social work inspection agency

An inspection into the care and protection of children in Eilean Siar

SCOTTISH EXECUTIVE

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Introduction

1. In October 2003 13 adults were arrested in relation to the alleged abuse of three children. Nine adults were subsequently charged. In July 2004 the Crown Office announced that it was not proceeding with the case against any of the individuals charged. In the same month Comhairle nan Eilean Siar (CNES) invited the Social Work Services Inspectorate (SWSI)[1] to undertake an independent review of their involvement in providing services to two families (identified in this report as family A and family B) and report their findings and any lessons which could be learned to its child protection committee. SWSI agreed to review the role played by CNES. Subsequently representatives from police, health and education joined the inspection team which examined the actions of all of the agencies involved who provided services to the families.

2. The inspection team comprised Angus Skinner, chief inspector of social work[2], Gillian Ottley, depute chief inspector of social work and Dr Chris Robinson and Fiona Clark, social work inspectors. Detective Superintendent Brian Yule was nominated to join the team by Her Majesty's Inspectorate of Constabulary (HMIC). Professor Stewart Forsyth, a consultant paediatrician at Ninewells Hospital in Dundee, Dr Ian Bashford, a senior medical officer and Dr Linda de Caestecker, head of the Women and Children's Unit, both in the Scottish Executive Health Department, provided medical advice. Morag Gunion, an inspector nominated by Her Majesty's Inspectorate of Education (HMIE) provided advice on educational issues.

3. The remit of the inspection was to examine the role of all of the agencies[3] involved in providing care, welfare and protection services to all the children in family A and family B from the point at which the agencies first engaged with them to the point of completion of the criminal investigation. There was no remit to examine the conduct of the criminal investigation beyond its impact on the children and the provision of services to them during that period. Nor did the remit

[1] SWSI became an independent Executive Agency, the Social Work Inspection Agency, in April 2005.
[2] Angus Skinner retired as chief social work inspector at the end of March 2005.
[3] CNES, Western Isles Health Board and Northern Constabulary.

include the role of agencies who did not provide care, welfare and protection services to the children.

4. The history of family A is very complex and involves issues of physical, sexual and emotional abuse and neglect over a long period of time, spanning generations. We wanted to make sure that the life stories of the three children in family A were at the centre of our inspection. We therefore examined the local authority and health records since the births of the children. Our approach enabled us to form opinions from a wide range of sources written during the previous 20 years. This involved the full co-operation of the relevant agencies in Eilean Siar and in England where the family lived until August 1995, although our remit did not include inspecting the work of staff in the English authority. We visited both Eilean Siar and England. We also examined local authority and health records in Eilean Siar relating to the five children in family B.

5. We went on to examine the agencies' records of the criminal investigation including the witness statements. The children's witness statements and Mrs A's witness statements contained allegations of such severe abuse that we have not reproduced them here because of our intended wide circulation of this document. In total we read and analysed approximately 220,000 pages of material. In addition the Crown Office provided us with further material in July 2005. A full account of the process of the inspection is contained in appendix 1.

6. The police had already conducted an extensive criminal investigation and interviewed a large number of witnesses. We therefore decided not to interview staff in any of the agencies. We have contacted staff where necessary to seek clarification of the case records and to obtain an update on the children's current circumstances since our inspection began. We have met with the foster carers of the children and offered to meet with the children to discuss the process and conclusions of our inspection.

7. As a result of our examination of all of the records we established key facts in the children's lives in both Eilean Siar and England. These findings of fact name the children and their families, the staff involved from all of the agencies, the

people who were charged and those who were arrested but not charged. Given the unique circumstances and media coverage which has named the people who were arrested, it is not possible to anonymise the findings of fact and it would not be in the interests of the children for these to be published. The findings of fact have been agreed by all of the agencies concerned.[4]

8. This report contains an executive summary, our analysis, conclusions and recommendations. Additional information is set out in appendices. Our analysis is divided into two sections. Section one relates to the three children in family A. We begin by providing a brief summary of the key facts to enable the reader to make sense of the analysis. We go on to examine the standard of care and protection provided for the children by their parents. We then assess the impact of the agencies' involvement on the lives of the children. In section two we provide a brief summary of the key facts relating to family B and then analyse the impact of the agencies' involvement on the five children in the family. The names of the children, their families and other adults have been changed to protect their identities. Staff are not named. Throughout our analysis we refer to a number of pieces of legislation. Unless stated otherwise in the text, all statutory references are to the Children (Scotland) Act 1995.

9. We conclude our analysis in section three. We make recommendations throughout the report and summarise these in section four. These include recommendations for CNES and for national consideration. We recognise that smaller, rural and island authorities face particular challenges in protecting children. Nonetheless the issues arising from this inspection are relevant to all local authorities in Scotland, all NHS Boards and police forces. Throughout this inspection, we have tried to identify the lessons to be learned so that all the agencies involved are better prepared to protect children in the future.

[4] Chief Executive CNES, Chief Executive English County Council, Chief Executive of English Strategic Health Authority, Chief Executive Western Isles NHS Board, Chief Constable of Northern Constabulary, Chief Officer for the relevant area in England of the National Probation Service for England and Wales.

Executive summary

10. This report describes the story of three children who were neglected and abused over a period of many years. It is a disturbing account which has serious implications for all those involved in delivering child protection services in Scotland and elsewhere. The children's mother has a learning disability, had been sexually abused by her own father and was alleged to have abused other children. When her daughter was one year old, she married. Her husband was a schedule one offender convicted of indecently assaulting his daughter from a previous marriage. Mr and Mrs A went on to have two children. The various agencies tasked with protecting the three children worked with their parents for 11 years, offering support and assistance in an attempt to protect the children while keeping the family together. We have called this family, family A.

11. During October 2003 13 adults were arrested in Scotland and England in relation to the possible abuse of the children in family A. Nine adults were subsequently charged. The charges included rape, lewd and libidinous and indecent practices and behaviour and making indecent images or pseudo images of children on a computer. The basis of the allegations was statements made by the three girls from family A and their mother. In July 2004 the Crown Office announced that it was not proceeding with the case against any of the individuals charged. The inspection team did not have a remit to examine this decision or make an assessment of the credibility of the witnesses.

12. Comhairle nan Eilean Siar (CNES) had provided services to family A since August 1995 when they moved from England where they had received extensive services. Two of the adults arrested in October 2003 were the parents of five other children, identified in this report as family B. During the first few days of the criminal investigation these five children were briefly cared for by CNES and continued to receive services from them throughout the period of the investigation. There were no allegations that the children from family B had been abused.

13. We concluded that:

- The three children from family A had experienced severe and prolonged abuse.
- Social work practitioners and managers should have acted sooner to protect the children. Some of the decisions that were made were seriously flawed.
- Health professionals failed to respond appropriately to the potential child protection issues raised by the children's health problems and distress. The Western Isles NHS Board[5] did not have the systems in place to support health professionals in protecting the children.

14. The three children from family A were born in England in 1989, 1991 and 1993. Their names were almost continuously on child protection registers in England and in Eilean Siar until they were placed with foster carers, one child in 1998 and her sisters in 2001. Between 1990 and 2000, the professionals involved recorded over 220 health concerns and allegations or incidents of sexual, physical and emotional abuse and neglect about the children.

15. We found evidence of physical abuse, emotional abuse and neglect as well as symptoms and behaviour which are strongly suggestive of sexual abuse. We believe that all three children were repeatedly sexually abused[6]. Our conclusions are based on a range of evidence, from records going back to 1989, witness statements from professionals who knew the children at different periods in their lives and also from the children's own statements. We concluded that the children were physically abused throughout their childhoods until they were removed from home. The individual injuries were often relatively minor and, whilst medical opinion was sought regularly, there was not conclusive confirmation that their injuries were non-accidental.

16. Once in the safety of foster care (where they have remained) the children described the abuse they had suffered from adults. In the witness statements

[5] Western Isles Health Board became Western Isles NHS Board in 2003.

[6] In the 1998 Scottish Office guidance 'Protecting Children: A Shared Responsibility', sexual abuse is described as '…when any person(s), by design or neglect, exploits the child…in any activity intended to lead to the sexual arousal or other forms of gratification of that person…' (page 61)

they made during 2003 they described prolonged and severe sexual abuse, intimidation, violence and neglect. In statements taken separately the children's mother described abuse of her children over a ten year period. In statements to police both parents accepted that they had not looked after their children properly. The physical standards of their home were very poor. Money went on a computer rather than the basic needs of the children for food, clothes and bedding. One child routinely slept in a cupboard. We concluded that the children suffered emotional abuse as a result of their family's failures to meet their emotional needs.

17. Our report contains findings of fact from 1989 to 2004 (agreed by the agencies in England and Eilean Siar) and an analysis of practice, policy and management by all the agencies involved. The responses of the agencies did positively affect the children's lives at times, but despite their efforts the children continued to be physically, sexually and emotionally abused and neglected until they were removed from their family. The overwhelming emphasis was on helping their parents (and at times extended family) to bring up their children. However in our view there was an unhelpful imbalance in the weight given to this and to the rights and duties of parents as against the needs and rights of the children. In families where serious abuse occurs and the adults are not willing and able to change sufficiently within timescales important to the child, decisions need to be made to separate them from their children. The extent of the resources being provided and the willingness of parents to 'co-operate' with workers do not in themselves indicate improved parenting. In our view the children in family A should have been removed from home much earlier in their lives.

18. We concluded that the case conferences and children's hearings which were regularly held should have ensured staff responded proactively and effectively. They did not. Decision-making within and between agencies did not focus adequately on the needs of the children, or on exploring the legal options available to secure their protection. We found that professionals were too willing to believe the accounts of adult family members about what was happening at home, rather than the children's. All three girls at different times appeared to be trying to tell adults outwith their family that they were experiencing extreme distress and abuse. We found the first example in 1992 and many others in the

years which followed. Staff at all levels in the agencies lacked expertise in working with adults and children where physical and sexual abuse is suspected, and in the implications for staff management, case planning and implementation of action plans.

19. In this inspection we found that information was shared but was not acted upon decisively. We found references in the records to the family being 'supported' and a belief that this would improve the welfare of the children. Throughout the children's lives professionals were often over-optimistic about the capacity of members of family A to overcome their disadvantaged and abusive childhoods, manage their own mental and physical health problems, cope with poverty and poor housing and nurture and protect their children.

20. We found little evidence of a comprehensive evaluation of the impact of the adversities within the family. The absence of a recognised assessment framework within which these could have been debated and evaluated by all the professionals from different disciplines was a significant omission. However, gathering together large amounts of information is not an assessment. Sharing it does not constitute a child protection plan. Professionals seeking to protect children must take the next steps to state why they attach importance to some issues and not to others. The thinking behind their judgments must be explicit so that their judgements can be challenged and debated. We believe the children were disadvantaged by the apparent absence of debate amongst all the professionals involved and between professionals and members of the children's hearing.

21. We found a range of professionals in health centres, clinics, schools, nurseries, family centres and social work agencies conscientiously logged and shared concern about incidents indicating sexual, physical, emotional abuse and neglect but tough decisions to remove the children were not taken quickly enough.

22. Our report makes 31 recommendations. Seven are specific to CNES and the Western Isles NHS Board and are directed at improving how they manage the care and protection of children. One of these recommendations is specifically

about the legal arrangements for the three girls. Fourteen recommendations (for all local authorities, NHS Boards, child protection committees and police forces) focus on improving the strategic management of child protection, in particular analysing and using information collected about vulnerable children and the importance of taking account of family history when assessing risks to children. The demands on staff and foster carers are recognised by recommendations about training, support and supervision. Our report makes ten recommendations to the Scottish Executive. These seek changes to the fostering regulations when children are placed with relatives, improvements to the information available to children's hearings and a training programme for chairs of child protection case conferences. We are recommending a national system to provide advocates for children, the development of guidance for professionals on how to help children express their views and the amendment of guidance on interviewing child witnesses. We are also recommending a working group to examine best practice in the use of forensic medical examinations and the roles and responsibilities of paediatricians in child protection work. Two key recommendations are the establishment of a multi-agency resource on which all staff in Scotland working with complex child protection issues can draw for advice, expertise, training and research including the development of a national register of staff suitably qualified in joint investigative interviewing. Secondly, we recommend the Scottish Executive develop guidance to help professionals determine the most appropriate course of action where a child is found to be living in a household with a convicted sex offender.

Section 1 Family A

Background

23. This section summarises the key events relating to family A from the findings of fact agreed by the agencies involved.

Alice (born 1989)
Barbara (born 1991)
Caitlin (born 1993)
Mrs A (mother of all three girls)
Mr A (stepfather of Alice and father of Barbara and Caitlin)

24. Mrs A had attended a special school and she described herself as having a learning disability. Early case conference reports in England gave information about her past, as both a victim of physical and sexual abuse, including incest, and as an alleged abuser. Mr and Mrs A married in 1990. Mrs A already had a baby daughter, Alice. The family settled in an English local authority area. The first two years of agency involvement in England were marked by disagreement between staff in health and social services about the level of risk to Alice of possible sexual abuse by Mr A. In 1986 he had been convicted of indecent assault of his nine year old daughter from his previous marriage. Alice's name was placed on the child protection register in 1990. Between 1990 and 1995 the English social services department convened 12 child protection case conferences. With one early exception, the case conferences decided to place Alice, Barbara and, from 1993, Caitlin on the child protection register as at risk of sexual abuse. The children were also briefly registered as at risk of physical abuse.

25. From 1992 social services, health, education and voluntary sector agencies in England provided high levels of resources to family A. Alice and Barbara attended a local day nursery. Barbara's development was delayed and she was seen by a range of specialist health professionals. Mrs A received support from mental health services for her depression. Mr A was offered counselling in

relation to his conviction. Social workers undertook child care, protection and parenting work, assisted by a Home-Start volunteer and a family support worker. In addition the family received financial help and advice on managing their debts.

26. In the summer of 1995 family A moved to Eilean Siar. Social work, health and education staff in Eilean Siar tried to match the level of support given to the family in England. Services provided included risk assessments by criminal justice staff, a service commissioned from the local NCH project from 1998 and a homecarer from 1999. In 2003 Mrs A received a service from the community care team as a 'vulnerable adult'. Social work department staff also sought external advice from a child and family psychiatrist and two specialist child sexual abuse agencies. Education staff provided pre-school services and all three girls had involvement from an educational psychologist. Barbara continued to receive services from a range of specialist health professionals. She was assessed by a consultant paediatrician in 1998 and re-assessed in 2000 when she was diagnosed with mild cerebral palsy. All of the agencies in Eilean Siar shared information constantly about the family, both in and outwith formal meetings.

27. Between 1995 and 2001 the social work department in Eilean Siar convened 17 child protection case conferences. With one exception, the case conferences decided to place all three girls on the child protection register. They were variously registered as at risk of sexual abuse, physical abuse and physical neglect.

28. All three girls were referred to the children's reporter in February 1997. At a children's hearing in Eilean Siar in June 1997 they were all made the subject of supervision requirements under Section 70(1) of the Children (Scotland) Act 1995. This is still their legal status. Alice went to live with foster carers in August 1997 and returned home in the December. She returned to the same foster carers in March 1998 and has since lived continuously with them. Barbara and Caitlin went to live with relatives in June 2000. They moved to live with foster carers in September 2001 and have remained there ever since.

29. Since 1990 almost 100 professionals have provided services to family A in England or Eilean Siar. A total of 29 child protection case conferences were held between 1990 and 2000 in England or Eilean Siar. Social work department staff in Eilean Siar have convened at least 21 statutory reviews for the children since they became looked after. The reporter has arranged 24 children's hearings.

30. We assess the impact of agency involvement on the children's lives in this report. However, the welfare of children is primarily the responsibility of their parents. Therefore we begin our analysis by assessing the standard of care and protection provided to Alice, Barbara and Caitlin by Mr and Mrs A.

Was the standard of care provided to the children by their parents good enough?

31. We begin this section by giving a short account of the concerns recorded by various professionals about Alice, Barbara and Caitlin while they lived with their parents. We go on to consider whether Mr and Mrs A's parenting met the needs of their children. Finally we analyse the indicators which led us to conclude that their parenting was abusive and neglectful.

Reported concerns about Alice, Barbara and Caitlin

32. We tracked all the incidents and concerns that the professionals involved in England and Eilean Siar recorded about the three children while they lived with their parents. These 222 recorded concerns are listed in appendix 2. There were 29 records of suspected non-accidental injury and allegations of sexual abuse which were investigated by professionals. There were 22 records of incidents which we have described as neglect. There were 171 recorded instances where the children had marks, bruises or other physical injuries or where there were concerns about their health, including genital soreness, wetting, soiling and worries about their development. We have collectively called these 'health concerns'.

Alice

33. In 1990 Mrs A was first referred to social services after she said that she had slapped Alice on the face and needed a break from her. As Alice's stepfather had a previous conviction for indecent assault of his daughter from his first marriage, health and social work staff saw him as a potential risk to Alice. When Alice was 14 months old, Mrs A took her to her GP worried that her husband was sexually abusing her. Shortly afterwards neighbours reported that Alice was being left alone at night. In late October 1990 Alice started at nursery. From then until November 1991, the nursery recorded 17 occasions when she had a sore genital area, bruising to the tops of her legs or bruising to other areas of her body,

including her face and ear. In November 1990 she had a burn blister on her right hand.

34. In May 1991 the minute of a nursery review stated that, *'she seems disinterested in who takes care of her in nursery…She will go to anyone at all'.* In July they noted that *'She is still eating far too much and doesn't know when to stop, she eats soap and still mouths objects.'* In November 1991 Alice had a scald which resulted in a joint police and social work child protection investigation.

35. For much of 1992 Alice did not attend nursery and the only professional who had contact with her was the health visitor. Concerns about sexual abuse re-emerged in the summer of 1992 when Mrs A contacted the police worried that Alice was being sexually abused by Mr A. Two months later she contacted the health visitor worried that three year old Alice had been sexually abused by Mr A's son from his previous marriage who had been visiting the family. In December Alice told the social worker that her stepfather sexually abused her. All three referrals resulted in joint police and social work child protection investigations.

36. During 1993 a social worker, family aide or health visitor visited the family at least once a week and Alice attended nursery four days a week. The only recorded concern by any of the professionals was a report from the nursery in October 1993 that Alice was going to the toilet more often than was usual for her age.

37. In February 1994, when Alice was four and a half, there was a joint police and social work investigation following bruising to her face. Alice was registered as at risk of physical abuse three months later when a consultant paediatrician concluded that this, and a suspicious injury to her sister in May 1994, were likely to have been non-accidental. The professionals began to record concerns about neglect in 1994. The social worker described the house as dirty and untidy. In October, Alice had flea bites and was found wandering in a cul de sac. Mr A was £2000 in debt.

38. In February 1995 Alice's school noted that she *'looks poorly and has a constantly runny nose. Her toleration of others is poor and she has no friends. If*

she can get something in her mouth to chew – she will.' In March Alice hid in a phone box to avoid the school bus and the following day had scratches and bruises to her chest which were observed by the family aide. Mrs A took Alice to the GP as she was again worried about Alice's 'sexualised behaviour' and she told the GP that Alice was reluctant to relate to her stepfather.

39. The incidents continued when Alice and her family arrived on Eilean Siar. In March 1996 Alice started wetting when she had previously been dry both during the day and at night. She was just over six and a half years old. In September 1996, Alice had a burn which the GP considered compatible with a cigarette burn but he could not completely rule out other explanations, including that it had been caused by playing with a plastic bag and matches.

40. In February 1997 Alice alleged she had been assaulted by her stepfather and there was a joint police and social work investigation. Mr A was charged. The criminal case against him did not proceed but the police referred all three children to the reporter to the children's panel. The following month Alice alleged that her stepfather had sexually abused her. She later retracted this allegation but the following day her grandmother told the social worker Alice had been behaving in a sexually inappropriate manner towards Caitlin.

41. From August to December 1997 Alice lived with foster carers and the professionals did not record any concerns about her welfare. They noted that she put on weight and grew two inches in four months. She returned home in December 1997. In February 1998 she alleged that her stepfather had assaulted her and there was a joint police and social work investigation. The following month Alice returned to live with her foster carers where she has remained. Altogether professionals recorded 46 concerns in respect of Alice between 1990 and 1998. There were a few more concerns recorded about her after this point relating to the times she visited the family home. In October 1998 she returned from an unsupervised home visit with a bruise on her thigh and could not remember how she had got it. In February 1999 Alice told her foster carer that she was worried about one of the visitors to her family home and said *'I don't like him being alone with my mum.'*

Barbara

42. The concerns that professionals recorded about Barbara increased from 1994 and continued to rise until she was removed from her parents' care. Barbara started nursery in January 1994 just after she turned two. In April the nursery recorded their serious concerns about her developmental delay. The following month Barbara had multiple bruises to her ears, face and shoulder and she was additionally registered as at risk of physical abuse at the subsequent case conference. In October the nursery reported that she was often distressed and showed indiscriminate affection to adults whether they were strangers or known to her.

43. In September 1995, shortly after the family moved to Eilean Siar, Barbara sustained red weal marks on her forearm. The following month she came to school with a burn-like mark on her right forearm.

44. In 1996, professionals recorded five incidents of four year old Barbara sustaining bruising to her arms, thigh, spine and knees. Both health and social work professionals continued to record concerns about her delayed speech and her vision and hearing problems. In the minute of the December 1996 case conference, it was noted that Barbara had been arriving at school ravenous and sometimes inappropriately dressed for the weather.

45. In February 1997 Barbara sustained a deep burn on her hand. In the same month she soiled twice in school. During the year, her class teacher recorded incidents of Barbara wetting herself in school and being weepy and clingy.

46. In 1998 on two separated occasions Barbara sustained burns to her neck and hand. She alleged these were caused by Caitlin burning her with their father's lighter. In June 1998 Barbara, aged six and a half, had a stab wound which she said was inflicted by five year old Caitlin with a pair of scissors. The GP recorded: *'…the small disposable nurse's scissors shown to me were unlikely to cause such a neat wound. More likely a very sharp blade e.g. Stanley knife'.* In January she soiled twice in one day in school and in March she had red marks on

her upper thighs, a rash in her groin area and was sore going to the toilet. Towards the end of the year she became increasingly tired and upset in school.

47. The number of recorded concerns about Barbara intensified during 1999. Professionals recorded six incidents of physical injury to Barbara including a burn on her hand for which she gave three different explanations. In February she told professionals that Mr A had shaken her. The homecarer, Mrs A and Barbara herself on separate occasions talked about the inappropriate behaviour of adults visiting the home. Barbara increasingly showed signs of neglect during 1999, sometimes arriving at school unkempt, dirty and without her glasses or hearing aid. Her speech deteriorated. The homecarer reported that the house was very cold, bare and chaotic and that Barbara and her sister were not being consistently fed proper meals.

48. In March 2000 Barbara had started to bite herself and during May became increasingly tired and upset in school. At the end of May she alleged that Caitlin had been behaving in a sexually inappropriate manner towards her. There was a joint police and social work investigation. In June 2000 Barbara and Caitlin went to live with relatives.

Caitlin

49. The first concern that professionals recorded about Caitlin was in September 1996 when she started wetting at nursery. Their recorded concerns increased from 1997 onwards. Most of the concerns in 1997 related to Caitlin's wetting and soiling at both home and school. In May 1997 a GP recorded that four year old Caitlin *'must have a source of deep unhappiness.'* In the same month Caitlin sustained bruises when she fell out of a window and in October she had a burn on her hip, said to have been caused by a storage heater.

50. During 1998 professionals recorded their increasing concerns about Caitlin's health, largely due to her wetting and, in particular, her soiling. There were periods when she soiled on a daily basis and occasions when professionals recorded that she soiled as many as four times in one day. The records also

noted that her parents or grandmother did not always collect her from school. She sometimes came to school unkempt and smelly. In February Caitlin alleged that Mr A assaulted her and there was a joint police and social work investigation. In November Caitlin came to school first of all with a red mark on her face and later with a bruise on her face. She also told a professional that she had nightmares of a man coming into her room with a knife. She was not yet six. Caitlin had a further scratch and a bruise to her face in December. In the same month the social worker recorded that Caitlin was sleeping in a cupboard in bedding smelling of urine.

51. There were 66 concerns recorded about Caitlin's health during 1999, an average of more than one per week. This was largely due to an escalation in her soiling. The GP did not think that there was any physical reason for her soiling and concluded it was an emotional problem. During the year there were seven instances where Caitlin had bruises, marks or cuts to her face or head. She sustained several cuts or injuries to other parts of the body and on one occasion hit her head on the hearth at home. The homecarer, Mrs A and Caitlin herself reported inappropriate behaviour by adults visiting the home. The homecarer also reported inappropriate sexual behaviour by Mrs A towards Caitlin.

52. In April 1999 Caitlin came to school with a cut on her head and said she had fallen out of bed. On the same day Mrs A told the GP that Caitlin had bruised her head and hip having fallen in the bath. When Caitlin returned to school after the summer holidays, she seemed unhappy and complained of sore tummies, hunger and headaches. In October school staff reported that she was depressed and lethargic. The health visitor reported that her height and weight had dropped by nearly two centiles.

53. The concerns that the professionals recorded about Caitlin's soiling continued in the first half of 2000 at a similar level to 1999. At times she was very distressed in school. She soiled at the school sports day in May and did not want to go home with her family. At the end of May Barbara alleged that Caitlin had displayed sexually inappropriate behaviour towards her. In June seven year old

Caitlin was recorded as saying at school that she wanted to kill herself. She and Barbara moved to live with relatives later that month.

Standards of parenting

54. There is no legal definition in Scotland of what constitutes good enough parenting. Section 1 of the Children (Scotland) Act 1995 sets out the responsibilities of parents to a child under 16:

(a) to safeguard and promote the child's health, development and welfare

(b) to provide, in a manner appropriate to the stage of development of the child;

(i) direction

(ii) guidance to the child

(c) if the child is not living with the parent, to maintain personal relations and direct contact with the child on a regular basis and

(d) to act as the child's legal representative.

Parents have a number of rights set out in the Children (Scotland) Act 1995 but these exist in order to enable them to fulfil their parental responsibilities.

55. In *'Child Development for Child Care and Protection Workers'* Daniel et al. (1999) refer to 'helpful' and 'unhelpful' aspects of parenting and remind us that parenting tasks change as the child develops and that there will be cultural differences. Parenting will be influenced by a range of factors. These include parents' own experiences of being parented, material circumstances, genetic factors, relationships with each other and other adults, mental and physical health and wellbeing, the support they receive and prevailing social policies, e.g. encouraging parents to work, levels of benefits and tax credits.

56. In a major study commissioned by the Department of Health to contribute to a better understanding of parenting entitled *'Supporting Parents. Messages from Research'*, Quinton (2004: 26-27) summarises parenting as involving a combination of tasks, behaviours and relationship qualities. Tasks include giving basic physical care and protection, setting boundaries and providing supervision. Behaviours include giving affection and approval, providing consistency of care,

encouraging age-appropriate learning (including play) and being responsive to children's needs as they develop. Relationship qualities include providing consistent and predictable warmth and promoting a secure attachment. Any assessment of parenting should include their strengths and weaknesses. This theme will be revisited in discussion of the work undertaken with Mr and Mrs A by the various agencies.

Parenting tasks

57. In England case conference reports noted a number of worries about standards of parenting. For example, nursery staff commented on Alice's poor health and her parents' unwillingness to take this seriously. She and her sister also consistently over-ate at nursery. In Eilean Siar, the children's appearance became increasingly unkempt. The children were often not washed properly and the homecarer, introduced in 1999, reported that they were not always given proper meals. Many years later Barbara said she was so hungry at times she ate cat food.

58. The children's health was not always cared for by their parents. Both in England and in Eilean Siar, Mr and Mrs A failed to return consent forms for school medicals. There is evidence of delays in seeking appropriate medical treatment for the children and a failure to promote good health. For example, Barbara's class teacher had to urge Mr A to take Barbara to the GP when she had a suspected urinary tract infection and the homecarer in Eilean Siar had to ask Mr A to buy toothbrushes and toothpaste for the children.

59. The children appeared to lack supervision appropriate to their developmental age. In England the social services department did not expect Mrs A to be left for long periods on her own with the children. The Home-Start volunteer helped her to care for the girls if Mr A was away from home. In Eilean Siar, where Mrs A had much less practical help until 1999, the children had numerous minor physical injuries which will be analysed in more depth later under the section on physical injury. There were scalds to Alice when she was aged two and again aged eight. She was found wandering in a cul de sac at age five. At age seven she had a suspected cigarette burn. The explanation which she finally

gave to the social worker (and which medical opinion was unable to discount) was that she had burnt herself playing with a plastic bag and lighter/matches. Barbara was not quite four when she had a burn to her right hand and six when she alleged her sister stabbed her with scissors (medical opinion thought the injury more consistent with a sharp blade such as a Stanley knife). Caitlin was just five years old when she was alleged to have burnt Barbara with a cigarette lighter.

60. Family members first told the social worker that Alice was behaving in a sexually inappropriate manner towards Caitlin in March 1997. Mr and Mrs A gave assurances to the social worker that the children were being closely supervised. Yet Caitlin told her school, social work and NCH staff that this continued to happen. In May 2000 Barbara told her class teacher that Caitlin was behaving in a sexually inappropriate manner towards her. During the investigation which followed she said this had been happening for some time.

61. In Eilean Siar a number of adults known to Mr and Mrs A visited their home regularly. The homecarer described one such occasion:

> *'To me it was as if the girls were an exhibition. I just didn't like the girls running around half naked with him in the house. They would be climbing on his knee; they would do that with everyone.'*

62. Mr and Mrs A also took the children to visit the homes of some of these adults. One of the adults later admitted in a police interview that he had, on a number of occasions, touched at least one child in an intimate and inappropriate manner. In October 1999 the minute of a case conference stated that the family continued to visit these adults:

> *'In the light of this the question was asked, were [Mr A and Mrs A] able to protect the children from inappropriate behaviour by adults who may be seeking to take advantage of the children'.*

Social work staff's response to the inappropriate touching of the girls is discussed later in this report.

Parenting behaviours

63. The records in England and Eilean Siar regularly refer to the difficulties Mr A had in showing appropriate affection to the children, particularly to Alice who was his stepdaughter.

64. Barbara had a serious developmental delay and attended family room sessions at the nursery in England with her mother. Family room staff noted that Mrs A was often poorly motivated to play with Barbara although, with intensive work, this did improve before the family moved to Eilean Siar. The family aides in England also noted that Mr and Mrs A needed help to appropriately stimulate their children, particularly Alice. Alice's foster carer noted when she first came to stay with them:

> *'I noticed that she seemed a bit strange with the toys as if she didn't know what to do with them or how to play. We noticed later on from this time that Alice could not even assemble a very basic jigsaw puzzle, even a child's one.'*

65. Mrs A has a learning disability, was a victim of physical and sexual abuse, including incest, and was an alleged abuser. She received counselling in England for mental health problems including depression. In Eilean Siar she was diagnosed with epilepsy after suffering from blackouts. This information was reported to a case conference by her GP in November 1997, yet the minute stated that the GP had not raised any significant issues. We were unable to find an assessment of the degree to which these factors may have affected Mrs A's emotional availability to her children and her capability as a parent. However, the links between childhood sexual abuse and adult mental illness are widely recognised (Howe, 1995) as are the effects of parental mental health problems on parenting (Cleaver, Unell and Aldgate, 1999). We found examples in the records of her inability to relate emotionally to her children. At a school sports day in May 2000 Caitlin soiled and became very upset. The auxiliary staff member noted that *'Mum seemed very blank emotionally and did not seem to relate to Caitlin's distress at all.'*

Relationship qualities

66. We found examples of both Mr and Mrs A demonstrating inappropriate boundaries with their children. For example in their first contact session with the children after Mr A left the family home in 1999, they sat kissing and holding hands rather than interacting with the children. In the next session Mr A adjusted his wife's suspenders in front of the children and the contact centre staff. As a result Mrs A was asked not to attend the contact sessions. In a statement to police Mr A admitted that he had not paid enough attention to the children. From the time she started nursery in England, Alice was reported to be indiscriminate in her approaches to adults. All three children behaved inappropriately with adults who they did not know. For example, Caitlin was very friendly towards workmen at her school and Alice rushed up to, and hugged, adult visitors to her foster carers' home whom she had never met before. Barbara constantly sought physical touching from adults.

Abusive and neglectful parenting

67. Abuse and neglect lie at the extreme end of poor parenting. We found signs of physical and emotional abuse and neglect as well as symptoms and behaviour which, taken together, are strongly suggestive of sexual abuse.

Sexual abuse

68. We have used the definition of sexual abuse contained in the descriptions of the categories of abuse for registration in the 1998 Scottish Office guidance *'Protecting Children: A Shared Responsibility'*:

> *'Any child may be deemed to have been sexually abused when any person(s), by design or neglect, exploits the child, directly or indirectly, in any activity intended to lead to the sexual arousal or other forms of gratification of that person or any other person(s) including organised networks. This definition holds whether or not there has been genital contact and whether or not the child is said to have initiated, or consented to, the behaviour.'* (1998: 61)

69. Sexual abuse by its very nature is secretive and silent. We recognise the difficulties for prosecutors in securing convictions because of the evidential requirements. The difficulty of securing convictions is recognised by the provision of the Criminal Injuries Compensation Authority which is able to make payments to victims of sexual abuse even if there has not been a conviction. Therefore the decision of the Crown not to proceed against the suspects in this case did not affect our view that the children had been sexually abused by some adults, men and women.

70. We believe that all three children were repeatedly sexually abused. Our conclusion is based on our analysis of all the material we have seen. Alice made two allegations of sexual abuse by a family member in 1992 and 1997. In 1992 she was believed but it was unclear who was the perpetrator. In 1997 she retracted her allegation and was not believed. Indeed, the family succeeded in making her the focus of concern at this point by revealing her inappropriate sexualised behaviour towards a younger family member which they had known about for some time.

71. In their later disclosures to their foster carers and statements to the police, the children described repeated sexual assaults by a number of adults. In statements taken separately their mother described abuse of her children over a number of years. During this period, all three children were in foster care and had only supervised contact with their mother. Barbara and Caitlin had not lived with Alice for nearly five years and had only limited contact with her. The children's distress about certain adults visiting their home was recorded at the time by their social worker.

72. The children described a home where there appear to have been no sexual boundaries. The records suggested that they witnessed their parents having sexual intercourse. Mr and Mrs A failed to prevent the inappropriate sexualised behaviour between the girls. The homecarer's descriptions of her visits also provided evidence of inappropriate relationships and a lack of boundaries between the adults and the children:

> *'Everything had a kind of sexual side to it with [Mrs A]. I remember stopping her a few times because I didn't think she should talk about certain things in front of the children. It was as if she didn't have any boundaries about what she would say in front of her children.'*

73. The case records show a long history of health and behavioural symptoms which in isolation cannot provide conclusive evidence of sexual abuse. Taken together, and in the context of the other evidence, we think they strongly suggest the children were sexually abused. With hindsight such patterns are more obvious. Nonetheless, in our view the scale of these symptoms would have been evident at the time had they been listed. In England Alice frequently had a sore genital area and/or bruising to her upper thighs. In Eilean Siar all three children were regularly treated by their GP for urinary tract infections. There were also incidences of unusual marks or bruises around the upper thighs and abdomen (appendix 2).

74. The children demonstrated sexualised and overly familiar behaviour with other children and with adults from an early age. The younger two girls increasingly showed signs in Eilean Siar of serious emotional distress including soiling, wetting, bad dreams, withdrawn behaviour, clinginess and uncontrollable weeping. In a handbook for social workers on child development and protection, Daniel et al. state about sexual abuse:

> *'Many clinical studies describe reactions to the abuse which may be subsumed under the heading of fear and anxiety. These include various kinds of sleep disturbances, flashbacks, hyper vigilance, regression, nervousness, clingy behaviour and withdrawal from usual activities'* (Daniel et al. 1999: 146)

75. In the section on parenting we discussed Mr and Mrs A's failure to protect their children from the adults who were regular visitors to the house and who the family regularly visited. There is evidence from the children's statements that Mr A actively encouraged them. Barbara said in a later statement to police: *'He was getting paid for other people doing bad things. To both of us Caitlin and me'.*

76. In her many statements to police, Mrs A repeatedly admitted that she had failed to protect her children from her husband and other adults who visited the family. In one witness statement she said why:

> *'I tried to tell them to leave the girls alone…I think this was when X the Social Worker was working with us. But I never told [x]. They threatened to kill all the girls. They all made me do it. They made me mess with the girls. I said no. They were hitting me.'*

77. All three girls were medically examined twice as part of the criminal investigation. Only a small percentage of children who disclose sexual abuse have any medical evidence to support their disclosure. In respect of the girls in family A, there was a significant time interval between the forensic medical examination and the end of the period where the abuse allegedly took place. Nonetheless, there was conclusive forensic medical evidence relating to one child. The complex issues surrounding forensic medical examinations are discussed later.

Physical injury

78. The definition of physical injury contained in the descriptions of the categories of abuse for registration in the 1998 Scottish Office guidance *'Protecting Children: A Shared Responsibility'* is:

> *'Actual or attempted physical injury to a child, including the administration of toxic substances, where there is knowledge, or reasonable suspicion, that the injury was inflicted or knowingly not prevented.'* (1998: 61)

79. We concluded that the children were subjected to physical abuse throughout their childhood until their removal from home. Some of the physical injuries to the children were caused by over-chastisement by Mr A. Once in England and twice in Eilean Siar he admitted at the time to losing his temper and/or causing an injury. In a later statement to police he said:

> *'I did have a temper…like anybody I became aggressive, shouting and shaking…if I had to smack them I would smack them, but I'm heavy handed …on the legs…bruising…'*

80. We recognise that during the period when these physical injuries to the children occurred, common law entitled someone with parental responsibilities and rights relating to a child and someone with care and control of a child to physically punish the child. It entitled parents to use force to discipline their children provided their actions could be justified in court as 'reasonable

chastisement'. Section 51 of the Criminal Justice (Scotland) Act 2003 set out to clarify the law relating to the physical punishment of children. The 2003 Act specifically prohibited blows to the head, shaking and the use of an implement. However, in all other cases the defence of 'reasonable chastisement' remains and the onus is on the prosecutor to prove that the punishment went beyond this. Mr and Mrs A were, and still would be, legally entitled to physically punish the children and if prosecuted could have claimed a defence of 'reasonable chastisement'. While there is evidence that professionals, particularly in England, did encourage Mr and Mrs A to use more positive methods of discipline, they could not legally prevent them from using physical punishment.

81. Health and social work staff have relatively little information from research or practice about what is 'ordinary' within families. We drew upon a recent study *'A Normative Study of Children's Injuries'* (2004) which is one of the few studies of childhood injuries. The researchers found that minor injuries were very common and that parents were not aware of their cause in over two-thirds of cases. Only 5% of injuries were 'significant' and 1% 'serious'. However, they discovered there were clear patterns to 'normal injuries' including their relationship to the age of the child. The large majority were cuts and bruises with burns being relatively uncommon. After age two (the peak age for minor injuries) the largest proportion of injuries were to the legs, mostly the knee or the shin. The researchers concluded:

> *'There was considerable variation between children in the numbers of injuries, but little variation in the pattern. Exceptions to the normal pattern merit investigation and exploration.*' (Quinton 2004: 215-218)

82. From the records we saw that the physical injuries to the children varied considerably from the pattern identified by the research quoted above. Burns to the children were common, the largest proportion of bruises were to the face, arms and upper body and the peak period for injuries was when Barbara and Caitlin were six or seven. Moreover the researchers defined 'significant' injuries as, for example, a large coloured bruise and 'serious' injuries as, for example, a deep cut on the thigh.

83. A further indicator of physical abuse is that the children could often give no explanation for the injury or there were a number of conflicting explanations from the children and/or their parents. In Eilean Siar from 1998, the children became increasingly secretive about their injuries. Both Barbara's and Caitlin's class teachers recorded occasions when the girls said they could not remember how they had got a particular injury. The teachers thought the injuries would have hurt and therefore it was very unlikely the children would not remember how they were caused. The individual injuries were often relatively minor and, while medical opinion was regularly sought, the doctor was never able to conclusively confirm that the injury was non-accidental. However on at least two occasions in England and also in Eilean Siar the medical staff involved considered the injury likely to be the result of physical abuse.

84. The physical abuse to which the children were subjected may well have been aimed at preventing them from telling about their sexual abuse. In their later disclosures and statements to the police, both the children and their mother described threats and intimidation to keep quiet. For example, Alice described being hit in the face:

> *'He used to threaten me, he said if I told anyone what was going on he would hit me twice as hard. We weren't allowed friends and no one from the village or school of my age was allowed to visit…I was frightened most of the time I was living there. I don't think I told anyone what he was doing.'*

85. In a statement Mrs A said:

> *'Two or three times, me Alice and Caitlin were burned because we threatened to tell. Mr A put our hands and arms in the fire. When the girls went to school they were told to say they'd fallen or to basically make up any excuse, but not to tell what actually happened. Once Alice was told to say that Caitlin had done it that is put her hand in the fire. Caitlin was told once to say she'd done it herself… Mr A also gave Alice cigarette burns, in fact of all of them. The kids were told to say nothing.'*

A report commissioned by Northern Constabulary from a burns expert in November 2003 confirmed that, in his view, both Barbara and Caitlin showed evidence of scarring caused by deliberately inflicted cigarette burns. Caitlin in particular had multiple scars.

Neglect

86. The descriptions of the categories of abuse for registration in the 1998 Scottish Office guidance *'Protecting Children: A Shared Responsibility'* define physical neglect as follows:

> *'This occurs when a child's essential needs are not met and this is likely to cause impairment to physical health and development. Such needs include food, clothing, cleanliness, shelter and warmth. A lack of appropriate care, including deprivation of access to health care, may result in persistent or severe exposure, through negligence, to circumstances which endanger the child.'* (1998: 62)

The Scottish Executive's *'Protecting Children and Young People: Framework for Standards'* published in 2004 contains this definition of neglect:

> *'Failing to provide for, or secure for a child the basic needs of food, warmth, clothing, emotional security, physical safety and well-being.'* (2004c: 23)

87. We concluded that the children suffered increasingly serious neglect until they were removed from home. In a statement to police Mr A said:

> *'…we didn't look after the kids as well as we should have done…Not caring for them properly…Not as clean as they should have been… and accepted that he had provided a lower standard of care for his children.'*

88. We have already discussed the evidence of poor parenting in both England and Eilean Siar. In England the professionals identified poor parenting but did not consider it to be neglect. We agree but believe that the poor parenting was prevented from becoming neglect by the range of services and financial aid offered to the family there.

89. Evidence of poor parenting continued in Eilean Siar. The pre-school home visiting teacher who visited from October 1995 said:

> *'During the entire time of the home visits the house was awful…The house was overrun with mice. On occasion I worked in the kitchen when there was no fire in the living room…there was one occasion when the house was really, really cold and the kids' teeth were chattering'.*

90. Lack of parental care became central in discussions among professionals from the end of 1998 onwards. In March 1999 Barbara and Caitlin were

additionally registered as at risk of physical neglect. In a case note just prior to the case conference, the social work team leader recorded:

> *'The parents:*
> - *Have failed to meet children's basic needs – warmth, clothing, affection.*
> - *Live in a house which is extremely unclean and extremely bare in terms of bedroom furniture.*
> - *Live in a house where there is excrement on the floor'.*

91. Physical standards in the home were very poor. The homecarer described conditions in the home as the worst she had ever seen. She remembered her first visit to the house:

> *'… I was horrified when I went into the house at first because I couldn't believe people could live like that. Firstly it was just so dirty. The children's bedrooms were so sparse. There wasn't even a table lamp just a bed in the middle of the floor. There weren't even bedclothes on the beds. There were dirty clothes piled on the floors in Caitlin and Barbara's bedrooms… Barbara was wetting the bed almost every night and the wet clothes would just be on the floor. The animals would be running through everything. I remember the cats soiling in the bedclothes. There was a distinct smell in the house. I used to take the girls clothes for school home with me to wash them and even then I felt I could still smell the house off them… I remember they used to drink goat's milk and they used to strain the milk through whichever rag was lying around. I remember seeing them strain the milk through a pair of pants before putting the pants in the washing machine.'*

92. The family kept farm and domestic animals and there was animal excrement on the floor, on the children's bedding and, on one occasion, on a school bag. The children's bedrooms were very sparsely furnished and at one stage Caitlin was sleeping in a cupboard. Bedding was regularly soaked in urine. The children often arrived at school inappropriately dressed for the weather and very hungry. Barbara regularly went without her glasses or hearing aid. As the extent of the neglect grew worse, the younger two girls frequently smelt strongly and it appeared that they were not properly washed. Finances in the home were tight but the parents consistently failed to prioritise the children's basic needs for food and clothing before their own. For example in 1999 the records state that Mr A was spending £10 per week for a computer which he almost exclusively used, the phone was disconnected for non payment and Caitlin had no shoes to wear.

Emotional abuse

93. We concluded that the children suffered emotional abuse both as a result of the other abuse and neglect they suffered and as a direct consequence of their parents' failure to consistently meet their emotional needs.

94. Children are almost certain to suffer emotionally from any of the types of abuse discussed above ('*Department of Health Child Protection (1995a) Messages from Research': 14)*. We reviewed the meaning of the term 'emotional abuse' and drew on the work of an expert in this area, Dorita Iwaniec who noted that:

> *'It is… generally recognised that emotional abuse is at the core of physical and sexual abuse, and might have a greater effect in the long term than physical or sexual abuse.'* (Iwaniec 1996: 4)

95. The physical intimidation of the children in family A to keep secret the abuse they experienced has already been discussed. The emotional impact served to increase their isolation. For example, at age five Alice hid in a telephone box to avoid the school bus as she had scratch marks on her chest caused by her father the previous day.

96. In addition to the emotional consequences of the physical and sexual abuse and neglect that the children suffered, we found indicators of emotional abuse in the home. The Scottish Executive's *'Protecting Children and Young People: Framework for Standards'* published in 2004 contains this definition of emotional abuse:

> *'Failure to provide for the child's basic emotional needs such as to have a severe effect on the behaviour and development of the child.'* (2004c: 62)

97. Alice was a stepchild and less favoured than her sisters. Several professionals in England noted this at an early stage. Shortly after Barbara was born, the health visitor noted her mother's concern that her husband shouted at his stepdaughter and pushed her away, giving his attention to the new baby. The nursery later noted that Mr A was warmer towards his own two children than his stepdaughter. When the family aide was introduced she noted Alice's isolation in the family and felt she was ignored, leading her to 'wander off'.

98. Alice's isolation increased after the family's arrival on Eilean Siar. She was identified by her family as the cause of their problems and unwittingly the professionals reinforced this view. For example, on the same day as Alice's allegation of sexual abuse by her stepfather was investigated, her extended family reported to the social worker that she had been behaving in a sexually inappropriate manner towards her sister. This was compounded by the child protection case conference registering her sisters as at risk of sexual abuse by implication from Alice.

99. The adults were believed by professionals but not challenged as to how they had allowed this to happen. When Alice's stepfather physically assaulted her in early 1997, the records show that she believed he blamed her for the police becoming involved. Ultimately Alice was removed from home. She returned home briefly in 1998 but was blamed for the rapid deterioration in the family situation and returned to foster care where she has remained. Her mother opposed Alice's return home on the grounds that her stepfather shouted at her as soon as she came in the door when she came home to visit. By early 2000 the records noted that Alice was settled with her foster carers and seemed to be recognising them as her family.

100. Barbara had a range of disabilities but it was not until 2000 that a proper diagnosis was made and she received support in a holistic manner. Her parents seemed unable to support the work of the large number of specialists involved with Barbara. We found examples of her father calling her *'stupid'*.

101. Caitlin's soiling had become chronic by 1999, sometimes two or three times a day. Mr and Mrs A could often not be contacted by the school to deal with the problem and she sometimes sat for two hours in the school dining room in soiled underwear. Auxiliary support had to be provided by the local authority. Her father physically punished her for soiling and her grandmother called her *'a dirty little sod'.*

102. In the next section we go on to discuss and analyse the response of the agencies.

Did the agencies' response make a difference to the care and protection of the children?

103. The response of the agencies did positively affect the children's lives at times. For example, the introduction of a homecarer in Eilean Siar in January 1999 improved the physical care of the children until she was withdrawn later that year when Mr A became hostile to her involvement. All of the children have thrived with their foster carers. Yet in spite of what the agencies tried to do, the children continued to be physically, sexually and emotionally abused and neglected until they were removed from their family.

104. We found that about 100 professionals had contact with the parents and children in family A from 1990 onwards. Education and health staff provided resources to family A in both England and Eilean Siar. The family also received social work services during most of the period they were in England and all of their time in Eilean Siar. These were delivered by the local authority's own staff or through commissioning arrangements with voluntary sector providers. The nature of the services family A received and the level at which they were provided varied. For example, the English authority offered Home-Start volunteers, financial assistance, and play sessions involving the parents both at home and at the nursery and regular visits by the social worker. Health visitors visited Mr and Mrs A frequently at home and offered advice about the welfare of the children. In Eilean Siar education staff kept detailed daily diaries of the children's behaviour and progress in school and pre-school teachers spent time in the family home. From 1998 the local NCH project provided play sessions and individual work. Appendix 3 sets out all the agencies and their activities.

105. All of the services provided by health and social work staff were designed to support the parents to bring the children up themselves. This is in keeping with the essential principles behind the Children (Scotland) Act 1995 that so far as is consistent with safeguarding and promoting the child's welfare, the local authority must promote the upbringing of children by their families (section 22 (1)). However, in families where serious abuse continues, this approach is not consistent with safeguarding children's welfare. In these circumstances the

children may need to be removed from home. This difficult issue is recognised in the Department of Health *'Framework for Assessment of Children in Need and their Families'* which noted:

> *'It has to be recognised that in families where a child has been maltreated there are some parents who will not be able to change sufficiently within the child's timescales in order to ensure that their children do not continue to suffer significant harm. In these situations, decisions may need to be made to separate permanently the child and parent or parents.'* (DOH 2000: 58)

106. In our view the children could and should have been removed from home earlier.

Key decision-making points

107. We identified a number of key decision-making points in Eilean Siar in seeking to understand why the agencies did not try to remove the children from home at an earlier stage. In this section we consider these key points where a different decision should have been made to protect the children and to make their lives better. We go on to explore the reasons why the agencies seemed unable to turn the extensive information they had about the abuse and neglect of the children into evidence to seek their removal from home.

The family's move to Eilean Siar

108. Social services staff in England referred family A to CNES social work department in July 1995, a month before the family's arrival on the island. They provided staff in Eilean Siar with extensive background material about family A including copies of all the child protection case conference minutes and other selected background papers. However the social work case files, which in our view contained significant additional material, remained with the English authority.

109. CNES social work department convened a case conference the week before the family arrived. A social worker who had worked with the family in England attended this initial case conference in Eilean Siar and stated that Mr A might have decided to move there to escape the 'close monitoring' of the English authority and their partner agencies. The professionals who attended this case conference identified the children as being at risk and placed them on the child protection register.

110. In our view, this information, and the family history provided by the social worker, should have led the case conference to consider a referral to the reporter. There was sufficient evidence to frame grounds for referral under section 32(2)(dd) of the Social Work (Scotland) Act 1968 as Mr A was a schedule one offender. This means that he had committed one of the offences specified in schedule one of the Criminal Procedure (Scotland) Act 1975 (indecent assault of his daughter from his first marriage). *'Protecting Children: A Shared*

Responsibility' contains an explicit recommendation that referral to the reporter should be considered at all case conferences, but it was not published until much later in 1998. We note that the Western Isles Child Protection Committee inter-agency procedures and guidelines dated September 1999 stated that case conferences must consider referral to the reporter.

111. The extensive background information from the English social services department should also have been given greater consideration in the ongoing assessment of the family by social work and health staff in Eilean Siar. However, only by reading **all** of the social work files held by the English local authority, could staff in Eilean Siar have grasped the scale of the support the family had received in England. Staff there had delivered a high level of monitoring and had consistently focused on the risks posed by Mr A as someone who had abused in the past.

Recommendation: All local authorities should make sure that when a child known to them moves to a different authority with their family, all the files or copies of the files are transferred immediately. Staff in the receiving authority must be given time to read them fully and must appreciate the importance of doing so.

112. The children's complete health records were transferred from England to health staff in Eilean Siar but had not arrived at the time of the December 1995 case conference. They included case conference minutes, medical reports on injuries to the children and records of visits to the home. The local Eilean Siar GP was invited to the initial child protection case conference but declined to attend as the family had not at that point registered with him. When the family did register with their GP, it was treated as a routine practice registration. The GP did not take account of the context of a family with a strong history of suspected child abuse. The GP reported to the December 1995 case conference that Mr and Mrs A were co-operative and open and he had no concerns.

The initial risk assessment of Mr A in Eilean Siar

113. In December 1995 a criminal justice social worker conducted a risk assessment of Mr A and assessed him as at low risk of re-offending. One factor in the worker's assessment was the statement in their report that:

> *'…with an offence of this nature it is unusual for it to occur in isolation, but there does not seem to be any evidence of abuse prior to, or following the offence. Even if there have been other episodes of abuse it seems highly unlikely that these would have been frequent.*'

The opportunity to read all the English files could have told the worker that this may not have been an isolated incident in the opinion of at least two professionals.

114. The risk assessment was reported to a review case conference in December 1995 and was accepted by all of the agencies present. According to the minutes of the meeting no-one present questioned a possible disparity between the outcome of this assessment and the perception of workers in England that Mr A posed a continuing high risk to his children. The opinions of two workers from probation and social work, based on their counselling sessions with Mr A were:

> *'As little work has been carried out and because of Mr A's inability/unwillingness to work out his cycle of offending, it is difficult to assess what his level of motivation to offend would be. In the absence of this information we consider his risk to re-offend is high*.'

The details of these sessions were included in the material sent to Eilean Siar staff by the English local authority. The outcome of the 1995 risk assessment in Eilean Siar significantly lowered concern about the possibility of sexual abuse in family A. It had a major impact on decision-making until a further risk assessment of Mr A was finally undertaken in October 1999.

115. Managing the risks posed by a sex offender who is a parent living with very young children is a complex and challenging task. Whatever the level of supervision provided, the risks to the children can never be completely eliminated. We drew upon *'Studies Informing Framework for the Assessment of Children in*

Need and their Families', (Department of Health 2001*)* and their conclusions on the value of risk assessments:

> *'Risk assessment scales, at their present stage of development and implementation, offer a range of predictors and factors derived from what in the past has contributed to dangerous actions. They provide a map of clusters of factors which, when aggregated, indicate cause for concern. The deficit of this approach is that, despite increasing sophistication in the ability to devise scales and evaluate them, the variables involved and their inter-relationships are so complex that any decision making requires a high level of professional judgement and qualitative assessment.'* (2001: 11)

116. A risk assessment of a sex offender is a tool which should be used in context and with caution. It should never be the only or the deciding factor in determining the risk the offender poses to children. It must form part of a wider inter-agency assessment of the children's needs for care and protection, including their developmental ages and stages and subsequent vulnerability, together with an assessment of the ability of the non-abusing partner to protect them. Even the term 'low risk' means that there is still a real risk which needs to be managed. It is not a term of reassurance. A recent inspection report by the Social Work Inspection Agency (SWIA) noted that *'it is our view from the SWIA inspections in other local authority areas that there are significant variations between areas in the processes used for sex offender management.'* (2005: 4.21)

Recommendation: The Scottish Executive should urgently develop guidance to help professional staff determine the most appropriate course of action where a child is found to be living in a household with a convicted sex offender.

Recommendation: Where agencies know that a convicted sex offender is acting as a parent, social work managers and frontline staff should be informed. They should make sure that risk assessments of the offender's behaviour form part of a comprehensive assessment of the care and protection needs of the children. Particular attention should be paid to the risks which the person presents in a family context and how this will be managed. The assessment should also address the ability of the other parent to protect the children if necessary.

The December 1996 case conference

117. At the case conference in December 1996 the children's names were removed from the child protection register because they were in regular contact with all the agencies, the parents were *'co-operating fully',* there were signs of progress *'within limits of family situation'* and a high level of resources was being provided. With the possible exception of the limited signs of progress, none of these reasons related directly to the potential risk to the children and whether this had decreased.

118. By 1996 the social worker was focusing on the marital and family relationships in family A and how their parents managed the children's behaviour. In our view, for the children to have remained safely at home, both parents needed to make real changes which resulted in visible and measurable differences to the welfare and development of their children. Changes in parental behaviour should have determined the measure of progress rather than the extent to which they were 'co-operating' or the level of resources being provided. Mr and Mrs A were 'co-operating' with social workers in that they allowed them to visit and to talk to them and their children. Parental co-operation alone does not reduce risk to children. Reducing the risk requires changes in parental attitudes, behaviours and motivation.

119. The assertion of 'progress' was not supported by the evidence from the contacts the children and their parents had with all of the agencies in the preceding six months. Since the previous case conference there had been a child protection investigation regarding a burn to Alice's hand which the GP stated was consistent with a cigarette burn. There had been deterioration in her behaviour and she had been suspended from school. Barbara was arriving at school ravenous and at times inappropriately dressed for the weather and there were three separate reports of her sustaining bruising. Caitlin had wetting and soiling problems. Mrs A was reported to be suffering from blackouts which were still being investigated at the time of the case conference. There were continuing issues with parenting and standards of cleanliness in the home. Nevertheless, the

social worker recommended that the children's names be removed from the register. The minutes of the meeting do not note that anyone dissented from the decision.

120. There were clear signs in the family of stress, neglectful parenting and probable physical abuse which should have alerted the agencies to the need to continue with the children's registration. Furthermore there should have been a re-assessment of the risks to the children, particularly as the criminal justice worker who carried out the initial risk assessment stated that any significant changes or an increase in stress in the family could increase the risk posed by Mr A of re-offending.

121. Decisions at case conferences must be based on a current assessment of the likelihood and severity of possible harm to the child. In England, the reports for the case conferences which we read summarised the factors currently indicating risk to the children and those which could be seen as protective factors. We thought this a helpful aid to child-focussed decision-making.

Alice becoming the focus of concern

122. In March 1997, sexual abuse again became the focus of the agencies' attention, following the discovery that Alice had been behaving in a sexually inappropriate manner towards Caitlin. The allegation was made by her grandmother, in the midst of an investigation into an allegation by Alice that Mr A had touched her sexually. Alice retracted this allegation.

123. The timing of these two events does not appear from the case file to have been considered or questioned. We found no record of any serious challenge to the family as to why they had allowed Alice's behaviour to continue. They did not appear to have been asked why they had not mentioned it before and why it was brought up at the point when Alice had made an allegation against Mr A. The professionals believed the allegation made by the adults, but not the allegation made by Alice.

124. Mr A seems to have been considered even less of a risk at this point than ever before despite the allegation by Alice that he had abused her. The records noted that staff believed that:

> *'The assault perhaps indicates the level of frustration that Mr A felt towards Alice who is a difficult child to deal with*.'

125. The outcome was that Alice was identified in social work reports as a risk to her sisters. At the subsequent case conference her sisters were placed on the child protection register as at risk of harm from her. Alice was seven years old. The case conference recorded concern at the parents' inability to protect their children and discussed the removal of all three. However, it decided that Alice should be received into care:

> *'with a view to providing some specialist input in relation to her sexual behaviour'* and *'on the grounds that she presented a real risk to Barbara who is unable to express herself or protect herself, that she has sexually abused Caitlin, and that her parents are unlikely to be able to offer the protection needed by both Caitlin and Barbara.'*

126. It was the primary responsibility of Mr and Mrs A to provide protection for Alice and her sisters. By recommending the removal of Alice alone, she bore the blame for the abuse of her sister, rather than her parents for their failure to protect all of them.

The children become subject to supervision requirements

127. The police referred all three children to the reporter in February 1997 by reporting an alleged physical assault committed by Mr A against Alice. At the children's hearing in June 1997 the social worker recommended compulsory measures of care. The hearing made home supervision orders in respect of all three children. The social worker also informed the hearing that the social work department was seeking to remove Alice to foster care, once a family became available for her.

128. In the initial social background report, the social worker cited a number of reasons for recommending compulsory supervision, including the alleged assault on Alice by Mr A, the emotional deterioration in Barbara and Caitlin, the risk posed

by Alice to her siblings and the apparent inability of their parents to protect the three children from harm. However the social worker concluded by saying:

> *'At present the maximum support for the family is being provided. All three children are away from the home four days a week with pre-school support being provided on the fifth day. Clearly, the service provision is not effecting significant change in this situation'.*

129. In making a supervision order under section 70, the hearing required to be satisfied that this would be better for the children than not making such an order (section 16(3)). It is difficult to see from the report how compulsory supervision was going to achieve the significant change required as 'maximum support' was already being provided and the parents were continuing to 'co-operate'. The March 1997 case conference minutes noted:

> *'The reaction of Mr and Mrs A regarding Alice's abuse of Caitlin is a cause for concern. Neither appears significantly concerned and this has not inspired confidence as far as this Department is concerned in their ability to protect all three children from harm. They appear unable to recognise risk factors.'*

130. In the previous section we stated that by removing Alice alone from home she bore the blame for the risk to herself and her sisters. She was not to blame. Her parents failed to protect all of their children. Other options should have been presented to the children's hearing. The removal of all three children was discussed at the case conference in March 1997 but was not presented as one of the options to the hearing.

131. Following the involvement of the children's panel, for the first time Mr and Mrs A began to make limited changes to their parental behaviour. They would have benefited from a clear statement setting out the changes they had to make within a stated timescale, failing which the social work department would request a review hearing and recommend the removal of all three children. This option could also have been presented to the hearing.

132. We are aware that the Scottish Executive is currently consulting on *'Getting it right for every child'* (2005c), phase two of the children's hearing review. The Executive sets out proposals for a single integrated assessment, planning

and recording framework for all agencies working with a child. Where a child may need compulsory measures of care (and in other appropriate circumstances), an inter-agency action plan will be required. This inter-agency action plan will form the basis for any subsequent supervision requirement made by a children's hearing. The plan will set out:

- the child's needs
- what is required to address their needs
- who has responsibility for these actions (including the child and their parent(s)/carer(s))
- the milestones against which progress will be assessed, the timescales for achieving these and arrangements for monitoring and reviewing the plan.

Importantly, all the agencies involved in a plan agreed at a hearing will be required to implement it. Only a review hearing will be able to amend any plan endorsed by a hearing as a condition of a supervision requirement.

133. This positive proposal could have helped to avoid the drift in decision-making which we found in respect of family A. We urge the Scottish Executive to make sure that the inter-agency action plan sets out clear expectations of the changes the child's parent(s)/carer(s) are expected to make and what action will be considered if this is not achieved within timescales which are realistic for the child.

Alice's return home

134. Alice went to live with foster carers in August 1997 and returned home in December 1997. The local authority acted reasonably in seeking to return her home although she had made excellent progress in foster care. She put on weight, grew nearly two inches and her school attainment improved. Barbara and Caitlin's health and behaviour also improved when their sister was away from home. However, Alice's improvement in foster care was greater than the progress made by her sisters at home in the same period.

135. Alice was returned home following an assessment by her social worker that abuse by Mr A was unlikely and that he and his wife were more able to deal with Alice's behaviour. The social worker discounted the possibility that Alice was being abused in favour of the theory that she was in some way acting out past abuse perpetrated by Mr A's son from his first marriage. The social worker's assessment focused on Alice's sexually inappropriate behaviour, whether or not it was exploitative in nature and why she might be behaving in this way. In our view this assessment did not take sufficient account of the possible origins of her inappropriate sexualised behaviour or the inability of Mr and Mrs A to prevent it and protect all three of their children. Nor did it provide any evidence to support a belief that they would be able to do so in the future.

136. Barbara and Caitlin's welfare deteriorated rapidly when their sister returned home. Following an alleged assault by Mr A, Alice returned to the same foster carers in March 1998.

The failure to remove Barbara and Caitlin from home in March 1999

137. For a short while after Alice returned to live with her foster carers, Barbara and Caitlin became a little more settled but Caitlin continued to soil and Barbara was often very tired in school. During the rest of 1998, Barbara and Caitlin showed increasing signs of emotional distress and physical neglect. Barbara continued to be very tired in school and Caitlin's soiling increased. Yet at a combined review case conference and looked after review in September 1998 the agencies discussed plans for Alice to return home.

138. From December 1998 the social work department decided to convene monthly meetings of the professionals involved, without Mr and Mrs A. The stated purpose of these meetings was to share progress and concerns with a view to compiling evidence to decide by March 1999 on action to be taken. However at the review case conference in March 1999, the children's registration was continued without significant change to the care and protection plan.

139. By this stage social work staff had compiled a list of worries about Barbara and Caitlin which we consider provided overwhelming evidence of the need to remove them from home. Barbara and Caitlin's very basic needs for food, appropriate clothing and adequate living conditions were not being met. Caitlin's soiling was chronic and Barbara was tired and weepy in school. Both children were increasingly secretive about the frequent bumps, bruises and other injuries they sustained. Mrs A stated that she was unhappy in her marriage and that the children were frightened of their father. The children talked of inappropriate behaviour by adult visitors to the house. Mr and Mrs A told the social worker that they could not do any more to improve the situation at home. In our view there was sufficient evidence on the grounds of neglect alone by March 1999 for CNES to have taken decisive action to try to remove Barbara and Caitlin from home.

The re-assessment of Mr A as high-medium risk

140. In October 1999 two social work staff carried out a new risk assessment of Mr A. It is not clear from the records why this decision was made. The new risk assessment placed him at high-medium risk of re-offending. The children's social worker recommended a radical change in the care plan. Mr A agreed to leave the family home and the social worker recommended to a children's hearing that Barbara and Caitlin should live with their mother with only supervised access to their father. The hearing made supervision requirements which gave effect to this recommendation.

141. We found that, firstly, no-one made an assessment of Mrs A's ability to protect her children and, secondly, no-one took steps to make sure their father had only supervised access to them. One of the professionals saw him near the family home early one evening. Mrs A's poor parenting skills and difficulties with her own physical and mental health were already well documented in previous social work reports. Indeed in a report written in 1996 Mr A was regarded as holding the family together. It was therefore very unlikely that Mrs A was going to cope on her own, even with the extended family and the agencies offering to support her. There was plenty of evidence to demonstrate that Barbara and Caitlin could not be kept safe at home.

Barbara's and Caitlin's move to relatives in July 2000

142. Barbara and Caitlin went to live with relatives in July 2000. Shortly afterwards a children's hearing made it a condition of the children's supervision requirements that they should live with them. In making this decision, local authority staff took account of one of the essential principles behind the 1995 Act that the local authority should promote the upbringing of children by their families. The local authority paid the relatives fostering allowances.

143. Relatives often provide vital help to parents and children and social workers are expected to encourage their involvement. Where a child is looked after by the local authority the regulations relating to this part of the Children (Scotland) Act 1995 require kinship carers to be approved as foster carers (The Fostering of Children (Scotland) Regulations 1996 No.3263, regulations 3 and 7). The regulations allow for emergency placements with relatives with only limited checks (regulation 14). However, if the placement continues, the regulations require the kinship carers to be approved as foster carers. The exception is that, where children are placed with relatives through a children's hearing, only the checks relating to an emergency placement require to be undertaken (regulation 15). (*'Scotland's Children. The Children (Scotland) Act 1995. Regulations and Guidance Volume 2'*, 1997)

144. The case records contained three pieces of information which indicated that one of the relatives was not a suitable person to care for Barbara and Caitlin. In October 1999 the social worker had contacted the former employer of one of the relatives who was becoming more involved in helping the family. She recorded the conversation in the case file. She was told that the relative concerned had been dismissed from his post. As he had been employed for less than two years the employer was not obliged to give him reasons. Informally the social worker was told that there were serious concerns about the conduct of the relative. He was alleged to have watched pornographic videos whilst on night duty in a caring capacity with older people. In addition he had, on application, failed to declare a conviction for living off immoral earnings. Other staff had also expressed concerns about his personal care of the residents. Despite being

aware of the conviction and the allegations the social worker recommended to a children's hearing in July 2000 that the children should live there. We were unable to find the full hearing report in which the social worker made this recommendation and we do not know if the children's hearing was made aware of the previous conviction and the allegations.

145. We found no record of an assessment of the suitability of their relatives to care for Barbara and Caitlin. We recognise that the local authority was not legally required to assess the children's relatives as foster carers. However the imperative to promote the upbringing of children within their families must be balanced by an appropriate assessment of the suitability of extended family members to provide a safe home. Later disclosures by the children suggest that they continued to be abused during their stay with relatives.

Recommendation: The Scottish Executive should amend the fostering regulations and relevant guidance so that relatives and friends must be formally approved as carers for a child who is looked after when that child is placed with them as a condition of a supervision requirement made by a children's hearing. Approval should be based on an assessment of their ability to care for, protect and meet the needs of the child.

146. We found no record of a statutory review for Barbara and Caitlin for over seven months after they moved to their relatives. The local authority has a duty to review children looked after and placed by them within six weeks of their placement and again within three months of this first review (The Arrangements to Look After Children (Scotland) Regulations 1996 No. 3262, regulation 9(1)). Barbara and Caitlin continued to be seen by their social worker but no records of these contacts could be found in the case files. In our view the local authority failed in its statutory duty to safeguard and promote the welfare of Barbara and Caitlin during their stay with relatives.

The evidence for earlier decisive action

147. By 1998 staff in the agencies were sharing and recording information about Mr and Mrs A's inadequate care of their children and their views that the children were being both physically and sexually abused. They sought the opinion of external consultants who confirmed that abuse within the family was a strong possibility. However staff responded by putting in more resources rather than planning how to remove Barbara and Caitlin.

148. To take a major decision to remove the children from home local authority staff should have undergone a three stage process. Firstly, they should have reviewed the information they held. Secondly, staff should have taken legal advice to assess the quality of the evidence. We found no record of this in the local authority case files. Thirdly, if they were advised that this constituted grounds for action, then they should have instigated the legal processes to remove the girls from home.

149. The ability of the staff in the agencies to obtain enough evidence to remove the children from home was hindered by their consideration of problems on an incident by incident basis. For example, the case files record attempts by social workers to obtain conclusive medical evidence from a GP that one of the children had been deliberately harmed in an individual 'incident'. Even when a non-accidental injury was strongly suspected, the GP was not able to completely rule out other explanations provided by the child and/or parents on the basis of the clinical presentation of the injury. By comparison, in England there was an incident where Barbara presented with bruising which the examining doctor felt could not be fully explained as accidental. In the light of this, and because of the previous child protection concerns in the family, the consultant paediatrician decided to review an earlier injury to Alice, previously considered as accidental, and concluded that it too was likely to have been non-accidental.

150. This illustrates the importance of considering 'new' information or incidents in the context of previous history and in particular patterns over time. With family A the concerns built up and escalated over time. Considered on an individual

basis, most incidents of physical injury and the majority of health care issues appeared relatively minor. It was the pattern, the enduring nature and the relationship between the physical health issues, physical injuries, the children's behaviour and the physical neglect which were significant. Had these patterns been analysed on a systematic basis, the evidence of a need to remove the children would have been clear.

151. When put together, the evidence in social work, health, education and NCH records is substantial. The family's medical practice was initially a single GP but later merged with a group practice. After this family members were seen by more than one GP and contacts were recorded in each child's or adult's medical record. A chronological record of all health contacts would have helped to identify patterns across the family, had it been reviewed regularly by key medical personnel. This could then have been submitted to inter-agency case conferences even if the GP was unable to attend in person.

152. When Alice started school in England in 1994 her class teachers kept a detailed daily record of her behaviour, progress and any marks, bruises or injuries she arrived at school with, or sustained in school. In Eilean Siar Barbara's special class teacher kept a diary of any issues which worried her about Barbara's behaviour, health or any marks, bruises or injuries from the day she started school. At times, the teacher reported these to the head teacher who then informed social work department staff. In September 1998 Caitlin's class teacher began to keep a similar diary, which included a detailed record of incidents of soiling and wetting and reported some of these to the head teacher.

153. We found that some of these incidents or concerns were also recorded in the social worker's case records and some others in minutes of child protection case conferences. However, we cannot tell precisely which or how many of these regular and sometimes daily recordings were passed on to the social worker and when. The full impact of the teachers' detailed observations could only have been realised if the diaries had been read and analysed on a regular basis, and in the light of the information from other agencies. Partial reporting of chronological contacts, and a lack of systematic analysis, restricted the possibility of identifying

patterns and therefore potential evidence of the abuse and neglect the children suffered.

Recommendation: All of the agencies involved in protecting children must gather the information they have on individual children at risk into a chronology of key events and contacts, review it regularly and make sure that it is passed on to the professional with the lead role in protecting the child. The professional with the lead role must co-ordinate this into a multi agency chronology on a regular basis.

154. If a local authority decides that a child needs to be removed from home, it must seek to use its legal powers. In the next section we examine the failure of staff in CNES to use the legal powers available to them to remove the children at an earlier stage, and then to secure their placements on a more permanent basis.

The legal framework

Changes in legislation

155. The 1989 United Nations Convention on the Rights of the Child provided a benchmark in the growing awareness of children's rights. The relationship between parents and their children has also moved towards one of parental responsibilities, rather than parental rights. The implementation of the UN Convention by the UK Government in December 1991, along with a number of high profile child protection inquiries, such as in Cleveland (Butler-Sloss, 1988) and in Orkney (Clyde, 1992), led to a major review of child care legislation first in England and Wales and then in Scotland.

156. We acknowledge that both in England and in Eilean Siar the local authorities became involved in the lives of the children in family A at the time where these major changes were taking place. The Children Act 1989 came into force in England and Wales on 14 October 1991 and the relevant provisions of the Children (Scotland) Act 1995 started on 1 April 1997. Both of these Acts have an underpinning principle that children should be brought up within their own families wherever possible. Services were to be provided in a positive way to support and enable children to be brought up by their families rather than in a negative way to prevent children having to be removed from home.

157. The response of the local authorities to partnership with parents has often been understood in practice as meaning that voluntary measures should be preferred to compulsory ones. The National Commission of Inquiry into the Prevention of Child Abuse (1996) noted that this approach can hold agencies back from intervening forcefully enough to protect children in some cases:

> *'Professionals were so uncertain about how to interpret the new provisions that there was indeed at least a six months lull with very few cases being brought to court and with judges worrying constantly that the new principles laid down in the statute, principally the emphasis on working in partnership with parents and trying to ensure that children stayed with their families as much as possible, has meant that social workers were reluctant to intervene to protect children from potential abuse and neglect.'* (1996: 271/2)

Kathleen Marshall, writing in 1996, noted that there was a tension created by both the 1989 Children Act and the Children (Scotland) Act 1995, between the child's right to protection and the strong emphasis on the position of parents which is supported by a high level of formality in the processes of compulsory intervention (1996: 274).

158. The Children (Scotland) Act 1995 requires that local authorities shall:

> *(a) safeguard and promote the welfare of children in their area who are in need; and*
> *(b) so far as is consistent with that duty, promote the upbringing of such children by their families,*
> *by providing a range and level of services appropriate to the children's needs.*
> (section 22(1))

159. There is a presumption that services are best directed towards maintaining the child at home. However there is also recognition that sometimes a child's welfare can only be safeguarded and promoted by removing the child from home in accordance with the provisions in the Act (Norrie, 1995:53). These include emergency measures to protect children (child protection orders), child assessment orders and referral to the reporter and the children's hearing system.

160. In Eilean Siar local authority services were primarily provided to support Mr and Mrs A to bring up their children themselves, but a range of legal measures was available. The local authority could, for example, have referred the children to the reporter as children in need of compulsory measures of care from the time they arrived in 1995. There was sufficient evidence for the reporter to frame grounds for referral under Section 32(2)(dd) of the Social Work (Scotland) Act 1968 as Mr A was a schedule one offender. (The 1995 Act had not then been implemented). The police made the referral to the reporter in February 1997 in accordance with Section 37(1) of the Social Work (Scotland) Act 1968. The reporter decided to refer the children to a children's hearing. Although the grounds of referral were framed under the old legislation, the hearing made supervision requirements under the new Children (Scotland) Act 1995.

161. Each time a children's hearing decided to make supervision requirements in relation to the children they had to consider whether or not to impose any conditions. Section 70 of the Act states:

> *'(3) A supervision requirement may require the child –*
> *(a) to reside at any place or places specified in the requirement and*
> *(b) to comply with any condition contained in the requirement.'*

162. The children's hearings did impose conditions on the children's supervision requirements at a number of points (appendix 4 lists the dates and outcomes of all hearings), including requiring them to reside with foster carers or relatives and making conditions relating to contact (in accordance with sections 70(3)(a) and 70(5)(b) of the 1995 Act).

163. Local authority staff should have considered **all** the options available at each key decision-making point. In consultation with their senior, the social worker should then have presented a range of options in a report to the hearing setting out the advantages and disadvantages of each with a clear recommendation. For example, in April 1999 there was an annual review of Barbara's and Caitlin's supervision requirements. A review case conference the previous month had additionally registered Barbara and Caitlin as at risk of physical neglect and there were serious concerns about standards in their home. The social worker's report to the hearing could have included an option to set a number of clear targets for the parents and return to an early review hearing in perhaps three months. In October 1999 the social worker's report to the hearing could have included the option of requiring Barbara and Caitlin to reside elsewhere and the report should have discussed the ability of Mrs A to protect them from their father if they remained with her.

164. We acknowledge that local authority staff did on one occasion recommend imposing a condition of attendance at an NCH project which the hearing rejected. We also acknowledge that Mr and Mrs A successfully appealed against the decision of the hearing in March 1998 to impose a condition that Alice live with foster carers. The sheriff asked the hearing to reconsider their decision. They did so in May and imposed the same condition but this time Alice's parents did not appeal. A children's hearing can impose any condition, provided it is in the best

interests of the child. This is a wide-ranging power and hearings rely on professional advice as to the range of options which might be helpful in each case. CNES staff should have made much more creative use of their recommendations in hearing reports in order to address the lack of progress in this case and to safeguard and promote the children's welfare.

165. In Eilean Siar, the children were involved in the children's hearing system by 1997. In all the decisions made by a children's hearing, the welfare of the child throughout his/her childhood must be their paramount consideration (section 16(1)). The children in family A continued to be abused and neglected despite the fact that they were subject to supervision orders through a children's hearing.

Children's hearings

166. The children's hearing is a lay tribunal of trained members of the public. Their role is to consider and make decisions about the needs of the child before them, whether the child has been referred as in need of care and protection or because he/she has committed an offence. The children's hearing must make decisions at all times in the best interests of the child. The children's hearings for Alice, Barbara and Caitlin provided the opportunity for an independent consideration of their best interests. Yet the hearings too failed to consider the need to remove Barbara and Caitlin from home at an earlier stage.

167. The children's hearing relies on professionals to provide background information about the child, an assessment of their needs, possible options to address these needs and a recommendation on the action which should be taken. Members of the hearing may accept the recommendation or they may not. At present the social worker's report to the hearing is the main source of this information although the reporter regularly requests reports from other relevant agencies such as the child's school or the health visitor.

168. In our view some of the reports that the children's hearing were given about Alice, Barbara and Caitlin lacked analysis of the impact of the family history on the children's current needs using an explicit theoretical framework. We

discuss this further in the later section on professional knowledge, skills and expertise.

169. The social worker's initial report did provide a chronological account of the family history and the worries of staff in England about the family but this became truncated in subsequent reports. The abbreviation of the historical background information may have not have conveyed fully the degree of concern about the children expressed by all staff working with family A in England. It also meant the hearing did not have full information about the level and patterns of abuse and neglect in the family in the past.

170. Social workers have to convey more and more information about children in their reports to children's hearings the longer they are involved with a family. The Scottish Children's Reporter's Administration has a policy which prohibits past reports being given to panel members, with the exception of safeguarder or similar reports. Report writers are expected to include a historical summary of their agency's involvement. Summarising this in a narrative will inevitably lead to the abbreviation of some earlier events at the discretion of the author. This then denies the hearing the chronological information about patterns of abuse and neglect crucial to effective decision-making. It can also lead to the suffering of the children being minimised or sanitised by global terms such as 'abuse' or 'neglect'.

171. We are aware that the Scottish Executive is currently undertaking the second consultation phase of the review of the children's hearing system. We welcome the aim to reduce report writing to a minimum. However, if children's hearings are to be able to make an independent decision in the best interests of the child, they must have information about the child's and the family's history and an assessment by the social worker which takes account of significant past events. We consider it essential that social workers provide hearings with an inter-agency chronology (recommended in paragraph 153) in their reports.

Recommendation: The Scottish Executive children's hearing review should make sure that reports provided to the children's hearing include information about the child's family history and an assessment which takes

account of significant past events. The inter-agency chronology of events outlined in paragraph 153 should always be included with these reports.

172. The task of the children's hearing is to look at what the child needs not what the agencies think they can provide at any given time. The hearing should create the opportunity to explore all the possible options for meeting the child's needs. The chair can ask the reporter for clarification of the available options during the hearing if they do not feel these are clear from the reports.

173. Under section 41 of the 1995 Act each children's hearing must consider whether to appoint someone to safeguard children's interests in the proceedings. In Eilean Siar the hearing regularly decided not to appoint a safeguarder because they considered that Alice, Barbara and Caitlin were able to express their views. However, a safeguarder might have provided a child-centred impartial view of their best interests, particularly in early 1999 when concerns about neglect were at their height. The ability of professionals to always act in the best interests of the child can be affected by the impact of working with the parents, the views of other agencies and the constraints of their own organisation.

174. In their evaluation of the children's hearing commissioned by the Scottish Office and published in 1998, Hallett et al. found:

> *'The contribution of children and young people in observed hearings was limited and interviews with them confirmed the difficulty some felt in participating…To achieve greater participation child advocacy schemes might be required. ...In the context of international developments such as the UN Convention and the legislative requirement in the Children (Scotland) Act 1995 (s16 (2)) that children's views be sought and taken into account, it may be that the point has now been reached when an extension of representation or advocacy (paid for out of public funds) before and during hearings is required.' (*1998: 125)

175. We are aware that the Scottish Executive is currently consulting on the role of the safeguarder as part of phase two of the review of the children's hearing system, *'Getting it right for every child'* (2005c). In our view there is still a need for children's hearings to be able to request an assessment and recommendation from an independent person whose role is to focus on the best interests of the child. This independent advocate should also be available at reviews for looked

after children, case conferences and other inter-agency meetings. *'Getting it right for every child'* includes proposals for a unified approach to meeting children's needs which will, in time, replace meetings such as looked after reviews and child protection case conferences with a framework of co-ordinated meetings. We believe this proposal provides an opportunity to develop a national system of advocates for children whose role is to focus on the best interests of the child.

Recommendation: The Scottish Executive should set up a national system for all children involved in children's hearings and other inter-agency meetings to have the opportunity of an advocate, when decisions are made about their needs, care and protection.

Permanency planning

176. The foster placements of the children from family A have been secured through the children's hearing for Alice since 1998 and for Barbara and Caitlin since 2001. Decisions made by a children's hearing must be subject to review at least on an annual basis, more often if a review is requested by the parents or the local authority. There is evidence that the girls are now upset by the uncertainty created by continued hearings.

177. There are no plans to return the children to their parents. Yet both parents retain parental rights in relation to Barbara and Caitlin and Mrs A retains parental rights in relation to Alice. Any significant decisions regarding the younger girls continue to require the consent of both their parents. Significant decisions regarding Alice continue to require her mother's consent.

178. Volume 3 of the 1995 Act guidance states:

> *'Where a child is already looked after and it has been identified, within a child care review, that the child is in need of long-term care, security and stability away from his or her birth family, local authorities should consider, having sought the views of the child, whether a parental responsibilities order would be the best way to meet the child's needs and safeguard and support his or her welfare.'* (1997: 60)

179. There continues to be a disparity between the permanency of the care arrangements for the children and their legal status. The importance of exploring a more permanent legal status for Alice was recognised and discussed as early as 2000. Social work department staff were anticipating in October 2000 that the younger children's move to their relatives would be permanent although it is understandable that there was a delay when an alternative placement had to be sought when the relatives indicated they were not able to offer the girls a permanent home. The local authority could have secured a more permanent legal status for them either by seeking a parental responsibilities order themselves (Section 86) or by the foster carers seeking a residence order (Section 11). In 2004 CNES commissioned a report from an independent adoption agency which identified options for securing a permanent legal status for the girls. It is unacceptable that at the time of writing the girls' legal status has not changed.

Recommendation: CNES should as a matter of urgency seek a more permanent legal status for the children in family A.

Children's views

180. Under the 1995 Act anyone exercising parental rights and responsibilities must have regard to the views of the child (section 6 (1)). Children's hearings must have regard to the views of a child when making decisions (section 16(2)) and local authorities must take account of children's views before making any decision and in making any decision in relation to a looked after child (sections 17(3)(a) and (4)(a)).

181. From 1997 the children were subject to supervision requirements through a children's hearing. Under section 45(1) of the 1995 Act children have the right to attend their children's hearing and indeed are required to do so unless the hearing dispenses with this requirement (section 45(2)). The Act also provides for hearings to appoint someone to safeguard the interests of the child in the proceedings. By contrast the child protection system has no basis in statute although *'Protecting Children: A Shared Responsibility'* states:

> *'Case conferences should take account of children's views and feelings, having regard to their age and understanding. Whenever children are able to express their wishes and feelings and are able to contribute to assessment, planning and review, they should be invited to attend the case conference, if this is consistent with their welfare. The social worker should prepare each child by giving full information about case conferences. The child should also be told that he or she can ask for someone to be present for support at the conference.'* (1998: 34)

182. The children did not attend case conferences, nor did Alice attend her early reviews which were held jointly with case conferences. Alice was eight when she first moved to foster care. Scottish Executive guidance on the 1995 Act suggests that, from age twelve, children should be invited to attend their reviews and that *'the attendance of younger children should be considered in the light of their age and understanding.'* (Vol.2, 1997: 21). Alice chose not to attend one of her reviews in 2004.

183. The local authority is required to take account of the views of children who are looked after. The Scottish Executive guidance stresses the importance of active participation by children which involves more than just attending reviews:

> *'Someone with a special relationship with the child should prepare him or her for each review considering which issues are most urgent for the child and how he or she can be helped to make his or her views known. For example, even though children in the six to ten age groups may not understand the complexities of decision-making, it is still important to ascertain their wishes and feelings and give them an explanation of events and plans and the reasons for them.'* (1997: 22)

184. We found that social workers did make use of the *'Looking After Children in Scotland'* (1999) (LAC) materials to help the children to have their say at reviews. Social workers and NCH staff consistently spent time with the children both in and outwith the home, to seek to build trusting relationships with them.

185. Case conferences in both England and Eilean Siar were 'all adult' gatherings. The involvement of Mr and Mrs A and at times their legal representative in both case conferences and reviews may well have resulted in a greater acknowledgement of parental rights than the rights of the children. If parents are present it can be difficult for children to give their views in ways which ensure they are heard. The chair of a case conference or a LAC review therefore

has a key role to make sure that the child's views are heard and taken into account. They must also critically examine the opinions of agency staff and the children's parents and take an overview of the current situation from the viewpoint of the child.

186. Professionals should seek to enable children to express their views on an ongoing basis. It is particularly important that children are encouraged to do so and that professionals make sure their views are heard at key decision-making points. We believe that the good practice described in the Scottish Executive guidance about preparing a child for a review should extend to all meetings or decisions made about a child. The Scottish Executive's development of a unified approach to meeting children's needs provides an opportunity to do this.

Recommendation: The Scottish Executive should provide guidance for professionals on how to help children express their views. This should be developed in consultation with practitioners and must take account of the diverse communication needs of all children.

Children affected by disability

187. Since April 1997, the local authority has had a duty to Barbara as a child affected by disability under section 23 of the 1995 Act. Alice and Caitlin may have been affected by the disability of their sister and all three girls by the disability of their mother. They may therefore have been children 'in need' as defined by section 93(4)(a) and should have had their needs assessed accordingly. We found evidence of Barbara's needs being assessed, but no evidence of an assessment of the impact of her disability on the others or the impact of Mrs A's disability on any of the children. We discuss assessment of Barbara's needs in relation to the joint investigation later in the report.

188. Section 23(1) states that the general provisions of the Act apply to children with a disability, notwithstanding the specific provisions relating to them. In the case of family A, the general provisions and those relating to children in need of compulsory measures of care seem to have dominated and eclipsed the needs of

the family relating to disability. Barbara's head teacher repeatedly expressed the view in case conferences that Barbara could be additionally vulnerable to abuse due to her disabilities. This does not appear to have been taken seriously. A meeting of professionals in February 1999 noted:

> *'It is felt that perhaps the fact that Caitlin is so bright and able that the effects of what appears to be chaotic parenting and a basic lack of parental care is having a more profound effect on her than say Barbara.'*

Local authorities must ensure that they take account of their specific duties towards and the particular needs of children affected by disability who are also children in need and/or children who are looked after.

Professional knowledge, skills and expertise.

189. This section explores the contribution of professional knowledge and expertise. A distinction is made between the knowledge, which different professions employ to decide on plans for children and expertise, which encompasses the application of knowledge and skills. For example, talking with children requires skill and we found many examples of professionals talking and listening to Alice, Barbara and Caitlin. However expertise is needed to make sense of what children are saying and translating that into a wider understanding of what might be happening to them at home. We found professionals, both in health and social work, lacked expertise in working with children who were being physically, sexually and emotionally abused.

190. Professionals tried hard to help both parents. When the family moved to Eilean Siar the staff there sought to match the support the family had received in England. However, they did not have the resources of staff, finance or facilities to provide the high level of monitoring and financial help available in England. The earlier efforts of two social workers, a probation officer, a health visitor, school teachers, and a Home-Start volunteer, plus specialist health staff working with Barbara's disability, may have contributed to the family moving away. No one in Eilean Siar seemed to consider the possibility that if the adults had wanted help with their parenting they would have stayed where they were.

191. When the family arrived in Eilean Siar the professionals appeared to start over again with their assessment of the risks to the children and their support to help the parents to bring up their children themselves. Their well-meaning commitment to keep the family together should have been qualified by their knowledge of the parents' backgrounds, the allegations of sexual abuse by Alice and the strong suspicions of physical abuse of Barbara and Alice.

Understanding child sexual abuse

192. The directors of social work for Scotland in a post Orkney publication in 1992 stated that:

> *'Assessing information/evidence in child sexual abuse is dependent on a firm knowledge base. What has to be recognised is that knowledge and understanding about sexual abuse in the UK is at an evolutionary stage. The accounts of adults abused as children indicate that denial is likely to be a common response. It is therefore fundamental to the investigation of child sexual abuse that 'the truth' will rarely be obvious. Victims are reticent and can withdraw statements, perpetrators deny because of the implications of loss of liberty for them if they confess, family and other professional workers may deny the possibility of sexual abuse because they do not wish to believe sexual abuse has happened to the child.*
>
> *Nevertheless whilst the possibility of denial must be faced, no investigation should take place on the unquestioning assumption that child sexual abuse has happened: the guiding principle for all concerned should be to keep an open mind and provide an open door should further information be forthcoming…There may be situations in which parents appear unable to see the risk and protect their child wittingly or unwittingly colluding with the perpetrators relationship with the child if not aiding it. Knowledge about this phenomenon is in its infancy.'* (1992: 34)

193. The increasing awareness of child sexual abuse among professionals has its origins in the growing children's rights movement and increasing knowledge and concern about child health. Knowledge and research into child sexual abuse has developed in the last thirty years. The increasing recognition of abuse of boys (Finkelhor, 1979, 1984), (Bagley and King, 1995), and that some abusers are women (Elliott, 1997) has changed a concept of abuse endured only by females. The fate of children who are not believed when they seek to communicate their abuse is frequently discussed within the literature on child sexual abuse. We have drawn on this literature in our comments and, in particular, have referred to the work of Tillman Furniss, *'The Multi Professional Handbook of Child Sexual Abuse',* which was first published in the UK in 1992. Furniss' work was well known in the 1990's and he contributed as a speaker to several major conferences on child abuse, organised by the British Association for the Study and Prevention of Child Abuse.

194. The reasons for disbelieving children are complex. We found examples of the children from family A not being believed by adults tasked with protecting them. A greater knowledge and expertise in child abuse may have helped them to recognise that in their work with family A, adults' views and values took precedence.

195. The work of Roland Summit has concentrated on what he called '*the reluctant discovery*' of child sexual abuse. Summit recognised the reluctance of courts and wider society to believe the testament of abused children.

> '*What is not so clear is that the victim of child sexual abuse faces disbelief, retaliation, and revictimisation at each level of disclosure within the world of adults. It is not only the court and the community of men that are so incredulous of sexually exploited children. The basic reason for disbelief is 'adocentrism*', *the unswerving and unquestioned allegiance to adult values. All adults, male and female, tend to align themselves in an impenetrable bastion against any threat that adult priorities and self-comfort must yield to the needs of children*' (1984: 128).

'*Adocentrism*' has at its roots the power of adult society, male and female. Summit's concept has been criticised and has limitations but remains a powerful reminder of how concerned and caring adults can unwittingly overlook the needs of children.

196. The imperative to ensure that the focus of child protection stays on the needs of the child sounds very simple but is in practice immensely difficult. There is research by Gough (1997), which found that the views of abused children rarely figure in discussions and decisions. The willingness of the adults to 'co-operate' is often a key factor in allowing the children to remain within the family. We found examples of co-operation by the children's parents being a reason for not taking legal action to protect the children in family A, for example in 1992 and again in 1996.

197. In this inspection we found that professionals appeared to be too willing to believe the accounts of adult family members about what was happening, rather than the children's.

198. All three girls at different times appeared to be trying to tell adults outwith their family that they were experiencing extreme distress and abuse. For example in 1992, a case conference concluded that *'it was likely that Alice had been sexually abused… the child protection plan was strengthened…'* Five years later, the social worker in Eilean Siar concluded that *'the question of Alice twice alleging that Mr A 'touched her' once when she was three years old and then in March 1997 still remain a mystery…'*

199. In 1998 Barbara and Caitlin told workers at NCH about nightmares. They told their social worker at the time about being *'tickled by family friends.'* In 1999 Alice told her foster carer that *'bad things had happened when she had been on holiday…'* Shortly afterwards Alice told her social worker that, *'…she doesn't remember all the bad things that have happened to her and that she has blocked them out…'*

200. In May 1999 the social worker raised the issue of the girls' secrecy with their parents. The social worker recorded *'…They made no commitment to change their attitude but accepted that the secrecy displayed by the children came from them.*' In the same month, Caitlin told her social worker that *'she had a big worry'*. A month later Barbara told her teacher that *'she knew bad people who had tied up her and her mother…'*

201. A year later when Barbara and Caitlin were going to stay with relatives, Caitlin, then aged seven, told her teacher that, *'She had too many worries, she will jump out of the window to kill herself and take her worries with her…'* When Barbara and Caitlin were first fostered, their foster carer Mrs E was concerned about Barbara telling lies. The social worker noted that '…*my feeling is that secrets within this family were deep seated and that Barbara was encouraged to hold onto secrets and tell lies. Her "lies" are probably quite complex – may indicate that she wants to tell us more e.g. what was happening at home…'*

202. In February 2002, Caitlin told Mrs E that she had felt unsafe when in bed at her relatives' house. This pattern of hinting at abuse by children is not uncommon and is recognised in the literature on child sexual abuse, for example:

> *'I have not yet seen cases of long-term child sexual abuse within the family context where the child has not tried to communicate the abuse to someone within the family or outside. Time and again we find children reporting that they have tried to tell their mothers, other family members or outsiders, only not to be believed, to be called a liar and to be punished for the disclosure.'* (Furniss 1995: 23)

203. Social workers did at various times spend time with the children trying to find out what was happening to them at home. This work was often described as 'self protection work'. Child sexual abuse prevention programmes have

developed rapidly since the mid 1980s. There has been longstanding disquiet by some professionals about these programmes being employed with young children who may not fully understand them. There is little research on the impact on young children.

204. Prevention programmes have been developed to use with children from the age of three onwards. Questions have been raised as to whether children can understand the concepts of good and bad touch, and that these programmes overemphasise stranger danger. However, teaching children to be wary of familiar adults is very complex. A disadvantage of 'self protection' programmes, for children who may be being abused, is that they may cause them to feel guilty. Materials can be helpful where there is suspicion of abuse as they may give the child permission to tell. *'They should only be used by professionals who are trained and fully aware of the impact and anxiety they may create in an abused child.'* (Furniss, 1995: 241) The effect on the children of the lack of expertise among the professionals in Eilean Siar who used these materials is evident from the case records. One of the social workers recorded Caitlin's reaction on a home visit: *'She was quite scared by it! Strange reaction.'* Caitlin was four years and eight months.

205. Later in this section, we recognise and discuss the sustained commitment, care and concern of the foster carers of the children and the skilled work of the fostering social worker. The foster carers appear to have been placed under near intolerable strain by the lack of understanding all round them of the impact of fostering children who have been sexually abused. The possibility of Alice having experienced sexual abuse was for some years not fully acknowledged by social workers, consequently her foster carers were denied the opportunity to explore the questions listed below. Furniss (1995: 317) explained that five questions need to be addressed in support for foster carers. These are:

> *'1. How can we talk to the child about the abuse and how can we deal with disturbed and sexualised behaviour? …Sexually abused children can be frightened of foster fathers and can be very demanding of foster mothers…*
>
> *2. How does sexual abuse affect the personal and individual feelings of each foster parent? …Sexually abused children can show strong hostility*

towards foster mothers when they re-enact their relationship to their natural mothers who did not protect them from abuse…

3. How does the sexually abused child influence the partner relationship? Sexually abused children can create problems in even previously stable relationships….

4. How to deal with the abused child in the presence of other children in the household? Sexually abused children often have problems in their peer relationships. They may have felt isolated for many years. They often feel dirty and different from other children…'

5. How to talk and deal with social contexts of school, nursery, youth clubs and neighbours? Sexually abused children have a right to privacy…but good communication and shared knowledge between foster carers, schools etc can be very helpful…' (1995: 317)

206. The placement of sexually abused children in foster homes requires intensive support and help for the family in understanding the issues the child may bring to them. Sexually abused children often re-enact sexual behaviour towards other children in the family. The records indicate that there was stress in the foster family and an impact on relationships, which no one appeared to quite understand at the time. Unlike many other foster placements, which founder on these dynamics, Alice's was sustained by the commitment of her carers. Her placement over seven years demonstrates the resilience and staying power of both foster carers and Alice, together with the consistent, skilled and caring help from the fostering social worker. A similar picture emerges in respect of Barbara's and Caitlin's foster carers who cared for the girls for two years before the investigation began and experienced some similar tensions and anxieties which affected their whole family.

207. As we have discussed, children who have lived in families with unclear sexual boundaries can have a significant impact on their foster family. Foster carers should have appropriate initial and ongoing training and support to help them to understand and manage the children they are caring for and sustain their own family. Only relatively recently has the role of foster carers' own children been recognised and the demands which foster children can make on them and their parents.

Recommendation: Local authorities should make sure that all foster carers have access to training appropriate to their caring role. The needs of foster carers' own children should be considered and if necessary additional help offered to them through group or individual work.

208. The fostering social workers in Eilean Siar provided a focussed and appropriate service to the foster carers. The work of the current fostering social worker demonstrates his commitment and professionalism. His conscientious recording enabled us to look closely at his work with the foster carers, their families, the children and other professionals. He offered practical help. He talked at length with the carers and their own children. He sought to develop support groups and looked for experts who might offer additional guidance. The stress and demands on the foster carers were particularly apparent throughout 2003. The fostering social worker kept in close contact with both foster families and also with the girls' social workers. There is evidence of skilled and sensitive work by him, with recognition of the effects of the investigation on all the family members.

209. There was substantial evidence of the 'staying power' of social workers and health visitors in England and again of social workers in Eilean Siar. No comment can be made about the standard of health visiting on Eilean Siar due to the loss of the health visitor records. Visiting patterns by health and social work staff in England were regular, often weekly or fortnightly, and contact was recorded carefully. In England the workers had forthright discussions with both Mr A and Alice's grandparents. There was no evidence of attempts to collude with Mr A. Likewise, the health visitor records at the time reveal an uncompromising approach to pursuing the children's welfare. Social workers in Eilean Siar also demonstrated commitment, serious concern about the family and regular visiting patterns.

Assessing risks to children

210. From 1993 onwards there were attempts by workers in England to assess Mr A's risk to his children. His refusal to complete the counselling offered by the

joint workers, probation and social worker, was interpreted by them as placing his children at high risk. A second assessment undertaken by one criminal justice worker in Eilean Siar in 1995 resulted in Mr A being assessed as 'low risk.' Later assessments in 1999 and 2000 resulted in his ultimately being required to leave the family home.

211. The importance attached to the 1995 low risk assessment was a pivotal factor in decisions not to protect the children sooner. Risk assessment of sex offenders was in its early stages of development at that time. The Sex Offenders Act 1997 introduced new arrangements for monitoring. The Scottish Office reviewed arrangements for the supervision of sex offenders and the report *'Commitment to Protect'* was published in 1997. This report stated that different professionals assess risk for different purposes. The police assess risk in terms of informing agencies about an offender in the area; psychiatrists when considering discharge from hospital. Social workers assess risk with schedule 1 offenders when preparing reports for courts, prisons and the parole board when determining supervision programmes and when making referrals to community resources.

212. The 1995 risk assessment was based on one social worker interviewing Mr A and using references to Wolf, undated but assumed to be 1984 *(*Wolf, S. A *'Multifactor Model of Deviant Sexuality')* and Marques and Nelson (1989) *'Understanding and preventing relapse in sex offenders'.* The worker interviewed Mr A by himself. Even in 1995, this was unusual. Most risk assessments are undertaken by two social workers. The social worker appeared to rely on the accounts by Mr A and less on the actual data provided by the previous conclusions on risk identified in England. He appeared worried about Mr A and his children but when his interviews were 'converted' into the risk assessment format Mr A was deemed to be a 'low risk'. The worker concluded that stress or pressure on Mr A could increase his likelihood of re-offending. Not only did the term 'low risk' seem to generate reassurance about the safety of the children, but also the model of risk assessment chosen reinforced the desire on the part of professionals to support the family to stay together.

213. In the 1980s family systems theories were fashionable in addressing abuse in the family, defining it as a result of family dysfunction, for instance Bentovim (1987) described a *'systems model of initiating and maintenance of sexually abusive behaviour'.* The theory has been criticised for failing to consider the power differentials in family relationships. The belief that sexual abuse of children in the family is partly caused by an upset in the equilibrium can lead to prolonged unhelpful professional efforts to sustain the family system. There was explicit evidence in Eilean Siar of workers seeking to support the family to sustain an equilibrium, which, it was believed, would lessen the risk of Mr A abusing his children. We think the evidence from England of physical abuse of the children should have formed part of a much more comprehensive assessment of the risk and possible harm to them at this time.

214. The second risk assessment undertaken by two staff in 1999 found Mr A to be high risk. It is not clear from the case records which model was used for this second assessment but the third risk assessment in 2000 followed a similar format. It was taken from *'Management and Assessment of Risk in Social Work Services, SWSI (2000b)'*. This third risk assessment reached slightly different conclusions from the second, e.g. that *'In reality his view of things and attitudes had not changed substantially since last assessment but he had learned new phrases and clichés which he used throughout interview.*' However the assessment concluded his risk of offending was medium and commented that: *'The children hopefully would let someone know if anything happens and extended family more involved and vigilant will also help to reduce the risk.'* There appeared to be a misplaced faith in the extended family and the ability of the children to 'tell' of their abuse. In our view, protection of children should not be based on a guesstimate of their ability to tell. Their powerless position in the family must be recognised.

215. Risk assessments are one tool in trying to find out the risk an abuser is likely to present to children. However as Briggs et al 1997 noted:

> *'It is as if 'risk assessment' has achieved the status of a discrete entity, the results of which are to be treated unquestioningly and without reference to the dynamics of the assessment situation or the person being assessed. Furthermore, some professionals enjoy the professional kudos of 'expert'*

> *for it serves their interest to perpetuate the notion of risk assessment being a definitive process'.* (1997: 144)

Briggs also emphasised that before any risk assessment is undertaken, a clear model should be drawn up to structure the hypothesis about risk and to inform the information gathering and assessment procedures. In respect of family A, workers seemed confused about the models and conclusions of their assessments. Rather than being reassured by the assessment of low risk, we think they should have been alerted to the fact that there was an identified and defined risk of harm to the children, and then carried out a comprehensive assessment of the whole family.

216. We looked for, but did not find after 1993, any form of comprehensive assessment of the family circumstances based on a recognised approach. Workers in England used the *'Orange Book'* (1988), which was an accepted assessment tool for many years. Developed in England it was nevertheless employed widely by social workers in Scotland. The DOH 2000 Framework has now superseded it in England for assessment. Scotland currently has no recommended theoretical assessment framework. However, the Scottish Executive is currently consulting on proposals for an integrated assessment, planning and recording framework as part of *'Getting it right for every child'*, the second phase of its consultation on the children's hearing system. In this inspection we found that assessment meant different things to different people within and among professional groups. We found a lack of professional knowledge and expertise by health and social workers in Eilean Siar in considering the factors in past and current family circumstances and in deciding how much they contributed to risks to the children's safety. In our view, this was compounded by the evident consensus amongst the professionals.

217. The early case conferences in 1990 and 1991 were marked by disagreements between health and social workers about the potential risks posed to the safety of the children by the backgrounds of their parents. One of the factors, allegations that Mrs A had sexually and physically abused children in the mid 1980s, was very rarely referred to after 1993. When staff in Eilean Siar

consulted the Lucy Faithful Foundation in 1997 they were advised that there were indications that abuse may be taking place and also that 'Mrs *A may be abusing herself?*' We did not find a record anywhere of an attempt by any worker to discuss these allegations with Mrs A or her sister, who made one of them. We recognise that the possibility of sexual abuse by women was rarely, if ever, considered at this time. However, there were other areas more readily recognised at the time, e.g. unexplained injuries to children, the children's distress, and sexually acting out behaviour, which should have been debated amongst the professionals who attended so many case conferences, reviews and discussions. There appeared to have been little attempt by any of the professionals involved at this time to determine Mrs A's capacity to protect or parent her children.

218. There was a wealth of detail about both families which should at least have alerted staff to the possibility that one or both parents would struggle with safe parenting. Mrs A's learning disability was well documented yet her capacity to function independently from her husband was not seriously assessed. We found notes in the records of her being afraid of and intimidated by her husband. Her witness statements described how she alleged she was raped repeatedly by adults who visited the family home. She appears to have been too afraid to report these at the time they happened. Her own extended family were often viewed as helping her with the children. No serious assessment of their parenting capacities appears to have been undertaken. Several of Mrs A's sisters were reported to have been sexually abused in childhood. This might at least have led to some consideration of the capacity of her mother to protect her children.

219. The records indicated a long-standing pattern of Mrs A's attempts to bring her anxieties about the welfare of her children to the attention of professionals. In England she appeared to have sought the involvement of volunteers, front line workers and police officers in turn. She did not convey her concerns in more formal settings, e.g. case conferences. In Eilean Siar this pattern was also evident, but there were fewer responses to her. For example, shortly after their arrival in Eilean Siar Mrs A went to the surgery to see her GP and burst into tears. Later she expressed concern about her children to the social worker. As this pattern was only apparent in the case recording in England, and not spelt out in

the case conference reports, it is likely that Eilean Siar professionals did not recognise, or grasp, the significance of what she was trying to tell them.

220. Many child abuse inquiries have found relevant information about the welfare of a child was not shared with other professionals working with the family. Therefore the frequent meetings held between the professionals to discuss family A were appropriate. In this inspection we found that information was shared, but was not decisively acted upon.

221. As a profession social work has placed great emphasis on partnership with parents as a professional imperative. The value placed on 'working together' has been enshrined in legislation, as discussed in the section on the legal framework. However, few studies of empowerment or partnership have addressed fully the complexity of the impact on children of a partnership with their parents, and how workers can achieve a genuine partnership or ensure the involvement of young children.

222. The importance of involving or taking into account the views of the family and child changed both in England and Scotland during the period within which we reviewed work with family A. The Scottish Office guidance to the Children (Scotland) Act 1995, states that:

> '*Achieving partnerships with parents and children in the planning and delivery of services to children requires that*
>
> - *they have sufficient information, both orally and in writing, to make informed choices*
> - *they should be aware of the consequences of decisions they may take*
> - *they should be actively involved where appropriate in assessments, decision-making meetings, care reviews and conferences*
> - *they should be given help to express their views and wishes and to prepare written reports and statements for meetings where necessary*
> - *professionals and other workers should listen to and take account of parents and carers' views*
> - *families have access to a complaints procedure*
> - *families have access to independent advocacy where appropriate.'*
>
> (1997; Volume 1: 6)

223. The 1995 Act provides that families should take account of the views of their children where they are of sufficient age and understanding to hold such views. There is no such similar requirement in England.

224. Both authorities who worked with the A family went to considerable lengths to ensure the involvement of adult family members both in their work, and in formal meetings such as case conferences. Whilst the family is a central unit in our society the use of the term 'family' in legislation and guidance implies a unity between parents and also extended family. In family A, there was a significant power differential within the family and indications that Mrs A was marginalised.

225. Case conferences formed the usual context for decisions about the safety of the children, which often were centred on their registration. The parents (and legal representative) and extended family often attended these. The children were, for much of the time, too young to attend and were not legally represented at them. Therefore these were all adult gatherings. We noted that in England, core group meetings were held without parents and after 1999 in Eilean Siar 'professionals only' meetings were convened. Mr A, through his lawyer, complained about these latter meetings but they went ahead nevertheless.

226. In our view, the involvement of young children does not necessarily mean having them present in the room whilst the risks to them are discussed. It does mean keeping their rights and needs constantly in mind. The children's hearing system is unique in insisting that children should attend unless their attendance is formally dispensed with. We consider that the crucial role of the hearing to provide an independent and lay view of the children's needs and safety, failed the children for a long time. We have reviewed the reports of each hearing in depth. We have no information as to whether members tried to talk to the children or seek their views. We concluded that two factors may have contributed to this failure to challenge seriously the position of the children: firstly, the apparent consensus between all the professionals and secondly, a lack of recognition of child sexual abuse on the part of panel members. Indeed, in their reasons for their decision at a children's hearing in 2000, the panel members paid tribute to

Mr and Mrs A's sacrifice in allowing Barbara and Caitlin to be cared for by their relatives.

227. The professionals failed to recognise the full significance of what they were being told by the children's mother and the children themselves. The possibility that the children's injuries were part of an attempt to silence them does not appear to have been considered in enough depth or by using all the medical evidence available. For example as early as 1994 medical reports indicated suspicion of physical abuse and the injuries suggestive of the girls being held down. At times the professionals did not make sense of the information at their disposal, for example stating that Barbara would be 'protected' by her disability, or that Mrs A would be more likely to be able to protect her children because she herself had experienced sexual abuse as a child. An up to date knowledge of sexual abuse might have told professionals that these factors could indicate increased risk of abuse (Kennedy, 1995; Cooke, 1997).

228. There was no recorded recognition by social work and health professionals of the issues of disability, both for Mrs A and Barbara. This is discussed further under the section on the law, but in terms of expertise, the lack of appreciation of the vulnerability and disempowerment of disability, was not addressed in work with Mrs A or her daughter.

229. A small, but significant, number of families are not safe places for children. Everyone working with families must hold this awareness in mind. Some families can be helped to sustain a safe home for children. Some refuse or are unable to make use of help. As discussed in the earlier section on parenting, social workers, doctors and other health professionals should have been more curious about the children's injuries. For example a suspicion about a cigarette burn should have been followed up by asking for a second medical opinion. The sexually acting out behaviour between the girls should have been considered more seriously and a referral made to child psychiatry.

230. The adults in the family appeared to have been anxious to allay the concerns of the professionals about injuries or health issues relating to the

children. There are examples, both in England and Eilean Siar, of either parents or extended family contacting the social worker, health visitor or school to give an explanation for an injury. For example in June 1998 Barbara was seen by the GP with a cut on her thigh. Her father informed the school and GP that she had cut herself with scissors. The GP record noted that *'the scissors shown to me were unlikely to cause such a neat wound.'* There was no further action taken on this injury. Later in 1998, Caitlin told her teacher that the injury to her hand was caused by a cigarette lighter. She told the GP that she fell and he concurred with this cause. An adult who visited the family regularly telephoned the family's social worker to tell the worker he had seen the child fall.

231. Where there were differing accounts between the child and the adults, the professional response was usually to believe the adults. The children giving three or four explanations or changing their stories often compounded this tendency. This highlights the difficulty for the professional staff in gaining and holding on to the child's perspective. Despite sustained attempts by a range of workers, including those in a voluntary child care organisation, to spend time with and get to know the girls in family A, they were not specifically told about their abuse. The girls did tell their foster carers. This may well have been because they were in a safe enough place to do so. Workers need to keep in mind that children who are being abused within their families are subject to powerful silencers, threats, physical abuse, guilt, and that they are very unlikely to risk telling adults of their abuse.

232. Health professionals and social workers working with families where there are problems in safe child rearing hope to be able to effect change to improve standards of parenting. However, this hope must firstly be securely based in a framework of knowledge and expertise and in an assessment which is constantly updated and not static. Secondly, there must be change within a timescale which meets the needs of the child. Thirdly, there must be a robust decision-making process which is centred on the needs of the child and the available legal options to secure their safety. Fourthly, workers and their managers need to be mindful of the impact that working with disturbed and abusing families may have on their ability to keep the needs of the child central. Many child abuse inquiries (e.g.

Blom- Cooper 1985 and 1987, London Borough of Lambeth 1987 and Bridge Child Care 1997) have identified the plight of the lone worker, usually a social worker, trying to balance and contain the conflicting demands of the parent(s) and child or children. Lord Clyde (1992) noted that not all staff are suited to child sexual abuse work. Therefore managers, as well as practitioners, should have up to date knowledge and expertise in child protection work to enable them to guide staff appropriately.

233. We found references in the records to the family being 'supported', and a general sense of optimism that this would improve the welfare of the children. Throughout the children's lives we found professionals were over optimistic about the capacity of members of family A to overcome their life adversities and to be good enough parents. Within the families of Mr and Mrs A we identified a series of difficult life experiences. These included having attended a special school for children with learning disability, growing up in residential care, having a parent who has epilepsy and a thyroid deficiency, growing up in a family where five out of six children were sexually abused within the family, living with adults who had been accused of physically and sexually abusing children, convicted of living off immoral earnings and convicted of sexually abusing a child. In addition, there were adults who had experienced inpatient psychiatric treatment and suffered from depression. The potentially serious impact of parental mental ill health is not always appreciated. Recent figures from the Office of National Statistics showed that mother's mental health was the only factor found to be significantly independently associated with the persistence of emotional disorders among children (Seltzer, Gatwood, Corbin, Goodman, and Ford, 2003). This research is drawn from the Department for Education and Skills study *'What Works in Parenting Support? A Review of International Evidence' (2004).* This review aimed to *'address the gap in the current literature on what works in parenting interventions.'*

234. Whilst it is important that professionals do not jump to conclusions, or label adults because of past life experiences, they must use their expertise to determine whether these experiences are a strength, or weakness, to their parenting. We found little evidence of rigorous evaluation of the adversities within family A. The

absence of a recognised assessment framework with an explicit theoretical base which could have enabled these factors to have been discussed and debated by professionals from different disciplines, was a significant omission in protecting the children in family A. Gathering together large amounts of information is not an assessment. Sharing it does not constitute a child protection plan. Professionals must take the next step to state why they attach significance to some issues and not to others. Their thinking behind these judgements must be explicit. Only by being so can they be challenged and debated.

235. Many families who experience difficulties are able to resolve them with help from the extended family, their friends and in some cases with help from professionals. There remains a minority of parents who, for whatever reason, are unable or unwilling to make use of help and whose children continue to be abused and/or neglected. If one parent is willing to accept help to stop the abuse and the other parent continues to abuse there may eventually be a stark choice for the non abusing parent. *'Leave your partner or lose the day to day care of your children.'* Mrs A does not appear to have been presented with this choice at an early stage in the girls' lives. Presenting these choices is difficult for professionals whose training and work ethos are focussed on keeping children and families together.

236. For social workers, evidence based practice should provide staff with effective means to develop assessments of parenting capacity and the ability to assess what is a reasonable standard of care. The *'Framework for the Assessment of Children in Need and their Families'* (DOH 2000) states:

> *'In a number of family situations where there is concern about a child's safety and future well being whilst living in his or her family, the findings from a core assessment may provide an uncertain picture of the family's capacity to change. These families are characterised by one or more of the following (Bentovim et al, 1987; Silvester et al, 1995)*
>
> - *Uncertainty as to whether the parents are taking full responsibility for either the abuse or the child's developmental state;*
> - *Whereas the child's needs may sometimes be viewed as primary, the parents put their own needs as dominant;*
> - *The child may be scape-goated and parent-child attachments are ambivalent or anxious;*
> - *Family patterns are rigid rather than healthily flexible;*
> - *Relationships with professionals are ambivalent.*

> *These families often cause professionals considerable concern. It is important that services are provided to give the family the best chance of achieving the required changes. It is equally important that in circumstances where the family situation is not improving or changing fast enough to respond to the child's needs, decisions are made about the long term future of the child. Delay or drift can result in the child not receiving the help she or he requires and having their health and development impaired.*
>
> *The details of the plan are bench marks against which the progress of the family and the commitment of workers are measured, and therefore it is important that they should be realistic and not vague statements of good intent.'* (2000: 4.29-4.31)

237. Professionals and their managers must ensure that decisions about risks to children and families are made on the basis of the best available research and evidence based practice and are regularly reviewed. Making decisions about the welfare of children is a complex activity which can be rightly contested in courts. This can be a stressful and time consuming process. Most of the staff who worked with family A are no longer working with children and families. We are aware from recent research published in Community Care 2005 that the majority of newly qualifying social workers have stated that they would prefer not to work with children and families.

238. High quality confident staff are necessary to protect children and help their families. Qualifying and post qualifying or post registration training must provide staff with the knowledge and skills to operate confidently in a changing social and political environment.

239. In this section we have looked at a number of key areas where we believe the professionals working with family A lacked the necessary expertise to effectively protect the children. We question whether an area such as Eilean Siar can ever have the range of expertise to address such complex child abuse issues. The directors of social work for Scotland, in their post Orkney publication in 1992, recognised the particular issues for small authorities:

> *'Part VII notes the issues for islands e.g.*
>
> *7.15 Because such cases (child abuse) are not dealt with on a regular basis, it is even more important that training programmes are in place and are woven into the fabric of rural and islands Departments….*

7.16 Dissemination and assimilation of new professional knowledge is therefore equally essential for remoter rural areas

71.10 The smallness and genericism of social work teams within island and sparsely populated rural communities present additional challenges to the effective management and supervision of complex cases.

71.14 In the field of child abuse as in many others there is a tendency to think that islands and rural areas are somehow apart from the mainstream and are not likely to experience major social problems which the general public and remote administrators tend to associate with centres of population.' (1992)

Indeed it is likely that all authorities will require access to some external expertise for staff working with complex child protection issues.

Recommendation: The Scottish Executive should establish a multi-agency national resource for those working with complex child protection issues. This should offer consultancy and co-working for staff in relevant agencies. It should set up a managed care network, based on the model of managed clinical networks, and establish a register of recognised experts who could be called upon if required. It should set up a database of relevant research and contribute expertise to qualifying training and continued professional development for staff working in relevant agencies.

The strategic management and supervision of staff

240. We consider that the failure of the agencies to take decisive action to remove Barbara and Caitlin at an earlier stage in their lives was in part due to failures in the supervision of staff and strategic management.

Education

241. Staff in all of the schools which the children attended recognised their distress and unhappiness and strived to educate them despite the effects of lack of parental care. They identified, and met, Alice's and Barbara's needs for additional support for their learning.

242. We found that all the children's class teachers recorded marks, injuries or bruises sustained by the children, or unusual behaviour. It was not always clear to us from the records which of these recorded concerns were passed on to their school senior staff, and whether in turn they were relayed to social work staff. It is important for protecting children that all school staff are aware of which pieces of information about a child should be provided to senior staff whose responsibility it is to decide whether these should be passed on to social work staff and to keep a record of that decision.

Recommendation: Local authorities should make sure that there is a senior member of staff in every school responsible for recording and passing on to social work or other agencies any information about a child or their family where there are concerns about child protection. If they record specific concerns in a child's file which are not passed on to the relevant agency, the reason for this must also be recorded in the child's file.

243. The extent and nature of line management supervision and support for the class teachers was not apparent from the records. However, Barbara's head teacher usually accompanied her classroom teacher to case conferences while it was usually Alice's and Caitlin's head teachers and, on some occasions, class teachers who were present. Barbara's class teacher and head teacher regularly

highlighted her vulnerability to abuse as a disabled child. The minutes of a child protection case conference in December 1997 noted that her head teacher *'expressed concern that Barbara was unable to express herself and could not perhaps relate any abusive experiences.'* In 1999 Caitlin's head teacher wrote to the social work department staff, on behalf of all of the school staff, to express concern that the underlying causes of her soiling were not being addressed.

244. A class teacher or other member of the school staff can be chosen by a child who is being abused as a trusted person to hear about their abuse. The children tried in different ways to tell their teachers what was happening at home. Their teachers did not always appear to appreciate fully what the children were trying to tell them. We do not know if teachers had the opportunity to discuss their observations with education staff who had expertise in protecting children.

245. Since 1990 local authority education services have been required to appoint a senior officer accountable for child protection policies who is responsible for ensuring that all education establishments have a fully trained child protection co-ordinator. (Scottish Office Education Department Circular 10/90). The Scottish Executive's recent guidance on child protection committees states that *'CPCs are responsible for promoting, commissioning and assuring the quality and delivery of inter-agency training.'* Standard 8.6 of the *'Protecting Children and Young People: Framework for Standards'* (2004c) underlines the importance of child protection training:

> *'Agencies seek to ensure that their staff are effectively and relevantly trained and that they are:*
> - *supported*
> - *supervised*
> - *accountable in their work.'*
>
> (Scottish Executive 2004c: 12)

The Scottish Executive has set up a working group to develop national materials to underpin the framework of standards.

Recommendation: Local authorities should make sure that all pre-school, primary and secondary school staff regularly participate in child protection training appropriate to their particular roles.

Health

246. Health professionals in England and Eilean Siar attached different importance to the family's non-medical history. For example, in 1990, a GP in England stated that his suspicion that Alice may have been sexually abused *'was based on mother's history and the social worker's history [of the family] rather than any clinical findings'.* Health visitors in England repeatedly drew attention to the risk to the children from the background of both their parents.

247. By contrast, the family's registration with a GP in Eilean Siar was treated as a routine practice registration. We did not find any reference to their non-medical history, and no special measures were taken by the practice to ensure good communication within the practice, with other health professionals or other agencies. In view of the previous child protection issues, and the number of health professionals involved with Barbara in England, we think adopting a standard rather than a special approach left the children vulnerable.

248. We are aware that the Scottish Executive, the Child Health Support Group, the Royal College of Paediatrics and Child Health and NHS Boards and regions have discussed development of regional and national managed clinical networks for child protection services to make sure that expert advice is available to health professionals in every area. In most areas primary care teams can contact a specialist in child protection. In smaller rural areas NHS Boards need to make arrangements for this expertise to be available through formal arrangements with other NHS Boards and managed clinical networks.

Recommendation: Primary care teams should agree when a family with child protection concerns registers with the practice how they will strategically manage the health care of the family and how they will communicate effectively about this on an intra-agency and inter-agency basis.

Recommendation: NHS Regional Planning Groups should work together with National Services Division and the Royal College of Paediatrics and

Child Health to develop managed clinical networks for child protection that ensure access to specialist advice in all NHS Boards with appropriate use of telemedicine. These managed clinical networks should be linked to the national resource for staff working with complex child protection issues recommended in paragraph 239.

249. Barbara received a considerable number of services from a range of health professionals who seemed to work from their own clinical perspective. There appears to have been no overall management of her health care and protection needs. The paediatrician would have been the most obvious person to have had overall responsibility for coordinating Barbara's care. However, in Eilean Siar he was not a community paediatrician in whom the role of co-ordinating health services would usually rest. We acknowledge that in some rural areas it might be necessary for a GP to take on this co-ordinating role in an individual case.

Recommendation: Every NHS Board should make sure that all children with complex needs have a health professional who takes an overview and provides coordination of their health care needs.

250. In Eilean Siar the health visitors' notes for the children in family A were lost when they started school. Our understanding is that the notes would normally be passed to the school nurse but as there was not a school nurse in post at the time of transfer the records appear to have been destroyed. This is not acceptable for any children and particularly for children with such a significant social and medical history. This issue must be urgently addressed by the NHS Board.

Recommendation: Western Isles NHS Board should urgently put in place arrangements to retain and effectively use health visitor records. They must be able to retrieve them if required. Where there are child protection concerns about a child, the health visitor should prepare a summary and pass this and the inter-agency action plan to the school nurse when the child starts school.

251. We found no record of any of the GPs in Eilean Siar seeking advice from health professionals locally or elsewhere with a specialist interest in child protection regarding any of the injuries to the children, particularly their burns. There was suspicion about the probable cigarette burn to Alice in September 1996. In September 2003 a paediatrician from another NHS Board was asked to undertake a joint forensic medical and requested an opinion from a burns expert on the scars to the children. It was only then that the extent of their cigarette burns was confirmed.

252. In Eilean Siar the health records did not contain any reference to health staff consulting with their line manager. Neither was there any indication of there being a senior health professional with a lead role in child protection. Some of the health professionals, e.g. the speech and language therapists, frequently spent time with Barbara on an individual basis. The reports which they presented to case conferences and their contributions to the meetings referred only to the development of her speech and language. We did not find significant awareness of their role in protecting Barbara. It is not clear to whom health professionals, including peripatetic and visiting staff, would have taken their child protection concerns or what the arrangements were for requesting a second medical opinion.

253. The guidance for health professionals relating to *'Protecting Children: A Shared Responsibility'* states that the health board should draw up a specification for a child protection service which should include:

> *'the identification in all Trusts of a Senior Nurse or Doctor with responsibility for ensuring that there are appropriate guidelines and procedures in place and that the Trust and its staff comply with local child protection/child protection committee procedures.*
>
> *the identification of a Senior Nurse and Lead Clinician within Trusts with paediatric services with experience and training in child protection to ensure that there are appropriate guidelines and procedures in place and to ensure that the Trust and its staff comply with local child protection committee procedures.'* (2000a: 11)

We acknowledge that this guidance was not published until January 2000.

254. The O'Brien report of the Caleb Ness inquiry in October 2003 found that it was not clear who in Lothian primary care trust was responsible for child protection throughout the trust. Therefore we consider it essential that in every NHS Board area there is a medical professional or team which has the leading role in child protection. We understand that Eilean Siar now has a child protection adviser to whom child protection concerns are taken. There should be an expectation that all child protection concerns are referred to that adviser. Arrangements for the provision of a second medical opinion and access to specialist advice in protecting children should be readily available to staff.

255. In Eilean Siar we found no record that the paediatrician had been told when family A first registered with the general practice. In view of the medical records indicating child protection concerns which were subsequently confirmed by the social work department, the paediatrician should have had close involvement with family A. In remote areas or smaller NHS Board areas the paediatrician may have a wide remit and we recognise that there may be resource implications. Nonetheless the strategic management of child protection cases must be addressed.

Recommendation: Western Isles NHS Board should review its arrangements for the strategic management of child protection cases. A lead medical and a lead nursing professional should be identified to oversee the health input to them all. The roles of lead professionals should be clear to all health staff and to staff in agencies involved in protecting children. All health staff should know where to obtain specialist advice on issues of child protection. Arrangements should be put in place to make sure that visiting health professionals are informed of child protection concerns about their patients.

Social work

256. Social workers and their team leaders discussed family A in supervision sessions on a regular basis. Although there are significant gaps in the available supervision records, there is also some evidence in the case files of informal supervision or consultation with senior staff taking place at other times. From the

records, supervision appears to have provided support and shared accountability but a number of key decisions were not recorded at the time they were made, e.g. the decision to undertake a review risk assessment of Mr A in 1999.

257. Where the social worker discussed decisions in supervision with the team leader the records do not indicate that the reasons and the basis for the social worker's conclusions were examined, for example, reviewing the belief that the family were making progress in December 1996. The social worker had decided to shift the emphasis of the work to family relationships, rather than child protection *'[The social worker] views Mr A as holding the family together and without his contribution there would be increased concerns.'* (December 1996). This should have been challenged in the light of other information about events within the family.

258. Team leaders have a vital role in making sure that social workers' recommendations are founded in a thorough, objective and evidence-based assessment. This should include examining the impact of the social worker's own values, gender and the dynamics of their relationship with the different family members. In addition, the worker's attitude to abuse and knowledge and expertise in a particular area may also impact on their professional judgement. The importance of this aspect of supervision was emphasised in *'A Child in Trust'*, the report of the inquiry into the death of Jasmine Beckford:

> *'It is almost inevitable that a social worker will become emotionally involved with a family with whom she is working closely. One of the most important tasks of a supervisor is to counteract any potential distortions of judgement.*'
> (Blom-Cooper 1985: 216)

259. The inquiry report goes on to cite Professor Greenland's evidence talking about the 'rule of optimism' in high risk cases:

> *'One of the problems of working with high-risk child abuse is what is called the rule of optimism. Because the problems are so complex, in order to develop enough enthusiasm and enough energy, the social workers tend to have a very optimistic view of what can be accomplished. They tend to exaggerate progress that has been made, and they may see progress where there is no progress. They do that to sustain their own morale, at least to some extent. For this reason, because of the loss of objectivity,*

> *professional supervision is vital, so that when the social worker reports that the marital relationship has improved enormously, it will be the job of the supervisor to say "where is the evidence for this?" He must compel the front line social workers to examine their judgements in a critical way…'* (Blom-Cooper 1985: 217)

260. Supervision is important in helping social workers identify, and take account of the development of the family over time. The supervision records we read suggest that all or most of the worker's many cases were discussed in each session, with a focus on current concerns. For complex, long-term work with children and families it is important that supervision enables staff to regularly review information and case planning in the context of the family history, enabling the identification of patterns of concern. This is particularly important at key decision-making points when the range of options must be systematically explored using knowledge of the law, social work approaches and current guidance and social policy. Decisions reached should be recorded in the case file, in addition to the recording of supervision sessions. Potential evidence identified through discussions in supervision can be important in future legal processes and the social work department should review their current policy of destroying supervision records after two years.

261. The importance of robust quality assurance arrangements was highlighted in Lord Laming's inquiry into the death of Victoria Climbie. Recommendation 45 stated:

> *'Directors of Social Work must ensure that the work of staff working directly with children is regularly supervised. This must include the supervisor reading, reviewing and signing the case file at regular intervals.'* (2003)

262. The social work department in Eilean Siar has a recently developed staff supervision policy and supervision practice guidelines. These provide a useful framework for the supervision process, but they should be amended to specifically address the areas noted above. The social work department also has a case recording policy and practice guidelines which includes the expectation that the team leader will regularly monitor the case file.

Recommendation: CNES social work department managers should review their staff supervision policy and supervision practice guidelines.

Recommendation: All local authorities should make sure that their policies and practice on supervising social work staff comply with the Scottish Social Services Council's codes of practice. Directors of social work/chief social work officers must make sure that staff who work directly with children are regularly supervised. The responsibilities of the supervisor should include exploring any issues which may affect the social worker's objectivity. The supervisor should be satisfied that the social worker's judgements are based on an analysis of the evidence. Current events should be examined in the light of previous patterns in the family history. Decisions made in supervision should be recorded in the case file and cross-referenced to discussion noted on supervision records.

All agencies

263. All staff working with children who are abused or neglected need regular good quality supervision, consultation and support from within their own agency. However, this work affects staff in different ways and can take a heavy emotional toll. The police in Scotland routinely require their staff working in areas which make particular emotional demands, e.g. homicide and complex child protection, to have a meeting with the staff welfare officer to discuss options available for support and counselling. In serious or protracted cases the senior officer can require this meeting to be compulsory, making sure that staff can have the option of help without it being seen as an individual problem or weakness. Staff then have a choice about whether they take up any of the options offered. We believe other agencies can learn from this policy.

Recommendation: All agencies should make sure that staff engaged in work protecting children have access to confidential counselling which is separate from their line management. Staff working in very distressing circumstances should be expected to have an initial meeting with an independent person outwith their organisation to discuss available options for support.

Leadership and quality assurance

264. The 1995 Act places a duty on the local authority to provide services to children in need (section 22). The Act also sets out the duties of the local authority towards children who may be in need of compulsory measures of care (section 53) and to children who are looked after (section 17). Local authorities usually delegate these responsibilities to senior social work staff. We think it was appropriate that social work department staff in Eilean Siar took the lead role in the overall strategic management of the welfare of the children in family A. However, social workers worked with other agencies in accordance with local inter-agency child protection systems. Many of the key decisions were made on an inter-agency basis. One of the leadership roles the social work department undertook was to convene inter-agency child protection case conferences and reviews of children who are looked after.

265. *'Protecting Children: A Shared Responsibility'* states:

> *'A child protection case conference…will undertake some or all of the following tasks:*
>
> - *ensure that all relevant information is shared and collated*
> - *assess the degree of existing and likely future risk to the child*
> - *identify the child's needs and any services from any of the agencies that may be needed to help him or her…*
> - *review a current child protection plan'* (1998: 31)

The case conference will decide whether or not a child's name should be placed on, should remain on, or should be removed from, the child protection register. If the child is registered it will agree an inter-agency child protection plan (1998: 32).

266. Good practice in the late 1990s was for case conferences to be chaired at a senior level by a manager who did not have immediate operational responsibility for the case. This became a recommendation when the 1998 guidance was published:

> *'Case conferences should be chaired by a senior member of the social work service with appropriate training and skills in the chairing of inter-agency conferences. The chairperson should not have first line management responsibility for decision-making about the case.'* (1998: 33)

267. Case conferences in Eilean Siar were chaired by the depute director of social work with the exception of one which was chaired by the director and two by a children and families team leader. It was the team leader who chaired the final case conference which decided to remove Barbara's and Caitlin's names from the child protection register. They were still living with relatives at this time. The chairing of case conferences by the depute director did provide a high level of seniority and a distance away from first line operational management of the work with family A.

268. Case conference chairs must make sure that there is a clear child protection plan which delegates responsibility for particular tasks to individual family members and professionals. In England a core group was set up from each case conference to monitor the child protection plan, comprising the social worker, nursery and/or senior school staff and the health visitor. The O'Brien inquiry into the death of Caleb Ness recommended the core group model (2003, recommendation 32). In Eilean Siar, case conferences tended to concentrate on the most recent events rather than looking at the whole period since the last case conference. Regular meetings of a core group could have assisted the case conference by regularly reviewing, and analysing, all of the information with the agencies involved. We note that the Western Isles Child Protection Committee is in the process of revising its inter-agency procedures and guidelines. We have seen drafts dated July 2004 and July 2005 which both contain a requirement, in the event of a child being registered, to draw up an inter-agency child protection plan, identify a key worker and form a core group.

269. Standard five of the Scottish Executive's *'Protecting Children and Young People: Framework for Standards'* (2004c) expects agencies to develop, monitor and review plans for children in need of care and protection. This standard includes the expectation that plans *'identify the professional with the lead role in ensuring the co-ordination of work amongst professionals'* and that they *'detail monitoring and review arrangements'*.

CNES should make sure that each child in need of care and protection has an action plan. Each plan should identify a professional with the lead role in

monitoring the action plan for the child and co-ordinating the work of all of the professionals involved. Each plan should also specify a core group of other professionals who play a key role in delivering and monitoring the effectiveness of the plan.

270. Case conference chairs must make sure that decisions are made in the best interests of the child. The children's parents and members of the extended family were often present at case conferences in Eilean Siar but not their children. Mr A wanted the children removed from the child protection register and was able to put his view across. We have recommended that professionals are given greater support to enable children's views to be heard at case conferences and other inter-agency meetings. The chair's most important task however was to make sure the children were the focus of the discussion and decision-making. We do not consider that the case conference chairs in Eilean Siar consistently achieved this. The effectiveness of the child protection plans needed to be increasingly challenged as there was mounting evidence of the children's distress.

271. Case conference chairs need appropriate skills and expertise to carry out their crucial role. The O'Brien inquiry made a recommendation about the training available to case conference chairs (2003, recommendation 25). We consider this issue requires to be addressed urgently at a national level.

Recommendation: The Scottish Executive should make sure that all chairs of child protection case conferences have access to a national training programme.

272. CNES had a statutory duty to regularly review the children from when they became looked after in June 1997 (section 31 of the 1995 Act). The purpose of the review of a looked after child (LAC review) is to monitor, review and where necessary change the child's care plan. LAC reviews must be held within required timescales (regulation 9 of the Arrangements to Look After Children (Scotland) Regulations 1996).

273. After Alice was taken into foster care in August 1997, and again in March 1998, LAC reviews were held for her but they were almost all combined with the review case conferences for all three children. Since her removal from the child protection register in March 2000 her reviews have been held separately, but the required timescales have not always been adhered to. Barbara and Caitlin moved to relatives in July 2000 but we found no record of a LAC review until February 2001. Since then, LAC reviews for Barbara and Caitlin have been held within the required timescales.

274. We recognise that the social work department's decision to hold Alice's LAC reviews jointly with the review case conferences may have been an attempt to ease the burden of multiple meetings on the agencies involved. Large numbers of meetings for the same family are difficult for the family and professionals to manage. However, the result was that it was not always clear to us from the very detailed minutes which decisions were made at the case conference and which were made at the LAC review.

275. The attendance at meetings by some of the education and health staff decreased once the children were removed from the child protection register and settled in foster placements which were viewed as permanent. We recognise that busy professionals will prioritise meetings. However, social workers cannot be expected to provide expert comment on the educational progress and health needs of looked after children. Education and health staff have a responsibility to ensure that children who are looked after have all of their needs addressed in order to fulfil their potential.

276. The chair of a LAC review must be able to take an overview of a child's current situation as someone who is not responsible for day to day practice and decision-making. The guidance on the 1995 Act states:

> *'Chairing a review requires professional knowledge and impartiality of judgement. Ideally the chairperson should not have line management responsibility for the case…'* (1997: Vol.2: 20-21*)*

The chair must be able to challenge current care planning and professional practice where necessary.

277. In Eilean Siar, once the children's LAC reviews were held separately from case conferences, they were chaired by the children and families team leader who had line management responsibility for the work being done with the family. As a result, there was no independent overview of the care planning and decision-making for the children. At a review in June 2002, the family's social worker chaired the review in the absence of the team leader, which was not appropriate.

Recommendation: CNES should make sure that reviews of looked after children are not chaired by the first line manager of the social worker responsible for the case. The chair should be a senior member of staff with sufficient authority to be able to challenge current care planning and professional practice.

Quality assurance

278. A number of the line managers supervising staff involved with family A failed to sufficiently quality assure their practice. The local authority should have internal quality assurance systems outwith the line management structure. For example in England there was an area child protection committee case review panel which in May 1993 considered the work undertaken with family A. The review was positive overall about the work but identified shortcomings in the assessment of both parents. Ten years later, Lord Laming's report stressed the importance of regular internal auditing. Recommendation 53 stated: *'Directors of social services must ensure that senior managers inspect, at least once every three months, a random selection of case files and supervision notes.'* (2003)

279. We acknowledge that CNES social work department undertook an audit of all child protection case files in 2004. We also recognise that they have since drawn up case recording policy and practice guidelines which state:

> *'The auditing of Child Protection and Looked After and accommodated case files will be undertaken as part of routine management and will be conducted at least on a yearly basis by the Children's Services Manager in conjunction with the Child Protection Officer. Any action to be taken as a result of the audit will be recorded and included in the case file.*

The Children's Services Manager will periodically survey and sample case recording practice and this should include appraisal of the organisational resource constraints that might impact on staff and performance.'

280. The Scottish Executive's *'Protecting Children and Young People: Framework for Standards'* (2004c) states:

Standard 8.2:

'Agencies rigorously monitor and review their work in protecting children and implement steps which lead to continuous improvement.'

Standard 8.10:

'Agencies have quality assurance mechanisms to ensure that these standards are met and that this can be demonstrated.'

281. The Scottish Executive has recently revised its guidance to child protection committees (CPCs) (2005a). The guidance makes clear that CPCs have an important role in promoting continuous improvement of child protection work on an inter-agency basis and a responsibility for the development and implementation of inter-agency quality assurance mechanisms.

Recommendation: CNES should review its quality assurance procedures for managing child care and child protection work to make sure that these meet the standards set out in the Scottish Executive's *'Protecting Children and Young People: Framework for Standards'* and monitor their implementation.

The joint investigation

282. This section discusses the stages of the investigation and the impact on the children in family A and their foster carers. Our sources for this section include the social work, health and police records (including the police video recording of a briefing meeting and the reports of the forensic medicals of the children). Where appropriate, we have drawn on extracts from witness statements, some precognition statements and reports of expert opinion. We did not have a remit to examine the investigation from the perspective of the eventual decision by the Crown not to proceed with the prosecution of the suspects. However this was an important stage for the children and their carers and we examine the processes and practice of the staff involved. Throughout the report we have recognised that many staff were out of their depth with the complexity of the issues with which they were presented. We recognise this again in this section and draw attention to the importance of the recent Scottish Executive *'Guidance on Interviewing Child Witnesses in Scotland'* (2003a). Our conclusion of this section recognises that very few cases of alleged child sexual abuse reach the courts.

283. The investigation fell into four distinct stages:

1) Initial disclosures
2) Extending the investigation - the increasing seriousness of the allegations and the response by agencies to bring in specially trained staff
3) Arresting the suspects
4) Developments in the investigation up to the final decision by the Crown not to proceed with the case against the suspects

Stage 1 Initial disclosures

284. In December 2002, Barbara told her foster carer that she had been abused by adults who visited her parents' home. These incidents had taken place some years ago. Barbara's foster carer contacted the duty social worker. Senior staff in the social work department had discussions with the police and they decided to

wait until the New Year to begin the investigation. Barbara and her sisters were safe. The Christmas and New Year holidays would have created an inevitable break in the process of the investigation.

285. The joint investigation began in January and continued until October 2003. The two younger children, Barbara and Caitlin, began by telling of abuse by unrelated adults. As the investigation proceeded they also named family members as abusers. Children who have experienced abuse rarely tell all of the events at the beginning. They tend to 'try out' their experiences and check out the response from adults.

> *'We need to be aware that initial disclosures by children very often are only partial disclosures. Children come out with lesser abuse first before they trust to tell the full story, often much later. Some children say initially that they have only been abused once and they implicate a stranger. Only later when they trust do they disclose long term abuse by friends, family members and strangers.'* (Furniss, 1995: 216)

286. Local staff undertook the first stage of the investigation, i.e. police and social workers based in Eilean Siar. In our opinion they could not have foreseen then how the allegations would unfold.

287. The investigation began by a police officer and social worker meeting with Barbara and Caitlin. Barbara described sexual touching by unrelated male adults, who visited the family home regularly. Mr A was informed by the police about the general nature of the enquiry. Mrs A was interviewed and denied that she knew of the abuse. When Mr A was interviewed he denied any knowledge of the allegations.

288. Mrs A was interviewed by a police officer and a social worker (with another worker acting as an appropriate adult) during February. She described her life and her medical difficulties, including her learning disability, epilepsy and depression. She described the move from England as very difficult. She stated that she missed the involvement of social services and felt isolated and depressed. After a couple of years she had begun to get to know other adults

who had moved from England. She alleged she was raped repeatedly by one of the adults. In later interviews Mrs A described the sexual abuse of her children.

289. At the end of May, Barbara had a second interview in which she described sexual abuse by another adult. When Barbara's father came to Eilean Siar from England for an access visit, Barbara refused to see him. She did see her grandmother. A week later when Barbara's foster carer was discussing her refusal to see her father, Barbara told of sexual abuse by her parents. She was interviewed and told of further abuse.

290. In early June police officers interviewed an unrelated adult at Stornoway Police Station. From our reading of all of the documents available to us, it is evident that he admitted to touching at least one child in an intimate and inappropriate manner on a number of separate occasions.

291. There was an entry in the police log kept at this time noting:

> '*A decision to discuss the case with the Procurator Fiscal and his instruction that at this stage Mrs A was to be continued to be treated as a witness. Northern Constabulary, noted in a Child Protection Initial Report that they would re-examine all case notes etc to try and gain evidence of cruelty and neglect as well as sexual abuse.'* (Northern Constabulary records, July 2003)

292. In July Barbara and Caitlin were having nightmares. The girls insisted their foster carer accompanied them to supervised access with their mother. Caitlin was writing notes in a journal, which she also wrote on behalf of her sister Barbara. She described sexual abuse by a number of related and unrelated adults and the inappropriate sexualised behaviour of her sisters. Caitlin concluded her journal,

> *'…Something has happened to me. I think it is along the lines of what Barbara said I did to her. It could be part of the reason I was soiling myself. If something has happened I have pushed it to the back of my head. I have to keep thinking until I remember completely. I am not totally certain.'*

293. The pace of the investigation during the first six months of 2003 was in our view very slow. There was a five month gap between the first and second interviews of Barbara. The foster carers strived to keep life as ordinary as possible. They insisted the girls were accountable for their behaviour. There was

a disagreement between the foster carers and the school and social workers about sanctions. The foster carers were determined Barbara should be treated as responsible and 'normal'.

294. Barbara tended to tell her foster carer about the incidents, whilst Caitlin used her journal to try to make sense of her thoughts. In our view her lack of clarity over events is not necessarily an indication that she had imagined her abuse. Caitlin was very young when many of the alleged abuses took place. The process of disclosing abuse is harrowing for children. There is often a mix of loyalty to the abusing adult, a sense of betrayal and guilt. For example, one of the girls explained in one of her statements that she told a male relative that she was being abused and she believed that he would tell her social worker. Instead, she alleged he also sexually abused her.

295. There is a difference between investigative interviews, which seek to discover the facts, and supporting children who are trying to tell of abuse, what is often referred to as giving children the licence to communicate about their abuse. At this stage Caitlin appeared to be seeking that permission. Giving children explicit licence to communicate about sexual abuse means addressing openly all possible anxieties, which may motivate the child not to disclose.
For example:

1) breaking the secrecy
2) the fear of not being believed
3) the fear about any threats not to disclose
4) the anxieties about the possible consequences of disclosure for the child and for the family
5) the fear of punishment and rejection by family members and professionals.

296. Finally, children need to be given explicit licence to communicate in sexual language. When children disclose sexual abuse there is a difficult balance to be maintained by caring adults, between giving them permission to tell what has happened and not 'leading or encouraging' them to embellish their experiences. We did not find any accounts of the children receiving skilled help to make sense

of their experiences. We consider that the lack of expertise of the staff involved inhibited them from fully considering these issues for the children. Children, however severely abused, often remain loyal to the perpetrator especially if they are close family members. Children who have been abused by numbers of adults are often very confused about what has happened, especially if they have been threatened with violence or separation if they tell someone. The records tell us that at different times the children did take a risk and tell an adult and they were not protected. Therefore we were unsurprised by their hesitancy in telling about their abuse. One child in a witness statement lists the reasons why she is afraid to tell about her abuse. She was afraid of *'what her friends would say; worried that people would know the police had been to her house; was frightened of going to court; scared of family members; did not want to get her mum into trouble and was scared of the other adults.'* Another child asked at the end of the interview, *'will I be like that when I grow up?'* The literature on child sexual abuse recognises the fear for children of telling about their abuse. For example Furniss noted that:

> *'Abused children are often told not to disclose to anyone within the family… As a result of threats of violence and threats of family disaster, children lie more often when they deny that sexual abuse has taken place than when they falsely accuse a family member of sexual abuse. Legal, child protective and health professionals need to face up to this crucial fact of child sexual abuse as a syndrome of secrecy.'* (1995: 24)

297. We think that the professionals may have been overly hesitant in creating a climate where the children could feel safe to tell of their abuse. This may have contributed to the slow progress in the early months of the investigation and the strains placed upon the foster carers. The introduction of a specialist child protection worker from the police in the next phase of the investigation appears to have helped the children to be less fearful of telling of their abuse. In our view it would have been better if the children could have been interviewed from the beginning of the investigation by staff with special training in joint investigative interviewing. We recognise that authorities in remote areas may have difficulty in employing staff with skills and experience in joint investigation and also recruiting staff temporarily to take part in interviewing. The national resource referred to at paragraph 239 should be able to assist agencies to access expertise when needed. Training courses in joint investigative interviewing have been developed

jointly by social work and police staff at the Scottish Police College and we consider it important that staff whose task is to protect children are properly trained.

Recommendation: Managers in social work agencies and in police forces must make sure that they have staff who are appropriately trained in joint investigative interviewing, or can arrange to recruit such staff temporarily either from another authority or elsewhere. The Scottish Executive should, in conjunction with the resource suggested in paragraph 239, develop a national register of suitably qualified staff. All staff who take part in joint investigative interviews should have completed appropriate and up-to-date training in joint investigative interviewing.

Stage 2 Extending the investigation

298. The second stage of the investigation was characterised by a tighter focus on planning and developing the scope of the investigation. The police called an interagency planning meeting at the end of July which was chaired by a Chief Inspector of police and the following strategy determined:

- *'Interview of Alice as a witness*
- *Review of the evidence for sufficiency and corroboration to identify suspects*
- *Interview of Mrs A as a prospective witness*
- *Identifying and interviewing of the suspects*
- *Clarification of family access to children*
- *Liaison with the Procurator Fiscal, Stornoway, was to be undertaken*

A police constable was dedicated to the enquiry and instructed to contact Force Headquarters, Child Protection Unit, for further advice and guidance. A Detective Sergeant was to oversee day-to-day progress. Police enquiry was to move forward along criminal enquiry lines. Social Work Department representatives agreed to consider moving forward in therapeutic lines for after-care of children involved. Daily updates to be provided by PC -- until further notice.'

(Extract from witness statement which was drawn from Northern Constabulary records, July 2003)

299. The girls from family A and their mother were interviewed during August 2003. Joint planning meetings between police and social work were held before each interview with a witness. There were also subsequent de-briefing meetings.

In mid August, a detective inspector was appointed as a senior investigating officer (SIO) and a specialist child protection police officer was appointed to oversee the enquiry. In her witness statement she noted that:

> *'I was aware that … had interviewed the three victims previously and that notes had been taken of their interviews. The bulk of the work that had been done was rapport building with the girls.'*

We transcribed and examined all the handwritten notes made by staff who did the early interviews with the children. The notes indicated to us that:

- the interviewers established rapport
- they sought to establish whether the child understood the purpose of the interview
- they asked the child to explain, with examples, the difference between truth and lies and
- they explained to the child that they were allowed to say they did not know or did not understand.

The notes indicated by initials which adult asked the questions and the child's replies. In some notes there were verbatim accounts of each answer. In others there were summaries with abbreviations. We found these less satisfactory as they did not tell us what the child said. Contemporaneous recording requires practice and skill and we discuss later the importance of video recording of interviews. The notes were in our opinion only just adequate in telling us about the process and content of the early stage of the investigation and were identified by the police as productions rather than witness statements. Witness statements from the children were taken in the next phase of the investigation which was led by a specialist police officer and we discuss this in detail later in this section. We also discuss the interviews with Mrs A below.

300. A police policy file was opened on 28 August 2003, and was maintained by the SIO. The policy file has been developed by the Association of Chief Police Officers crime committee to ensure that decisions made during an investigation are made clearly, with stated reasons and accountability. The policy file has one page for each decision, which is set out in a paragraph, with the reasons stated

below. The recording of social work decisions is less easy to follow. Social work decision-making in complex cases would benefit from a similar clarity in recording decisions.

301. The police officer who began the interviews with the girls was appointed as their victim liaison officer. This enabled the girls to be kept informed of progress in the investigation by someone they trusted and it seemed clear they valued the work of the officers concerned.

302. In her interviews, Mrs A described further accounts of sexual abuse of her children by a number of adults. At the end of August Barbara gave her foster carer a list of names of adults who had sexually abused her and her sisters. She was interviewed by the specialist police officer and her social worker, but her foster carer was not present. Caitlin and Alice were also interviewed on separate occasions. They described sexual abuse by male and female adults including family members. They described money changing hands between adults after they were abused.

303. Police officers met with the procurator fiscal who again confirmed he wished Mrs A to remain as a witness. We have examined Mrs A's witness statements in depth. Her early statements describe rape by men who visited the home. The men concerned were not charged. The social work case records kept at the time note that the children were telling their teachers that they were worried about their mother's relationships with some of these men.

304. In all interviews Mrs A was accompanied by an appropriate adult. She described in detail severe and prolonged abuse of her children by a number of adults. She was interviewed over a period of seven months. Towards the end of the period she described abuse of her children and others as part of various rituals conducted by numbers of adults. She was eventually advised by her appropriate adult to stop describing abuse. In her precognition statement she retracted her allegations against two of the former accused. We found no record of Mrs A being assessed by a psychologist as to her ability to be a witness. The impact of her learning disability appears never to have been determined.

Because of this we cannot be certain whether the impact of successive interviews might have led her to elaborate her accounts of abuse, rather than remaining focussed on what happened to her own children.

Recommendation: In major crime or protracted investigations where a witness or potential suspect is a vulnerable adult, the police should commission a psychological assessment to advise on the person's capacity to give evidence and on the length and number of interviews which should be undertaken with them.

305. Early in September there were planning meetings between police and social workers to discuss the developments and to plan for what was termed by the police 'enforcement day'. The police record noted that:

> '*The Procurator Fiscal recommends that in the interests of justice, the detention of suspects, house searches and secondary child protection enquiries be conducted on a single day co-ordinated operation. CNES SWD to provide sufficient staff to enable a joint enquiry(s) to be carried out on Enforcement Day (03.10.03).*
>
> *SWD also to provide staff members in managerial role to liaise with SIO as investigation progresses and on Enforcement Day. SWD also to provide appropriate premises (NCH) for interview of child witnesses in secondary Child Protection enquiry and to put in place arrangements for suitable accommodation for children should this need arise.'*
> (Northern Constabulary records, July 2003)

306. The social work department had brought in additional staff to offer advice and guidance to their staff. The police policy file noted that *'all staff involved in this case will be offered the assistance of the Force Welfare Officer. Consultation with the Welfare Officer will be compulsory for those Officers heavily involved in the case.'* (Northern Constabulary records, 2003)

307. This is standard procedure in the police force in Scotland for all staff working in circumstances which are stressful and distressing. By this stage of the investigation both agencies had appropriately recognised the demands upon their staff and the social work department staff were also offered counselling.

308. The stress and demands on the foster carers were substantial during the summer of 2003. Investigations of sexual abuse can unwittingly recreate the exclusion and secretiveness of the abusive experience. One carer described feeling she no longer had a parenting role. Another carer felt that she carried the burden, as she chose not tell her husband all of the details.

309. The children's recognition of the help given to them by their foster carers was found in their statements. Barbara, for example, when discussing sitting on adults knees, stated:

> *'…Nobody ever said it was wrong. We don't do that now…we used to rub against him (current male foster carer)…Dad taught us to do that. We weren't told it was wrong…we don't do that now. With (current foster carers) it's safe.'*

310. In mid September the girls were asked to give consent for forensic medical examination. As parental rights remained with their parents, their mother was also asked to give her consent. Barbara and Caitlin travelled to Aberdeen with their foster carers on one day and Alice and her foster carer travelled the following day. A paediatrician and a police surgeon examined the girls. The report on each child begins by commenting that, *'In considering child sexual abuse evidence the most important feature is the disclosure made by the child, particularly where this information is corroborated by an adult and siblings.'*

311. The doctors noted what they thought were scars suggestive of healed cigarette burns and requested a report from a plastic surgeon and burns expert.

312. During phase two of the investigation there were two references in the police policy file to statements that staff would review the social work files for pertinent information. We do not know the outcome of these reviews. In our detailed review of the files from 1990 onwards, we found a catalogue of allegations, indicators and incidents of sexual and physical abuse and neglect (appendix 2). These are discussed earlier in the section on parenting. As far back as 1994 there were suspicions by a paediatrician that the girls were being held down on hard surfaces. There were suspicions of cigarette burns from 1996. The children told their teachers how apprehensive they felt about adults who visited the home.

313. The early sharing of information between health and social work professionals could usefully have been extended to involving the police. For example the police could have been involved in investigating the extent of neglect in the home in 1999. The social worker and senior were so worried about the behaviour of two of the adults towards the children in family A that, in 1999, they visited them at home to issue a warning. In our view the police should have been involved at this earlier stage.

314. In 2003, the social work department and the police established a child protection specialist team which met regularly to discuss issues relating to the impending trial. In our view, this team, whilst valuable, should have been formed much earlier in the investigation.

Stage 3 Arresting the suspects

315. 'Enforcement day' was the 3rd of October 2003. There were frequent joint police/social work briefing meetings in the run up to this date. Family B were also involved in the investigation. Arrangements and subsequent services for their children are discussed separately.

316. In total 13 adults (7 men and 6 women) were detained in terms of section 14 of the Criminal Procedure (Scotland) Act 1995 on suspicion of rape, lewd indecent and libidinous practices. 6 men and 1 woman were detained in custody to appear in court on 6th of October when the names of the accused and the charges were announced. Two other adults who were on holiday on enforcement day reported to the police on their return and were detained on the same charges as the other suspects.

317. The girls were visited on Friday 3 October 2003 by their liaison officer and were told that the police were speaking to suspects. They were not told details of the case.

318. The fostering social worker remained in very close contact during this period. He visited both families on a Saturday evening, the day following the detention of suspects. Alice told her foster carers of further abuse by family members and subsequently made a statement to the police. The fostering social worker recognised that the families were under additional stress from questions in the community as well as coping with their own emotions. He suggested bringing in an external person, perhaps from the British Association for Adoption and Fostering, but this was not welcomed by the carers at this time. He noted in his record that:

> *'There was a thread running through that the carers did not feel adequately supported throughout, but especially at the beginning when such an independent person might have been helpful. They have all been through different stages of emotions from anger to frustration and even numbness. They were all very appreciative of the police's level of support and the girls' social worker. They were not so happy that senior management had not been in touch with them.'*

319. The depute director of social work and the SIO from the police visited the foster carers in late October 2003 to show their appreciation and support for their care of the girls. By the end of October the SIO confirmed that no further statements would be taken from witnesses.

Stage 4 Developments in the investigation up to the final decision by the Crown not to proceed with the case against the suspects

320. In early November 2003 the fostering social worker decided to organise a support group for foster carers on working with children who have experienced trauma. A new police liaison officer for the girls was appointed. They were sad to lose their previous officer.

321. The reports from the plastic surgeon and burns expert were completed in mid November. His report stated that:

> *'Drawing on a lit cigarette results in the middle of the glowing tip reaching a temperature of 700C. Without drawing, the middle of the tip has a temperature of 580C, whilst the side of the tip is 400C…the total pattern of scarring is not consistent with accidental injury or self-inflicted deliberate injury, but is consistent with abusive non accidental injury.'*

322. The plastic surgeon's report states that the girls had been burnt by cigarettes some years ago, but that expert advice was not sought at the time. The implications of seeking expert opinion at the time of doubt about a burn, or an injury, are discussed earlier in this report. The increasing use of video and computer imaging is valuable in enabling consultation between doctors and specialists, and has particular benefit in remote areas. At paragraph 248 we made a recommendation about the appropriate use of telemedicine as part of the development of managed clinical networks for child protection that ensure access to specialist advice in all NHS Boards.

323. The strains on the foster carers increased during this stage of the investigation. The children were arguing and demanding attention from them. There were frequent visitors to the home. Barbara expressed regret that she had told anyone about her abuse. Her foster carers' home was crowded and her foster carers had given up their bedroom and were sleeping on the settee so the girls could have separate rooms. Alice's social worker reported that Alice was feeling very low and unhappy with herself. There were tensions in her foster home. However at her review Alice wrote on her 'Have Your Say' form, *'I like it very much because I get loads of love and help'.*

324. At a joint police and social work planning meeting to discuss the girls it was noted that their parents still had parental responsibility for them. The possibility of securing their placements legally was discussed. By 2004, Alice had been in foster care for over six years and her sisters for nearly three years. In March her social worker noted that Alice was unsettled and upset by having to attend children's hearings.

325. In mid March, at the request of the Crown, the three girls went to Edinburgh for another forensic medical. Caitlin's foster carer recorded that Caitlin cried and Barbara was very upset. The paediatricians noted in their report that:

> *'The absence of physical signs neither confirms nor negates a diagnosis of child sexual abuse. A diagnosis of sexual abuse should rarely, if ever, be made on physical signs alone…A clear statement from the child is the single most important factor in making the diagnosis of child sexual abuse.'*

326. The conclusions of this forensic medical examination were different from those reached in the September 2003 forensic medical examination of the three girls. Both examinations were later reviewed by a third expert who supported the conclusions reached in the second examination.

327. The complex issues involved in forensic medical examinations have been recognised. In 2003 Dr Mok and Professor Busuttil (Mok and Busuttil, 2003) published a study which aimed to establish how widely guidance issued by the Scottish Executive Health Department was being followed by practitioners, NHS Trusts and health boards. The study asked nine questions to try to find out the range of current practice in child sexual abuse examinations throughout Scotland. They found that:

> *'There is, at present, no requirement for either pre-service or in-service training in this speciality nor is there monitoring of the services provided. The medical examination and the follow up care for children and young people in whom abuse or neglect is suspected has become more technical and complex as the result of colposcopy, the introduction of telemedicine and therapeutic counselling. It has been suggested that many general practitioners and general paediatricians are reluctant to care for these children because of the expertise and time required for medico-legal proceedings… It is acknowledged that at present, there are no established standards for the training of 'experts' in this field, and no process of accreditation to establish qualifications or document continuing education.'* (2003: 26)

328. There is an acute shortage of skilled paediatricians able and willing to work with suspected child sexual abuse in Scotland as in the UK as a whole. We are aware that this is being addressed in a number of ways. There is now a council for the registration of forensic practitioners. Mok and Busuttil (2003) noted that the Standing Committee on Child Abuse of the Royal College of Paediatrics and Child Health (RCPCH) is addressing the need for accreditation in this field. They also explored the concept of managed clinical networks:

> *'…These should consist of generalist practitioners and specialists in child abuse meeting regularly for peer support, continuing professional development and thereby ensuring that the agreed national standards are maintained and the guidelines followed.'* (2003: 24)

This concept was also proposed in the *'Report of the Acute Services Review'* (1998) and has been further supported in the *'National Framework for Service Change in the NHS in Scotland'* (2005b).

329. These networks have been the subject of much debate amongst paediatricians since the publication of the Acute Services Review. Most of the managed clinical networks in Scotland have been medical specialities involving only health professionals. However child protection work requires close collaboration between a range of agencies which has led to slower progress. Mok and Busuttil (2003) discuss the possibility of child protection clinical networks being developed at two levels. A local multi-agency network of GPs, social work, police and education would meet regularly for discussion of complex cases, peer support and training. At national or regional level they suggest a smaller number of specialist centres, perhaps three for Scotland. We consider these proposals could link with the development of the multi-agency national resource for developing work in protecting children set out in paragraph 239.

330. We are aware that the Scottish Executive Health Department, RCPCH and Crown Office have started discussions about the complex issues involved in forensic medical evidence in suspected child sexual abuse. We consider that this important area should be urgently taken forward by the Scottish Executive who should set up a group with a clear remit to prepare guidance in the use of forensic medical evidence. This should include reaching a shared understanding of the nature of the evidence that forensic medical examinations can provide and the roles and responsibilities of paediatricians in forensic medical examinations.

Recommendation: The Scottish Executive should work with NHS Quality Improvement Scotland and the Royal College of Paediatrics and Child Health to establish a working group of representatives from the Crown Office, RCPCH and NHS Scotland. The group should prepare guidance on the nature and use of forensic medical evidence, processes for obtaining and presenting this evidence and the roles and responsibilities of health professionals in forensic medical examinations.

331. There should also be urgent discussions between the Scottish Executive and the Royal College of Paediatrics and Child Health (Scotland) about how to improve recruitment into child protection.

332. In April 2004 the girls were visited by the plastic surgeon and burns expert from England. A psychologist based in Scotland was asked by the Crown to provide an opinion of the girls' reliability as witnesses. We have seen her precognition statement dated 19 and 20th May 2004. She was asked to provide an opinion on:

(1) whether the symptoms of soiling and wetting etc. are indicative of sexual abuse and

(2) the credibility/reliability of the girls.

She stated that this was one of the most extreme cases of neglect over a period of time she had ever seen. However she concluded that she *'would not say that sexual abuse has not happened in that family but I would be unwilling to place much reliance on Barbara or Caitlin's version of exactly what did happen.'* She also expressed reservations about the reliability of Alice as a witness. The psychologist noted that she was not present when the girls made their statements and their interviews were not recorded on video. As far as we can tell the psychologist did not interview the children and she reached her conclusions on their reliability from records and witness statements.

333. When the videoing of children's evidence was introduced in practice in England and Wales, no similar arrangements were put in place in Scotland. In England and Wales children can give their evidence in chief on video, recorded at the time of the investigation of the offence (Piggot, 1991; Department of Health, 1995b). The Criminal Procedure (Scotland) Act 1995, sections 260 and 262, allows for prior statements by a witness to be admitted at court in place of their evidence in chief. The statement can take the form of a written document, audio or visual recording. The Vulnerable Witnesses (Scotland) Act 2004 has included the use of a prior statement as one of the special measures intended to help vulnerable witnesses to be able to give their evidence and is being implemented in phases.

334. In England and Wales, the Criminal Justice Act 1991 extended the use of live television links for children and young people. In Scotland, the Criminal Procedure (Scotland) Act 1995, section 271 set out special provisions for vulnerable persons, including children, to be able to give their evidence. These

provisions included the use of a live television link and the use of a screen. Facilities are available in some, but not all, courts in Scotland for children to give their evidence by video link to the courtroom. Procurators Fiscal can make arrangements with Scottish Courts Service to install temporary facilities in any court which does have them already or to transfer a case to another court within the same sheriffdom.

335. The full list of special measures contained in the Vulnerable Witnesses (Scotland) Act 2004 is:

- use of a live television link, either in the same court building or outwith that building
- use of a screen in the courtroom
- use of a supporter
- use of a prior statement as evidence in chief and
- taking evidence by a commissioner

336. All children are now entitled to use those special measures which are 'standard', and these are:

- use of a television link
- use of a screen and
- use of a supporter if used in conjunction with either of the above

337. We believe that had the children in family A been required to give their evidence in court these measures would have been helpful to them. Guidance on each of these special measures has been issued and will shortly be available on the Scottish Executive website. However we remain concerned that the investigative interviews of the children in families A and B were not recorded on video tape.

338. Children's investigative interviews in Scotland are not currently routinely recorded on video tape. A pilot scheme in two areas of Scotland was started in 2003. The pilot has been evaluated and the findings of the evaluation are due in summer 2006. The findings will be important in deciding if Scotland should adopt routine video interviewing of child witnesses.

Recommendation: The Scottish Executive should consider the findings of the pilot schemes for video recording of the statements of child witnesses with a view to drawing up guidance on extending this throughout Scotland.

339. The Scottish Executive *'Guidance on Interviewing Child Witnesses in Scotland'* was published in September 2003. We recognise that this was near the end of the period of the joint investigation. A draft of the guidance was issued for consultation in October 2002 and we would have expected those involved in the joint investigation to refer to it as an indicator of good practice. However, it was a consultation document. Once guidance is published it takes time and resources for agencies to implement it in their policies and practice. While we identify areas where the conduct of the investigation differed from the guidance, we have taken care not to judge practice against it. We have instead sought to identify any further recommendations to improve practice in this area.

340. The Solicitor General for Scotland in the foreword to the guidance states that: *'It is crucial that those working with child witnesses are equipped with special skills and understanding to enable children to give their best evidence.'* The guidance defines an investigative interview as:

> *'…a formal, planned interview with a child, carried out by staff trained and competent to conduct it, for the purposes of gaining the child's account of events (if any) which require investigation.'* (2003a: 8)
>
> *The main purposes of the investigative interview are as follows:-*
> - *to learn the child's account of the circumstances which prompted the enquiry*
> - *to gather information to permit decision making on whether the child in question or any other child is in need of protection*
> - *to establish whether a crime has been committed.'* (2003a:10)

The guidance draws a distinction between a child telling a teacher or foster carer and an investigative interview. Although the guidance was not available until the autumn of 2003, the foster carers and workers appreciated this distinction and acted appropriately.

> *'Although children may first approach those people who are around them daily (e.g. teachers) to communicate their worries, these discussions are not to be confused with the investigative interview. If the child does*

> *spontaneously disclose information – outside of the formal context - of a nature that might require investigation by the authorities, the receiver should (i) listen, and support the child; (ii) make a written record of the child's remarks in their own words as soon afterwards and as accurate as possible; and (iii) seek help from the appropriate agencies*.' (2003a: 9)

341. Once an investigation is underway the guidance identifies various stages to be followed:

1) strategy discussion
5) pre-interview briefing
3) investigative interview
4) debriefing meeting

342. Each of these four stages was followed in the interviewing of the children in family A. However the process of the interviews did not follow the guidance which was subsequently published, for example, that *'the interviews should be carried out by professionals who are trained and competent to conduct them…the interviewer should have knowledge of the child's understanding and their needs.'* We have discussed earlier that in our view Barbara's needs as a child with disabilities should have been assessed. It would have been appropriate to assess any particular needs she might have had in relation to the interviewing process, for example assistance in giving her statements.

343. The guidance states that *'the location of the interview should be a suitable setting'.* The majority of the interviews were conducted at the offices of a voluntary organisation or a house designated by the police which we understand had been adapted to provide a relaxed setting. There is a balance between finding a setting where the child feels safe and comfortable, and achieving a degree of formality and separation from the child's home. It is important for some children to feel that they can leave the discussion of their abuse 'behind' in the interview room.

344. The guidance recommends that personnel should be kept to a minimum,

> *'…if the child wishes or may benefit from having an adult present- every effort should be made to establish that this person is not a witness or potential witness nor someone who has a personal investment in the case.'*

'If a supporter is present it is best they are only there for the rapport phase. Ideally the supporter should be near, in another room to be called on if necessary.' (2003)

345. The investigation began because one child told her foster carer about some of her abuse. Her disclosure was the beginning of a painful journey for her and her sisters. In our view the workers involved had a difficult judgment to make, whether or not to allow her foster carer to be with her in the early interviews. The presence of a 'trusted' person might be crucial in enabling a child to talk about their abuse. Police and social work staff decided in the first stage of the investigation to accede to the children's wish to have their foster carer present. In later interviews they were not present.

346. The chart below sets out the number, venue and presence by foster carers at the interviews. The police regarded the earlier interviews as rapport building and therefore the presence of foster carers (who were also potential witnesses) was in our view acceptable in the early stages of the investigation.

Interviews	A	B	C
Number	10	11	6
Suspects	13	13	13
Venue- home	6	4	2
NCH unit	-	5	4
Police house	4	2	-
Police staff	2	4	2
SW staff	2	2	2
NCH staff	-	-	1
Foster carers present	6	8	4

Diagram 1: record of number, venues and personnel - joint investigative interviews, 2003.

347. All the above interviews were conducted jointly between social workers and police officers. The interviews took place during eight months, the majority between July and October 2003. As discussed earlier the children disclosed their abuse slowly. The guidance, published in October 2003, warns against interviewing children too often. The guidance states that the:

> *'aim of joint interviewing is to reduce the number ideally to one but more may be needed. Where more than one interview is to be conducted it is important that the needs of justice be carefully balanced with the needs of the child. Extra information could be acquired following each subsequent interview. However the greater number of further interviews, the more likely that each successive one is to be perceived as excessive and unnecessary, and this will in turn affect the strength of the evidence obtained. Furthermore the emotional trauma and stress the child may endure from repeatedly recalling events could have serious repercussions for their well being. Another problem that interviewers must be aware of, particularly with multiple interviews is confirmation bias; suggestions may be instilled in the child's mind and then reinforced within and across interviews.'* (2003a: 16)

The guidance is valuable for interviewing a child abused recently by one adult. In our view the guidance does not advise staff how to proceed in very complex investigations where there may be multiple abusers and several children.

Recommendation: The Scottish Executive should further develop the guidance on interviewing child witnesses to include guidance for police and social workers investigating complex cases where the allegations of abuse include several adults and where several children are involved.

348. Mrs A has learning difficulties and an appropriate adult was always present at her interviews. The appropriate adult chosen was often the children's social worker. We believe a more independent person should have been found. We recognise that resources on Eilean Siar are limited. We are aware that the recent guidance on appropriate adults specifies clearly who should be chosen as an appropriate adult.

349. At the end of June 2004, the Crown decided not to proceed with the case. The Crown considered carefully how best to tell the children about their decision. The social worker recorded that the girls reacted to this news by being angry and upset. Barbara and Caitlin stated that they never wished to see their family again and wanted to remain with their foster carers permanently. Alice's foster carers noted that she was initially upset then settled, but they felt she might react later on. The implications for children of a case not proceeding can often be confusing and leave them feeling disbelieved and angry. Children who have been at the

centre of an investigation often gain a lot of adult attention. It can be very hard for them to lose this attention. Settling down to 'ordinary' life can be unbearable. Some children want to continue to talk about their abuse, others deny it ever happened. Whatever the response of the child, a heavy burden rests with their carers in trying to help them to find a resolution to their abusive experiences and the outcome of legal processes.

350. We have recognised the complex issues for prosecutors in cases of alleged child sexual abuse, which because of secrecy and the evidential requirements often mean a prosecution cannot be raised for want of sufficient reliable evidence. The Scottish Executive has already taken steps to improve the opportunities for children to give their evidence with as little distress as possible. We think staff who are tasked to protect children should have access to training and, where necessary, specialist advice. However it is important to be cautious in looking for single experts in child sexual abuse. To accept the notion of experts in child sexual abuse can create the unrealistic expectation that somebody who knows could tell others who do not know. It is more realistic to look for a range of professionals who have knowledge and expertise in relevant areas which might include medicine, psychology, social work, child development, disability etc. The tasks, skills and responsibilities in the overall intervention are larger than any single professional or agency can encompass. Therefore we emphasise the importance that staff in every agency understand the roles and responsibilities of all the agencies involved when a child discloses abuse.

Section 2 Family B

Background

351. This section summarises the key events relating to family B from the findings of fact agreed by the agencies involved.

Andrew (born 1991)
Bridget (born 1994)
Caroline (born 1998)
David (born 2000)
Edith (born 2003)
Mrs B (mother)
Mr B (father)

352. Family B moved to Eilean Siar from England in a mutual exchange of houses with Mrs A's sister in 1997. In 2003 the children in family A made allegations of abuse against a number of adults. As the investigation developed, the police concluded that some of the allegations were being made about Mr and Mrs B. Mr and Mrs B have five children.

353. Little is known of family B's experiences on Eilean Siar. The health visitor records stated that Mrs B suffered from post-natal depression and that her husband was very supportive. The family home was reported to be in a very poor state without a bath and with wires hanging out of the wall. There were numerous animals, 19 cats and dogs, about the house. The health visitor recorded that whilst the house was in a very poor state of repair, there was electronic equipment and computers in the home.

354. The health visitor referred Mrs B to the social work department in March 2003 for home support. A social work assistant was allocated to help Mrs B and she provided support until July 2003. By the end of the summer the health visitor had again contacted the social work department, as further help was needed and the social work assistant returned.

355. On 2 October social work department staff applied for child protection orders in respect of the children in family B. The following day Mr and Mrs B were arrested and detained. Mrs B was released without charge later in the day and was reunited with her seven-month-old baby. Mr B was remanded in custody. He was transferred to a prison in Inverness but was released from custody on 13 October 2003 and did not appear in court with the other adults who were charged.

356. When their parents were arrested in October 2003, the B children (Andrew aged 11, Bridget aged 8, Caroline aged 4, David aged 3 and Edith aged 7 months) were taken to a local NCH children's unit. Police and social workers interviewed Andrew and Bridget twice and Caroline once. The children said nothing that indicated abuse at home.

357. On 3 October Mrs B joined her children at the children's unit and returned home with her three younger children four days later and the two older children the following day. An exclusion order was granted in respect of Mr B and he was provided with alternative accommodation. He had supervised access to his children and the social work department provided mobile phone cards. A safeguarder was appointed at the children's hearing.

358. At a child protection case conference in November the children's names were placed on the register as at risk of emotional abuse. An educational psychologist held individual weekly sessions with Andrew and Bridget. At a review case conference in February 2004, the children's names remained on the register and Mr B agreed to his voluntary exclusion from the home. In March the social work department financed a short holiday for Mrs B and the children. Mr B returned home in early May 2004. There was a review case conference, which decided that the children should be additionally registered as at risk of sexual abuse. At the end of June the Crown announced that they would not be proceeding against any of the accused. The children's names were removed from the child protection register and the records noted that the *'family were no longer an open case to Comhairle Eilean Siar'*.

Analysis

Parenting

359. The professionals who had contact with the B family in Eilean Siar were the health visitor and school teachers and, for a short period, a social work assistant. After the investigation, a social worker, NCH and an educational psychologist became involved with the children.

360. The principal concern about Mr and Mrs B's parenting was the state of the home. The police reported that the living conditions were below acceptable standards. Andrew said when interviewed that the children had to repeatedly fight off the family's cats to be able to eat meals in the home. The house had two bedrooms. Andrew and David slept in bunk beds with only blankets for mattresses in one bedroom. Bridget and Caroline slept in the other room on bunk beds with only blankets for a mattress. Their parents slept in the living room on the floor with the baby.

361. The children had good general health, and saw the health visitor and the doctor as required. There were very few reports of the children sustaining even minor injuries.

362. The children attended school regularly and their teachers were satisfied with their development and behaviour. The health visitor, who recorded regular contact with the family, was satisfied with the progress of the younger children.

363. After the investigation the children attended NCH regularly for eight months and the eldest two saw an educational psychologist. Comments about the children were positive. For example, Andrew was reported to be very caring to his siblings and spent most of his time making models or swimming. When the children returned to school, Andrew coped well and the head teacher reported there were no particular problems.

364. David was very unsettled after being at the NCH children's unit. Their records indicated that, for several weeks afterwards, he was very angry and difficult to manage and appeared to have been upset by his separation from his parents.

365. Social work, health and NCH staff continued contact with the family up to June 2004. A case conference in May 2004 described Mrs B's ability to cope as 'admirable'. The children were well disciplined and well behaved. They had positive relationships and were active in the community.

Agencies responses

366. The health visitor twice referred Mrs B to the social work department for help from a homecarer when she suffered from postnatal depression after the birth of Edith. Mrs B was bringing up five children, her husband was working away from home on occasions and she received practical help with the home.

367. The help offered by the agencies, both before and after the investigation, appears to have been appropriate and effective in improving home standards. After the investigation the extent of the poor state of the home and the neglect of the basic living conditions for the children came to light. The homecarer and the social worker tackled these. The number of cats was reduced and a grant was given for sheets, bedding and food. In April 2004 at Mrs B's request the social worker organised a skip and large amounts of rubbish were cleared.

368. The police planned the arrests of Mr and Mrs B. Arrangements for the children were planned jointly by police and social work in a series of meetings leading up to the 3rd October 2003. Social work department staff obtained child protection orders, which were not subsequently served. The records of the planning meetings contained discussion of ways to minimise the trauma to the children of their parents being arrested at 6.30am. NCH provided a small unit, which could accommodate all the children when their parents were detained. Staff who knew the children and staff from NCH came to the home with the police and looked after the children and took them to the children's unit.

369. The decision by the police to go so early in the morning was part of a wider plan to arrest all the suspects at the same time. Police policy is that the most likely time to find everyone at home is in the early morning. The arrest of both parents at whatever time in the day is an alarming experience for children. We noted that the Western Isles Child Protection Committee inter-agency procedures (revised in 2004 and 2005) do not offer guidance on how to best care for and protect children when their parents are arrested. For example North East Scotland child protection committee guidance stresses that:

> *'care must be taken to ensure that in acting to protect a child, including making inquiries into allegations that a child has been harmed, agencies should avoid causing the child undue distress or adding unnecessarily to any harm suffered by the child.'* (2004: 45*)*

Recommendation: All child protection committees should develop guidance on how best to care for and protect children when their parents are arrested.

370. We observed the video recording of a police briefing meeting for staff who were to undertake the arrests, and noted the frequent references by the senior investigating officer of the need for sensitivity towards Mrs B and the children. Police were advised not to rush, to give Mrs B time to get the baby organised and to allow the children to gather their belongings and some toys to take with them.

371. Keeping the children together was important in sustaining some sense of security for them. NCH staff provided a high level of attention and activity for them and their mother was able to join them by the end of the first day.

372. At the children's unit social workers and police interviewed the three eldest children. The initial interviews of the children went ahead without the consent of Mrs B, who did consent to the second interviews. The police proceeded with the first interview on the grounds that parental consent could be dispensed with because to *'not do so would seriously impede the criminal investigation.'*

373. We gave thought to the decision to interview the children soon after their arrival at NCH. The police perspective was that from the allegations, which had been made against their parents, there was a possibility that they had been

abused or had witnessed abuse. The balance between a criminal investigation and the needs of children is a fine one. The interview transcripts, which we read, showed that the interviewers had tried to explain the purpose of the interview and to gain the consent of the two older children. Both children did agree to be interviewed although it is very probable that by that time they felt unable to refuse. The interview with their four year old sister was more of a play session. We did not think there should have been any attempt to interview her. It is very doubtful if she could have given any kind of meaningful consent. None of the children were medically examined. We thought this a correct decision. Nothing from the children's demeanour or statements gave any justification for a medical.

374. Andrew stated in the afternoon *'I was really nervous and didn't know what was happening. I did what I was told when I got up. I was really worried and scared. I feel much better now…'.*

375. Bridget was described as initially tearful and nervous. She asked where her mother was. The older children appeared able to express their feelings and ask some questions. David showed the most distress but at three years old it was likely he would have been bewildered and angry at being separated from his parents so suddenly. Even very young children can benefit from explanations and advance warnings of events, and in an investigation these cannot be given. On a later occasion when the police decided to search Mr and Mrs B's home, two social work staff took the four older children out and on return stayed until the police left at 3.30pm and helped Mrs B to put the children to bed.

376. After Mr B came out of prison he agreed with the social work department to remain outwith the home. However it had been made clear to him that if he returned home the children would be removed. He had supervised access to his children for two hours a week. Mr and Mrs B were not happy with this level of access and wanted longer. Access was increased to four days per week.

377. In our opinion the continued involvement of NCH staff appears to have been positive. The children took part in various leisure activities, which may have taken some of the strain off their mother and helped them to express themselves.

378. The records of the sessions with the educational psychologist gave us partial accounts of what took place. The children appeared to have completed worksheets about their likes and dislikes, drawn pictures and shared their feelings. The educational psychologist noted concern about Andrew, who she felt was very low. However, by May 2004 Andrew was reported to be no longer depressed.

379. The staff of the children's schools appear to have been closely associated with plans for the children during the investigation. We were impressed with the care and sensitivity to the feelings and needs of each child. School staff appeared to us to have steered a path between recognising what was happening and talking with them, without making the children more conspicuous. The children continued to make good progress in school.

380. Mr and Mrs B attended child protection case conferences. Their requests for more access for Mr B were acted upon. In early May 2004 Mr B decided to return to live at home. Supervised access was stopped. The case conference decided to additionally register the children as at risk of sexual abuse. Mr and Mrs B agreed to voluntary contact with the social work department. In June the records state that the atmosphere at home had become more tense. Mr and Mrs B requested that Andrew stop attending NCH. We could not find any record of Andrew's views on this. The views of the children are difficult to ascertain throughout the records on the B family. We recognised that in the early stages of the investigation the opportunity to discover the children's' views was very limited. The staff at NCH appear to have worked hard to get to know the children. However the circumstances of their attendance may well have affected the children's' ability to trust and open up to adults.

381. This section has been concerned primarily with the circumstances of the arrest of Mr and Mrs B and the subsequent arrangements and after care for the children and their mother. The standards of care in the home were poor at the time of the arrest of Mr and Mrs B and the social work department provided substantial material help to improve standards and help Mrs B with her parenting role. They also provided accommodation and some financial help to Mr B.

382. We found thorough and effective planning which kept the children together and provided them with adult care and attention. We were impressed by the sensitivity of all professionals including the police in trying to protect the children from shock and upset, as far as the circumstances allowed.

Section 3 Conclusion

383. Parents are primarily responsible for the care and protection of their children. In family A the children's parents failed in all respects to care for or protect them adequately. Between 1991 and 2000, we found over 220 indicators of sexual, physical, emotional abuse and neglect, which were logged conscientiously and shared by a range of professionals in health centres, clinics, schools, nurseries, family centres and social work agencies. We recognise that with hindsight patterns are easier to detect. Nonetheless, if the indicators had been listed and rigorously examined at the time, the probability that the children were being abused should have been evident to those working with them. In our opinion, the professionals collectively had more than enough information about harm and distress to the children to have tried to secure their safety much sooner. It is hard to make sense of how so much professional energy could be devoted to sharing so much information, to such little effect, for the safety and welfare of the children in family A. Tough decisions to remove the children were not taken quickly enough.

384. Professionals in Eilean Siar tried hard to help both parents. We recognise that at this time new legislation (the Children (Scotland) Act 1995) was designed to protect children within the context of partnership with their parents. This, together with the aftermath of the Orkney Inquiry (1992), may have contributed to the prolonged attempts to engage with the family rather than try to remove all three children. The privacy of the family is an important principle of political and social policy. Staff are required to invade that private zone of family life for the safety of the child. We believe that the tensions between the public duty to protect children and the private world of the family are not sufficiently explored in training all staff responsible for protecting children.

385. The children have attended hearings since March 1997 to the present day. In the children's hearing, Scotland has an established system for caring for and protecting children, which could have offered an independent consideration of the best interests of the children. It is disappointing that there is little evidence that the hearings understood fully the underlying problems and responsibilities of the

parents of family A. The recommendations which they were asked to consider were, in our view, reactions to crises within family A rather than proactively planned attempts to meet the needs of the children and they were not challenged by the hearings.

386. The professionals' limited understanding of sexual abuse within families and between adults and children was, in our view, a major contributor to the failure to act to protect the children sooner. This is an area of work which requires greater consistency of practice. Very often, when one adult in a family is abusing children, professionals rely on other family members to protect them by reporting the abuse. A greater appreciation of how adults can be affected by an abusive past, depression and disability could have alerted staff to undertake comprehensive assessments of the family as whole, and to critically review any suspicious medical factors and injuries to the children.

387. We also found an unhelpful over-emphasis on the conclusions of the 'risk assessments' of Mr A. There was a lack of clarity about what this meant in terms of the actual risks posed to the children in his care and the management of these risks.

388. Taking difficult decisions requires skill at all levels of an organisation. We found medical personnel who did not seek second opinions of burns or suspicious injuries and social work staff who believed adults' versions of these injuries. There is plenty of evidence from previous child abuse inquiries that front line staff who are in daily contact with parents often find it hard to sustain their suspicions about them. There is a vital role for managers of all professionals involved in protecting children to hold this awareness and to challenge and support staff to constantly review and update their opinion of the children's safety in the home.

389. The full extent of the services offered to family A in England could not be matched by the much more limited resources of a remote part of the UK. In addition we recognise the different environment of small communities. Workers can be much closer to the people they serve. Sustaining professional distance, and taking unpopular decisions with intimidating adults, can be challenging. The

pool of expertise and consultation is smaller than in larger authorities and the opportunities for training more limited. Despite these, we consider that the range of issues demonstrated by the abuse of the children in family A would have presented a major professional challenge to health, education, social work and police staff in any part of Scotland.

390. We may never know the effect on the children of years of abuse, unprotected and betrayed by their family. The sustained commitment of their foster carers has enabled the children to thrive, enjoy family life and develop educationally and socially. Their foster carers have been able to offer security and protection and the children have been able to tell what has happened to them.

391. Once the Crown Office had decided not to proceed with prosecutions in July 2004, CNES immediately invited SWSI to undertake an independent review of their involvement in providing services to family A and family B and report on what could be learnt. Their staff have co-operated fully with our investigation and made sure we had all available information. We have looked at potential parallels with previous child abuse inquiries and investigations in the UK. We conclude that the circumstances which we have examined raise some issues which have been identified before, but there are significant differences from any of the inquiries which have taken place in Scotland. We consider that there is much to learn from this inspection. Our recommendations have therefore been written with a view to identifying broader lessons which might help others working to protect children across Scotland and the rest of the UK.

Section 4 Summary of recommendations

We have made a total of 31 recommendations throughout this report and we summarise them below. We have grouped them by the agency or agencies to which they refer.

CNES

One of our recommendations concerns current care plans for the children. The other four recommend that CNES review their supervision guidelines, their management of work to protect children, their care of looked after children and their quality assurance procedures.

1. **CNES should as a matter of urgency, seek a more permanent legal status for the children in family A (paragraph 179).**

2. **CNES social work department management should review their staff supervision policy and supervision practice guidelines (paragraph 262).**

3. **CNES should make sure that each child in need of care and protection has an action plan. Each plan should identify a professional with the lead role in monitoring the action plan for the child and co-ordinating the work of all of the professionals involved. Each plan should also specify a core group of other professionals who play a key role in delivering and monitoring the effectiveness of the plan (paragraph 269).**

4. **CNES should make sure that reviews of looked after children are not chaired by the first line manager of the social worker responsible for the case. The chair should be a senior member of staff with sufficient authority to be able to challenge current care planning and professional practice (paragraph 277).**

5. **CNES should review its quality assurance procedures for managing child care and child protection work to make sure that these meet the standards set out in the Scottish Executive's *'Protecting Children and Young People: Framework for Standards'* and monitor their implementation (paragraph 281).**

Western Isles NHS Board

We have recommended that the Western Isles NHS Board make sure they retain their health visitor records and review their strategic management of child protection cases.

6. **Western Isles NHS Board should urgently put in place arrangements to retain and effectively use health visitor records. They must be able to retrieve them if required. Where there are child protection concerns about a child, the health visitor should prepare a summary and pass this and the inter-agency action plan to the school nurse when the child starts school (paragraph 250).**

7. **Western Isles NHS Board should review its arrangements for the strategic management of child protection cases. A lead medical and a lead nursing professional should be identified to oversee the health input to them all. The roles of lead professionals should be clear to all health staff and to staff in agencies involved in protecting children. All health staff should know where to obtain specialist advice on issues of child protection. Arrangements should be put in place to make sure that visiting health professionals are informed of any child protection concerns about their patients (paragraph 255).**

All local authorities

We have made recommendations about the importance of the timely transfer of records when families move to another authority, appropriate training and support for foster carers and their families, recording and sharing of information by school

staff, training for school staff on child protection and supervision of social work staff.

8. **All local authorities should make sure that when a child known to them moves to a different authority with their family, all the files or copies of the files are transferred immediately. Staff in the receiving authority must be given time to read them fully and must appreciate the importance of doing so (paragraph 111).**

9. **Local authorities should make sure that all foster carers have access to training appropriate to their caring role. The needs of foster carers' own children should be considered and if necessary additional help offered to them through group or individual work (paragraph 207).**

10. **Local authorities should make sure that there is a senior member of staff in every school responsible for recording and passing on to social work or other agencies any information about a child or their family where there are concerns about child protection. If they record specific concerns in a child's file which are not passed on to the relevant agency, the reason for this must also be recorded in the child's file (paragraph 242).**

11. **Local authorities should make sure that all pre-school, primary and secondary school staff regularly participate in child protection training appropriate to their particular roles (paragraph 245).**

12. **All local authorities should make sure that their policies and practice on supervising social work staff comply with the Scottish Social Services Council's codes of practice. Directors of social work/chief social work officers must make sure that staff who work directly with children are regularly supervised. The responsibilities of the supervisor should include exploring any issues which may affect the social worker's objectivity. The supervisor should be satisfied that the social worker's judgements are based on an analysis of the**

evidence. Current events should be examined in the light of previous patterns in the family history. Decisions made in supervision should be recorded in the case file and cross-referenced to discussion noted on supervision records (paragraph 262).

All NHS Boards

We have recommended improved arrangements for the strategic management of child protection in primary care teams, the development of managed clinical networks to enable health professionals to access expertise in child protection and better coordination of services for children with complex additional needs.

13. **Primary care teams should agree when a family with child protection concerns registers with the practice how they will strategically manage the health care of the family and how they will communicate effectively about this on an intra-agency and inter-agency basis (paragraph 248).**

14. **NHS Regional Planning Groups should work together with National Services Division and the Royal College of Paediatrics and Child Health to develop managed clinical networks for child protection that ensure access to specialist advice in all NHS Boards with appropriate use of telemedicine. These managed clinical networks should be linked to the national resource for staff working with complex child protection issues outlined in recommendation 27 (paragraph 248).**

15. **Every NHS Board should make sure that all children with complex needs have a health professional who takes an overview and provides coordination of their needs (paragraph 249).**

All agencies involved in protecting children

We have made a recommendation about risk assessment. We have identified the importance for all the agencies involved in protecting children to better bring

together, analyse and regularly review the information they gather about a child and their family. We have also recognised the demands placed upon staff who work in this difficult area and recommended accessible staff counselling.

16. **Where agencies know that a convicted sex offender is acting as a parent, social work managers and frontline staff should be informed. They should make sure that risk assessments of the offender's behaviour form part of a comprehensive assessment of the care and protection needs of the children. Particular attention should be paid to the risks which the person presents in a family context and how this will be managed. The assessment should also address the ability of the other parent to protect the children if necessary (paragraph 116).**

17. **All of the agencies involved in protecting children must gather the information they have on individual children at risk into a chronology of key events and contacts, review it regularly and make sure that it is passed on to the professional with the lead role in protecting the child. The professional with the lead role must co-ordinate this into a multi agency chronology on a regular basis (paragraph 153).**

18. **All agencies should make sure that staff engaged in work protecting children have access to confidential counselling which is separate from their line management. Staff working in very distressing circumstances should be expected to have an initial meeting with an independent person outwith their organisation to discuss available options for support (paragraph 263).**

Child protection committees

We have made a recommendation about the need for guidance on how best to care for children when their parents are arrested.

19. All child protection committees should develop guidance on how best to care for and protect children when their parents are arrested (paragraph 369).

Police

We have made a recommendation to the police about seeking expert advice on interviewing vulnerable adults who are witnesses or potential suspects.

20. In major crime or protracted investigations where a witness or potential suspect is a vulnerable adult, the police should commission a psychological assessment to advise on the person's capacity to give evidence and on the length and number of interviews which should be undertaken with them (paragraph 304).

Joint Police - Social Work

We have made a recommendation on the training of police and social work staff involved in joint investigative interviewing.

21. Managers in social work agencies and in police forces must make sure that they have staff who are appropriately trained in joint investigative interviewing or can arrange to recruit such staff temporarily either from another authority or elsewhere. All staff who take part in joint investigative interviews should have completed appropriate and up to date training in joint investigative interviewing (paragraph 297).

The Scottish Executive

We have recommended that the Scottish Executive change the fostering regulations to ensure the robust assessment of relatives and friends when children are placed with them through a children's hearing and take steps to improve the information available to children's hearings. We recommend a

national system is set up to provide advocates for children and guidance produced for professionals to enable children to express their views. We make recommendations about a national training programme for chairs of child protection case conferences, best practice in the use of forensic medical evidence and the role of paediatricians in child protection work. Two key recommendations are the establishment of a multi-agency resource to which all staff in Scotland working with complex child protection issues can draw upon for advice, expertise, training and research. Firstly, it should include the development of a national register of staff suitably qualified in joint investigative interviewing. Secondly, we recommend the Scottish Executive develop guidance to help professionals determine the most appropriate course of action where a child is found to be living in a household with a convicted sex offender.

22. The Scottish Executive should urgently develop guidance to help professional staff determine the most appropriate course of action where a child is found to be living in a household with a convicted sex offender (paragraph 116).

23. The Scottish Executive should seek to amend the fostering regulations and relevant guidance so that relatives and friends must be formally approved as carers for a child who is looked after when that child is placed with them as a condition of a supervision requirement made by a children's hearing. Approval should be based on an assessment of their ability to care for, protect and meet the needs of the child (paragraph 145).

24. The Scottish Executive children's hearing review should make sure that reports provided to the children's hearing include information about the child's family history and an assessment which takes account of significant past events. The inter-agency chronology of events outlined in recommendation 17 should always be included with these reports (paragraph 171).

25. The Scottish Executive should set up a national system for all children involved in children's hearings and other inter-agency meetings to have the opportunity of an advocate, when decisions are made about their needs, care and protection (paragraph 175).

26. The Scottish Executive should provide guidance for professionals on how to help children express their views. This should be developed in consultation with practitioners and must take account of the diverse communication needs of all children (paragraph 186).

27. The Scottish Executive should establish a multi-agency national resource for those working with complex child protection issues. This should offer consultancy and co-working for staff in relevant agencies. It should set up a managed care network, based on the model of managed clinical networks, and establish a register of recognised experts who could be called upon if required. It should set up a database of relevant research and contribute expertise to qualifying training and continued professional development for staff working in relevant agencies. The Scottish Executive should, in conjunction with this resource, develop a national register of staff suitably qualified in joint investigative interviewing (paragraphs 239 and 297).

28. The Scottish Executive should make sure that all chairs of child protection case conferences have access to a national training programme (paragraph 271).

29. The Scottish Executive should work with NHS Quality Improvement Scotland and the Royal College of Paediatrics and Child Health to establish a working group of representatives from the Crown Office, RCPCH and NHS Scotland. The group should prepare guidance on the nature and use of forensic medical evidence, processes for obtaining and presenting this evidence and the roles and

responsibilities of health professionals in forensic medical examinations (paragraph 330).

30. **The Scottish Executive should consider the findings of the pilot schemes for video recording of the statements of child witnesses with a view to drawing up guidance on extending this throughout Scotland (paragraph 338).**

31. **The Scottish Executive should further develop the guidance on interviewing child witnesses to include guidance for police and social workers investigating complex cases where the allegations of abuse include several adults and where several children are involved (paragraph 347).**

APPENDIX 1

Process of the inspection

Initial planning

We visited Eilean Siar in July 2004 to meet with council officials to discuss the process of the inspection. We undertook four key tasks during our visit:

1. We met with senior officials of the council to discuss the proposed inspection.

2. We met separately with social work staff to discuss the current welfare of the eight children who had been affected by the investigation.

3. We reviewed the available records, copied them and then took 50 files back to Edinburgh. We were also given a CD-rom, which contained extensive amounts of reports, records and witness statements. We began working immediately by making an initial review of all the documentary material available. We found detailed and extensive recording of the children's lives by social work, health and education professionals.

4. On the final afternoon of our visit, we met with a range of staff from the council to explain the process of the inspection. We explained that the lives and experiences of the children affected would be the central theme in all of our work. Staff were informed that initially we would examine issues for the children up to December 2002. Only when a clear picture of the children's lives and events had been determined would we move on to consider events following December 2002.

Reading the files

We have read and analysed 91 social work, health, police and education files containing approximately 220,000 pages of statements and records. As noted above, we read all the material which pre-dated 2002 first. The starting point was

the family backgrounds of the children and information on their parents. For one family this meant reading records from the mid 1980s. The three children who were the principal focus of the inspection moved with their parents to Eilean Siar from England in August 1995. The children's names had been on the child protection register in an English authority. There were detailed social work, school and health records from that authority. One child, who has disabilities, was the subject of extensive medical records from hospitals and other health professionals both in England and in Scotland. All these records were studied to ensure that we obtained as full a picture as possible of the lives of the children.

Developing profiles of the children

We allocated each one of the three girls for whom there were extensive records to an inspector with the task of developing an individual picture of their lives. We decided to allocate pseudonyms to the children to try to protect their confidentiality. We called them Alice, Barbara and Caitlin. The five children, for whom there was much less data, were also allocated to an inspector to undertake a similar process. We discuss this family in section 2 of this report. We allocated pseudonyms to these children and called them Andrew, Bridget, Caroline, David and Emma. We recorded key events in the children's lives, dates of birth, starting school, moving house and also the children's legal status.

In the course of reading the records it became apparent that each of the three girls in family A had been the subject of many allegations of sexual, physical abuse and neglect between 1990 and 2000. We recorded these allegations as part of the profiles which were being developed of the children. The profiles were completed on the children's lives up to December 2002. In respect of the five children from family B, health records gave a brief picture of their lives before their parents were the subject of investigation. We did not find any allegations in respect of these children.

Working as a team

In early August 2004 HM Inspector of Constabulary assigned a detective superintendent from Grampian police to the team. He began to examine the information held by the police and developed time lines on key events so the lives of the children could easily be compared with data obtained from other records. This enabled us to correlate the data and ensure that it was as accurate as possible.

Widening the picture

Once we had completed profiles of the children's lives up to 2002, we moved on to examine the events post 2002. The police again provided time lines for these events from their records and again these were cross-indexed with the records provided by the other agencies. The material from the police records indicated that there were a number of joint police/social work investigations into allegations of abuse of the children between 1990 and 2003. By the time the police and social work material had been combined, the records indicated a series of incidents and allegations dating from October 1990, when the eldest of the three girls, Alice, was a year old, until 2001 when all three girls were in local authority foster care.

The police held all the 15,000 pages of witness statements and we studied these together with the police logs and police policy file which enabled us to examine the process of the criminal investigation in relation to the children.

Extending the team

In September 2004 we were joined by a consultant paediatrician and, from the health department of the Executive, two doctors. An inspector from HMIE joined us for two months in October 2004.

Identifying professional issues

Once we were confident that the profiles of the children were as accurate as possible we moved on to examining professional issues. A four-fold approach was adopted:

1. What action was taken to protect the children?
2. What it was designed to achieve?
3. What was the impact on the children's lives?
4. What could be learnt?

Interim reports for CNES child protection committee

We presented an interim report on the early findings of the inspection to the child protection committee in August 2004. There was a further brief updated report in October 2004.

Preparing a chronology which formed the findings of fact

We developed a factual account of events which affected family A in Eilean Siar between August 1995 and June 2004. This, together with photocopied extracts from the files and witness statements which supported each entry, was sent to the Chief Executive CNES, the NHS Board and to the Chief Constable Northern Constabulary on 22 December 2004. Senior staff in these agencies were responsible for consulting with their staff and giving them the opportunity to read and check for accuracy the entries in the records which they had written. We requested comments on the accuracy of the content to be made by the end of January 2005. Minor changes were requested by all agencies and the findings of fact were confirmed as accurate by the end of March 2005.

As the inspection developed we recognised the importance of developing a similar account of the lives of family A in England. The depute chief social work inspector and an inspector visited the English authority social services, and met with representatives from social work, health and probation. With their agreement we

read all available records on family A. Most of the files were copied and accessible to us in Edinburgh. Some original material going back to 1978 was made available in England and one inspector spent three days reading these files. The findings of fact covering 1990 to 1995 were completed on 4 February 2005. Comments on accuracy were requested by 21 February 2005. Minor changes were requested. The account was confirmed as accurate by the end of March 2005.

Preparing the final report

We read all of the material in the records, about a quarter of a million pages, and developed themes for further review. To better understand the decisions that were made, we examined each of the 29 child protection case conferences which were held to discuss the children in family A and the three child protection case conferences in respect of family B. We examined each report written for the hearing and all LAC review reports. We listed all the allegations, injuries, and health related concerns about the children in family A (appendix 2). There were no allegations or injuries recorded in respect of the children in family B. In conjunction with the police we analysed every witness statement. The circumstances of the alleged offences against the children in family A were examined in relation to the case records written at the approximate times of these offences.

All of the above material contributed to our analysis and conclusions in the final report. We found that almost 100 professionals had contact with family A over the years. We met with the children's foster carers. We formed our conclusions by looking at the facts reported in the records. We considered very carefully our decision not to interview the children involved. We were mindful of the numbers of adults who had already asked them questions in their lives. We do plan to meet with the children, if they wish to do so, so they can ask the team any questions.

We read policy statements and procedures from CNES and from England. We reviewed child protection inquires from Maria Colwell 1975 to the O'Brien inquiry

2003. We studied the legislation and guidance relating to the Social Work Scotland Act 1968, the Children Act 1989, and the Children (Scotland) Act 1995. We reviewed a wide range of guidance including guidance on sex offenders, child witnesses, vulnerable adults, child protection and child protection committees (appendix 5). We received additional material from the Crown Office in July 2005.

As our inspection covered the period from 1986 to 2004, we recognised that practice should be reviewed within the context of the period. We took care not to examine the practice of the past by the standards of today. Therefore we reviewed literature on topics relevant to our inspection published during this period. There is a very wide literature base on child sexual abuse and it was not our task to review this. We have drawn on material which may help to better understand the issues facing the families or their children and workers at the time. We have also drawn on very recent major studies of parenting which contributed to our conclusions about the adequacy of parenting and the risks to the children.

APPENDIX 2

Anonymised concerns recorded by professionals about the children while they lived with their parents in date order.

Key – spa = suspected physical abuse
ssa = suspected sexual abuse
neg = neglect
hc = health concern

Date		Child age at event	Code
Sep 90	hit in face by mother	1y1m	spa
Oct 90	suspicion of sexual abuse - mother told sw	1y2m	ssa
Oct 90	neighbours allege left alone in the flat	1y2m	neg
Nov 90	red marks around urethra	1y3m	hc
Nov 90	red marks around urethra	1y3m	hc
Nov 90	small bruise upper thigh - spots around genitals	1y3m	hc
Nov 90	burn blister	1y3m	hc
Dec 90	bruise on right thigh	1y4m	hc
Jan 91	very sore vagina	1y5m	hc
Jan 91	sore genital area and tops of legs	1y5m	hc
Jan 91	sore urine burns - genital area	1y5m	hc
Feb 91	bruise on top of left thigh	1y6m	hc
Feb 91	red swollen vulva	1y6m	hc
Feb 91	genital area sore, red and blistered	1y6m	hc
Mar 91	poor health, dislike of having nappy changed	1y7m	hc
May 91	did not seek or respond to affection at nursery	1y9m	neg
Jun 91	bruise on ear, faded brown marks on cheek	1y10m	hc
Jun 91	mouth ulcers	1y10m	hc
Jul 91	eating soap and mouthing objects at nursery	1y11m	hc
Jul 91	numerous small fading bruises on back and left side and 3 fading linear bruises on thigh	1y11m	hc
Sep 91	3 fading bruises on torso and thigh – had been absent previous day – no sign of cold reported by mother	2y1m	hc
Oct 91	sore - upset when nappy changed	2y2m	hc
Oct 91	nursery report after absences returns with fading bruises	2y2m	spa
Nov 91	joint police/social work investigation scald and bruising under eye	2y3m	spa
Nov 91	red rash on bottom and tops of legs	2y3m	hc
Jul 92	mother alleges to police sexual abuse by Mr A	2y11m	ssa
Jul 92	vaginal soreness – no evidence of sexual abuse	2y11m	hc
Sep 92	mother alleges sexual abuse by Mr A's son	3y1m	ssa
Dec 92	child alleges sexual abuse by Mr A	3y4m	ssa
Oct 93	nursery reported child going to toilet more often than usual for her age	4y2m	hc

Feb 94	bruising to face – later medical opinion likely to have been non-accidental	4y6m	spa
Apr 94	nursery recorded degree of developmental delay serious concern	2y4m	hc
May 94	multiple bruises to ears, face and shoulder - consultant paediatrician reports injuries (and Feb injuries to sibling) strong possibility were non-accidental	2y5m	spa
Jun 94	appointment with paediatrician cancelled by parents	2y6m	neg
Jul 94	concerns at developmental delays	2y 7m	hc
Oct 94	covered in cat flea bites	5y2m	neg
Oct 94	wandering in cul de sac	5y2m	neg
Oct 94	nursery reported often crying, indiscriminate affection, development delayed	2y10m	hc
Jan 95	school medical consent form not returned	5y5m	neg
Feb 95	school concerned poor health and isolation from other children	5y6m	hc
Mar 95	hid in phone box to avoid school bus	5y7m	neg
Mar 95	following day social worker saw scratches and bruises to chest	5y7m	spa
Mar 95	mother took child to GP concerned she was reluctant to relate to Mr A and showing 'sexualised behaviour'	5y7m	ssa
Sep 95	red weal marks on forearm	3y9m	spa
Oct 95	came to school with burn-like mark on right forearm – thought unusual as she is right handed	3y10m	spa
Oct 95	has vaginal soreness	6y2m	hc
Feb 96	bruises on arm	4y2m	hc
Feb 96	bruises on both arms near elbows	4y2m	hc
Mar 96	started wetting - had been dry day /night	6y7m	hc
Jul 96	GP notes delayed speech, poor vision and hearing	4y7m	hc
Aug 96	has bruising down right thigh	4y8m	hc
Sep 96	wetting at nursery	3y7m	hc
Sep 96	alleges Mr A burned child with cigarette	7y1m	spa
Sep 96	has bruises down spine	4y9m	hc
Nov 96	has bruising on knees	4y11m	hc
Dec 96	bedwetting and soiling at nursery (sometimes 2-3 times a day)	3y10m	hc
Dec 96	had been arriving at school ravenous and sometimes inappropriately dressed for the weather	5y0m	neg
Jan 97	urinary tract infection	3y11m	hc
Feb 97	soils at school	5y2m	hc
Feb 97	has a deep burn on hand	5y2m	spa
Feb 97	soils at school	5y2m	hc

Feb 97	assaulted by Mr A - joint police/social work investigation	7y6m	spa
Mar 97	wets herself at school	5y3m	hc
Mar 97	wets herself at school	5y3m	hc
Mar 97	urinary tract infection	5y3m	hc
Mar 97	alleges sexual abuse by Mr A – later retracts	7y7m	ssa
Mar 97	following day same child alleged to display inappropriate sexualised behaviour towards sibling	7y7m	ssa
Mar 97	very weepy and clingy in school	5y3m	hc
Mar 97	no school medical consent form sent	5y3m	neg
Mar 97	had become withdrawn, pale and jumpy at school with poor concentration	4y1m	hc
May 97	wetting and soiling	4y3m	hc
May 97	various bruises - fell out of window	4y3m	hc
Jun 97	soiling	4y4m	hc
Jul 97	soiled at home during social worker's visit – sw had to tell mother to change her	4y5m	neg
Oct 97	has rash on right thigh and abdomen	4y8m	hc
Nov 97	burnt her hip on storage heater	4y9m	hc
Dec 97	suspected urinary infection	6y0m	hc
Jan 98	wetting and soiling at home and school	4y11m	hc
Jan 98	soiling regularly at school	4y11m	hc
Jan 98	tired and lethargic at school – soiled twice in one day	6y1m	hc
Feb 98	ear infection	6y2m	hc
Feb 98	urinary tract infection	6y2m	hc
Feb 98	alleges assault by Mr A – joint police/social work investigation	8y6m	spa
Feb 98	alleges assault by Mr A – joint police/social work investigation	5y0m	spa
Mar 98	has burn-like marks on her chin	6y3m	hc
Mar 98	red marks on upper thighs	6y3m	hc
Mar 98	sore going to toilet – rash in groin	6y3m	hc
May 98	still soiling	5y3m	hc
May 98	burn on neck – alleges sibling burnt her with Mr A's lighter	6y5m	neg
Jun 98	soiling daily, sometimes as many as 4 times	5y4m	hc
Jun 98	stab wound – alleged was inflicted by sibling with a pair of scissors	6y6m	neg
Jul 98	soiled during two of weekly play sessions	5y5m	hc
Sep 98	coming to school unkempt and smelly	5y7m	neg
Sep 98	child alleges sibling burnt her with Mr A's lighter	6y9m	neg
Oct 98	soiling escalating	5y8m	hc
Oct 98	tired and weepy - complained to school sibling had been 'pinching' her all night	6y10m	hc

Oct 98	returned from home visit to foster home with bruise on thigh - could not remember how happened	9y 2m	hc
Nov 98	soils in school	5y9m	hc
Nov 98	soils at school	5y9m	hc
Nov 98	red mark on face – gave 3 different explanations	5y9m	hc
Nov 98	has bruise on right side of face	5y9m	hc
Nov 98	soils in school – school having difficulty contacting relatives to collect her	5y9m	neg
Nov 98	soils in school	5y9m	hc
Nov 98	soils in school	5y9m	hc
Nov 98	soils in school	5y9m	hc
Nov 98	soils in school	5y9m	hc
Nov 98	soils in school	5y9m	hc
Nov 98	soils in school	5y9m	hc
Nov 98	tells worker of nightmares and man coming into her room with a knife	5y9m	hc
Dec 98	soils in school - bruise and scratch on face	5y10m	hc
Dec 98	very tired and upset in school	7y0m	hc
Dec 98	concerns about poor standard of home – child sleeping in cupboard in bedding smelling of urine	5y10m	neg
Jan 99	soils in school	5y11m	hc
Jan 99	soils twice in school	5y11m	hc
Jan 99	homecarer records inappropriate sexual behaviour by mother to child	5y 11m	ssa
Jan 99	soils in school	5y11m	hc
Jan 99	homecarer records inappropriate sexual behaviour by visiting adults to child	7y1m	ssa
Jan 99	soils twice in school	5y11m	hc
Jan 99	homecarer records inappropriate sexual behaviour by visiting adults to child	5y11m	ssa
Jan 99	had a burn on her hand - gave 3 explanations	7y1m	hc
Jan 99	hit head on hearth being tickled by mother	5y11m	hc
Jan 99	at school with mark on her nose - acted strangely when asked about it	5y11m	hc
Jan 99	soils in school	5y11m	hc
Jan 99	reported being ‘tickled’ by adult visitors to the home	5y11m	ssa
Jan 99	soils twice in school	5y11m	hc
Jan 99	homecarer reported home very cold, bare, chaotic	5y11m	neg
Jan 99	homecarer reported home very cold, bare, chaotic	7y1m	neg
Jan 99	soils in school	5y11m	hc
Jan 99	wetting and not making progress in school	7y1m	hc
Jan 99	soils in school	5y11m	hc

Jan 99	soils twice in school - called dirty sod by grandmother	5y11m	hc
Jan 99	very ill when visiting sibling at foster home – parents unaware	5y11m	neg
Feb 99	soils in school	6y0m	hc
Feb 99	soils in school	6y0m	hc
Feb 99	to school with bruise to face - no explanation	6y0m	hc
Feb 99	comes to school with sizeable cut - cannot remember how happened	6y0m	hc
Feb 99	soils in school	6y0m	hc
Feb 99	soils in school	6y0m	hc
Feb 99	soils in school	6y0m	hc
Feb 99	soils in school	6y0m	hc
Feb 99	soils twice in school	6y0m	hc
Feb 99	soils twice in school	6y0m	hc
Feb 99	alleges Mr A shakes her	7y2m	spa
Feb 99	soils in school	6y0m	hc
Feb 99	soils in school	6y0m	hc
Feb 99	mother reported that child is tickled and smacked by family friends	7y2m	ssa
Feb 99	mother reported that child is tickled and smacked by family friends	6y0m	ssa
Feb 99	bruise on back of head - fell backwards at home	7y2m	hc
Mar 99	soils in school	6y1m	hc
Mar 99	soils in school	6y1m	hc
Mar 99	soils twice in school	6y1m	hc
Mar 99	soils in school	6y1m	hc
Mar 99	soils in school	6y1m	hc
Mar 99	soils twice in school	6y1m	hc
Mar 99	soils in school	6y1m	hc
Mar 99	to play session with five inch mark on thigh – could not recall how happened.	7y3m	spa
Apr 99	has ‘scrape’ on finger	7y4m	hc
Apr 99	bruise on face - no explanation	6y2m	hc
Apr 99	soils twice in school	6y2m	hc
Apr 99	to school with bad cut on head - fell off bed	6y2m	hc
Apr 99	same day as above mother reported to GP bruised head and hip – fallen in bath	6y2m	hc
Apr 99	soils twice in school	6y2m	hc
May 99	soils in school	6y3m	hc
May 99	soils in school	6y3m	hc
May 99	soils in school	6y3m	hc
May 99	soils in school	6y3m	hc
May 99	soils in school	6y3m	hc

May 99	soils in school	6y3m	hc
May 99	soils in school	6y3m	hc
May 99	cut on chin – caught in door	6y3m	hc
Jun 99	showed teacher pin pricks on hand – no reason	7y6m	hc
Jun 99	soils in school	6y4m	hc
Jun 99	soils in school	6y4m	hc
Jun 99	soils three times in school	6y4m	hc
Jun 99	told teacher she knew bad people - described being tied up by 'family friends'	7y6m	hc
Jul 99	comes to play session with injury to groin	6y5m	hc
Aug 99	school reported child came back new term – unhappy, sore tummies, hungry and headaches	6y6m	hc
Aug 99	soils in school	6y6m	hc
Sep 99	bruise on face - no explanation – soiled in school	6y7m	hc
Sep 99	homecarer reports child soiling during summer- parents denied this	6y7m	hc
Sep 99	homecarer reports child not consistently fed proper meals	7y9m	neg
Sep 99	homecarer reports child not consistently fed proper meals	6y7m	neg
Sep 99	soils in school	6y7m	hc
Sep 99	soils in school	6y7m	hc
Sep 99	soils in school	6y7m	hc
Sep 99	soils in school	6y7m	hc
Sep 99	soils in school	6y7m	hc
Sep 99	soils in school	6y7m	hc
Sep 99	very tired and weepy in school – saying sibling would not let her sleep	7y9m	hc
Sep 99	to school with large cut on elbow – says she fell	7y9m	hc
Oct 99	cut on leg	6y8m	hc
Oct 99	reported by school to be depressed, lethargic; height and weight dropped by nearly 2 centiles.	6y8m	hc
Oct 99	often at school without glasses or hearing aid and losing weight	7y10m	neg
Nov 99	bruise on face – no explanation	6y9m	hc
Nov 99	wets in school	6y9m	hc
Nov 99	soils in school	6y9m	hc
Dec 99	soils at school	6y10m	hc
Dec 99	soils at school	6y10m	hc
Dec 99	speech and language therapist reported child's speech deteriorated	8y0m	hc
Dec 99	soils at supervised contact with Mr A	6y10m	hc
Dec 99	soils at school concert	6y10m	hc
Feb 00	soils at school	7y0m	hc
Feb 00	soils at school	7y0m	hc

Feb 00	soils at school	7y0m	hc
Feb 00	soils at school	7y0m	hc
Feb 00	wets at school	7y0m	hc
Feb 00	very distressed at swimming	7y0m	hc
Mar 00	soils at school	7y1m	hc
Mar 00	soils at school	7y1m	hc
Mar 00	soiled twice in school	7y1m	hc
Mar 00	biting herself	8y3m	hc
Mar 00	wets at school	7y1m	hc
May 00	soils at school	7y3m	hc
May 00	soils three times in one day at school	7y3m	hc
May 00	soils at school	7y3m	hc
May 00	very upset and tired in school	8y5m	hc
May 00	homecarer reports child wet in the morning more often than before	8y5m	hc
May 00	soils in school	7y3m	hc
May 00	soils at school sports day - became very upset - did not want to go home with family.	7y3m	hc
May 00	tells teacher sibling has been touching her in a sexually inappropriate way - joint police/social work investigation	8y5m	ssa
Jun 00	soils in school	7y4m	hc
Jun 00	saying at school that she wishes to kill herself	7y4m	hc

APPENDIX 3

	1990	1991	1992	1993	1994	1995E	1995ES	1996	1997	1998	1999	2000
EDUCATION												
Daily diary												
Home visiting teacher												
Learning supt												
Auxiliary health needs												
Record of needs												
HEALTH												
Health Visitor												
HV-extra visits												
Paediatrician												
Speech/lang. therapist												
ENT												
Eye clinic												
OT												
Physio												
Psychiatry adult												2003
CMHT												2003
Psychiatry child												
SOCIAL WORK												
Allocated SW	3/12	3/12										
Assessments												
Focus-mother-role												
Parenting												
Individual work-child												
Financial help												
Counselling												2003
Play sessions in family room												
Family aide												
Home carer												
Nursery												
CMHT												
VOL ORGS												
Home-Start			3/12									
NCH												
JOINT ORGs												
S/work/police joint invests												and 2003
Core groups-SW-HV-Ed												
Profs only												
Child protection conferences												
Children's hearings												

Services provided to family A from 1990 to 2000 by agency

Key: Education

Daily diary – this row indicates where teachers kept a daily diary about the welfare and education of the children in family A
Home visiting teacher – indicates years when teacher spent time in the home
Learning supt – indicates when learning support was provided at school
Auxiliary health needs – indicates when provided
Record of needs – indicates a record of needs

Health

Health visitor – indicates routine visit by health visitors
Health visitor-extra visits – indicates fortnightly or monthly visiting by health visitor to provide additional help to family
Paediatrician – indicates when paediatrician involved with children
Speech/lang. therapist – indicates work by the speech and language therapist
ENT – indicates when child had treatment
Eye clinic – indicates when child had treatment
OT - Occupational therapy – indicates when child had treatment
Physio - Physiotherapy – indicates when child had treatment
Psychiatry–adult – indicates when adult family member had treatment
CMHT – community mental health team – indicates when adult family member had treatment
Psychiatry – child – indicates when psychiatrist advised about child soiling but did not see her

Social work

Allocated SW – indicates when family had allocated social worker
Assessments – indicates records of social workers undertaking assessments with individual members of the family
Focus–mother-role – indicates records of social workers seeking to work with mother on her role as a parent
Parenting – indicates records of social workers seeking to work with both parents on their role as parents
Individual work–child – indicates records of social workers seeking to work with individual children
Financial help – indicates records of social workers providing financial help
Counselling – indicates records of social workers offering counselling to parents
Play sessions in family room – indicates nursery staff working with parents to improve their play with the children
Family aide – indicates work by family aide with family A
Homecarer – indicates work by homecarer with family A

Nursery – indicates children attending nursery/family centre
CMHT – indicates social worker from community mental health team working with mother

Voluntary organisations

Home-Start – indicates volunteer spending time with family A
NCH – indicates children attending NCH project

Joint work between organisations

S/work/police/joint invests – indicates joint social work/police investigations into allegations of abuse about the children in family A
Core groups - SW-HV-Ed – indicates core groups held to discuss the welfare of the children in family A
Profs only – indicates professionals only meetings held to discuss the welfare of the children in family A
Child protection conferences – indicates years in which child protection case conferences were held
Children's hearings – indicates years in which children's hearings were held

APPENDIX 4

Children's hearings held in respect of Alice, Barbara and Caitlin

Date	Child	Grounds	Decision
Mar 97	A,B,C	Section 32(2)(d) of the Social Work (Scotland)Act 1968	Remitted to sheriff for proof due to the ages of the children
Jun 97	A,B,C	As Mar 97 – established by sheriff in May	Supervision requirements (SRs) for all 3 (section 70(1))
Aug 97	A	Review of SR at request of SWD	SR with condition to reside with foster carers
Dec 97	A	Review of SR at request of SWD	SR at home – condition removed
Mar 98	A	Review of SR at request of SWD	SR with condition to reside with foster carers. Parents' appeal upheld by sheriff
May 98	A	To reconsider March decision as directed by sheriff	SR with condition to reside with foster carers continued
May 98	B, C	Annual review of SRs	SRs at home continued
Apr 99	A	Annual review of SR	SR with condition to reside with foster carers continued
Apr 99	B, C	Annual review of SRs	SRs at home continued
Oct 99	B, C	Review of SRs at request of SWD	SRs with condition that they live with their mother and have only supervised access with their father
Mar 00	A	Annual review of SR	SR with condition to reside with foster carers continued
Jul 00	B, C	Review of SRs at request of SWD	SRs with condition to reside with relatives
Feb 01	B, C	Review of SRs at request of SWD	SRs with condition to reside with relatives continued
Feb 01	A	Annual review of SR	SR with condition to reside with foster carers continued
Aug 01	B, C	Review of SRs at request of SWD	SRs with condition to reside with relatives continued
Sept 01	B,C	Review of SRs at request of SWD	SRs with condition to reside with foster carers
Dec 01	A	Annual review of SR	SR with condition to reside with foster carers continued
Jul 02	B, C	Annual review of SRs	SRs with condition to reside with foster carers continued
Nov 02	A	Annual review of SR	SR with condition to reside with foster carers continued
Jun 03	B, C	Annual review of SRs	SRs with conditions to reside with foster carers continued
Oct 03	B, C	Review of SRs at request of SWD	SRs with condition to reside with foster carers continued and condition that they have no contact with their father
Oct 03	A	Annual review of SR	SR with condition to reside with foster carers continued
Sept 04	B, C	Annual review of SRs	SRs continued.
Oct 04	A	Annual review of SR	SR continued

Key: A – Alice, B – Barbara, C – Caitlin, SR - Supervision requirement, SWD - social work department

APPENDIX 5

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