Child Practice Review Report

Cardiff and Vale Safeguarding Board
Extended Child Practice Review

Re: *CVSB CPR 07/2018*

Brief outline of circumstances resulting in the Review

An Extended Child Practice Review was commissioned by Cardiff and Vale Safeguarding Board (CVSB) in accordance with the Social Services & Well-being (Wales) Act 2014, Working Together to Safeguard People: Volume 3. An Extended Child Practice Review is commissioned where a child at risk has, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has:

- died; or
- sustained potentially life-threatening injury; or
- sustained serious and permanent impairment of health.

Introduction

The Cardiff and Vale Safeguarding Board commissioned an Extended Child Practice Review chaired by Beth Aynsley, South Wales Police and later Sarah Manley, Cardiff Council. The joint reviewers were Lucy Treby, Vale of Glamorgan Children and Young People Services and Nick Jones, Vale of Glamorgan Housing Services. The following agencies were represented on the panel:

- Cardiff Children's Services
- Cardiff and Vale University Health Board
- Probation
- Wales and West Housing Association
- Cardiff Education
- South Wales Police

Administration and support to the panel was provided by Cardiff and Vale Safeguarding Board Business Unit.

The family under consideration was subject of concurrent judicial proceedings, which delayed completion of this review. An interim report was produced to highlight the early learning to ensure corrective actions and practice improvements were put in place prior to the delayed leaning event and the final child practice review report.

Background

A referral was made to Cardiff Children's Services (14 September 2018) from School 2 following concerns around Child G who was displaying extreme sexual behaviour and extreme distress in school, which carried on for several days, until she left the school, as a result of becoming looked after.

Child G started at School 2 that same week (10 September 2018), and she had told school every morning that she had not been given breakfast and had asked her taxi driver to buy her food. She had been so distressed in school that she had been rocked to sleep. Child G also made a concerning allegation of an adult male sexually abusing her in the family home. Her behaviour escalated in her time at School 2 indicating abuse, neglect, and sexual harm.

Child G spoke in school of three adult males being in the family home and disclosed sleeping in a bed with one of them and also that they had physically hurt her.

It was reported that Child G had sores around her mouth and always eats McDonalds as there is no food in the house.

She also referred to an adult uncle and stated that he sleeps with mum, and he is a good dad. Cardiff Children's Services believe that this is actually Child G's maternal uncle whom there has previously been a range of concerns about including significant domestic abuse.

Due to this referral a strategy meeting was held in MASH and Cardiff Children's Services history reviewed as well as other agency information. Partners felt that a referral was required for a Child Practice Review.

Following the strategy meeting, a joint section 47 Investigation was initiated, and Child G and her brother were removed under Police Protection Powers. Child G's distress and the harm caused to her, led to behaviour and language becoming so worrying that foster placements have broken down.

Review period and historical matters

The review covered the period 1 January 2017 to 17 September 2018, however, there were some historical issues and concerns which led to Child G being placed on the Child Protection Register from 27 November 2013 to 1 July 2016.

The matters arising prior to the review period were considered by the panel, including the decision to remove Child G from the Child Protection Register, however, they were not formally included within the review period. This is because the length of the review period and the matters identified provide opportunities to identify appropriate learning.

A brief summary chronology can be found under Annex 2.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

Voice of the child and her lived experience

The Panel identified there were missed opportunities for hearing the 'voice of the child'. Throughout the review period, a range of professionals involved all raised concerns regarding Child G's behaviours which included aggression, verbal outbursts, sexualised language, 'defiant and disruptive'. These behaviours were typically framed as 'attention seeking' rather than 'attention needing'.

The learning event and information that has been received, indicate that there were sporadic and limited attempts to understand Child G's lived experience in her home. The relationships with professionals were not established, and no one person had a consistent trusted relationship with Child G. Although both schools and police were concerned, the environment to explore her experiences may not have been conducive to getting a direct clear disclosure of abuse from her. There was a reluctance to ask Child G about her experiences for fear of jeopardising any future court hearing regarding sexual abuse.

It was apparent that Child G had experienced ongoing and protracted abuse for some years prior to her becoming looked after. This was further evidenced by the family members consulted as part of this review who raised their concerns about Child G and her brother's experiences, but they were discounted. The adults in Child G's life were able to manipulate professionals and sway focus from the children to themselves. Services working with the adult men known to Child G, did not join the dots to recognise that Child G was at risk from them.

Her behaviour was interpreted as relating to historical trauma, or as neurodevelopmental origins. However, it is the panel's view that her behaviour and presentation presented a clear and consistent pattern that should have led to further concern.

Professional curiosity

Following this, the panel concluded that there should have been a more active curiosity taken about the circumstances and history of this family. Probation staff should have sought out safeguarding information when they became aware of children in the family. In court proceedings, mother was found to be a 'liar, devious and manipulative'. She was able to trivialise concerns, and deflect attention to other adults i.e. paternal grandparents, and school staff. She also deflected blame on Child G's presentation to Child G herself querying a neurodevelopmental cause to her behaviour, rather than as a response to her lived experience, and trauma.

Mother was said to engage with services, in the main, but there were periods where she withdrew and cancelled appointments. In compiling a timeline of events for this review, it is apparent that her 'engagement' was related to concerns heightening and section 47 enquiries being initiated. Home condition (fleas in the home, broken toilet, cat faeces on the floor, lack of bedding, lack of food in cupboards etc.), as well as Child G's physical presentation (smelly and dirty) were consistent and regular issues over a long period of time. It was apparent that when discussed with mother, she would state that things would change, and occasionally a small improvement was seen but not maintained. With this in mind, it was clear to the panel that mother was showing 'disguised compliance' but professional curiosity should have seen through this pretence.

Despite a number of written agreements being put in place and signed by mother, visitors to the home (particularly men) were not asked who they were, and mother was not challenged about their presence.

The Paediatric review of developmental trauma was another opportunity to review the needs and risks. On receipt of the letter declining that a neurodevelopment assessment is required, professionals should explore further signposting for support to be offered. In this case the child was offered a place in a well-being service. There have been changes to the service since this time and practice would now see a referral being made to psychology too.

Multi agency working and information sharing

During the course of this review, both from the panel, and from the learning event, it was apparent that professionals were worried about Child G's experiences.

During the review period, there was evidence of some form of information sharing with Children's Services on thirty-nine occasions leading to five section 47 enquiries. Eight of these were MARFs, twelve PPNs, and the rest were informal contacts. There is inconsistency across agencies about what was sent or received, and information does not always correlate so these number are approximate. There were instances where joint visits were arranged for Children's Services and Police and these did not always take place.

The learning event highlighted those professionals wanted to keep an ongoing dialogue with mother, and the need to maintain a positive relationship impacted on their actions. At one point a MARF was submitted by school but rejected because school had not sought mother's agreement to the referral. As a result no further action was taken, a missed opportunity to intervene and prevent further abuse of Child G.

Consent to make referrals should normally be sought from families unless there is a specific safeguarding concern suggesting otherwise. In Child G's situation, the lack of consent from parents should not have impacted on decision making. The Wales Safeguarding Procedures states that "the interests of the child at risk of harm must be the overriding consideration when making decisions as to whether to seek child and/or parental consent, prior to making a report.

Practitioners should try and seek consent from the parents. The reasons for this are that involving families and carers are more likely to:

- lead to engagement in the safeguarding process and to child-centred outcomes;
- promote an effective working partnership with the family."

School staff described repeatedly seeking advice from Children's Services, and raising concern, but feeling that the increased expertise and the professional judgment of social workers, should be believed and accepted. People were going to the home, downplaying, and trivialising what they saw. They did not trust their own instincts, nor robustly seek to evidence their worries. There was an accepted perception that Child G's presentation was as a response to what had happened before, and therefore was a child in need of care and support, rather than at current risk of harm, and this view was not challenged.

Despite there being this number of worries and referrals, there was no escalation of concern that led to a robust consideration of Child G's life at home. Professional challenge or escalation of concerns was ineffective and procedures to address professional differences were not followed which enabled continued abuse of Child G.

Professionals were involved across the board with this family, but a holistic view of what was happening in the home was not collated. Events were taken in isolation and not joined to complete the picture.

Long term work with families

This review found that the consistent oversight and overview of the history of involvement and work with this family was lacking.

The difficulty in compiling an accurate history has led to work 'starting again' every time a new worker or manager was allocated, with workers repeatedly trying the same interventions with no evidence of change. Work was piecemeal and episodic, based on an overoptimistic view of Child G's safety in the home. Concerns were often discontinued and minimised as historic, leading to closure, with no professional putting all the episodes of concern together to show the abuse that Child G had and was experiencing.

Records for all agencies were vague and sometimes descriptive, lacking any analysis reflecting a pattern or themes over the duration of Child G's life. Had this information been viewed then a clear pattern of neglect and abuse would have been apparent perhaps stopping further abuse of Child G. Supervision did not challenge nor lead to enhanced oversight. Actions were agreed that were not enacted and to all intents and purpose no meaningful or effective intervention made. The number of strategy meetings and section 47 enquiries should in itself, have led to enhanced concern, but enquiries were superficial at best, and information available discounted and closed down.

Had this information been available, and considered within the whole context, with all professional and family observations considered, it would have been apparent that the family were not able to enact sustained change, nor keep Child G and her brother safe. Effective action could and should have been taken sooner.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the CVSB and its member agencies and anticipated improvement outcomes:-

Despite professionals' best efforts, Child G was not adequately safeguarded. Mother was found to be manipulative, and we know that she experienced harm as a child. We wondered what her experience of receiving parental care was, and how this impacted on her being able to keep her children safe. The following recommendations are made with this in mind, and the knowledge that most workers are doing their best for the children they support, and we have had the time and benefit of hindsight to complete this

review. The busy professionals that were involved with Child G's care did not have this. That being said there are learning points for agencies and workers as follows:

Voice of the child, her lived experience, long term work with families and professional curiosity

- Workers should always seek to get to know the children they support and understand what their daily experiences are. They must consider all explanations for their presentation and behaviour, even when we find this behaviour difficult or distressing.

- Agencies should enable workers the time and resources to form meaningful relationships with children, as well as support them to consider all explanations including how workers interpret and act on signs of sexual abuse.

A recommendation in relation to disclosure was made in 'The Report of the Independent Inquiry into Child Sexual Abuse' which was published in October 2022 where it states:

"Institutions, whether state or non-state, should not rely on children coming forward as the sole means of identifying and detecting child sexual abuse. Most statutory agencies provide simple information on their websites about how to recognise indicators of potential sexual abuse, and what to do if an individual suspects abuse has occurred. It is evident from these summaries that child sexual abuse came to the attention of people in authority in institutions in many different ways, at different times, and with widely varying responses, or none at all."

- Supervision and senior management oversight for all agencies should begin with curiosity about children's lived experiences, behaviour and presentation moving from descriptions to considering what these might mean and incorporating all possible explanations including the role of adults in children's lives and family history.

RECOMMENDATION/S

1. **The Safeguarding Board should receive assurances from board agencies that their staff are given the time and support required to get to know the children they support and understand what their daily experiences are, to include the role of adults in children's lives and their family history.**

2. **The Safeguarding Board should be assured that practitioners within the region are aware of the signs of CSA and understand how to respond appropriately**

3. **The Safeguarding Board needs to be assured that practitioners reviewing referrals into Children Services consider the current referral within the wider family context, that decision making takes accounts of previous referrals / contacts, that risk analysis, scaling, next steps and rationale for decision are evidenced and appropriate for referral information and history and that there is a clear understanding of the risk to the child.**

Multi agency working and information sharing

- Mother was said to engage with services, in the main, but there were periods where she withdrew and cancelled appointments. In compiling a timeline of events for this review, it is apparent that her 'engagement' was related to concerns heightening and section 47 enquiries being initiated. It appears that at the time, this was not identified and mother's uncooperative behaviour went unchallenged.

- Analytics multi-agency chronologies should be available. It is of note that this technology (Chronolator) is available to the Safeguarding Board but not to individual agencies.

RECOMMENDATION/S

This learning in relation to multi agency chronologies has been identified across a number of CPRs undertaken within the region and therefore no further recommendation will be made, however it is expected that the Safeguarding Board will continue to progress the ongoing work in this area. i.e consideration around the use of the Chronolator.

4. **The Safeguarding Board should be assured that practitioners within the region are able to identify uncooperative behaviour when working with families, and know what action to take where they suspect parents or carers of 'uncooperativeness'**

Record Keeping and Policy Development

- Recording practice should be specific, clear, accurate, and factual. It should be free from jargon and clearly record actions or no action (including join agency action) and decisions with rationale.
- Where a professional has a concern, they should submit a MARF/PPN and emails should not be used to share concerns or new information regarding safeguarding of children at risk.
- If professionals remain concerned or do not consider that appropriate action has been taken, they must escalate using the professional differences policy.

This learning is further supported by the IICSA report where it states:

"All institutions involved on a regular basis with children must be proactive and vigilant. If information about known or suspected sexual abuse is held by anyone in the institution, the information must be acted upon and proper investigation must take place, regardless of cultural, religious, educational or societal norms and beliefs. There should be no exceptions to this requirement." (The Report of the Independent Inquiry into Child Sexual Abuse, October 2022)

RECOMMENDATION/S

Learning in relation to record keeping has been identified across a number of CPRs and APRs undertaken within the region and therefore no further recommendation will be made, however it is expected that the Safeguarding Board will continue to progress the ongoing work in this area. i.e. a guidance document on record keeping

5. **Board agencies must ensure that staff are aware that they should submit a MARF/PPN for all safeguarding concerns, and emails should not be used to share concerns or new information regarding safeguarding of children at risk.**

Learning in relation to use of the protocol for the resolution of professional differences has been identified across a number of CPRs and APRs undertaken within the region and therefore no further recommendation will be made, however it is expected that the Safeguarding Board will continue to progress the ongoing work in this area. i.e. review of and promotion of the protocol and inclusion in the multi-agency safeguarding training.

This review has found that basic best practice models for working with children and families were not followed which had a profound impact on Child G. All agencies should consider what systemic issues may contribute to practitioners being unable to follow best practice and how it can be ensured that professionals have the time, capacity and skills to carry out fundamental safeguarding work. It should be noted that the findings and recommendations in this review are not dissimilar to other more recent Child Practice Reviews.

Statement by Reviewer(s)

REVIEWER 1		**REVIEWER 2** ***(as appropriate)***	
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the child or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*		**Reviewer 2** *(Signature)*	
Name *(Print)*	Lucy Treby	**Name** *(Print)*	Nick Jones
Date	December 2024	**Date**	December 2024
Chair of Review Panel (Signature)			
Name *(Print)*	Sarah Manley		
Date	December 2024		

Appendix 1: Terms of reference

Appendix 2: Summary timeline

Child Practice Review process

To include here in brief:

- *The process followed by the CVSB and the services represented on the Review Panel*
- *A learning event was held and the services that attended*

• *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*
☐ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to CVSB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	

ANNEX 2 CHILD PRACTICE REVIEW SUMMARY TIMELINE

Cardiff and Vale Safeguarding Board
Summary Timeline
Re: *CPR 07/2018*

Date	Incident
Pre January 2017	Child G was known to services and noted to have spent 2 ½ years of her life on the Child Protection Register, having been registered twice and known since she was 3 weeks old. Removed on 1st July 2016, following a unanimous decision as mother had made changes. This has been briefly reviewed and evidence to demonstrate change appears limited.
January / February 2017	Child G started at School 1. School were worried about Child G's behaviour and after she started, the health visitor informed them she was a 'child in need' (CIN). This information was not initially shared by children's services. FISS involved and education note support meeting held. Mother and grandfather reported good behaviour at home but 'anti-social and occasionally more bizarre behaviours' were observed at nursery. Health visitor observed 'defiant behaviour' and Child G swearing, and records indicated that maternal uncle must be supervised with children. Children's Services made a decision to close case, but this was not actioned.
March 2017	School submitted a referral as Child G bit 2 babies, and she had a younger brother. Later in the month they made a referral to Early Years Forum. School later noted concerns about sexualised behaviours and recorded that a Social Worker visited and advised 'no cause for concern'. A later 'information only' MARF school submitted by the school did not include this information. Social Worker arranged Child in Need (CIN) meeting at school and during that mother agreed to engage with FISS and it was noted that 'mother will need to put strategies in place'. FISS was later declined by mother. Uncle was sentenced (12 month community order) for breaching non-molestation order. Probation officer allocated and uncle denied any involvement with Children's Services regarding his children. No mention of Child G or her brother in this entry.

	Step-father called 999 and reported that uncle assaulted him and Child G, which uncle denied. No further action was taken. Probation notes 'the requirements of the Order are not clearly recorded' on their recording system, and there was no recording of information sharing with children's services. Police noted that strategy meeting happened, but a PPN was not submitted. Joint Sec 47 enquiries were agreed. Mother noted to have gone away, and children stayed with grandfather (where Probation previously note uncle is living). Written agreement with children's services that uncle did not have unsupervised contact with the children. Police records seemed to indicate ending of sec 47 on 28th April 2017.
April / May 2017	School and health visitor noted continued 'attention seeking behaviour' including sexualised behaviour that might have indicated abuse. Health records from a care and support meeting, indicated this was blamed on paternal grandparents. Children services noted that mother felt behaviour was attention seeking and FISS were helping her. During mid May, it was noted that a legal surgery and planning meeting advised 'PLO and/or consider CP conference. Actions agreed: • Check to see where maternal uncle) is living • Signs of Safety Plan to be completed • Danger Statement to be completed • Safety goals to be put in place There was a joint visit from Housing and Children's Services about home condition and supervision of the children. Notes taken during that visit - Child G 'looked a bit frightened' of uncle, mother denied any concerns. Children's Services did not note any further action in this regard but did note challenging mother about diet. GP contacted Social Worker to advise that mother has requested an ADHD assessment, but GP considered 'attachment issues', recommended play therapy and refers to paediatrician. Children's Services concluded that FISS work should continue. Children's Services later noted that uncle was in the home during a FISS visit. Father was also mentioned at this time, and mother said Child G had met her real father. School and Children's Services noted that father brought Child G to school. Police later noted that father's current partner had threatened mother. Father told his Probation Officer that he was seeing his daughter. He also reported to Emergency Duty Team that Child G had arrived unkempt and said, 'no I don't want to have sex daddy', amongst other concerning statements.

	Police noted step-father raised concern that uncle had sexually assaulted his child, making step-father concerned for Child G. Children's Services recorded that a written agreement was in place that uncle will not have unsupervised contact. Probation were aware of this.
June / July / August 2017	Children's Services had CIN meeting. This was recorded as a visit and that children had been seen. School noted 'Child G reported that she was happy when she shares [her younger brother's] bed and is on top of him', noted that information was shared with Social Worker who investigated but found no concerns. They also noted that Child G said 'yes he has a big penis' which mother attributed to her teaching the children the correct words for body parts. Continued concerns were raised regarding housing and home conditions, included a flea infestation. Probation officer noted that father was in contact with ex-partner, subject of a restraining order. Probation Officer for uncle changed and he was fined for breaching his order by failing to attend. New Probation Officer recorded contact with Social Worker as reported that uncle had contact with children. In August evidence emerged that indicated uncle was having sexual intercourse with a vulnerable 16 year old in Child G's home. On 31st August 2017 Strategy discussion with EDT was instigated by Children's Services. Single agency sec 47 agreed with written agreements to ensure uncle not allowed to be in the home with the 16 year girl.
September 2017	Evidence of neglect and poor home conditions continued. Child G continued to show behaviour that may have indicated abuse. Family presented at 'signs of safety care planning panel'. FISS involved with the family, offered work to address these concerns. All agencies noted strategy discussions and a range of activity followed a number of concerns regarding uncle having contact with the children, and 'relationship' with a 16 year old girl. Child G's worrying behaviour included in this section 47. Police and Children's Services joint visit was planned but did not take place. Child G was seen at school by Social Worker with a Teacher present. Police visited later in the month. They note that she was dirty, wearing a stained dress. Child G said she 'hated' uncle and lunged and spat at the officers when he was mentioned. No direct disclose of abuse was made by child G. Outcome of Section 47 enquires was that, mother was reminded of her written agreement and Cren remained on CIN plans. Police noted (5th October 2017) it was not possible to proceed with criminal neglect as not child protection. Mother blamed others for the range of concerns that were present, and she avoided Social Work contact. Uncle made threats to Social Worker that were reported to 101. This was dealt with by way of restorative justice. Step-father told Social Worker the home is used by drug takers, and uncle had a rape conviction.

October / November / December 2017	Health noted Child G had poor hygiene and infected spots/flea bites on her face twice in this period. Uncle breached probation order and was said to have little contact with children and their mother. 9th October 2017 Police made an unannounced visit, home was dirty, Child G's brother had head lice and Child G showed 'sexualised behaviour'. Police advised mother to accept support or they would intervene. Children's Services visit as a response to police concerns, and state that the property had been cleaned. Mother was said to be engaging with support - so no further action was taken. 11th October 2017 CIN meeting was held at school. No further information noted. 30th October 2017 a Social Worker visited - home conditions were described as 'good' but noted flies in the home still and the carpet was 'gritty', mum's reasons for this were accepted', agreed that contact with mother's brother, and both fathers would stop. 16th October 2017 noted from health visitor to school nurse – hand over notes Child G 'unkempt and smelly, that she demonstrates poor behaviour, swears and picks food off the ground and eats it even if she has already had lunch'. 3rd November 2017 mother reported threats from father to Police. Step-father also reports uncle visiting the family home. Police visited on 6th November and recorded no concerns about welfare, uncle was present, mother reported he is not unsupervised with the children. 21st November 2017 care and support meeting (CIN) noted school's escalating concerns about Child G's presentation and neglect, but mother reported positives at home, however father's parenting described as inconsistent. 5th December 2017 Children's Services supervision noted family had engaged with FISS and recommended closure. School noted they did not agree with decision.
January / February / March 2018	4th January – Children's Services close case – 'neither home conditions nor sexual behaviour had been raised as a recent issue'. School records note that they contacted Children's Services to raise concern about this decision, feeling that the family 'still needed support'. School noted various concerns about Child G's behaviour and referred her for ALN support. Uncle breached Court Order and was held in prison for 4 weeks. In March, held in immigration centre for deportation.
April 2018	Mother called Police alleging step-father made threats to her. She did not agree for a referral to Cardiff Women's Council (Cardiff Women's Aid), at the time but later contacted them directly, was invited to visit the office but did not.

	Step-father reported to Police that uncle was at the property, and 'the house was in a state'. Mother told the Police that children had not been left alone with uncle.
May / June 2018	School started process to move Child G to well-being provision, no space available but she was to be prioritised. School submitted MARF but mother's consent had not been obtained to 'maintain positive relationship with mother'. Children's Services duty manager noted 'concerns are worrying' but do not reach threshold for section 47 and advised school to monitor progress and seek consent to offer support. Later school noted 'Child G is aggressive at school, spitting and throwing items and smearing blood from picking her face'. Child G was placed on a pastoral support plan and reduced timetable. Also referred to educational psychologist, CAMHS and neurodevelopmental pathway. School recorded various incidents of Child G showing sexualised and other behaviour that may indicate distress including "humping games, saying she has liked other children's genitals, making a penis out of paper and trying to wee out of it". This was framed as resulting 'from early childhood and observed adult behaviours' but were concerned that there was no change. Police and Probation confirmed that uncle had been deported. Step-father was reported for domestic abuse of current partner.
July / August 2018	Neurodevelopmental assessment was declined because 'her presentation is more likely due to the developmental trauma she has experienced.' Child G was given place at school 2 Wellbeing Class for September. 17th July 2018 Child G's paternal aunt reported to police that Child G's father had sexually abused her when they were both children. Joint Section 47. Children's Services record 'A further family member had reported that they have overheard Child G stating "I had to stop daddy having sex with me" when in the care of father. She was also reported to "have made a similar remark about her step-father".' Child G was spoken to alone and noted to be very hyperactive and bouncing around the room - so limited information was gained from her. The Social Worker reported mum was acting protectively, had stopped contact last year and that Child G had made allegations before, including about teachers at school (which had been unfounded). Outcome of this joint section 47 was that allegations were not substantiated and 'historic' and had been addressed by social services. Closed to Children's Services.
September 2018	Child G started transition to school 2 and in the first week they noted rapid escalation of concerns about her behaviour and presentation. On fifth day (Friday 14th) of Child G attending school 2, they submitted a referral to Children's Services (see introduction above). School was advised to speak to mother about the men. They weren't able to reach mother and were then advised by Children's Services to send Child G home.

	On Monday 17th School 2 requested to do some work with Child G who drew pictures and made further disclosures of physical and sexual abuse. Children's Services noted 'Child G is reporting to have slept on the sofa with "Adult T" and her mum tells her to wear a bra top and underwear, Adult T wears boxers. Child G reported that Adult T "is mean and hits her" and one time tied her hands and feet together and put tape over her mouth. Child G told her teacher that Adult T touched her in her genitals and chest with his tongue.' The house was found to be in a filthy condition with hundreds of flies everywhere. Police used their powers of protection and care proceedings were issued.

Detailed timelines were produced by the relevant services for the purposes of the review to assist the understanding of the complex interactions between events and services in this case. This summary and partial timeline contains limited and anonymised details and is provided to supplement the outline of circumstances in the Child Practice Review report.