the threshold has been met for applications for Interim Care Orders with a recommendation that all children should be removed from Ms C's care pending full and proper assessment. The children were not judged to be at immediate risk of significant harm so care proceedings were to be "issued on notice". The children were to remain with Ms C while the proposal for their planned removal from her care was put before the courts.

7.2.42 However, just a few days later, concerns emerged that there was ongoing sexual activity between some of the children in Ms C's care. This led to a swift change of plan, so that now all the children were to be moved to separate foster-placements. Not only was this a decision taken in haste, it was an unrealistic requirement of the fostering service to find seven separate placements for such damaged children, with a particular and unusual cultural background, some of whom might pose a risk to other children. In the service's accounts of events the disharmony between staff groups and individuals is clear. The IMR tells us that

*"During this phase key staff within CSC were not regularly brought together to share information and review progress and plan... This failure to communicate between the teams working with this complex case contributed to the feeling of frustration. A number of meetings were held to try and resolve issues but this was managed at too low a level largely between senior practitioners and did little to resolve the conflict. As a result of the internal disagreements there was unnecessary delay".*

Yet again the failure of senior managers to get involved and "get a grip" is clear.

7.2.43 There was a demonstrable improvement in the quality of work and the way it was managed once the children came into care and the case was managed by the "long term" team.

*"The children together and separately were part of a number of comprehensive assessment days ...observation and conversation with the children during this time significantly assisted in identifying individual needs. The process also supported decisions about placement choice and further intervention and therapeutic support, that each of the children will need for the foreseeable future".*

There is now evidence that, for the first time, the children's individual needs, their relationships with each other and their own wishes and views were taken into account.

7.2.44 It was eventually agreed that the 3 youngest children could remain together and the older 4 should be placed individually. For some of the children there was effectively no choice of placement and they went to carers who struggled to meet their needs. Two of them subsequently repeatedly absconded from care and returned to the traveller site. These circumstances were physically and emotionally draining for staff who were charged with repeatedly returning absconding young children,

7.2.45 Meanwhile delays were developing in the work needed to bring the care proceedings into court. All of the work on this case had been allocated to one temporary social worker. The tasks were formidable:

- The children were placed in various locations, as far from Southampton, and as far apart, as the Midlands and the West Country. All needed statutory visits and regular reviews.
- None of the children had education placements or plans and all had significant health issues which needed to be progressed.
- The children continued to disclose abuse so further ABE interviews were required.
- The views of their parents had to be ascertained though neither was local or easy to contact.
- Several staff had to be involved in arranging contact between the children because of the vulnerability and the demands of each individual child.
- Visits to Norfolk were necessary in order to review and rewrite the chronology

7.2.46 Perhaps unsurprisingly the officer charged with this work left at short notice. It is then to the credit of the staff who inherited the situation that they tackled it with determination. The resource issues created by such a demanding case were finally recognised. The IMR sets out the changes and the injection of resources that were needed to ensure the effective management of the case which

*“significantly improved when a permanent experienced social worker was allocated to the case (working) alongside a newly qualified social worker. Social services assistants were also used to support the volume and complexity of tasks that needed to be completed. The Senior Practitioner remained a constant feature ... and developed a good understanding of the case and was able to offer a regular and an adequate level of supervision. One consistent team manager had responsibility for the case once the case transferred”.*

7.2.47 The application for Care Orders was not resisted by either parent. The case was “issued” in mid July and completed, with full care orders being obtained in relation to all 7 children in 18 weeks, well below the Public Law Outline<sup>13</sup> expectations of 26 weeks.

7.2.48 There were aspects of this case that were hard to manage – the number of children, the requirement to see them and treat them as individuals, the need to take account of their heritage which was unfamiliar to most or all members of staff, the hostility of members of the community. But none of these were insurmountable problems had the council’s approach been led by experienced, consistent management. Instead, as discussed in section 8.2 below, senior managers effectively abrogated their responsibility and the management of the case was left to a series of staff who did not have the skills, experience or seniority to deal with it.

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<sup>13</sup> The judicial protocol governing care proceedings

### **7.3 Southampton City Council – Prevention and Inclusion**

7.3.1 This IMR considers the involvement with the family of a range of services with responsibility for children's education, all contained within a part of the council called "Prevention and Inclusion". For the sake of clarity this Overview Report generally refers to "Education services". The IMR also reviews in depth the issues of elective home education and the education of children from gypsy and traveller families. Those matters are discussed in section 8 of this report.

7.3.2 Education services in Southampton became aware of this family in August 2011. There were communications from Norfolk and with local health, housing and social care services. Those communications were at times confused and ill-informed. Norfolk provided details of only five children and it was not until July 2012 that a SCC Education Welfare Officer (EWO) finally registered the presence of Child 1 and clarified that there were seven children in the family (and one of them subsequently "slipped off the radar" for a period after the arrest of Mr A). Importantly, Norfolk did not provide appropriate information about the children subject to statutory statements of SEN.

7.3.3 There was also confusion about the children's educational history. Norfolk had given the name of a primary school attended by some of the children but the Health Visitor accepted, and relayed to other services, an account from the family of the children having always been home educated. There were delays and inefficiencies in recording information so that when education staff first contacted the family those officers were not aware of all the information from Norfolk. Education officers visited the family, accepted that the children had been and would continue to be home educated, and documented that. They established that Mr A was illiterate but felt that this did not prevent him from educating the children at home.

7.3.4 The Education staff who had that initial contact with the family were a senior EWO and a senior officer with responsibility for vulnerable pupils. By the time of their visit there were clear indications in the local systems that some of these children had statements of Special Educational Needs. The Southampton GP had been told that in a copy letter from Community Health Services in Norfolk. Internal correspondence within Education services, some 4 weeks prior to the visit, referred to the possibility that some of the children had "SEN". One of the visiting officers was told directly by housing staff that some of the children had "special educational needs" but this was not explored further. Similarly this officer had been told that Mr A had a history of mental ill health but this also was not explored. The visiting officers appear to have viewed their visit as an administrative exercise, to complete the necessary paperwork relating to home education.

7.3.5 Given the specialist nature of these officers' responsibilities it is disappointing that these matters were not explored more thoroughly. The principal purpose of their visit may have been administrative but that did not mean that actions arising from the visit had to remain purely administrative.

They may not have been fully informed but they had enough information to recognise that the welfare of the children required some local follow-up. It is even more disappointing that one of the officers, reflecting on this for the purposes of this review, said that

*“given the purpose of the visit, to clarify Mr A’s intentions regarding his children’s education, (even if they had full information about the background) this would not have altered her approach to this visit or triggered further investigation”.*

This raises the issue, discussed further below, of whether professionals had low expectations of travelling families or approached their responsibilities in a different way with this group.

7.3.6 After this visit there was no action by Education officers for nearly a year. The next contact with the family was to establish the arrangements proposed for the education of Child 7, who had been below school age at the time of the previous contact. A visit was made by an Education Welfare Assistant and a social worker linked to the Education Welfare Service. They established that Child 7 was also to be home educated but were concerned by the family’s presentation. Concerns were also raised with them by a resident who told them

*“if you saw the babies it would make you cry”.*

7.3.7 The social worker made this referral to her colleagues in CSC.

*“All seven children were seen at the caravan site, they all smelled dirty and looked unkempt. (We) were not allowed inside the van, but when the van was opened it looked filthy and smelled damp and dirty...one of the other mums (said)... dad was leaving them alone in the caravan, the children are always hungry and dirty.... dad was a previous drug user and is on a methadone script”.*

(There is no evidence that Mr A was taking prescribed methadone – this seems to be a mistaken belief that developed perhaps from comments he himself had made).

7.3.8 The slow and weak response to this from CSC, leading to a decision to take no further action, has been outlined above. However Education services also took no further action on the basis that they did not

*“have a legal duty to do so, unless we are given evidence that the children are not being suitably educated”.*

As the IMR points out there was already cause for concern that the children might not be “suitably educated”, if only on the basis that the person taking responsibility for their education was himself illiterate. The IMR argues convincingly that the Education service was too ready to withdraw from the situation when there were growing concerns about the suitability of the children’s educational provision. Even though its powers are limited and Mr A was unlikely to co-operate, the Education service could have attempted to do more and would have had the legal authority to make such attempts.

7.3.9 The fact that some of the children had Statements of Special Educational Need began to re-emerge in January 2013, after the children had moved to live with their aunt. Despite repeated requests there was delay in

receiving documentation from Norfolk and it was not till the end of February that officers in Southampton had copies of all the statements and annual reviews. However, as circumstances changed and various plans were made and re-made, the issue of meeting the special needs of the children with statements lost priority and became secondary to educating all the children together. The upshot was *“a three month delay between the time that the (fact that they had) statements became known and the beginning of any process to identify any of their individual needs”*.

7.3.10 The IMR paints a picture of the incoherent approach to planning for the children’s education, referring to a

*“protracted discussion underpinned by*

- *lack of agreement or understanding about the children’s legal/care status.*
- *the children’s education status, that is whether Mr A’s choice of elective home education was still valid as Mr A was in custody.*
- *consequently, who could sign an application for admission to school.*
- *the usefulness or otherwise of making an application for a school attendance order.*
- *lack of knowledge about the parents’ wishes regarding home education versus attendance at school after the children went to live with Ms C*
- *some misunderstanding or disagreement between the Prevention and Inclusion Service and the Safeguarding Service about what is considered to be permissible and acceptable educational provision”*.

7.3.11 This was a complex situation but the various issues with which staff were struggling could and should have been resolved. Instead, throughout the time the children lived with their aunt, and beyond then for some of them, no educational provision was made. The issue of parental responsibility was allowed to take on an inappropriate priority. There was confusion about who had and did not have parental responsibility and a lack of drive by staff to liaise effectively with those who did have parental responsibility. It was also mistakenly believed – and this belief was based in part on inaccurate legal advice - that a child could only be enrolled in a school by someone with parental responsibility for that child.

7.3.12 There was also confusion and disunity between social care and education staff. There is evidence of resistance by social care staff to the idea that the children might be educated outside the family. This seems to have been largely a consequence of a wish, as the IMR puts it, to *“preserve the relationship with the community”*.

At the same time the IMR judges that education staff were too ready to accept that priority had to be given to issues related to resolving the children’s care status and developing an appropriate response to the growing evidence of abuse.

7.3.13 The confusion and lack of impetus persisted after the children left the care of Ms C. Initially, as the IMR notes, this was

*“understandable in the context of a situation that was changing from day to day”.*

Not only was the situation changing, but it was complex and demanding. Placements were being made in various locations for various combinations of children and inevitably those arrangements did not all progress smoothly. However there is evidence of a continuing lack of emphasis on ensuring the appropriate education of the children. Despite even the statements of SEN they were largely treated as a homogeneous group. Months after their admission to care no Personal Education Plans<sup>14</sup> (PEP) had been developed for any of the children. This was principally the responsibility of their social workers but as the IMR tells us

*“A joint approach to the development of the PEP by the Virtual School<sup>15</sup> and the (social workers), driven by the Virtual School, may have delivered an integrated assessment between the two professional groups at an earlier stage”.*

7.3.14 The IMR expresses a continuing concern about Virtual School arrangements in Southampton. That applies not only to this case where *“there is no evidence of the Virtual School driving plans for the children in any systematic, recorded or formal way”.*

The current staffing establishment in Southampton for the Virtual School is 3.6 posts but the allocation for the Head of the Virtual School is only 0.3 of a full-time post. There must be a concern as to whether that provision can deliver adequate leadership when the City Council is looking after, at time of writing, over two hundred school age children.

7.3.15 Many of the multiple problems identified in this IMR have their roots in administrative and information systems which are outdated and not fit for purpose. It is not necessary to explain that here in the detail given in the IMR but that report makes a convincing case that arrangements for case recording, including the recording of management decisions, are inefficient and inappropriate, and that key information was not adequately shared as a result of flaws in systems. For example

*“the relevant case notes, emails, meeting reports and minutes are located in at least five different places and few staff have access to all the recorded information for reasons of confidentiality”.*

The IMR contains appropriate recommendations to address these problems.

7.3.16 However the most fundamental weaknesses here are not administrative. The issue of home education was significant and is discussed below. But more important is the failure of the council’s two principal services to children, education and social care, to work well together. That failure can be seen in individual staff attitudes but also in a failure of leadership:

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<sup>14</sup> All children in care must have a Personal Education Plan which is reviewed regularly in conjunction with their Looked After Child review. The PEP forms part of their care plan.

<sup>15</sup> The Virtual School is a widely used organisational tool to enable effective coordination of educational services for Looked After Children, at a strategic and operational level. The school does not exist in real terms as a building, and children do not attend; they remain the responsibility of the school at which they are enrolled.

*“The lack of close joint working allowed incorrect perceptions of why each service was acting as it did to remain uncorrected”.*

As is repeatedly evidenced in this review there is a notable absence of consistent senior management input from the local authority into this very challenging case.

## **7.4 Hampshire Constabulary**

7.4.1 Police had relatively little involvement with this family before the events leading to the admission of the children to care. In July 2012 an officer on patrol noticed that Child 2 was not in school and had a bump on his head but was satisfied with the explanations provided by the child and his father.

7.4.2 In December of that year police detained Child 1 and Child 3 after they were involved in breaking into commercial premises and stealing stock. Police were concerned at the presentation of the boys – they were *“unwashed, wearing wet and dirty clothing and appeared to be underweight for their age”*.

Concerns were heightened when their father attended the police station and *“the presentation of Child 1 changed significantly. He became withdrawn and refused to speak or engage with the officer”*.

7.4.3 Police were also worried that Mr A appeared unconcerned about the boys. They liaised with CSC and were advised that there had been recent social work involvement, and that the family could be referred back to CSC by police, but no urgent action was necessary unless the boys made new disclosures. No such disclosures were made and the criminal investigation was concluded appropriately.

7.4.4 In the course of the investigation other police officers attended the site and searched the caravan. Those officers did not raise concerns at the time, and did not make full records of the search. However, when questioned for this review, one recalled that there were dog faeces in the home, which was described as “grubby”. This was about a month before the investigation which found the home to be unfit for habitation.

7.4.5 The failure of the officers to report any concerns suggests that an inappropriately high threshold was being used. That is, they may have been over-tolerant of matters that should have caused concern – or, to put it another way, they had low expectations of the care these children would be receiving. This was discussed by the Panel and it was acknowledged that there are organisational practices and pressures, in all services, which can lead to a “tunnel vision” approach to a task. Here the task was to carry out a search for evidence of a crime of theft, not evidence of children being abused and neglected.

7.4.6 In any event the information about the condition of the home was not reported back to the officers who had been concerned by Mr A’s presentation and the indications of neglectful care of the children. With hindsight this can

be seen to be a significant missed opportunity to trigger investigations that should have led to the earlier protection of these children.

7.4.7 The IMR comments that

*“The response of the frontline officers carrying out the search... is below the standard expected by Hampshire Constabulary in relation to both identifying and responding to indicators of neglect and also their wider safeguarding responsibilities”.*

This leads to appropriate recommendations in the police IMR.

7.4.8 The first substantial police intervention was their involvement in the difficult events which led to the children moving to the care of their aunt. The IMR analyses the police involvement in those events and identifies a number of ways in which their intervention could have been better prepared and more effective.

7.4.9 Police had received something of a mixed message from CSC, asking that police deal as a matter of urgency with a referral they, CSC, had received two days previously. Nonetheless there were a number of significant risk factors, identified in the IMR, which were known to or could be anticipated by police:

- *Due to the (nature of the) concerns...there was the potential for the children to be taken into Police Protection.*
- *Access to the plot inhabited by the family was likely to be restricted/prevented due to the caravan being surrounded by fencing with padlocked gates.*
- *The nature of the visit to the site could have resulted in tensions between the travelling community and professionals on site.*
- *Mr A had not been engaging with professionals thus far and was therefore unlikely to engage with the police officer and CSC staff attending the site.*

7.4.10 The police response was led by a sergeant who recognised the potential difficulties in the situation but did not draw up a clear strategy to tackle them. This officer had not been trained in the use of the police “National Decision Model” (NDM)<sup>16</sup>, a tool developed to plan and manage a range of operations and incidents. (All Hampshire officers are now trained in the use of this approach).

7.4.11 Had the NDM been followed this would have been recognised as a complex and challenging situation. More senior officers should have been alerted initially and the IMR judges that in fact this would have led to police managing the situation as a “Critical Incident”.  
*“Involving the Critical Incident Cadre (CIC) would have resulted in a further level of management oversight at Chief Inspector level considering potential outcomes, resourcing requirements, including the need for any specialist resources. This would also have ensured the input and oversight of senior*

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<sup>16</sup> [Police NDM.pdf](#)

*management at the appropriate level of seniority both on site and away from the scene”.*

7.4.12 The police IMR does not identify the same level of disharmony between social workers and police officers as is described in section 7.2 above. However both agencies approached a potentially difficult and dangerous situation without adequate planning, management or back-up.

7.4.13 The weaknesses in the police response to these events are contrasted with the police operation a few days later, after disclosures of sexual abuse were first made. This was perhaps potentially an even more challenging situation, given the nature of the allegations and the fact that Ms C, having taken the initiative to contact police, was concerned about how her community would react. Mr A was away from the site and had two of the children with him. On this occasion the police response was significantly better planned and implemented.

7.4.14 That response was *“co-ordinated by the CIC and involved a thorough, formal threat assessment being undertaken utilising the NDM. The response resulted in a number of resources including officers from the Child Abuse Investigation Team, the Safer Neighbourhood Team, the Targeted Patrol Team, the Force Support Unit (officers trained and equipped to deal with volatile situations) and also an Armed Response Vehicle attending the site. The level of planning, co-ordination and supervision assisted in the safe removal of all the children from the site into the care of the police and the later arrest of Mr A with no community tensions arising and no barriers to the course of action that was required”.*

7.4.15 The agencies might have co-operated more effectively in the immediate aftermath of these events. On the Monday police decided to discontinue the powers of police protection of the children. This was done without reference to CSC and shortly before the agencies were to meet formally under child protection arrangements. There seems no good reason for this – having taken the decision to use these powers it would have been appropriate, and made no practical difference to anyone, for them to remain in place until the agencies sat down together to agree next steps.

7.4.16 In fact both police and CSC convened separate meetings with effectively the same aims - to review events and make forward plans. The police meeting was a “Silver Strategy” meeting, part of the police arrangements for following up major incidents. CSC’s meeting was a “Strategy Meeting” under child protection procedures. There was no real reason why these meetings could not have been combined. The fact that they were not is compounded by a police failure to invite CSC to “their” meeting although police were invited to attend the CSC Strategy Meeting (and did so). The agencies need to review their working arrangements in the wake of major operations like this and there is consequently a recommendation from this report.

7.4.17 After the children left the care of their father police involvement was principally related to the prosecution of Mr A - a complex investigation involving a large number of charges being brought and, in turn, a significant custodial sentence. The IMR notes that the effectiveness of this investigation, resulting in an early guilty plea by Mr A, also served to assist in the swift progression of the care proceedings in respect of the children.

## **7.5 Southampton City Council Housing Services**

7.5.1 Housing services in Southampton were approached by Mr A in May 2011. He and the children were said to have moved already to stay with his brother and his family on a travellers' site. They applied to live on the site and, in early June, after housing officers had spoken to the family's landlords in Norfolk, were offered accommodation. The site was owned and managed by the local authority. The accommodation – a two-bedroomed "unit" was rented to the family by a private company, not an unusual arrangement. The IMR provides a helpful description:

*"The site consists of 14 plots of land which are rented to gypsy and traveller families on a long term basis. Currently there are 24 children under 16 years of age on the site ... On each plot there is small outbuilding which contains a kitchen and a bathroom which are owned by Housing. There is also a bungalow on site which is used as a staff office and for interviewing residents. Support services for residents (such as Surestart and Forest Bus) use the building as a meeting point".*

7.5.2 The extensive physical and sexual abuse of these children should not lead us to overlook the extent to which they were also neglected. Part of that neglect was that they lived in cold, dirty, overcrowded and increasingly squalid conditions. The first "unit" that they lived in, for over a year - a two bedroomed home occupied by a father and seven children - was, by the time they left it, judged by staff to be "*disgusting*" with part of a wall missing and extensive damp and mould throughout. They moved to a larger caravan in the summer of 2012 and, by the end of that year, when social workers finally gained access to the home, it was, as described in Paragraph 7.2.20, uninhabitable.

7.5.3 The extent to which the children were unsupervised and neglected, certainly as 2012 drew on, is well evidenced. It is hard to accept that such a situation would go unrecognised and / or unreported if these children did not live on a travellers' site, physically and culturally separate from other local communities.

7.5.4 The IMR identifies seven members of staff who at various times during the period under review had responsibilities which took them on to the site. It is clear that there was to some extent an identification of this family as different to other residents – one member of staff went so far as to describe the children as "*feral*". Yet, other members of the staff group, interviewed for this review, have suggested that there was no obvious cause for concern. It is difficult to reconcile those reports with the weight of evidence of neglect of these children.

7.5.5 Some staff to some extent may not have recognised the seriousness of the situation but there were other significant factors. Certainly there is evidence that staff had developed unacceptably low expectations of the care these children were going to receive. It is notable that more than one member of staff contacted police in December 2012 after receiving reports that some of the children might be involved in (low level) criminal activity - yet the more evident continuing neglect of the children went unreported. Staff may also have been apprehensive about the possible consequences of raising concerns – threats to their own safety and welfare as well as the potential for disruption within the travellers' community.

7.5.6 This was a difficult situation and that difficulty was compounded by issues within the staff team. There were a number of troubled relationships between members of staff, which prevented them from working together effectively. This certainly contributed to the way in which concerns did not get aired and shared as widely as should have been the case.

7.5.7 Reports of anti-social behaviour by the children were dealt with by a site warden but were not recorded and shared with the responsible housing officer, as they should have been – perhaps partly through carelessness but also, it seems, because communications within sections of the staff team were not good. There is evidence of cause for concern for the children soon after they moved to the site. Reports were received (from people walking dogs nearby) of children – believed to be these children – being seen defecating around the site. A warden with day to day responsibility for the site spoke to their father and aunt about this and they agreed to prevent any recurrence. That warden also received reports of the children shoplifting, and again spoke to the family. She reported this to her immediate manager but not to the housing officer, who should have been told. The IMR reports that *“the reason she did not share this information with the housing officer is to do with trust - what they would do with the information and how this might affect her safety on the site and her relationship with the site residents”*.

7.5.8 More crucially, a member of staff was told, in September 2012, by female members of the community that they feared that Mr A was sexually abusing children of the family. They did not say that in those explicit terms but it is clear that this was the nature of their concern. That member of staff discussed this with one colleague, and made a referral to CSC, but felt she had to conceal the reports from other colleagues, because she could not rely on them. The IMR describes how she *“could not trust her colleagues (particularly certain individuals) to keep this information confidential (because they) ... had a reputation for being indiscreet and unprofessional and ...had previously disclosed information to residents on the site”*.

7.5.9 One of those colleagues who did not have the confidence of the officer making the safeguarding referral was the person responsible for entering the details and nature of the referral on computerised records. This was consequently not done, so that this very important information was not recorded. In fact the responsible senior housing officer only became aware

when interviewed for this review that this member of Housing staff had made that referral.

7.5.10 It is not unusual that there are tensions between colleagues and that may be even more understandable in the working environment of a travellers' site, a closed and marginalised community. But in this case those tensions were allowed to impede the sharing of key information. The poor relationships between colleagues limited the opportunities for them to share and discuss the growing anxieties they must have had for the welfare of these children.

7.5.11 It seems that the inter-personal difficulties in the staff group were widely recognised but not addressed by managers. This degree of dysfunction will inevitably have contributed to the way in which the emerging concerns for the children were not adequately identified and addressed. The Housing service has recognised the need to address this problem and made a number of changes to staffing arrangements.

7.5.12 It is also right to recognise that it was the persistence of one member of staff – who made repeated referrals to CSC - which eventually brought this situation to a head and led to the protection of the children.

## **7.6 Solent NHS Trust**

7.6.1 This Trust was responsible for the provision of health visiting, speech therapy and school nursing services for the family from the time they arrived in Southampton. At that time only Child 7 was young enough to fall within the remit of the health visiting service. The HV responded swiftly and proactively, despite a relatively high workload in comparison to other localities, when informed of the family's arrival in the area. The background was explored with agencies in the previous locality and the HV initiated liaison with other Southampton agencies including adult mental health services. All this was done before the health visiting notes from Norfolk were received, some five weeks after the HV's first contact with the family. The HV remained actively involved throughout the period under review and made one of the referrals to CSC which brought matters to a head and led to the removal of the children.

7.6.2 The HV contacted Norfolk CSC on the day that she became aware of and saw the family – a very quick response. However the IMR does note a lack of structure in the HV's approach – the causes for concern were identified but there was no clear analysis of them or plan to address them. There was no liaison with the family's GP at that stage<sup>17</sup>, and equally no contact from the GP. The initial contact with CSC was unsatisfactory in that the HV did not challenge the inappropriate suggestion from CSC that she conduct a CAF. There were multiple indicators that

- the situation was far too complex for a response at that level, and

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<sup>17</sup> The HV advised in interview for this SCR that she had subsequently spoken to the GP on two occasions, which she did not document, about Mr A's mental health and was reassured that this was being managed satisfactorily

- it was unlikely that the continuing co-operation of Mr A could be relied upon.

The HV told the social worker that she judged a CAF to be inappropriate but the issue was then left undetermined, so that the social workers may have felt the HV would follow up and re-refer as necessary.

7.6.3 The HV did not escalate her concerns to more senior managers. It is a frequent finding in SCRs that professionals are too ready to accept an unsatisfactory response from another agency. There are a number of pressures that may explain this – professionals may feel unsure of their own judgment or may think that another agency's view is "more important". However all workers should feel able to challenge decision making and should see this as both a right and a responsibility, in order to promote the most effective safeguarding of children.

7.6.4 The speech therapy service was also aware of the family because of a referral from their Norfolk counterparts in relation to Child 2. The service offered an appointment to Child 2 but this was declined by Mr A. The service accepted this and, after discussion with the Health Visitor, took no further action even though the referral from Norfolk was comprehensive and pointed up the concerns that the children were being neglected.

7.6.5 Nationally the Royal College of Speech and Language Therapists<sup>18</sup> has commented on links between communication and safeguarding. Very young mistreated children often have speech and language delays and unusual interaction, which can be associated with the way that they have developed attachments with their parents. Children with communication difficulties may be unable to report abuse. The extent to which communication skills are developed can indicate how well children are coping with stress and unhappiness.

7.6.6 The IMR is clear that

*"The information already available to both the health visitor and the speech therapist could have alerted them to considering or suspecting neglect as identified in (formal guidance)".*

That judgment may benefit from hindsight but the important role that can be played by speech and language therapists both in detecting abuse and in assisting abused children, may often not be given adequate consideration.

7.6.7 At the time the family arrived in Southampton the school nursing service was commissioned to provide a service to children who were home educated or missing education, as would be available to children attending a state school. However none of the agencies with knowledge of the children made a referral to the school nursing service until the children were in local authority care in 2013. It is particularly disappointing that the Education officers with substantial experience of home education took a narrow approach to their responsibilities and did not think to make such a referral.

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<sup>18</sup> <http://www.rcslt.org/>

7.6.8 There was also a problem within the school nursing service. It is documented in November 2011 that Child 4's school nursing notes from Norfolk were sent by Southampton Child Health services to the school nurse team for home educated children but the specialist school nurse did not get to see them and it appears that they were simply filed without being assessed or screened in any way. Similarly the school nursing notes for Child 3 and Child 5 were received in Southampton in April 2012 but were treated in the same way.

7.6.9 Mr A may well have refused input from the school nursing service but we cannot know that. In any case, even if he had refused contact this would have

*“allowed for another professional to be aware of the children’s situation and history and allow for further consideration around father’s non engagement with health services and inability to prioritise his children’s health and development needs”.*

7.6.10 The NHS electronic patient records system, Rio, was being introduced when the family first arrived in Southampton and this may have contributed to the way in which the incoming records were managed. Throughout this case there are also numerous examples of information relevant to all the children being recorded only on records for some of them. Recent service audits, unconnected to this case, indicate that there are continuing problems with some aspects of the use of Rio and this is being explored further.

7.6.11 The problems around record keeping are not restricted to the introduction of Rio. The IMR author comments:

*“Throughout this review the author has identified frequent inaccuracies and inconsistencies in record keeping for all of the children”.*

One might expect some issues to arise in respect of such a large family but, as this comment indicates, the review has identified a weakness which may be systemic and needs to be resolved. This is addressed by an appropriate recommendation in the IMR.

7.6.12 The HV had some sporadic further contact with the family during 2012 as she had a general responsibility for families on the site. During visits to the site she saw the children and their father on a number of occasions and tried to engage them in accessing general health services. She noted some health and development issues and on one occasion saw Child 5 with facial bruising. She questioned the child who offered an explanation of this being accidentally caused. There was nothing further in the child's immediate presentation to cause concern, and it was appropriate that no further action was taken.

7.6.13 Health visiting and school nursing services were both involved in the multi-agency responses to emerging concerns from late 2012 but there are recurring examples of failures to share information across health services – the HV was not informed of dental appointments not kept, there was no liaison between HV and GP. A student HV was able to carry out the first height and weight assessments but, although the children were all on lower weight

percentiles – which was not necessarily a cause for concern – this was not analysed further.

7.6.14 In January 2013 the Health Visitor became aware of the mounting concerns on the travellers' site. She tried to see the children herself, but was denied access, and then acted swiftly in referring this situation back to CSC. She was persistent in challenging the CSC response that there had been a recent Core Assessment, on the basis of which CSC had terminated their involvement. Her persistence contributed to the multi-agency intervention which led to the separation of the children from their father. In the subsequent months she also continued to follow up and support the family even after all the children reached the age when a health visiting service was no longer necessary.

7.6.15 The school nursing service became formally involved with the family in early 2013, after the nature and extent of the abuse of the children began to emerge. That involvement was not substantial, partly because the children never did start attending school in Southampton. The IMR explains some of the challenges to a school nursing service seeking to work with children outside a school setting:

*“ (School nursing usually involves)...working with school age children in the school environment. This offers an opportunity for these children to talk confidentially about themselves and their health and wellbeing...*

*It is important that the practitioners are supported to build confidence and skills to use available assessment tools when children are seen in more complex environments and when parents/ guardians are present”.*

Those comments will be relevant as the service continues to work with children who – unlike these children – really are being educated at home.

## **7.7 The NHS Wessex Area Team – General practitioners and community dental services**

7.7.1 All the children and their father were registered with the same GP practice in Southampton. While in Southampton none of the children were brought for immunisations in accordance with the schedule. They were not taken to specialist appointments (four of the children were referred by the HV to ophthalmology). Head lice and threadworm treatment was requested on a number of occasions. A number of the children had speech and language delay and we know that Child 4 had been diagnosed with ADHD and significantly delayed language. During the review period only 3 of the children were seen in the surgery and treated for minor ailments.

7.7.2 Mr A was seen by the GP soon after moving to Southampton and disclosed a history of psychosis. He complained of sleep disturbance with low mood. The following summer he told the GP that he had disturbed sleep because of night time agitation, intrusive thoughts and hearing voices. He also reported a significant history of mental ill health in his close family. He was prescribed anti-psychotic medication and medication for anxiety. However no mental health assessment was carried out, nor were the home circumstances explored. There is no acknowledgement that he was a single parent with 7

children. The overall situation should have triggered concern for the welfare of the children but this did not happen.

7.7.3 In sum Mr A's history and presentation might be expected to have aroused some concerns for his ability to care for his children. There were also some evident causes for concern in the information known to the GPs about the children and their minimal contact with health services in the Southampton area. The IMR comments directly that

*"There is no evidence that needs of any of the children, other than those for immediate medical care, were considered or assessed (by the GPs) at any point in the review period".*

A number of important systemic issues are identified to explain how the GPs did not respond to the indications of at least the neglect of these children if not the nature and extent of the accompanying abuse.

7.7.4 The IMR explains the arrangements for the transfer of information when children and families move between areas and GP practices. When the "receiving" doctors are sent the paper notes, they should summarise all significant events onto computerised records, usually within eight weeks of receipt. This is done with a standardised system of recording clinical information (READ codes), including a uniform set of READ codes relating to safeguarding and child protection. These arrangements have been mandatory since 1999.

7.7.5 The IMR found no evidence that the children's records had been reviewed and updated with reference to READ codes when they moved to Southampton. The fact that they were behind in their immunisations was picked up and letters sent but, otherwise -

*"There were no risks or vulnerabilities recorded in the children's notes to identify the children / family had previously been of concern in another area, that Children's Services had been involved and that father had significant mental health issues - all of which should have triggered a more proactive and coordinated engagement with the family and involvement of the wider primary care team".*

7.7.6 The causes for concern for Mr A to which the GPs might have responded were not all historic:

*"Mr A was seen and treated for psychotic illness during the review period but this diagnosis does not appear to have triggered any consideration of his parenting capacity or the potential risks to the children posed by his mental health issues".*

Nor were the mental health issues themselves actively pursued. Mr A was first seen by the GPs soon after moving to Southampton, and disclosed a history of mental illness. This was not adequately recorded with reference to READ codes so that the GPs were not prompted, as they should have been, to carry out an annual review:

*"significant mental health issues had not been acknowledged by the assignment of the appropriate READ code and as such had not included him in the mental health register and therefore, would not have prompted reminders for regular reviews".*

7.7.7 In fact Mr A was reviewed when seen by GPs in July and August 2012 but that review again appears to have taken no account of the position of his children. This is despite the fact that he had approached the GPs because he felt there had been a significant deterioration in his condition, and disclosed a significant history of child abuse in his own family.

7.7.8 Child 4 was the child of the family for whom there might have been greatest concern in his own right – he had a diagnosis of ADHD (as well as special educational needs) for which he should have been reviewed and considered for medication. These matters were not READ coded and were not followed up – this child was never seen by the GPs while living in Southampton. This cannot be entirely ascribed to the way READ codes were used – a consultant Community Paediatrician in Norfolk had specifically written to notify the GPs of his condition.

7.7.9 It is right to acknowledge that, equally, no other agency ever formally approached the GPs about the children before the evidence of abuse began to emerge. Nonetheless, for the GPs themselves,  
*“Opportunities to identify this family as vulnerable and the children as potentially at risk were missed”.*

7.7.10 The IMR comments on the major changes in the NHS around the development of “clinical commissioning”, aiming to deliver more focussed and flexible services. However the IMR author judges that  
*“GPs have uniformly struggled with the increase in responsibility and accountability this brings and most have failed to respond in the way they deliver service provision. Currently there appears to be a lack of understanding of the fundamental principles of holistic integrated multi-disciplinary care and a reluctance to move from the existing model of Primary Care... This, with the lack of robust accountability and performance managing, means we are increasingly in danger of failing to identify individual needs and risks”.*

7.7.11 That may not be a view to which all GPs would subscribe but there seems to be no specific explanation in this case for weaknesses in administration and alertness to child protection concerns, other than a lack of thoroughness and professional curiosity. This is despite the fact that there has been a significant local investment in promoting the profile of children’s safeguarding among GPs, and in providing practical assistance to support that.

7.7.12 These GPs dealt with many travelling families. The extent to which the deficiencies may also be linked to the fact that this was a travelling family – and that alertness to social concerns might be correspondingly weakened – is discussed below.

7.7.13 Six of the children (not Child 1) attended the “Toothbus<sup>19</sup>” for assessment in August 2012. All except Child 7 had established caries (the worse the older the child, indicating a cumulative process), missing teeth and were judged to be at high risk of significant disease. The IMR notes that *“Recognising dental neglect is important because, in many cases, it is associated with general neglect”*.

7.7.14 However the likelihood of the children suffering general neglect was not considered. Department of Health guidance<sup>20</sup> is that when dental neglect is found and is accompanied by signs of general neglect a referral should be made to Children’s Services. In fact this rarely happens and it is unusual that there is a referral or sharing of information about anything which is not of an immediately dental nature.

*“There is still a widespread belief that safeguarding is not a “dental problem” and the link with neglect and poor attendance is considered to be one of poor education rather than abuse”*.

## **7.8 Southern Health NHS Foundation Trust**

7.8.1 The report from this organisation (SHFT) deals with Mr A’s contact with mental health services in Southampton. They were aware of Mr A because their Early Intervention in Psychosis (EIP)<sup>21</sup> service received a transfer request from their counterparts in Norfolk soon after the family moved to Southampton. They made a number of attempts to establish contact with Mr A and eventually succeeded in talking to his sister, Ms F. She reported that Mr A was well and compliant with medication. She would monitor his situation and contact the team if she had any concerns.

7.8.2 It was by this time August, and the three year EIP period would expire in October. The EIP Team therefore decided to terminate their involvement. All relevant partner agencies were informed of this. They did refer the case to colleagues in the Community Mental Health Team, who invited (by letter) Mr A to make contact with them but he did not respond.

7.8.3 The initial transfer request from Norfolk did not include key information about Mr A, particularly that he had left his wife and was living alone with seven children, and that information was not disclosed by Ms F when she reassured the service about the situation. The IMR is confident that, had they known this, the service would have taken it into account in determining how to respond to the referral from Norfolk. As a result of this SHFT have amended their referral arrangements so that there is a routine enquiry about family details. In fact their response was in any case comprehensive and persistent,

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<sup>19</sup> The Toothbus is mentioned here because, though it is not a service provided by the General Practitioners, it was commissioned, like the GP service, by the NHS Wessex Area Team

<sup>20</sup> Managing Dental Neglect Child. Protection and the Dental Team. <http://www.cpd.org.uk>

<sup>21</sup> This is a national programme in which Early Intervention in Psychosis teams work with people in the first three years after the development of symptoms which may indicate psychosis.

and established that Mr A did not want contact and his family were expressing no concerns about the situation.

7.8.4 When Mr A was first in custody in January police had concerns about his mental health and asked SHFT to take part in a formal assessment of his condition. An Approved Mental Health Professional<sup>22</sup> (AMHP) became involved, as required under mental health legislation. The IMR describes a very thorough assessment process which concluded that there was no indication of mental illness that should lead to detention under the Mental Health Act. The AMHP liaised well with all other services, including CSC. No issues arise from this contact.

7.8.5 This report also advises that after Mr A's imprisonment *"there was a Multidisciplinary Community Mental Health Team meeting ... to discuss Mr A's referral, but it was considered with all information received there was no indication of serious mental illness and therefore the referral was not accepted"*.

7.8.6 In so far as this agency was involved at all their interventions were thorough and no major issues arise from them.

## **7.9 Southampton City Council - Legal Services**

7.9.1 Legal Services (LS) were first involved in these events after the disclosures of sexual abuse emerged, and CSC began to make plans to secure the children's future. The plans originally proposed by CSC were principally driven by an intention to keep the children together in the care of their aunt, Ms C, who was being treated as a "family and friends foster-carer"<sup>23</sup>. This is discussed further below.

7.9.2 The IMR demonstrates that from the outset LS officers were unhappy with the proposed arrangements and gave advice that there was a clear basis on which to seek to bring the children into the care of the local authority through the courts. This was the recommended course of action although CSC, as the "client", had to make the decision as to how to proceed. Yet it was more than six weeks after leaving the care of their father before the Head of Service in CSC instructed social work staff to commence legal proceedings, to seek Care Orders on all the children.

7.9.3 It was then not until mid-July that LS received adequate instructions. As we know, the matter did then proceed very speedily and the full Care Orders were granted within three months.

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<sup>22</sup> In 2007 the Mental Health Act 1983 was amended to abolish the role of "Approved Social Worker" and replace this by the establishment of the AMHW, who would have a professional background in mental health services but need not have a social work qualification.

<sup>23</sup> A "family and friends carer" means a relative, friend or other person with a prior connection with somebody else's child who is caring for that child full time. A child who is cared for by a family and friends carer may or may not be "looked after" by the local authority.

7.9.4 The principal issues for LS from this review are *“the importance of keeping track of cases where advice has been given and where no proceedings have been issued and on escalation procedures within the Legal Service and with Children’s Services”*.

Where care proceedings have been formally initiated there are national arrangements for timetabling, scrutiny and review. In situations where advice has been given but not yet acted on, there were at that time no local arrangements for following that up. In this case the situation was left to drift for some four months and was not escalated to senior officers to be resolved.

7.9.5 The introduction of formal escalation arrangements – within LS and with client Departments – is recommended in the IMR but is echoed by a recommendation from this overview report, to cover all agencies.

7.9.6 One matter arises in relation to educational provision. There were significant delays after the children came into care in placing them in schools. One factor that contributed to that delay was legal advice that only someone with parental responsibility, in the legal sense, could apply to a school for the children. This advice was inaccurate. The legal advisor to the Panel has confirmed that anyone with day to day responsibility for a child can apply for a school place.

## **7.10 Southampton City Council, Adult Social Care Services – report for information**

7.10.1 This agency’s involvement consisted only of receiving a notification from police about Mr A. This was in January 2013 when Mr A went missing immediately after the children moved to the care of their aunt. A few days later, when his whereabouts were ascertained and he was seen by police, they sent a routine “Adult at Risk” notification to Adult Services. In response to a question on the form as to whether a “Community Care Assessment” was needed, police indicated that this was the case.

7.10.2 Adult Services took no further action on receipt of the notification. They had no previous knowledge of Mr A and the notification did not include enough information for them to determine what sort of intervention might be necessary.

7.10.3 There was no point in police sending this notification without indicating why they thought Mr A might be vulnerable and how he might be helped. Adult Services could not reasonably be expected to commit resources to following this up without more information. In fact police have identified that the notification sent was on an outdated pro forma. Had the correct version been used this would have prompted the officer to provide fuller detail. Moreover, police advise that *“Since this incident Hampshire Constabulary has developed a new form which prompts a much more comprehensive capture of information and will assist partner agencies in making a more informed assessment with regard to what, if any, intervention may be required. This form is currently being tested and*

*once it is confirmed it is fit for purpose it will be uploaded for officers to use and all outdated versions removed”.*

## **7.11 University Hospital Southampton – report for information**

7.11.1 There are no matters arising from these children’s contact with this hospital. Only 2 of the children – Child 4 and Child 6 – have had any involvement. Both of them were referred to the hospital as a result of matters arising from their child protection medicals in January / February 2013. Child 4 was not then seen at this hospital as he was no longer living with his aunt when the appointments were offered.

7.11.2 Child 6 was seen once in February for a second clinical opinion on skin marks found during her child protection medical. This review confirmed that the marks were consistent with inflicted injuries. Child 6 was brought to this appointment by her aunt, Ms C. She told staff about Child 6’s disclosures of sexual abuse and hospital staff liaised appropriately with community health services about this.

## **7.12 South Central Ambulance Service NHS Foundation Trust – report for information**

7.12.1 The ambulance service was involved in these events once, in relation to Mr A after the children came into care. There are no matters arising from that attendance.

## **8. ISSUES ARISING FROM THE OVERVIEW OF THIS CASE**

### **8.1 The significance of ethnicity and culture**

8.1.1 We know little of the detail of Mr A’s history, including the detail of his ethnicity. It is clear that he grew up in a travelling family, most of his siblings lived in a travelling community and – apart from some years in Norfolk – these children lived on travellers’ sites and identified themselves as travellers. Commentary and research identifies the challenges faced by those communities and it is right to acknowledge that context.

8.1.2 On the other hand research barely recognises that there are issues of safeguarding children which are particularly relevant to these communities. The National Foundation for Educational Research<sup>24</sup>, looking at core skills for working with young people in relation to gypsies and travellers has reported that

*“there is far less coverage of welfare and safeguarding”*

than any of the other areas they define, such as multi-agency working and community engagement. Yet it is a reality that the abuse of these children was easier to perpetrate and harder for the agencies to detect and prevent because of the circumstances of the family and the community they lived in. It

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<sup>24</sup> Approaches to working with children, young people and families for Traveller, Irish Traveller, Gypsy, Roma and Show People Communities, NFER

may also have been easier for members of that community to identify the abuse and neglect, and take protective action of some sort, than for a family living in a less open community.

8.1.3 The numbers of Gypsies and Travellers in the UK are unknown and they are not a homogeneous group. The term “traveller” or “gypsy” can refer to Gypsies, Irish Travellers, Scottish Travellers, Roma and others. The 2011 Census for the first time allowed people the opportunity to declare their ethnicity as Gypsies or Travellers and some 58,000 did so. That is likely to reflect significant under-reporting. In this case the ethnicity of the family, according to GP records, was White British. A support group for these communities, Friends Families and Travellers<sup>25</sup> (FFT) reports that, by combining direct counts of caravans, school records and other recording, there are government estimates of 300,000. Whatever the numbers, Romany Gypsies and Irish Travellers are recognised as ethnic groups and as such fall within the remit of the Race Relations Act and the Human Rights Act.

8.1.4 They are believed to be the most deprived group in Britain in relation to health and education and there is substantial research to support that:

- Life expectancy is 10 years lower than the national average
- Women are twenty times more likely to have experienced the death of a child

The IMR from Solent NHS Trust reports that *“the first in-depth study<sup>26</sup> into the health status of this community revealed high infant mortality rates, high maternal mortality, low child immunisation levels, mental health issues, substance issues and diabetes as being prevalent”*.

8.1.5 Educational outcomes are similarly telling. Illiteracy is high. FFT suggests there is evidence to support an estimate of 62% illiteracy among adults. In 2011 12% of Gypsy, Roma or Traveller children achieved five or more GCSE’s including English and mathematics, as against 58.2% of all students

8.1.6 They are also a group that experiences widespread discrimination. In one study,<sup>27</sup> profiling the nature of prejudice in England, Gypsies and Travellers were highlighted as the minority group about which people felt least positive. Media reports about Gypsies and Travellers have often reinforced a lack of understanding and the existence of negative stereotypes. Many of their negative experiences remain unreported and invisible. Feelings of injustice and persecution are understandable.

8.1.7 The most recent national public policy initiative<sup>28</sup> to address concerns about inequalities affecting these communities sets out an extensive range of commitments. These can be summarised as:

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<sup>25</sup> <http://www.gypsy-traveller.org/>

<sup>26</sup> The Health Status of Gypsies and Travellers in England, Parry(2004)

<sup>27</sup> Understanding Prejudice, Stonewall 2003

<sup>28</sup> Progress report by the ministerial working group on tackling inequalities experienced by Gypsies and Travellers, Dept for Communities and Local Government, April 2012

- Identifying ways of raising educational aspiration and attainment among Gypsy, Traveller and Roma children
- Identifying ways to improve health outcomes within the new structures of the NHS
- Encouraging appropriate provision of sites
- Tackling hate crime against the communities
- Improving aspects of the communities' involvement with the criminal justice system
- Improving understanding of how the communities engage with providers of employment opportunities and financial services
- Sharing good practice in engagement between public service providers and these communities

8.1.8 Yet there is no direct reference to the safeguarding of Travellers' children. The greatest part of the research reviewed for this report in some ways falls back on stereotypes about the strength of these communities and their support for "the family". Those stereotypes may derive from good evidence but they also conceal causes for concern.

8.1.9 It is clear that some staff accepted lower levels of care, and set aside evidence of abuse and neglect, because these children were Travellers. The Health Visitor, demonstrating an ability to stand back and look self-critically at her work, has stated that she believed that the children had not met the threshold for CSC assessment because they were from a travelling community – which meant that *"expectations and standards for the children were lowered"*. In the same way, despite her persistent concerns, she did not feel that this was a situation to be raised in safeguarding supervision<sup>29</sup>.

8.1.10 The CSC IMR reports that *"In interview a significant majority of staff involved in the case from January 2013 recognised that they had unconsciously made judgments and subsequent decisions about this family and this case which they would not have made if the family had not been part of the traveller community"*. Housing services consider that *"some of the judgements made in this case may have placed too much emphasis on (racial and cultural identity) and this had a negative effect"*.

8.1.11 At the most basic level staff were too ready to accept that the fact that the family were travellers could restrict the level of agency interventions – so that when social workers and the Health Visitor saw the children before they moved to their aunt, they did so without going into the family home. It is hard to imagine that staff would normally agree to such an arrangement when conducting child protection investigations. Similarly Education officers were routinely accepting that the children were being "home educated" when it is clear that they were not being educated in any way.

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<sup>29</sup> Safeguarding supervision complements routine clinical supervision. It provides a formal process of professional support to enable the development of a planned response to families where there are or may be particular safeguarding concerns.

8.1.12 The IMRs explore the causes for these problems. One of the issues that comes immediately to the fore is that staff were anxious about their own safety. That is not surprising – there were several examples of Mr A and residents on the site being aggressive and threatening violence to staff. The disorganised management of the first attempt to assess the children in their own home was very threatening for staff and the police involvement in that situation was not effective – which left some CSC staff feeling that they had to accept the situation the children were in.

*“The level of threat and intimidation posed by the community towards staff was the most significant reason for failing to intervene”.*

8.1.13 The CSC IMR also grasps the nettle and reports evidence from some staff of what might be termed “political correctness” –

*“because they were being culturally sensitive and wishing to retain the children within their wider family and community network this gave legitimacy to the plan, when in fact they knew that it was not what was in the children’s best interests at the time”.*

8.1.14 This is linked to some social work staff lacking professional confidence, which led them too readily to accept that there were particular considerations which explained or outweighed child protection concerns:

*“staff working on the site were perceived to have considerable expertise and knowledge in working with this community ... Their advice was...not robustly challenged in relation to the outstanding child protection issues”.*

8.1.15 There is some research evidence that prevalence of mental illness in travelling communities is high. One report<sup>30</sup> has stated:

*“Seventy-nine per cent of respondents reported that either they or a family member suffered from depression or ‘nerves’ [a general term used within the community for anxiety...]. The average prevalence of common mental health problems in England is 16.5% of the population.”*

Mr A had a very well documented history of psychiatric illness but this seems to have been given little weight in the assessments carried out by agencies before the children left his care.

8.1.16 It is easy to make criticisms like this with hindsight and there is no doubt that staff were dealing with a difficult, challenging set of circumstances. But the culture and ethnicity of this family became the defining influence in shaping the agencies’ responses to the situation. At such times agencies need to go back to first principles – the paramountcy of the welfare of the child – and they are likely to need direction and support in doing so.

8.1.17 It would have been helpful to the agencies to have drawn into the situation someone or some agency that was not directly involved but had knowledge and understanding of travelling communities. The Safeguarding Board has been able to do that, so as to ensure that this SCR is well

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<sup>30</sup> Health Needs Assessment, Cumbria Gypsies and Travellers 2009

informed. Similar action could have been taken in dealing with the management of the case itself.

8.1.18 The expert advice to the Panel was extremely helpful, providing layers of context that would not otherwise have been sufficiently well understood. The fact that Ms C came forward to care for such a large number of children was seen as less remarkable in this community, where there would have been a strong expectation that she should do so. When evaluating the delay before any concerns were raised by community members, the Panel was advised of the very hierarchical nature of such a community as this. Leading members of the community would not expect that government agencies would be drawn into a situation without their involvement and approval. It was stressed that within the community there would be an extremely strong pressures against involving oneself or “interfering” in the affairs of another family.

8.1.19 So, there were strong societal pressures against concerns being publicly raised. A corollary of that is that the concern felt by those community members who did come forward must have been extremely high for them to do so. A professional evaluating this situation with the benefit of informed advice would have better understood the depth of concern felt by some community members about the treatment of these children by their father.

8.1.20 It may be significant that the local authority had previously employed a Gypsy Roma Traveller Officer but had deleted that post. The Education IMR notes that

*“The deleted post led to reduced knowledge of the communities, lifestyles and culture of the families living on the site amongst education staff. There was a reduced capacity to establish trust through the familiarity of the residents with a consistent person, sensitive to traveller lifestyle issues.... there was no longer an education specialist who could advocate for the relevance of education to children’s futures and support parents in making decisions related to their children’s education”.*

The Panel heard that there had also been a similar specialist post in the Community Safety Service which had also been deleted.

8.1.21 Local authorities are under huge financial pressures and have hard decisions to make about staffing arrangements. They face great difficulties in maintaining specialist advisory services. Nonetheless such services can be drawn upon externally when necessary and one would have expected that to have happened here.

## **8.2 Management and direction**

8.2.1 The failure to engage specialist advice and input is one aspect of the absence of “management grip” that runs through the history of the case. This was by any measure a difficult set of circumstances for agencies to deal with. The issues of culture and ethnicity, the legal complexities, the sheer number of children involved - all flag up the need for management and planning and co-ordination of input from services. It is striking that throughout

the events there is little evidence of management intervention to support staff and direct the case.

8.2.2 This applies to some extent to all the agencies principally involved. Police acknowledge that they failed to ensure the first joint intervention with CSC was managed at an appropriate level. The Housing IMR identifies a number of dysfunctional staff relationships in which managers had failed to intervene, which hampered communications and information sharing. However it is in the local authority's children's services – both education and social care – that there is evidence of the most serious causes for concern about the management of this case and of the staff involved.

8.2.3 The Education IMR describes a bewildering set of management arrangements and comments that *“it has been difficult to establish the chain of accountability for (the various education services) in the management of this case due to the involvement and flexible roles of many of the involved professionals”*. In part that can be seen to be a consequence of service reductions and deletions of posts, so that staff were being asked to take on new and additional responsibilities. However it is clear that in this complex case there was never a designated lead manager across educational services.

8.2.4 The consequences in this service are most apparent after the children came into care, when attempts were being made to address their educational needs.

*“From the time that the children became looked after the Senior Advisor and Lead for the Virtual School took a lead role, but not on any formal basis and she did not communicate well with others who were also involved”*.

The IMR has been unable to establish who managed this officer, who had *“what appears to be a very autonomous role”*.

The officer subsequently left the employment of the City Council without any handover arrangements being made for the complex work she had been involved in.

8.2.5 There is a similar picture in CSC. The IMR makes a telling comment about prioritisation of work:

*“work was progressed through the system (so that) adherence to performance indicators around timeframes was prioritised over quality assessment and intervention”*.

But it is of the greatest concern that there is no evidence of the effective involvement of senior managers at any stage.

8.2.6 This had profound consequences for these children. When CSC first became aware of the family they took an inappropriate decision that they need not be involved at all, which was unchallenged by any management arrangements. The first attempts to assess the situation were made by social workers visiting alone and unannounced, despite the local authority's guidance on “lone working”. When agencies came together after gaining access to the home for the first time, it was left to a relatively junior member of staff to manage the meeting. Eight people had first line management

responsibility for the case between October 2012 and January 2013. The IMR notes that

*“There were 3 changes in managers operating over 2 different work bases in 3 days at the critical stage of this case in January 2013”.*

8.2.7 Similarly, after the children left the care of their father, relatively junior staff were left with a morass of responsibilities, which were sometimes conflicting – balancing their care needs with their educational needs, for example – without any clear management direction. This led to inconsistency, uncertainty and delay in planning.

8.2.8 Lack of effective management also meant that simmering discontent between the two arms of the council’s services to children was not identified and addressed. This was evidenced as early as the point at which CSC responded, ineffectively, to the first referral from Education in September 2012. It continued throughout the period after the children came into care, when there was a lack of direction about the priority that should be given to resolving care needs as against finding educational placements.

8.2.9 This case needed active management involvement at latest when it became clear that social workers had to make an assessment in the difficult physical circumstances of the travellers’ site, and then plan for the needs of seven siblings. Management needed to be consistent and at a level that could recognise and meet the need to allocate resources in unusual circumstances. From the outset it was clear that more than one social worker needed to be involved. As the IMR comments

*“The complexity of this case would have required a small team of staff to work together on different aspects of the assessment and care plan for these children”.*

Overall the IMR is also right to judge that

*“Senior managers failed to manage this case proactively at critical stages”.*

8.2.10 One manifestation of the absence of active management is the corresponding absence of evidence of effective supervision of staff. Research, including the analysis<sup>31</sup> of serious case reviews, has repeatedly concluded that supervision is necessary in order not only to plan how cases will be managed and taken forward but also to help staff to think about and deal with the emotional impact of their work.

*“Social work and social care are conducted through personal relationships and interactions, with or without practical support or personal care. They place particular demands on staff and it is the employer’s responsibility to ensure this dimension of supervision is provided as part of their duty of care”<sup>32</sup>.*

8.2.11 At a basic level it is not clear what supervision was provided to the social work staff involved in trying to respond to an extraordinarily difficult and stressful set of circumstances. The IMR notes that

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<sup>31</sup> See, for example, Brandon et al (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn? London: DCSF

<sup>32</sup> Effective supervision in social work and social care – SCIE Research Briefing #43

*“The supervision of individual staff was not timely, appropriate or reflective”.*

8.2.12 This came to a head after the disclosures of sexual abuse when one social worker was allocated to carry out all the case planning and management in this very complex and demanding case.

*“There is no evidence to suggest she received quality supervision and support throughout January 2013 whilst working with this family, there is no management supervision recording in relation to this case during this period”.*

8.2.13 There is a significant organisational context. During 2011/2012 five senior managers left the Council in various circumstances. There had been long standing concerns about the council’s ability to attract qualified social workers. Then, for over a year until the late summer of 2012, the council was involved in a high profile industrial dispute with the workforce as a result of changes to conditions of service. High numbers of staff left the council’s employment. In January 2012 only one qualified and experienced social worker had been appointed in a period of seven months and, in some teams, the use of agency staff was at levels of 40%.

8.2.14 There were large numbers of unallocated cases. In the “long term” teams, at July 2011, there were three hundred children whose cases were not allocated to a social worker. Standards of practice were low – at August 2011 the council identified eighty-five children in care by agreement whose cases should have been taken through the courts. During 2011 three children known to CSC died.

8.2.15 There were specific errors in the management of this case but they need to be understood in that organisational context. This was not an organisation in which staff, at any level, could feel secure, and where good practice was effectively championed.

### **8.3 Accommodation provided under section 20 Children Act 1989 and Parental Consent**

8.3.1 There was continuing confusion within the local authority about the legal status of the children and the issue of parental consent to their accommodation. This led to significant delay in driving forward the arrangements for their care and education.

8.3.2 The Children Act 1989 at section 20 places upon local authorities both a mandatory duty and a wider power to provide accommodation to children in certain circumstances, with the duty to accommodate being independent of any requirement to obtain the consent of any person with parental responsibility.

8.3.3 Section 20 states:

*Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of –*

- *There being no person who has parental responsibility for him*
- *His being lost or having been abandoned*

- *The person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care*

8.3.4 Once any of those conditions is met the local authority has an absolute duty to provide accommodation, after considering the child's wishes and feelings and deciding what weight to attach to that consideration.

8.3.5 The Legal Advisor to the Panel commented that *"It would appear that the requirement for active consent has achieved a status which does not appear anywhere in the statutory framework, and which in some instances could be deemed to have hindered decision-making around the protection of vulnerable children."*

8.3.6 Decision-making was certainly delayed in this case, as a result of a lack of clarity around this issue. The local authority has addressed that issue in the actions taken in response to this SCR.

## **8.4 Family and Friends Care**

8.4.1 A specific illustration of the absence of firm, well-informed professional management within CSC is found in the failure clearly to establish the legal status of the arrangements for the care of these children, and to tolerate inadequate standards of care, after the local authority had some direct responsibility for the children. Even acknowledging the weight that needed to be given to issues of culture and family bonds in these arrangements, the local authority failed to appraise this situation with adequate reference to legislative requirements.

8.4.2 It is a guiding statutory principle<sup>33</sup> that children should wherever possible be cared for by their family and friends. The Panel also heard that, around this time, there had been specific initiatives locally promoting Family and Friends Care for looked after children. However children should not be enabled to live with family and friends when *"that is not consistent with their welfare"*<sup>34</sup>.

8.4.3 When the children left their father it is right that the staff involved should have given considerable weight to the wish to keep them together, and to keep them in their own community. However, there were more compelling reasons why that might not be in their best interests.

8.4.4 In practical terms their aunt was being asked to look after nine children including her own, in a small caravan, while the guidance (Para 5.40) tells us that *"Children living with family and friends foster carers have the same rights to privacy and suitable sleeping accommodation as other looked after children"*.

<sup>33</sup> Section 22C Children Act 1989

<sup>34</sup> Family and Friends Care, Statutory Guidance, Para 4.4

8.4.5 Even more significant was the fact that these children had been known by their family and community to be grossly neglected, and that neglect had been tolerated in the community. Even at the point where social workers finally gained access to the family home their aunt was among those involved in attempts to disguise how desperate that home situation was. It is hard to square that with the requirement (Para 5.15) that *“prospective foster carers should be considered in terms of their capacity to look after children in a safe and responsible way...”*.

8.4.6 Procedurally the authority did not meet the requirement to ensure that the temporary accommodation arrangements made were approved by their nominated senior officer. This is another illustration of the confusion in the organisation at the time - there was a nominated officer with responsibility for these decisions in post but she was never approached about this.

8.4.7 The statutory guidance is quite clear (Para 5.1) that in such situations *“The National Minimum Standards (NMS) for Fostering Services apply”*. These arrangements could not possibly be said to meet any such minimum standards.

## **8.5 Neglect**

8.5.1 Neglect has been defined as *“the persistent failure to meet a child’s basic physical and/or psychological needs and which is likely to result in the serious impairment of the child’s health or development”*<sup>35</sup>.

Neglect is often chronic, its effects are cumulative and it often accompanies other forms of maltreatment. It is the most common reason for a child to be the subject of a child protection plan. There was an unacceptable lack of challenge across the agencies to the neglect of these children. There was extensive and compelling evidence that they were severely neglected throughout the time that they lived in Southampton and previously.

8.5.2 Sometimes manifestations of neglect are not obvious. That was not the case here. These children could be seen to be dirty and poorly dressed. Their behaviour was uncontrolled. They were often hungry. They were not educated and their special educational needs were not addressed. They were not vaccinated. They had dental caries and missing teeth. They lived in squalor in a cold, dirty, overcrowded home. There is no evidence that their emotional needs were ever considered. It seems to have taken the disclosures of sexual abuse to prompt agencies to grasp their need to be protected. Equally it was the disclosures of sexual abuse which prompted a family member to contact “the authorities” when the nature and extent of their neglect must have been evident in their community for many months.

8.5.3 Neglect is often not easy for organisations to deal with. It may be difficult to be clear about when the point of “neglect” is definitely reached and it is easy continually to defer making such a judgment. The fact that it has no

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<sup>35</sup> Working Together 2013

single cause or single means of being resolved can make the development of appropriate services difficult. But these children were grossly neglected and, nonetheless, the Core Assessment conducted in September 2012 recommended no further action.

8.5.4 It seems likely that cultural preconceptions played their part. It is hard to imagine that the evident gross neglect of children from a “settled” community would receive such a muted response from staff.

8.5.5 This is also a systemic, national issue. Action for Children has commented that  
*“Legislation, policy and guidance have developed with good intentions, but a distance has developed between common-sense empathy with the unhappiness of hungry, tired, unkempt and distressed children and an overly bureaucratic and anxiety-ridden system for reaching out to help them”<sup>36</sup>”*.

8.5.6 It is encouraging that this issue has been identified and prioritised by CSC in recommending that  
*“the profile of and understanding of neglect and the impact on children needs to be a priority within CSC. CSC staff will need to be continually supported to understand how to identify and respond to this issue and it needs to be prioritised and a mandatory element within training and development”*.

8.5.7 This is in line with the findings from very relevant research<sup>37</sup>, published as this review was being concluded:  
*“Those local authorities providing the strongest evidence of the most comprehensive action to tackle neglect were more likely to have a neglect strategy and/or a systematic improvement programme across policy and practice, involving the development of specific approaches to neglect”*.

8.5.8 However this is an issue for all agencies and there is consequently a recommendation from this report, taking account of the Ofsted research, to the Safeguarding Board.

## **8.6 Sexual abuse**

8.6.1 As discussed in the previous section, it was the emerging evidence of sexual abuse in January 2013 that finally led to the effective protection of these children. Yet there were clear indications of sexual abuse in the reports received in September 2012, which were simply not investigated at all. That cannot be attributed merely to a lack of thoroughness – it also suggests a reframing of the causes for concern into something easier to deal with.

8.6.2 There may be broader themes underpinning this. Nationally, in 2013 the numbers of children subject to a Child Protection Plan, where the initial category of abuse was sexual, was at its lowest since 2009<sup>38</sup>, and has

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<sup>36</sup> Child neglect; the scandal that never breaks (Action for Children March 2014)

<sup>37</sup> In the child’s time: professional responses to neglect (Ofsted 2014)

<sup>38</sup> [England \(2009-2013\) \(PDF, 40KB\)](#)

generally declined since 2010. The situation is even more marked locally: in 2009 / 2010 there were thirty children in Southampton subject to a Child Protection Plan where the principal reason for the Plan was sexual abuse, whereas the number in 2012 /13 had dropped to five<sup>39</sup>.

8.6.3 There is no evidence to suggest that the decrease in numbers can be attributed to a reduction in the incidence of familial sexual abuse. It may be significant that much public attention has been focussed more recently on the sexual abuse and exploitation of children outside their families, such as the cases in Rochdale and Peterborough.

8.6.4 Whatever the relevance of broader societal changes, the failure to follow up the earliest concerns about sexual abuse was significant. It was easier for professionals to feel that they could respond to neglect (and physical abuse) while keeping the children in the family. Had a thorough, structured assessment been carried out it is highly likely that this would have led to the identification of sexual abuse and that this would have led to the earlier protection of the children.

## **8.7 Elective Home Education**

8.7.1 After they moved to Southampton none of these children received any formal education, although those of school age had been attending school in Norfolk – and that school identified many of the early social and educational concerns for the children. On moving to Southampton the older children were all immediately declared by their father to be electively home educated (EHE). In due course the youngest child was also deemed to be home educated. This was reported to and noted by the local authority.

8.7.2 In fact the children received nothing resembling an education. For three of them identified special educational needs were not met. EHE for these children served only as a means of concealing from the authorities their continuing abuse and neglect.

8.7.3 The issue of EHE has been controversial. This section of the report considers the background to public policy on EHE, the links generally between EHE and safeguarding, the position of “statemented” children and issues relating to EHE and travelling communities.

8.7.4 Though education is compulsory in the UK for children between the ages of five and sixteen, school is not. Some families prefer to educate their children otherwise than at school, and it is their right under UK law to do so.

8.7.5 Local authorities have general duties to make arrangements to safeguard and promote the welfare of children. These powers do not give local authorities the ability to see and question children receiving EHE, or their parents, in order to establish whether they are receiving a suitable education, or for any other reason. Of course if local authorities have reason to believe

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<sup>39</sup> [Analysis of referrals assessments and CPP 2005-13 FINAL.PDF](#)

that any investigations into the physical or emotional well-being of home educated children are necessary, they can and should take safeguarding action in the normal way.

8.7.6 A report published in 2009 included a major review of the statutory arrangements for EHE. The review<sup>40</sup> was conducted by a former Director of Children's Services for Kent County Council, Graham Badman (and is henceforth referred to as the Badman Review).

8.7.7 That review followed and was to some extent prompted by the case of Kyra Ishaq, a seven year old girl who died in Birmingham in May 2008 as a result of extreme abuse and neglect. She had been taken out of the school education system in December 2007 and then effectively was starved to death. The subsequent SCR, the first to be published in full, judged that *"a significant barrier to effective intervention lay in the home education legislation (which) enabled adults to effectively remove children from state education and the effective oversight of professionals, ... enabling them to isolate the children, whilst also limiting the range of opportunities open to professionals to intervene"*.

The consequence was that

*"They were isolated, effectively removing their rights to be seen, heard, or protected"*.

8.7.8 The Badman Review introduced a chapter on the safeguarding of home educated children as follows:

*"Of all the matters considered during the course of this inquiry the question of safeguarding electively home educated children has prompted the most vociferous response. Many parents have expressed anger and outrage that it was suggested that elective home education could be used as a cover for abuse"*.

8.7.9 Badman judged that there were two key matters he should address:

- *"First, if there is abuse of children within the home education community, is it disproportionately high, relative to the general population?"*
- *Secondly where abuse does exist, would a change of regulation with regard to elective home education have either prevented or ameliorated such abuse?"*

8.7.10 Badman noted a range of comments from home educators:

*"It would be wrong to assume that home educators do not take the question of child safety, their own and others, very seriously. Some home educators who contributed to this review argued for periodic spot checks by authorities. The view was also expressed that attendance at school was no guarantee of a child's safety, as other tragic cases have indicated"*.

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<sup>40</sup> Report to the Secretary of State on the Review of Home Education in England  
[Home%20Ed/Badman%20report.pdf](#)

8.7.11 He also noted a number of comments from agencies involved in the protection of children. These were largely in favour of measures which might allow and promote more scrutiny and consequently more effective safeguarding of home-educated children. The NSPCC argued vigorously that *“We ... think that monitoring should be strengthened... (because) there is nothing in the current guidance or framework that would prevent children being abused by people who may claim to be home educators.”* The NSPCC highlighted the “Catch 22” that there may be no opportunity for concerns to be raised about children because no-one sees them to detect such concerns.

8.7.12 The relevant government department, the former Department for Children, Schools and Families, decided bluntly that *“Current DCSF guidelines for local authorities on elective home education place insufficient emphasis on safeguarding the welfare of children”*.

8.7.13 In response to his two original questions, quoted at Paragraph 8.7.9 above, Badman judged that *“First, on the basis of local authority evidence and case studies presented, even acknowledging the variation between authorities, the number of (home educated) children known to children’s social care in some local authorities is disproportionately high relative to the size of their home educating population. Secondly, despite the small number of serious case reviews where home education was a feature, the consideration of these reviews and the data outlined above, suggests that those engaged in the support and monitoring of home education should be alert to the potential additional risk to children”*.

8.7.14 This conclusion led to a wide range of recommendations based around the introduction of regulation of home education. The leading recommendation was that *“the DCSF establishes a compulsory national registration scheme, locally administered, for all children of statutory school age, who are, or become, electively home educated”*.

8.7.15 The recommendations of the Badman Report were accepted in full by the government and a Select Committee was set up to consider them further. The representations made to that Committee included an extensive campaign by families of home educated children. In December 2009 the highest number of petitions ever presented simultaneously on a single topic – home education - was submitted in the House of Commons.

8.7.16 The Select Committee, reporting in December 2009, now took a different approach to the government’s original response to the findings of the Badman Review. The emphasis on safeguarding shifted towards an emphasis on the rights of parents. The Select Committee stressed the responsibility of local authorities to support home educating families. In May 2009 proposed changes were dropped because of insufficient cross-party support. A newly elected Chair of the Commons Education Select Committee, on 17/7/10, commented that

*“It is astonishing that the Chief Inspector of Schools should stray onto home education and get it so wrong...Parents, not the state, have the statutory duty to ensure that their children have a suitable education”.*

8.7.17 The idea of compulsory registration arrangements was replaced with proposals for voluntary registration, which are now in place. Local authorities can insist on seeing children in order to enquire about their welfare where there are grounds for concern (sections 17 and 47 of the Children Act 1989). However, these powers do not extend to the ability to see and question children subject to EHE in order to establish whether they are receiving a suitable education, or whether there might be any other concerns for those children. The current arrangements largely assume that there will be co-operation between families and agencies. A decision by a parent not to co-operate does not of itself constitute a ground for concern.

8.7.18 For children with statements of SEN, which three of these children had, the local authority is in some ways given more responsibilities but not commensurately greater powers. For a “statemented” child the local authority must arrange special educational provision unless a parent has themselves made “suitable” arrangements to meet their special needs. But it may be difficult or impossible for the authority to satisfy itself that any arrangements made are suitable. Parents can be reminded of the duties placed on local authorities but are not required to comply or co-operate. Local authority officers cannot insist on visiting a home or seeing a child. It may be impossible positively to establish that a child is not being suitably educated if there is simply not enough information available to the authority.

8.7.19 There are other considerations in respect of children from travelling communities. Levels of EHE are believed to be very high. There are obvious practical difficulties, for those travelling families who actually do travel, in repeatedly enrolling children at different schools, and differences in approach between schools / local authorities to how such enrolments are dealt with. Those travellers who lead a “settled” life do not lose their identity as travellers and there are undoubtedly still problems of communication and connection between schools and “settled” travelling families.

8.7.20 Some researchers have argued that authorities and schools have not made school attendance easy for travelling families. There is research evidence<sup>41</sup> of racist attitudes and bullying of children from travelling families who do go to school. Some families fear “cultural erosion” as a consequence of school attendance. Many parents have poor literacy skills and a negative experience of their own contact with the formal education system.

8.7.21 The disconnect between travellers and the formal education system is particularly pronounced after children reach secondary school age. Families may simply not see the point of what schools offer once literacy and numeracy skills have been established.

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<sup>41</sup> Eg, Gypsy Traveller Students in Secondary School, Derrington & Kendall (2004)

8.7.22 The Legal Advisor to the Panel assisted in putting this issue in its current statutory context, which is not straightforward. There is a legal definition<sup>42</sup> of a “suitable” education as *“one that primarily equips the child for life within the community of which he is a member”*.

That definition arises from a case considered in 1985 and has become widely used and quoted in discussions around EHE.

8.7.23 The Legal Advisor told the Panel that reliance on this case is unsatisfactory as it predates the definition accorded by Parliament in the Education Act 1996 (s7) that

*“The parent of every child of compulsory school age shall cause him to receive efficient full-time education suitable-*  
*(a) to his age and ability and aptitude and*  
*(b) to any special educational needs he may have*  
*either by regular attendance at school or otherwise.”*

The legislation contains no reference to what might be described as the “cultural” factors inherent to the first definition. The legal situation is complicated further by DfE guidelines (not statutory guidance) on EHE published in 2007, which relied heavily on the 1948 judgment rather than the content of the Education Act.

8.7.24 This is not to say that cultural influences are irrelevant to the test of suitability but here the issues of culture seem to have become almost the first consideration rather than something to be taken into account once the statutory test had been addressed. The legal advice to the Panel was that *“the test (of what constitutes a suitable education) set down by Parliament has been significantly diluted on the basis of little more than Guidelines from the DfE, of themselves having no statutory underpinning, placing too high a reliance on a case which had preceded very specific statutory provision”*. There is a recommendation from this report addressing that national issue.

8.7.25 It can be seen that this is a complicated context for local authorities trying to meet their various responsibilities. Ultimately though, as the relevant IMR states,

*“there is no legal requirement for home educating parents to teach the National Curriculum, to provide a broad and balanced education or fulfil many other characteristics of a school based education”*.

8.7.26 Where there are concerns that a child may not be receiving a suitable education there is a process of issuing a formal notice to parents and serving a School Attendance Order (and here, for “statemented” children, there is a specific requirement for the local authority to name a school to be attended). In the event of continuing non-compliance a local authority can apply for an Education Supervision Order. A parent who does not comply with such an Order can be prosecuted and fined. This is self-evidently a long, complicated

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<sup>42</sup> R v Secretary of State for Educational and Science, ex parte Talmud Torah Machzikei Hadass School Trust, 1985

and potentially fraught process. It is not clear that any authority has ever pursued a case to such an extent.

8.7.27 So, in this case, the agencies were faced with what was regarded as a fait accompli – these children would be home educated, there was no immediate basis for legal challenge to that and there were legal / cultural / environmental factors which supported that as a reasonable choice by Mr A. The children were not unusual in the sense that most of the children living on the site were also home educated. Mr A said at one point that he would use a tutor provided for his sister's children to teach his children, though the SCR did not receive any evidence of his doing so. The children occasionally used other services visiting the site.

8.7.28 It may be significant that Southampton City Council had previously employed a specialist EHE officer who *“undertook a home circumstances report for all home educating families and offered termly contact to support the education arrangements of the children. Her remit included the children's work, living arrangements and conditions, although she operated within the constraint that she had no legal right of entry”*.

That post had been deleted and the responsibilities divided between other posts – so, although the co-operation of families was still voluntary, the way in which that specialism promoted the welfare of these children was diluted.

8.7.29 All of those factors, linked to EHE and how it is approached, contributed to the weaknesses in the agencies' responses to the safeguarding needs of these children. This is not a comment on EHE per se. However the reality is that the framework of policy and resourcing around EHE made it easier for the father to abuse the children and more difficult for agencies to detect and respond to that abuse. There were structural and systemic influences on these events which are directly linked to the arrangements for responding to EHE.

8.7.30 The Select Committee, commenting on the Badman Review and the government's initial response to that Review, stated that: *“Where we believe that the Badman Report and the proposals in the Children, Schools and Families Bill run into difficulty is in their conflation of education and safeguarding matters”*.

That does not mean that the two issues, home education and safeguarding, might not be linked in some circumstances. This is the fifth SCR in which the author of this report has been directly involved that has featured the use of home education arrangements to disguise and compound inadequate or harmful care.

8.7.31 This report therefore suggests that, on a national level, steps – such as an evaluation of relevant SCRs – might be taken to assist in determining the nature and extent of any relationship between safeguarding concerns and elective home education. The agencies should also consider ways of improving services locally and the Education IMR, which echoes the comments on EHE in this report, sets out a number of practical ways of doing

that. Most importantly, this report supports the headline recommendation from that IMR:

*“It is recommended that the SSCB bring the circumstances of this (case) to the attention of the DfE Secretary of State and make representations for a government response to improve the safeguarding arrangements for children and young people receiving elective home education”.*

## **8.8 Good practice**

8.8.1 The agencies were asked, as is usual, to identify instances of good practice in their work with this family.

8.8.2 There is evidence of thoroughness and strong processes in the attempts by staff in Southern Health to engage Mr A. The Health Visitor from Solent NHS Trust stuck with the case even when the children were not of an age to be receiving health visiting services. The determination and hard work of staff in CSC and Legal Services once the care proceedings were initiated has been noted. The efficacy of that input followed in part from the realisation by CSC managers that this was an unusually complex situation and needed dedicated resources, so that two social workers were given the responsibility for the case. Although it is technically outside the timescale and general remit of the SCR, the sensitivity and determination of the criminal investigation is rightly highlighted by police.

8.8.3 The Education IMR notes the difficulty in identifying good practice here: *“There are challenges in identifying good practice in a situation where seven children looked after and three children looked after with statements of SEN remained without any assessment of education need or education provision for between three and six months.”*

However that IMR does, on an individual level, highlight the commitment of the various staff involved who tried hard to deal with a complex and changing situation.

8.8.4 When SCRs were individually evaluated by OFSTED<sup>43</sup> it was suggested that SCRs should identify

*“Good practice... with... potential for wider implementation”.*

The good practice identified here is to be found in individual effort and commitment. The review has not identified any initiatives or working practices which could be implemented elsewhere.

## **8.9 SCR process**

8.9.1 An impressive example of individual effort and commitment is to be found in the work of those officers who administered not just this SCR but the four others being conducted simultaneously in Southampton. These are complex exercises which require organisational ability, adaptability and patience. These officers have played a major part in ensuring that the process of this SCR has been smooth and efficient.

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<sup>43</sup> OFSTED SCR Descriptors January 2009

8.9.2 A early decision was made to confine the period under review to the time the family lived in Southampton. As the review unfolded increasing evidence emerged that there had been serious abuse and neglect of the children when they lived in Norfolk. After discussions with the Norfolk LSCB an arrangement was made for that Board to be fully informed about the matters arising which might be relevant for them, and these are being followed up in Norfolk.

## **9. CONCLUSIONS – A SUMMARY OF KEY CAUSATIVE FACTORS AND LESSONS LEARNED**

9.1 The review has identified weaknesses in the management of aspects of this case by a number of the agencies involved. Those failings were particularly pronounced across the local authority's provision for children and families. The two arms of that service – education and social care – did not work well together at any stage. The failure to scrutinise decisions and to provide leadership in managing the case is evidenced throughout the period under review, even initially after the children had been removed into care.

9.2 Those failings need to be understood in the organisational and political context of the fallout from a major, long-running industrial dispute across the council, and a sustained lack of stability in senior management arrangements. In social care there were acute staff shortages and large numbers of unallocated cases. There are also concerns – prompted by the number of SCRs now underway in Southampton which were not initiated in a timely fashion - that the LSCB may not have been providing adequate scrutiny of the work of local agencies.

9.3 The transfer from Norfolk of information and responsibility for managing the case was not satisfactory. Most significantly:

- children's social care services in Norfolk did not inform their counterparts in Southampton of their involvement when the family left their area.
- the fact that three of the children had Statements of Special Educational Need was not notified to Southampton.

9.4 When this family arrived in Southampton there was a fundamental lack of rigour in the response of the agencies, so that they did not establish full and accurate accounts of the family's composition and circumstances. This was a particularly large and complex family but there were avoidable errors, and weaknesses inherent in the agencies' systems for gathering and sharing information.

9.5 From the outset the local authority's children's services (CSC) failed to respond appropriately to reports suggesting that these children were in need of protection. The early referral to CSC from the Health Visitor was rejected despite multiple indications that the new situation should be assessed. At the most basic level it was known that safeguarding services in Norfolk had a continuing involvement immediately before the family moved – but it was still decided, without assessment, that CSC in Southampton need not be involved. There was no adequate system for the screening of such decisions by more senior managers, so that the operational system allowed one relatively junior officer to make this decision.

9.6 In the education service officers took a narrow view of their responsibilities, focussing primarily on an organisational task rather than on the well-being of the children. The enquiries made about the children's

background were not sufficiently thorough so that the fact that three of the children had Statements of Special Educational Need was not firmly established for more than eighteen months, until the children were in care. Consequently the special educational needs of those children were not addressed. Several education officers were involved with the family but there was no coherent approach to assessing and managing the situation.

9.7 When CSC did first assess the situation in September 2012 that process was cursory. Very basic mistakes were made, including not directly assessing the children or challenging the father's refusal to allow access to the home. There were particular organisational pressures at that time so that staff were struggling to cope with the level of incoming work and failing to complete tasks thoroughly. Nonetheless, even the most basic management screening should have indicated that this was an incomplete assessment and could not be used as a basis for terminating involvement, but the case was closed.

9.8 Although there is evidence of organisational disarray there were also clear individual misjudgments in both arms of the local authority's services to children. There is a continuing concern that some officers still maintain, in the face of compelling evidence to the contrary from this review, that actions taken were appropriate.

9.9 Many of the agencies contributing to the review found weaknesses in their performance. For police these related first to a search of the home, carried out in relation to suspected offences of theft, which failed to note evidence pointing to the neglect of the children. There were then serious weaknesses in police involvement in the first attempt to assess the children's home circumstances jointly with CSC. Police underestimated the complexity and challenges arising from what was seen by members of the travelling community as an intrusion. The officer leading this operation was not fully trained in this area and did not follow national guidance which would have provided a better planned and resourced approach.

9.10 One consequence of the lack of planning was an unco-ordinated approach by the police and social work staff involved. There was further evidence of that during and following the second intervention, a few days later, after the first disclosures of sexual abuse. Police responded swiftly and used a properly organised and resourced approach to pursue the criminal investigation while ensuring the safety of the children. However police and CSC records are unclear about the subsequent level of involvement and consultation between the agencies. Powers of Police Protection were removed by police without reference to CSC, a decision taken immediately before a meeting set up to plan next steps across the agencies.

9.11 Before the children came into care housing officers managing the travellers' site were not sufficiently alert to the evidence that the children were being neglected. Their expectations of the level of care the children should receive were too low and they were anxious about the possible consequences of raising concerns – consequences for their own safety as well as the potential for disruption within the travellers' community. Some relationships

within the staff group were strained so that officers did not share information appropriately with each other. These factors were not identified and addressed by managers. They played a part in the continuing failure of agencies over many months to draw together a fuller understanding of the situation in which the children were living.

9.12 No health services, except the Health Visitor, had any significant contact with the children while they were in Southampton. The Health Visitor was the first professional to identify cause for concern and followed this up swiftly. However she did not escalate her concerns to her managers in the face of the CSC decision not to investigate. All workers should feel able to challenge decision making and should see this as both a right and a responsibility, a necessary feature in the promotion of the most effective safeguarding of children across agencies.

9.13 The GPs had no significant contact with any of the children although they had been informed about the special health needs of one of the children. Poor use of recording arrangements for GPs meant that this information was missed and this child was never seen or followed up. The GPs did see Mr A and were aware of his problems of mental ill health but failed to consider how that might affect the fact that he was a single parent of seven children. The review found that these weaknesses in administration and in alertness to child protection concerns were a consequence of a lack of thoroughness and professional curiosity.

9.14 The review commented on the links between evidence of dental neglect and neglect of children more generally. There was concrete evidence from a dental outreach service that all the children seen were at significant risk of serious dental disease. This might have prompted that service to initiate further enquiries about the children's welfare or even to make a safeguarding referral. They did not do so and this is mirrored nationally in the widespread belief that "safeguarding is not a dental problem".

9.15 After the children came into care there was a continuing failure by the local authority to "get a grip" on the case. For some months all the responsibility for dealing with all aspects of an unusually large, complex and challenging case were left with one poorly supported social worker. Confusion about the children's legal status and the legal options for securing their well-being also continued for months until care proceedings were finally initiated. During this time officers in Legal Services became increasingly unhappy about delay and changes of plan but again did not escalate their concerns to more senior officers for resolution. There was a failure across children's services to integrate the planning for the children's general care with the arrangements for their education, so that they were left for some months without any or any adequate educational provision.

9.16 Throughout the period under review responsibility for managing this challenging situation within children's services was left with a succession of junior managers. This led to inconsistency, uncertainty and delay in planning and a failure to draw together the input from services. There is little evidence

of reflective practice, where staff are encouraged to think about how they will be perceived and the broader implications of their actions. The extent to which staff were left without direction, inadequately supported and supervised, to deal with such a demanding case raises serious concerns about the safety of the service more generally at that time.

9.17 CSC managers finally grasped the size and complexity of the task and more resources were allocated to the case. From this point a more coherent approach was developed and care proceedings were completed efficiently. Managers had been very slow to take control of case management in this way and may have been overawed by the organisational and financial implications of the case.

9.18 Some staff accepted low levels of care, and set aside evidence of abuse and neglect, because these children were travellers. Agencies were too ready to accept that the fact that the family were travellers could restrict the level of their interventions – for example social workers assessed the family without visiting the home. Staff were anxious about their own safety – unsurprisingly, given the evidence seen by the review of intimidation of staff by some members of the community. Some staff gave too much weight to issues of cultural difference, using this to explain and accept evidence of abuse and neglect.

9.19 Expert advice to the Panel provided contextual information. The fact that Ms C came forward to care for such a large number of children is less remarkable in this community, where there would have been a strong expectation that she should do so. When evaluating the delay before any concerns were raised by community members, the Panel was advised of the very hierarchical nature of such a community as this. Leading members of the community would not expect that government agencies would be drawn into a situation without their involvement and approval. It was stressed that within the community there would be extremely strong pressures against “interfering” in the affairs of another family.

9.20 Ultimately though it would have been easier for members of that community than for neighbours in a less communal situation to identify the maltreatment of the children. The abuse of these children was easier to perpetrate and disguise, and harder for the agencies to detect and prevent, because of the circumstances of the family and the community they lived in.

9.21 There is very little research into the abuse of children in travelling communities. More commonly there are unevidenced stereotypical propositions that the inherent strengths and resilience of the community will ensure that children are not abused. This review is about one family. It does not seek to make generalised statements about the extent of safeguarding concerns in those communities. But traveller communities are believed to form the most deprived and marginalised societal group in the country. The fact that these children came from a traveller family had a profound impact on the extent to which they were safeguarded by the agencies involved in this

review. It will be important to try to engage with the travelling communities in disseminating the lessons learned from this exercise.

9.22 These children were said by their father to be educated at home. It was not unusual in their community, certainly for older children, that they were said to be home educated. In fact these children received nothing resembling an education. Three of them had statutorily identified special educational needs, which were not addressed in any way.

9.23 The development of public policy on Elective Home Education (EHE) has been controversial. Current arrangements weigh against the involvement of the state in any way that might undermine parental choice about how their children are educated. That position does not take account of the fact that some parents, such as Mr A, will use EHE arrangements to enhance their ability to abuse their children without detection. Some of these children were abused before they were educated at home but it is a reality that EHE can be used to disguise and compound inadequate or harmful care.

9.24 All these children were, in some combination, neglected and physically and sexually abused. Agencies were not alert to the evidence of neglect and failed to respond to the early concerns, expressed by community members, about sexual abuse. Evidence of physical abuse of one of the children was not followed up under child protection arrangements. These are very fundamental failings and it is not possible to tell, from this one review, whether they are or were widespread. Members of the Safeguarding Board will want to satisfy themselves that their basic child protection arrangements are now sufficiently robust, so that there would be a satisfactory response to such overwhelming evidence of cause for concern.

## **10. THE RECOMMENDATIONS FROM THIS SERIOUS CASE REVIEW**

### **10.1 Introduction**

10.1.1 The Panel took account of the responsibilities set out in the government's statutory guidance<sup>44</sup> to the Director of Children's Services and the Lead Member for Children's Services.

*"The DCS and LMCS should each have an integrated children's services brief, ensuring that the safety and the educational, social and emotional needs of children and young people are central to the local vision. Between them, the DCS and LMCS provide a clear and unambiguous line of local accountability".*

In the light of the issues emerging from this review the Board will want the local authority to demonstrate clearly that those responsibilities are met and that the arrangements for the management of children's services are safe and effective.

10.1.2 These recommendations to the Board reflect the key lessons to be learned from this review. They draw on the views of the SCR Panel and the author of this report. The review does not make a recommendation for every point of learning that has been identified. The recommendations are complemented by more detailed recommendations, specific to each agency, contained in the IMRs from those agencies.

10.1.3 Agencies have not awaited the completion of this review in order to tackle issues arising from these events. Some of these recommendations, or aspects of them, have been identified and addressed already.

### **10.2 Recommendations to the Southampton Safeguarding Children Board**

10.2.1 The Board should disseminate the findings from this review in ways which re-emphasise to agencies and communities that issues of race and culture should not outweigh the responsibility which we all share for the safeguarding of children.

10.2.2 The LSCB should require the local authority to demonstrate that, where a child may be at risk of significant harm, investigations and consequent assessments are conducted without delay and meet all procedural and good practice requirements. These will include

- being consistently directed and managed by an appropriate senior officer
- seeing the child(ren) involved and treating them as individuals
- consulting with those who have parental responsibility
- making thorough agency checks
- drawing on specialist advice when necessary
- providing formal feedback to those who have made referrals
- ensuring compliance with the local authority's "lone working" guidance

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<sup>44</sup> [directors\\_of\\_child\\_services - stat\\_guidance.pdf](#)

- ensuring that key decisions, including a decision to take no further action, are “countersigned” by an appropriate manager.

10.2.3 The Board should develop and implement an improvement programme addressing local policy and practice in respect of child neglect. In doing so the Board should take account of the guidance<sup>45</sup> recently published by Ofsted on services to children who experience neglect, and of the effectiveness of previous local initiatives aimed at improving services to neglected children.

10.2.4 The Board should arrange for local agencies to agree guidelines for proactively seeking, receiving and sharing information when they are made aware that children for whom there may be safeguarding concerns have moved into the area, taking account of the weaknesses which this review has brought to light.

10.2.5 The Board should require the local authority to ensure that all relevant staff are aware that the need to use formal child protection arrangements may continue, or may arise, when children are in the care of the local authority.

10.2.6 The Board should require the local authority to demonstrate that there are appropriate and effective arrangements for the professional supervision of staff at all levels within children’s services.

10.2.7 The Board should ask the local authority to investigate the evidence from this review that some officers or former members of staff may not have fully understood the causes for concern about aspects of the case, and to take action as necessary.

10.2.8 The Board should

- require all agencies to remind staff, in the light of the matters arising from this review, of the established arrangements for escalating concerns to more senior managers.
- develop an audit programme across all agencies to evaluate the use and effectiveness of escalation arrangements.

10.2.9 The Board should require the local authority’s housing, children’s social care and education services to demonstrate that they have made arrangements to deal with any unsatisfactory relationships within and between staff groups, as identified in this review, which may affect the safeguarding of children.

10.2.10 The Board should highlight to the Department for Education the lack of research into the safeguarding of children from Gypsy and Traveller communities.

10.2.11 The Board should

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<sup>45</sup> In the child’s time; professional responses to neglect (Ofsted 2014)

- I. ask the Department for Education to clarify the definition of “suitable education” in relation to children educated otherwise than at school.
- II. ask the Department for Education to re-evaluate the evidence of safeguarding concerns for children who are electively home educated, including any Serious Case Reviews where this is a feature, to satisfy themselves that national guidance in relation to the safeguarding of these children is sufficiently robust.
- III. ensure that local multi-agency guidance in respect of the safeguarding of children who are electively home educated is informed by the findings of this Serious Case Review.
- IV. ask all agencies to consider ways in which they can increase the support they offer to children who are electively home educated, in the light of the issues arising from this review.

10.2.12 The Board should ensure that the Norfolk Safeguarding Children Board is briefed about the content, process and outcomes of this review so that it can take further action as necessary.

10.2.13 The Board should ask all agencies to review arrangements for the debriefing of staff following complex multi agency operations, to ensure that, where appropriate, debriefings are conducted on a multi-agency basis and used to contribute to forward planning.

10.2.14 The Board should ensure that the dissemination of lessons learned from this review includes, as well as the “headline” issues reflected above, commentary on

- the need for a “Think Family” approach, so that professionals providing services to vulnerable adults remain alert to the safety and well-being of any children of the family.
- the links between safeguarding and dental care.

## **APPENDIX A: THE LEAD REVIEWERS**

### **Jane Wonnacott**

Jane Wonnacott chaired the Panel of agency representatives which oversaw the process of this review. Ms Wonnacott trained in social work and social administration at the London School of Economics and qualified as a social worker in 1979. She has an MSc in social work practice, the Advanced Award in Social Work and an MPhil as a result of researching the impact of supervision on supervision practice. She has published two books on supervision and co-wrote with Tony Morrison the national training programme for social work supervisors. Since 1994 she has been the author or chair of numerous serious case reviews and in 2010 completed the accredited Tavistock Clinic and Government Office London nine day training programme for panel chairs and authors. She has also attended the 2012 DFE serious case review training programme.

### **Kevin Harrington**

Kevin Harrington also trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has worked on more than 40 Serious Case Reviews in respect of children and vulnerable adults. He has recently been engaged by the Department for Education to re-draft high profile Serious Case Review reports so that they can be more effectively published. Mr Harrington has been involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council, and has undertaken investigations commissioned by the Local Government Ombudsman. He has served as a magistrate in the criminal courts in East London for 15 years.

## APPENDIX B: THE SERIOUS CASE REVIEW PANEL

<b>Name / Designation</b>	<b>Organisation</b>	<b>Role</b>
Ms Jane Wonnacott	Independent	Lead Reviewer ( Panel Chair)
Designated Nurse	NHS Southampton City Clinical Commissioning Group (CCG)	Panel Member
Designated Doctor	NHS Southampton City CCG	Panel Member
Detective Chief Inspector	Hampshire Constabulary	Panel Member
Senior Manager	Southampton City Council (SCC), Children's Social Care Services	Panel Member
Head of Education	SCC, Education Services	Panel Member
Service Manager	SCC, Housing Services	Panel Member
Service Manager	SCC, Adult Services	Panel Member
Service Manager	NSPCC	Panel Member
Traveller Education Officer	Hampshire County Council	Panel Member
Assistant Head of Legal Services	Hampshire County Council	In attendance
Manager	Southampton Safeguarding Children Board (SCCB)	In attendance
Business Co-ordinator	SCCB	In attendance
Kevin Harrington	Independent	Lead Reviewer (Report author) In attendance

## **APPENDIX C: TERMS OF REFERENCE**

### **REASON FOR SERIOUS CASE REVIEW**

Family A, a family of seven children between the ages (now) of 14 and 6, was originally known to agencies in Norfolk between 2005 and 2011 as a result of recurring concerns about neglect and physical abuse of the children. A number of the children had Statements of Special Educational Needs. The father was known to have mental health problems and there was evidence of domestic abuse. There were a number of referrals and assessments but no substantial, continuing involvement by the local authority.

Family A were members of the travelling community. In 2011 the father and mother separated and the father, with all the children, moved to a travellers' site in the Southampton area. All the children were now said to be educated at home by the father, although he was unable to read or write.

Concerns for the general welfare and safety of the children persisted but there was no continuing child protection involvement until evidence emerged that children of the family had been sexually abused by the father over many years. After this the children were initially cared for and educated within the travelling community by relatives of the father but these arrangements were not successful. It also gradually emerged that there was increasing evidence of sexual abuse, physical abuse and neglect, and evidence of sexual activity between children.

Eventually all the children were brought into the care of the local authority. The father admitted numerous charges of sexual abuse and received a long custodial sentence.

### **SCOPE**

#### **Period under review**

The timescale of the review is from 01 June 2011, around which time it is believed the family first moved to Southampton, until all the children had left the care of their family in July 2013. The local authority also wishes to consider the quality of care planning immediately after that, until the children were made subjects of Interim Care Orders in August 2013.

#### **Contextual information**

Agencies in Norfolk have provided contextual information, which will be set out in the Overview Report.

### **ANALYSIS ISSUES**

**Each IMR author is asked to explore not only what happened but why professionals took the actions they did. Factors that might have influenced practice should be considered including:**

The nature of the family circumstances including level of complexity, the nature of the issues presented, the way family members interacted with professionals.

Individual staff factors including knowledge skills and expertise, previous experiences of similar situations, assumptions that may have driven responses, levels of stress and any relevant personal circumstances.

Influences on the effectiveness of inter professional communication and practice including the nature of relationships between professionals (within and across agency boundaries), systems and processes in place to support communication and the impact of status and hierarchy on decision making.

Organisational and strategic factors including priorities, resources and quality of guidance

Quality of management and team support including the effectiveness of supervision in promoting reflective practice, team relationships, learning and development opportunities.

**The following should be covered within the report but authors should not feel constrained by these topics and should actively explore any issues that emerge as important influences on practice. Each IMR author is asked to address the following issues:**

Were the child(ren)'s wishes and feelings ascertained and given appropriate priority? Were there any barriers that prevented this happening? Did agencies and practitioners focus on what it was like to be a child living in this family?

Were practitioners knowledgeable about potential indicators of abuse or neglect and what to do if they had concerns about a child's welfare? Did agencies consider the possibility of sibling abuse? Was there evidence that might have prompted agencies to consider this?

Were assessments and investigations carried out and followed up appropriately? What factors may have influenced the quality of assessments? What was the quality of joint investigations?

Where formal plans were in place in relation to adults or children in the family, did they give appropriate priority to outcomes for the children? Were they clear in relation to professional roles and responsibilities and revised in the light of any new information?

Did the fact that this was a travelling family affect professional practice? Were there any barriers to providing appropriate help? Were interventions affected by concerns for the safety of staff? Was practice generally sensitive to racial, cultural, linguistic and religious identity and any issues of disability?

How did the agencies respond to the issue of home education? What were the factors influencing that response?

Were communications, within and between agencies, effective? Did agencies challenge each other appropriately? If not, what were the barriers – personal, organisational or practical – to this?

Were managers and supervisors appropriately involved in this case and how did their involvement affect the quality of work being undertaken with the family?

Did any resourcing issues affect the way this case was dealt with? If so in what way and why was this?

Is there evidence of good practice in the way this case was handled? If so what was this and what factors contributed to enabling such good practice?

### **INVOLVEMENT OF STAFF**

IMR authors should identify and interview any staff that they feel can add value to the review. It may also be appropriate for the lead reviewers to interview staff but this will be subject of discussion and agreement of the serious case review panel.

### **INVOLVEMENT OF FAMILY**

The lead reviewers will seek to engage with family members throughout the review process. The lead reviewers will meet with family members who wish to contribute to the review.

### **TIMESCALE**

The review was formally initiated on 9<sup>th</sup> July 2013. The Board will aim for completion within six months, in line with prescribed timescales, but, because this is one of several SCRs being carried out at the same time, it is likely that this timescale will not be met. The Board will keep this under review.

## APPENDIX D: REFERENCES

Footnotes have been used to indicate specific quotations from or references to research, practice guidance and other documentation. This Overview Report has been generally informed by the following publications

- Working Together to Safeguard Children, (HM Government 2013)
- The Victoria Climbié Inquiry (Lord Laming 2003)
- The Protection of Children in England: A Progress Report ( Lord Laming 2009)
- Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003 Wendy Rose & Julia Barnes DCSF 2008
- Analysing child deaths and serious injury through abuse and neglect: what can we learn – A biennial analysis of serious case reviews 2003-2005
- Understanding Serious Case Reviews and their Impact - a Biennial Analysis of Serious Case Reviews 2005-07 DCSF 2009
- London Safeguarding Children Board – SCR Toolkit (2010)
- The Munro Review of Child Protection: Final Report (HMSO May 2011)
- The Munro Review of Child Protection: Interim Report (HMSO February 2011)
- Publication of Serious Case Review Overview Reports: Letter from Parliamentary Under Secretary of State for Children and Families 10<sup>th</sup> June 2010
- Approaches to working with children, young people and families from Traveller, Gypsy, Roma and Show People communities- a literature review (Robinson, Martin 2008)
- Progress report by the ministerial working group on tackling inequalities experienced by Gypsies and Travellers (DCLG 2012)
- The Health Status of Gypsies and Travellers in England (University of Sheffield 2004)
- Gypsies and Travellers: simple solutions for living together (Equality & Human Rights Commission 2011)
- The situation regarding the current policy, provision and practice in elective home education for Gypsy, Roma & Traveller Children (Dept of Education & Skills 2005)
- Inequalities experienced by Gypsy and Traveller Communities- a review (Cemlyn et al, EHRC 2009)
- Report to the Secretary of State on the review of Elective Home Education in England (the Badman report) (June 2009)
- The Review of Elective Home Education (House of Commons Children, Schools and Families Committee 2009)
- Elective Home Education, Guidelines for local authorities (DCSF 2007)
- The Kyra Ishaq Serious Case Review (Birmingham LSCB, 2010)
- Safeguarding in Elective Home Education (C4EO 2010)
- In the child's time: professional responses to neglect (Ofsted 2014)

