



LOCAL SAFEGUARDING  
**CHILDREN BOARD**  
NORTHAMPTONSHIRE

# SERIOUS CASE REVIEW

BOY CHILD A

GIRL CHILD B

BABY C

**Executive Summary**

**August 2008**

# EXECUTIVE SUMMARY

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## 1. PURPOSE & SCOPE OF THE CASE REVIEW

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This is a summary of a Serious Case Review undertaken by the Local Safeguarding Children Board (LSCB) following the arrest of the parents of A, B and C. Both were subsequently convicted of serious sexual abuse and the making and distribution of pornographic images; they are serving custodial sentences. The children, aged 3, 18 months and 5 months, now in the care of the Local Authority, had lived with their parents at various addresses in Northamptonshire. Their home circumstances were of serious concern to Health and Social Care workers who had been working with the family in a variety of ways over two years to improve their standards of care.

An Executive Summary merely provides an explanation of the case review process, an overview of the circumstances in which the children lived, lessons learned from the case review and recommendations for action by the LSCB. Findings from the review have been reported to the Office for Standards in Education (OFSTED) as is required.

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## 2. REVIEW PROCESS

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The Serious Cases Review Panel, whose members were drawn from the constituent agencies of the LSCB, oversaw the process of the review between January and May, 2008. Individual agency reports received from NHS Trusts, the Police, and the Children & Families Service of the Local Authority, provided information for the case review. Independent authors were commissioned to compile an overview report which was received by the LSCB in June, 2008.

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### 3. OUTLINE OF CIRCUMSTANCES LEADING TO SERIOUS CASE REVIEW

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- Boy A was born in Kettering in 2005. His mother, who had a moderate learning disability, was helped to care for him by her extended family and he made good early progress. His father played no part in his life.
- When A was a year old, his mother, who was pregnant, formed a relationship with Mr. Z. They all moved to Northampton to stay in the home of her grandfather. Their move triggered a concerned referral to Children and Young Peoples Services (CYPS). Inquiries confirmed that there were adult residents of the grandfather's house who were alleged to have sexually abused children. Actions were taken to ensure that A, his mother and Mr. Z sought alternative accommodation and that they agreed to protect A.
- During the next few months the Health professionals who continued see the family became increasingly worried about the standard of care offered to A. Following reports that he had been left alone, CYPS again became involved. Although the parents were reluctant to accept help to improve their parenting, they were assisted in a move to temporary accommodation.
- In the summer of 2006, Mr. Z admitted that they had downloaded and saved a DVD containing pornographic images of children. Child Protection Procedures were not used to investigate these circumstances. Following the birth of Child B the family continued to be regularly visited by a Health Visitor and social worker who were concerned that the children were being physically neglected. The family again refused services designed to address these issues.
- In March, 2007 home conditions and the treatment of Boy A deteriorated further, mother was again pregnant, and the Health Visitor referred to CYPS. During the months proceeding and following the birth of Baby C the family were jointly visited, supported and advised by a Health Visitor and Social Worker.

- In November, 2007 information received from the FBI (USA) led to the parents' immediate arrest and the children's accommodation, initially with extended family but subsequently in foster care.

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#### **4. INTER-AGENCY LEARNING ARISING FROM THE REVIEW**

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- The assessment of parenting capacity is central to effective intervention with families who neglect their children.
- Working in partnership with parents demands constant attention to the the needs and interests of children.
- The interests of very young children who are seriously neglected are not well met by successive periods of short term intervention.
- All professionals require the knowledge to identify and confidence to act appropriately in circumstances where children may be sexually abused.
- Clear Terms of Reference and the preparation of Single Agency Authors are crucial in the conduct of Serious Case Reviews.

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#### **5. RECOMMENDATIONS TO THE LSCB**

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In addition to acting on the recommendations of the Single Agency Management Reviews, the findings of this SCR demand three basic changes in the approach to practice if children are to be adequately protected from significant harm arising from neglect.

- A greater awareness of, and acceptance by, ALL agencies of the factors which may predispose certain parents to seriously neglect their children and of the implications for interventions.
- An agreement that the process of safeguarding children who are neglected should not be divided between "support "and "protection" in a way which delays assessment of risk.
- An agreement that, in such cases, medium or long-term intervention will almost always be essential; closing cases is usually unrealistic and may be dangerous.

To achieve these changes in approach, all relevant agencies must pool information at all stages and have the appropriate forum to do so.

It is therefore recommended:

1. That the LSCB establish a working group which will specifically address the points above and identify the different strands of activity which will be required to achieve change. Although training initiatives will play a part, clarification of policy and process at local and national levels is critical.

Additionally, it is recommended

2. That the LSCB exploit the opportunities afforded by the appointment of an E-Safety Officer to ensure that staff have the knowledge and confidence to safeguard children who are vulnerable to sexual abuse, with particular reference to the use of new technologies. In this initiative, the Police and Family Support service should receive priority attention.

3. That, drawing on the existing knowledge base, the LSCB review current guidance, resources and practice regarding the assessment of parenting capacity in cases of learning disabled parents and make recommendations to secure effective co-operation between adult and children's services in this matter.

4. That the LSCB clarify existing guidance with reference to the management of all aspects of Strategy Meetings and ensure interagency agreement and compliance.

5. That all children who are accommodated as a consequence of alleged sexual abuse have a forensic paediatric examination.

6. That the LSCB's Serious Cases Sub-Committee use the learning arising from this Serious Case Review to inform its current work; particularly in relation to the preparation and support of Single Agency Management Review Authors.