Warwickshire Safeguarding

Warwickshire Safeguarding Children's Board

Learning from Amy

2019

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Case A

1.Background to the review

This review was commissioned by the Warwickshire Local Safeguarding Children's Board (WSCB) in June 2018 at the time it was proposed to undertake a Serious Case Review using Appreciative Inquiry as the methodology. However, in March 2019, following the appointment of a new Chair to the WSCB and concern over the length of time since the events had happened, changes and improvements that had been made to services, a Learning event was commissioned. The aim of the event was to provide the WSCB with the reassurance that if given a similar set of circumstance the current response from the relevant services would be robust enough to prevent a similarly poor outcome for the child and family concerned.

It was agreed although the reason for the removal of Amy and her siblings from the family was the rape and sexual abuse of Amy and the subsequent narrative of coerced surrogacy, the issue that agencies were asked to focus on was the frequently faced challenge of controlling and coercive men joining vulnerable families. This in no way detracts from the fact that Amy's mother was collusive and failed to protect her children and that both her and her partner were found in Court to be culpable.

2. Voice of the Child

In order that the voice of the child be heard in this process Amy via her social worker and foster carer were offered an opportunity to be part of the process so that their own questions and views on what would have helped her at the time could also be voiced here. The reviewers and WSCB are grateful to Amy and her foster carer for helping all agencies to learn from her reflections on her experiences. I wish to pay tribute to the good grace, resilience and maturity she has shown in agreeing to and helping us in this.

3. Statement of Independence of the reviewers

Pickles and Bickerton Ltd were commissioned as the subject matter experts for this case review. Jan Pickles OBE and Ian Bickerton are both qualified and experienced Independent Social Workers and undertake similar reviews across the UK. They are based in Wales and are not employed by any of the agencies involved in the review. Jan Pickles has undertaken a Domestic Homicide Review in Warwickshire for the Community Safety Partnership. Jan Is a member of the National Independent Safeguarding Board in Wales and Chair of the Centre for Expertise in Child Sexual Abuse she has worked directly with many survivors of historical child sexual abuse. Ian Bickerton is a qualified Social Worker, trainer and facilitator and together they have undertaken reviews into institutional failings where children and adults have suffered abused

4. The methodology

The methodology set out below for this reassurance exercise was created by Pickles & Bickerton Ltd and agreed by the WSCB.

1. The already prepared chronology would be reviewed by the consultants and the questions extracted posed to the agencies involved.

2. Agencies were given the questions in advance and had two months to address those questions internally and prepare a response to be presented by them at the learning event.
3. One of the facilitators would in the interim meet with Amy and her foster carer. The aim of this meeting was to hear Amy's views on the way she was treated and the questions both Amy and her foster carer had of the agencies that had been involved.
4. A facilitated learning event based on all the information available would be held at the WSCB's July 2019 meeting. By creating a safe space for agencies to share the changes that they have made in the light of Amy's experiences (**Appendix.I** provides details of agencies who attended the learning event). All agencies undertook to be accepting of constructive challenge by their peers on the Board. A brief version of the chronology was presented to the Board to refresh their knowledge and provide a context for newer members. All agencies were asked to demonstrate to the WSCB that the relevant changes made following this case were effective, mainstreamed into service delivery and sustainable.
5. The facilitator undertook to feedback the learning event to Amy and her foster carer.
6. After the event the process was to be written up and shared with all agencies involved. (This report is that document).

5.Background to Amy

Amy, then aged 12 was one of three young children who lived with her mother and her mother's new partner, 'Frank'. All the children had by then already been treated poorly by their biological parents who had earlier separated, the children remaining in the care of their mother. Following the arrival of 'Frank', family life continued, generally with little stability, sense of safety and security and a home life where violence, disapproval and lack of care and affection were ever present. Crises escalated, bringing services into contact with the family due to these and other serious allegations and concerns. It was the pregnancy of Amy later known to be the rape of her by her mother's partner 'Frank', that changed things for Amy and her siblings.

Following 'Franks' removal by the police from the family home in response to an allegation of physical abuse made by Amy's brother, Amy felt able to disclose the sexual abuse and rape she had experienced by him. After his arrest all the children were removed from the family home. Sadly, Amy was unable to stay with her siblings as a placement able to accommodate them all was not available. Amy was never to live with her siblings again, despite wanting this. Amy's baby was born and was later removed from Amy aged three months due to her not being able to look after her.

Amy believes that she herself made the decision for her baby to be placed for adoption. She stated during our first interview that she made the decision for her baby to be placed for adoption in her baby's best interests and she struggles daily with the sadness she feels because of losing her. She believes that she made the right decision for her baby's sake.

6.The questions asked by Amy of the agencies

See **Appendix II**

7.The questions posed to the agencies from the chronology

The aim of this process was to look at both the events that took place then and how they were managed. All services were aware that they needed to improve practice following this case and have made changes. This process examined what happened and why and provides the WSCB with an opportunity to examine whether the changes in practice and procedures now in place give the members of the WSCB confidence that were a similar event to happen again, it will be responded to more effectively.

The questions posed to the agencies came from the chronology supplied to the facilitators. It was noted at the event that Children's Social Care felt that the chronology was not detailed enough to do justice to the work they had undertaken with Amy. For a full list of the questions posed to agencies see **Appendix III**.

In the following section of the report we will summarise the answers provided by each agency represented at the learning event and responses to any subsequent questions or discussion, and where relevant the written responses provided to the questions by the agencies involved.

7.1 Children's Services response

The representative from Children's Services addressed the WSCB members and other interested parties at the learning event on behalf of Warwickshire Children's Services. The representative stated that the chronology that was provided was not complete and that the representative herself knew that more was done than was indicated in the chronology to elicit Amy's' wishes, and that a specialist worker was engaged to work with Amy in helping her make decisions about where she wished to be placed following her removal from the family.

In terms of changes made that might reassure Amy and WSCB, the representative stated that the culture within the agency has changed in that the authority now uses 'Safety Plans' which are designed on the assumption of working in partnership with the family or young person in order to identify and establish how to secure safety for the child or young person. There are within the Safety Plan template prompts that direct the worker to engage the service user in partnership. It is now required where appropriate that General Practitioners are consulted regularly in terms of the needs and risks facing the family, child or young person. All front-line staff have received training in which they have been urged to seek the voice of the child from the outset. And in all contacts to ensure that children and young people are interviewed separately from other family members. This is routine and embedded.

Families such as Amy's – 'high support and high challenge' would now be allocated to a worker better able and prepared to respond to them. The representative acknowledged that because resources were limited it would be difficult to commit to being able to allocate an identified social worker to a family in line with their fit and/or skills. She added that all social workers are now partnered with a social work assistant who supports them. In addition, there

is on site support for social workers from a team of psychologists who can offer help with difficult to engage and chaotic families such as Amy's. In meeting with complex families, it is now seen as good practice for a social worker to work jointly with other key workers – their manager or a specialist worker, or police officer for instance. There are now more Risk Assessment Meetings than before which indicates heightened awareness of risk within families.

The written response stated that the 'Workload Measurement Tool' measures the time taken and the complexity of case, rather than just the number of cases, and so should prevent worker overload. In addition, there was evidence that a good relationship between the Social Worker and Amy existed- her disclosure was evidence of this. Signs that a positive co-working culture already exists in the agency.

The representative acknowledged that in terms of being prevented from identifying the risks posed to the children within the family by controlling and coercive family members the service fell short. She stated that now there is throughout the service a move to 'reflective supervision' in which the focus has moved from measurement of quantitative tasks such as timeliness to one that looks at the experience and feelings of the worker and using that to identify concerns and next steps involving children and families. Supervision is now a process in which the worker and manager are encouraged to share doubts, concerns and fears which should lead to safer practice being developed. The agency had also changed its approach from one in which compliance with agreements and plans made with families was assumed and in which there was limited monitoring of progress to one which used 'Safety Plans' the design of which regularly prompted the Social Worker to seek the voice of the child and look for signs of progress or decline in ability to change. There is an active system of case auditing undertaken randomly, reflective supervision, and regular training to ensure the new approach is embedded.

The representative accepted that knowledge and ability to recognise and respond to domestic abuse within Amy's family was lacking, and that in particular the issue of coercive and controlling behaviour was not promptly identified by workers involved as abuse. The absence of violence meant the family was mistakenly not seen as experiencing domestic abuse. The representative stated that there has since been a programme of training on domestic abuse and that also Domestic Abuse Specialists are in place through the County as a resource for workers. The written response from the service stated that in some cases in the past when services were more local there was a tendency for workers who had been involved for a long time with a family to miss key information. The written response also stated that that issue had been resolved with the move to County allocation of workers enabling more robust assessments.

The representative responded to a question from a member of the WSCB concerning the care of future children who lacked maturity and were not able to articulate their wishes, saying that in every meeting there is a 'voice of the child' agenda item, and that she was surprised that this was not referenced in the chronology, as it is a feature of every meeting concerning a child. A question was then asked from a member of the Safeguarding Board as to how the child's voice being heard is evidenced? The representative replied that this was done through involving the Advocacy Service, regular case file audits one of which ratings is based on the question 'Has the child been heard'?, random samplings of cases

and a culture in which learning from individual cases is spread through the authority. A follow up question from a Board member was raised concerning the ability of a child to articulate their wishes? The representative responded by saying that access to the Advocacy Service was now offered as a standard to every child. In addition, speaking to the child on their own, incorporating their views into reports and assessments enabled this.

Children's Services felt that the Legal Services department were now better involved in the progress and decision making around children in care, with an overarching Senior Manager who heads a multi-agency meeting with oversight of the child's progress.

A question was raised from a Board member about Amy's seven placements in one year; why they broke down, and whether Amy's views were canvassed about this? Why a Residential Unit was considered for Amy, given her age? and why the current foster placement had worked so well, what was different about it from the others? The representative did not feel able to answer these more specific questions given the period that had elapsed. The facilitator added that from the chronology the drive to a residential placement came from a recommendation made at an earlier Family Court meeting and concerns over the court's expectations that such a placement be found. The facilitator who had visited Amy at her foster home suggested that in her view there were a number of factors as to why the current placement had worked where others didn't - time, maturation and acceptance by Amy of her trauma and loss of her baby and importantly the quality of the relationship that existed between Amy and her foster carer. It was recognised that the foster carer was exceptional, she was very warm, persistent and consistent in her care of Amy.

There was finally a question about 'home schooling' and Children's Services response to this, particularly relevant as 'Frank' threatened and did remove Amy and her sister from school to be 'home schooled'. It was recognised by members that this was a national problem, given the probable link between home schooling and potential risk to children identified in Serious Case Reviews, and that the WSCB would retain it for the moment as an agenda item.

The WSCB representatives were asked by the facilitator if they were reassured overall that the appropriate changes in practice made would make such an event less likely in the future. All indicated they were reassured.

7.2 Midwifery and Antenatal Care at University Hospital Coventry and Warwickshire and South Warwickshire NHS Foundation Trust

Two representatives from Midwifery and Antenatal Care addressed the WSCB members at the learning event. Both represented the two health trusts that had had contact with Amy during and following her pregnancy.

Both representatives felt confident that expectant mothers being seen for the first time would be seen on their own. However, this cannot be insisted on if the expectant mother does not wish it. For a child, antenatal staff would be particularly inventive in gaining lone access. However both representatives assured the panel that staff are aware of any partner attending and in any way preventing staff seeing the mother on their own as suspicious and that they have developed 'ways and means' i.e. by taking the mother to the toilet etc to see them on their own. The representatives assured WSCB members that all staff are trained

and aware of the dynamics of domestic abuse and coercive and controlling behaviour and will be able to identify it. Likely responses would be either to provide information- advice lines etc providing it was safe to do so or contact the MASH Team or if they were unable to see the expectant mother on her own, the Domestic Abuse Team. They stated that midwives are actively encouraged to information share and a culture now exists in which staff that feel 'uncomfortable' with something they have witnessed or overheard will contact the family's GP for information exchange. Antenatal services do access and do use the Domestic Abuse Stalking &Harassment (DASH) tool in relevant cases. It was suggested that this would not be suitable for a 12-year-old expectant mother such as Amy presenting. It was affirmed however that such a child would be referred to the MASH with a marker for DA provided.

Asked how antenatal services would respond now to seeing a 12-year-old expectant mother, the representatives described a set procedure involving a routine enquiry to the MASH, a screening for learning disabilities, this they described as the 'Green Book' containing mandatory questions for staff to ask expectant mothers. Issues of concerns regarding domestic abuse could be taken up with the Specialist Domestic Abuse Team or in safeguarding supervision, mandatory for all Community Midwives and Health Visitors and provided by a safeguarding trained supervisor. It was stressed that if the staff member suspected conception to have occurred before the age of 13 it is standard practice to make a safeguarding referral to Children's Services.

The representatives acknowledged that the issue of 'continuity' was a problem, and that vulnerable or potentially vulnerable expectant mothers would not see the same midwife through visits to delivery. Such arrangements were not always practically possible, but services were looking as to how this could be improved and are currently trialling ways of doing this.

The WSCB representatives were asked by the facilitator if they were reassured overall that the appropriate changes in practice made would make such an event less likely in the future. All indicated they were reassured.

7.3 South Warwickshire NHS Foundation Trust (SWFT)

South Warwickshire NHS Foundation Trust were involved in Amy's case due to the issue of Amy's sister not being brought to clinic on several occasions and the issue of managing controlling and coercive men in clinic when such behaviour impeded necessary medical care. The representative reported that both health services now have a Safeguarding Unit that is integrated within their health trusts. Now cases such as Amy's sisters would be referred to specialist services that would contact the family and child and provide education and support to encourage attendance. Staff could, in particularly difficult cases refer to the in - service Psychology Unit. If it felt appropriate, referral into MASH would be made if safeguarding concerns were identified. Should a parent wish to be responsible for administering medication, the training needs of them doing so would be explained and their ability to do so would be a requirement. If matters were not satisfactorily resolved, a referral to Children's Services would be made. Further it was stated that in cases of a child not being brought to clinic, consultants would be encouraged to consider if this had safeguarding

consequences and if so that a referral should be made given the risk of harm likely to the child, and not be seen simply as a ‘did not attend’ (DNA).

The WSCB representatives were asked by the facilitator if they were reassured overall that the appropriate changes in practice made would make such an event less likely in the future. All indicated they were reassured.

7.4 The Police Service

The police representative addressing the meeting reassured board members that the Service takes domestic abuse seriously, all police officers are trained to recognise the signs of domestic abuse, and that a large number of officers have also completed ‘DA Matters’ training which was rolled out to enable officers to identify and collect evidence of coercive and controlling behaviour. The representative also pointed out that all officers in callouts are encouraged to ‘look beyond the obvious’ and always be aware for signs of abusive behaviour. Officers attending incidents are encouraged to ‘follow through’ and there are mechanisms to refer to Domestic Abuse Risk Officers (DARO) in cases of ongoing concern. In terms of safeguarding children in call outs involving domestic abuse, attending police officers are all aware they should carry out ‘safe and well checks’ and where possible speak to the children. However, it could not be confirmed to what level this is done. Operation ENCOMPASS, soon to be operational will ensure all information from call outs involving children will be passed on immediately to the MASH, and schools, with the expectation that staff at school will check in and help the child through the day. This approach was warmly received by members attending, one describing it as “worth its weight in gold” and being “elated” by the news.

The WSCB representatives were asked by the facilitator if they were reassured overall that the appropriate changes in practice made would make such an event less likely in the future. All indicated they were reassured.

7.5 Adult Social Care

Although Adult Social Care were not directly involved in this case, they had been asked to identify any learning from this case that could be applied to the services they deliver. The questions posed to them were therefore generic.

The representative from Adult Social Care informed the meeting that all staff now receive mandatory training in recognising domestic abuse. It was recognised that less obvious forms of abuse such as coercive and controlling behaviours were harder to identify given the acute nature of the services delivered and the often-brief contacts by their staff with adults. That said, the training of social workers was now followed up by managers who worked to a ‘Customer Journey’ model in supervision and that supervision by a line manager was also supplemented by peer to peer supervision.

The ‘Mosaic’ recording system is now used by Adult Social Care which links them to Children’s Services and helps them to gather information on the whole family which will help to identify safeguarding issues in future.

In addition, both Adult Social care and Child Safeguarding Teams now shared the same office and often attended training together. This has made communication better and easier and led they believed to improvements in practice for both.

Adult Social Care accepted that the brief nature of its involvement meant that staff are limited in the time they have to engage and motivate service users when they are victims of abuse and are unable to offer continuity and engagement with the same professional.

Case oversight is now properly embedded with regular case audits and an 'understand me to support me' approach with adults. This approach has encouraged a more holistic approach, in one area a trial was ongoing involving a change in culture away from brief interventions and case closure, to one in which workers stayed involved until they were sure the issues had resolved. The representative stated that this approach was new and that there may be resourcing issues as worker's caseloads inevitably grew. Whether it was sustainable and could be rolled out across the County had yet to be established. This gave the Trust confidence that they would be able to identify the more subtle behaviours within coercive and controlling relationships. The representative was confident now that there would be more take up when workers signposted services because of their deeper involvement with service users.

The representative stated that overall the approach is now one in which the parts of the system speak to each other, an example of this was given of the 'Children's Transition' meetings, a multi-agency forum that would support the child transition into leaving care and more independence.

A final point was then made from the floor that the MASH was not available for concerns involving an adult at risk, and could the brief for the MASH be extended to take this on? The point was made in response that the MASH was only intended for child safeguarding, and that adults at risk were not within its brief.

WSCB representatives were asked by the facilitator if they were reassured overall that the appropriate changes in practice made would make such an event less likely in the future. All indicated they were reassured.

8. Summary/Analysis key learning points

With the benefit of hindsight and avoiding hindsight bias the following learning points have been identified from the investigation undertaken

1.Failure to recognise and respond to the issue of coercive and controlling behaviour

Overall, in our view the most significant event in the tragedy that befell Amy and her siblings was the arrival of 'Frank' into the family and the failure, unwillingness or inability of Amy's mother to protect Amy and her siblings. This was a family that was already on the radar of services in the area. Amy's father had already been excluded from living with the family due to a conviction of sexual abuse related to a child. Despite this the services involved, in particular Children's Services had little oversight, control or influence over this family on an ongoing basis. We have seen interventions and assessments made in response to allegations and concerns made, for services then to step back once the immediate situation

had been dealt with. This approach may have been due to resources or methodology of intervention but it is plain to us that this allowed Frank to enter the family (following risk assessment by Children's Services) in which its previous history would suggest vulnerability and from then on to establish control over the family and isolate the children systematically from those that could potentially have protected them- the children's school, medical staff at outpatients appointments and A&E. It is significant that Amy only felt able to disclose her abuse when Frank had been arrested and removed from the home following Amy's brothers' allegations of his abuse at his hands. This demonstrates the totality of his power and control over this family and ability to control other professionals.

It is also of note that the State Institutions that encountered him did not seek to challenge Frank's assumption of responsibility. Services referred to him as the 'father' in case records despite there being only his claim to that position and Amy's mother's apparent acquiescence to his assuming that role. He was allowed to assume responsibility for decisions that would have life changing implications for the children- removal from school of Amy, and responsibility for the management of her sister's long-term health condition, despite being without any biological or legal right to do so. There are instances in which Frank and Amy's mother were disruptive and challenging in clinic, and that Amy's sister was only brought to a fraction of the appointments that were made for her. She was admitted on an emergency basis to Hospital due to her condition and yet no action other than a safeguarding referral to Children's Services was made. This referral was of course appropriate in itself but we have no record of Amy's sister receiving the medical care she had a right to. Frank had ample time and freedom to assert his power and control over the family which was only broken by his arrest and removal from the family.

2.Failure to put the child first.

Amy in the course of her pregnancy was seen by the antenatal team on a number of occasions. She was not seen without her mother, nor offered the opportunity for this. This was clearly in hindsight an opportunity missed in which Amy could have chosen to disclose the abuse. This failure for her to be offered and provided with this opportunity reflects an underpinning attitude and belief that a mother could not be involved in the sexual abuse of her child in any way. This is contrary to good practice as at a Sexual Assault Referral Centre no assumptions are made about the presenting non abusing parents.

3. Failure to recognise anger as a healthy and appropriate response to trauma

Amy at the time of her disclosure and pregnancy was 12 years old and had some Learning Disabilities which have not been specified to us as a part of this enquiry. By this point Amy had experienced significant trauma and had lived with a controlling man who she was fearful of. She was, soon after her disclosure removed from the home along with her siblings. She was never to live with them again. This separation would have reduced her resilience to cope with her trauma and may have fed into other negative feelings linked to self-worth, guilt, anger and aggression etc. There is no record of her experience being acknowledged with her nor of any help being offered or strenuous efforts made to reunite the siblings or offer a timetable in relation to that. Amy experienced innumerable placements in the intervening years, each placement being met by her challenging behaviour, and placement breakdown. The only intervention offered was a suggestion of a referral in response to her 'anger issues'

for anger management. In our view Amy's anger and displays of anger was a rational and predictable response to her situation and it was predictable she would be angry during her supervised contact with her mother and father, this resulted in her throwing a can at the Social Worker.

4. Failure to provide effective advocacy for the child

It is striking and in our view a matter of sadness that Amy at no point from disclosure to becoming a 'Looked After Child' had anyone advocating on her behalf in the sense of soliciting from her what her wishes were and promoting them at any multi agency decision making meetings. We have seen no evidence of Amy in a structured and measured way being helped to formulate how she might begin to rebuild her life. It appears Amy was expected to cooperate with a supervised contact involving her mother and father to whom she felt extreme anger and resentment. This is evidence to us that the 'voice of the child' was not sought, something that Amy some years on, still feels bitter about. Nor in addition did we see any evidence of her learning disabilities being recognised and adjustments made for that.

It appears inevitable that Amy would feel that she has been punished for the actions and omissions of her parents. She had to give up her baby, conceived through rape after being given the time to bond with her, she still regrets not giving her up immediately, has never been able to live again with her siblings, and is only now, some years after the abuse beginning to feel she can take some control over life with the support of someone she trusts and respects. It is a tragedy those lost years were so devastating and lonely for her.

Recommendations

1. When a new adult joins a family, who is open to Children's Services and are deemed to be vulnerable, partner agencies need to assess the likelihood of risk of significant harm posed by that person to the child/ren in that family. Information should be recorded and authorised by the responsible social worker's line manager and referred to partner agencies, if deemed appropriate. It would be expected good practice that any judgement of risk of significant harm be based on verified information from more than one source.
2. That Children's Services are encouraged to use information from all sources and to use 'healthy scepticism and cautious optimism' in making assessments in decisions concerning families. This approach should be reviewed in supervision.
3. That all front facing staff in Health and Social Care including reception staff receive training and be able to identify potential indicators of coercive and controlling behaviour.
4. Failure to be brought for medical appointments should be escalated if a pattern already exists or if a certain number of appointments made are missed to the Safeguarding Lead who has responsibility to decide if it is a safeguarding matter and if so, contact appropriate agencies.
5. All staff should be reminded that the DASH Risk Checklist is not the appropriate tool for cases of children under 16 years of age.

6. Children brought to antenatal clinic must be seen on their own at some point on first appointment, Medical details and the protocol of management of information, right to privacy etc should be sought and given. Relevant information concerning pregnancy and young people be provided in confidence.
7. The Safeguarding Board should seek assurance that effective advocacy is in place to ensure the voice of the child is central to case management of the child. An advocate whose only responsibility is to represent the voice of the child is the only way to reduce the likelihood of Amy's experience happening again. That advocate should be seen as having equal weight and influence and right to attend and vote in forums involving decision making with other professionals, and a duty to inform the child of decisions made.

APPENDIX.I - List of Agencies who attended the joint learning event on 18 July 2019

Warwickshire County Council
Warwickshire Probation NPS
North Warwickshire Borough Council
Princethorpe College
Nuneaton & Bedworth Borough Council
South Warwickshire NHS Foundation Trust
Warwickshire Probation CRC
Warwickshire North Clinical Commissioning Group
Warwickshire Police
Healthwatch Warwickshire
Coventry & Rugby Clinical Commissioning Group and Warwickshire North Clinical Commissioning Group
Warwickshire Community & Voluntary Action
University Hospital Coventry & Warwickshire
Coventry & Warwickshire Partnership Trust
South Warwickshire Clinical Commissioning Group
VoiceAbility
Warwickshire Fire & Rescue
Rugby Borough Council

APPENDIX. II - Question posed by AMY

" Why were my feelings not considered or identified? "

" A direct question ie. "is it someone in the house?" Would have helped agencies to understand what had actually happened to me "

" Why did professionals not take the opportunity to speak to me on my own? "

" After I told the school how I felt, why did social workers visit me at home to discuss this with me and not come and see me at school? "

"Why was I not seen alone, away from home, away from Frank (the perpetrator)?"

" Why was I not asked what I wanted?"

" Why were assumptions made about Frank's parental rights (the perpetrator) when he had none? "

" I should have had a choice in deciding who went in to medical appointments with me, why was I not asked? "

" Why did professionals fail to check parental rights… this led to Frank (the perpetrator) being in the room at all times? "

" I wanted to go into care before the baby arrived but wasn't given the opportunity to express this, why?"

" I was 12 years old when I had my baby, why was I not supported to manage the expectations of a new mum… I felt I was set-up to fail?"

" Why was I allowed to bond with my baby when the plan was always to put her up for adoption…… I was allowed to fall in love with her and bond which was like having a limb ripped off me when she was removed 2 months later……. I was only 12 years old? "

" Professionals should have been asking me what I wanted to happen on every visit"

" I didn't feel supported or listened to whilst being moved around the system "

APPENDIX. III - Questions posed to partner agencies

Ante Natal Services
Questions:
What protocols are now in place to plan for a child who is pregnant living in a potentially abusive family and in which the explanation for the pregnancy does not add up?
How would a child in which part way through her pregnancy it was suspected she had been raped by her mother's partner be treated? How would this knowledge affect the care and manner in which she was worked with towards her delivery?
What channels exist between agencies that enables intelligence and suspicions concerning potential abuse not yet established but important to the safety of children to be shared and managed safely?
A pregnant child wishes her mother to attend all appointments with her. Her mother is equally insistent and is aggressive in demanding this. This will prevent the child being seen on her own. How is this managed?
Children's Services
Questions:
What are the mechanisms in place that ensure Legal Services are and remain in the loop when working in partnership with Children's Services in investigations?
How are staff enabled to manage difficult and aggressive service users about whom there are long standing, regular and serious concerns about their children?
How is case supervision designed so that difficult to manage cases receive more oversight and resources?
How does the case allocation system align difficult to engage and manage service users with workers able to manage them safely?
How are indicators of potential risk that are not serious in themselves identified early on so that preventative work can be undertaken and serious incident avoided, or escalation identified and responded to?
How are children that are known to live in families that are always on the edge of moving into crisis and are resistant to change treated differently to high need families that are not?
A 13 year old girl, who has just had a baby, has been the victim of rape and removed from her family and siblings is causing problems due to her behaviour and outbursts of anger and aggression in her placement. How would she be managed today? What outcomes would be seen as positive? What resources would be provided?
A child has been separated from her baby, family and environment and placed in a strange home with unknown people and is faced with an almost impossible to solve dilemma, and has to make a decision with very little information. She is not asking for help, and would probably resist if offered any. What would be the right approach and appropriate first steps with her?
Adult Services
Questions:
How confident do you feel in your staff's ability to recognise and respond to Coercive Controlling behaviour presented by a potential domestic abuse perpetrator?
How confident are you in your staff's ability to identify, access and engage appropriate community Domestic Abuse resources on behalf of a service user?
How confident do you feel in your staff's ability to engage and motivate a service user who is a victim of Domestic Abuse but is reluctant to seek help to do so?

Health Services
Questions:
How are instances of coercive and controlling behaviour witnessed by Nursing staff on hospital premises identified and recorded and that information passed on to the appropriate agency?
How would the case of a child with a potential life threatening condition e.g. Diabetes not being managed successfully by the parents, resulting in several A&E admissions be handled?
How is a parent managed who insists on controlling and providing the treatment of their child ie insulin injections, blood tests who has no recognised ability to neither do so nor interest in acquiring the skills?
How is regular non-attendance of children at outpatient's appointments with potentially life threatening conditions managed?
How are non-compliant parents who complain and make demands to the point of obscuring the medical needs of children handled by staff?
What escalation processes exist for concerns relating to the management of children's health?
How is information between providers of healthcare at different locations and specialism's within the Health Authority shared and responded to relating to children?
Is there a protocol in place that requires information relevant to children's well-being to be shared with relevant others?
In what situations might a child not being brought to an appointment be considered a safeguarding issue? If there are what would be done?
How would a child diagnosed with diabetes and who has attended the Diabetes Clinic spasmodically but has not attended the clinic for 5 months be treated? If they had attended A&E with different but related conditions over this time what would happen? Who would A&E share that information with? Would it be seen as significant? Who has oversight of such decisions?
Police
Questions:
How are safe & well checks carried out now in callouts in which domestic abuse is suspected or known?
How are Police officers attending able to establish emotional and physical impact on children in safe & well checks?
General
Questions:
How are 'hard to reach families' worked with and how are workers and managers prepared for the impact they can have in terms of time energy and emotions?
How would you summarise the different approach your organisation has adopted since this case and what leads you to believe those changes are effective?
If a family presented with a similar scenario what would be different about the journey this time? What would the family/ worker/ Legal Services/ Police/ Partner Agencies? Chair of the Child Protection Panel notice that was different?
How would you convince the Chair of your Safeguarding Board that they can be confident in the improvements you have made in the light of this case?
How do the partner agencies articulate and resolve concerns about the safeguarding arrangements being made for a service user already known to be vulnerable? What are the next steps if those concerns aren't recognised or addressed? Could you provide examples of such cases?
How is the child engaged in a 'therapeutic alliance' so that the child has confidence that their hopes and fears are recognised and considered in decision making?

Is this responsibility invested in one person, if so to whom are they accountable and what is the yardstick for success?