Southampton Safeguarding Children Partnership

Synopsis of learning from Serious Case Review: Freddie

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Synopsis of the case & review

In January 2019 Southampton Local Safeguarding Children Board commissioned a Serious Case Review examining the circumstances of agency involvement with a child under eight years old who, for the purposes of the review, will be known as Freddie. Freddie and his family had a long history of contact and involvement with statutory services due to concerns about neglect and harmful sexual behaviours. The family consisted of Freddie, his mother and his two older half-siblings. As a result of these concerns Freddie was judged as no longer safe to remain living with his family and was taken into local authority care. Whilst in care, Freddie made a number of statements about sexual abuse by family members, as well as providing information about other sexual abuse that had taken place within the family. Given the involvement of a number of statutory agencies at the time of this alleged abuse taking place, the decision to conduct a Serious Case Review was deemed appropriate due to the abuse or neglect of a child being known about or suspected at that time, and that a child had been seriously harmed and there were concerns about the way in which agencies had worked together. The Police initiated a criminal investigation into these matters however at the point of concluding this review no further action was to be taken.

By way of a summary, the review has highlighted a number of lessons for the safeguarding partnership. These include;

- Freddie was subject to a Child Protection Plan for nearly two years; this was mostly ineffective, and offered little additional safety to Freddie and siblings. There was considerable drift, a lack of pace and purpose and ineffective multi-agency working.
- There were a number of contributory factors to the drift. The most notable include there being a collective uncertainty across the professional network about how to best manage the risks to Freddie, delays in assessment work being completed, sympathy for the Mother's situation distracting the professional view about the children's safety and welfare, and inadequate management oversight from Children's Services.
- Challenge and escalation by professionals across the partnership was limited.
- The ability of Children's Services and to effectively fulfil their statutory functions as the lead agency were compromised due to multiple systemic challenges during the critical time period of Freddie being subject to a Child Protection Plan.

The review has also highlighted ongoing challenges and opportunities as services improve for the professional network in responding to cases that have a similar profile as this case.

This independent review has benefitted from the contributions of a number of agencies and professionals that were involved with the children, gained Freddie's mother's perspective, captured a number of points for learning and improvement and concluded with recommendations for the Safeguarding Partnership to take forward. A full and thorough independent review was completed and which adhered to the requirements of statutory guidance - Working together to safeguard children (2015) - under which it was commissioned. As well as individual agencies identifying their own learning and improvement activity, the review highlighted learning for all professionals involved and concluded by making a number of recommendations. This document provides a synopsis of the learning taken from the full report; for further information please refer to the full SCR report: http://southamptonlscb.co.uk/seriouscasereviews/

The quality & effectiveness of multi-agency working and child protection processes

'Complexity makes it hard for practitioners to understand cause and effect, predict outcomes and control the course of events. To manage complexity, the team around the child may need to operate as a strategic unit rather than a collection of tactical interventions. When complex cases become 'stuck', professional networks may need additional support and consultation from specialist agencies'. (1)

Learning from this case review highlights;

- As a mechanism for protecting children, the child protection conferencing process and associated Core Group activity relies on procedural compliance but also relationships and human interaction. When either aspects are dysfunctional the risks to the child are highly likely to increase thereby rendering the multi-agency plan less effective. The assertive use of challenge and escalation outside of the dysfunctional dynamic in which professionals may find themselves unwittingly trapped is always an appropriate step for any professional to take.

- Creating local arrangements that bring professionals together, and reduce silo working, can be beneficial when working with complex cases where there is extra-familial risk. Assessing the family context and exploring issues around exploitation, peer on peer abuse, neighbourhood violence and criminality, relationships and other risk factors can feed into other professional forums, thereby creating a more holistic approach to intervention.

- Receiving regular high quality management support and supervision is important when working with intra-familial child sexual abuse. Seeking additional input from specialised services can be of equal value in helping professionals remain objective, child focused and attentive to unconscious processes which may impact on assessment and decision making.

- An effective safeguarding partnership is more than a collection of representatives, organisational structures, systems, processes and procedures. It is also a combination of complex relationships between individual professionals and leaders and the combined efforts of organisations. Partnerships require time, effort and investment in order to become, and remain, effective.

- Research (2) into other Serious Case Reviews highlights *'… the child protection conference can be a crucial, pivotal point in the overall child protection process, facilitating analysis of information, appraisal of risks, decision making and planning for intervention. As with any pivot, its effectiveness is dependent not just on the structure and function of the conference itself, but on the processes on either side …'.*

- When working with children and families, irrespective of which process is being followed, if parents/carers state that they no longer understand why professionals are involved in their lives or what the issues are then it is time to pause, re-group and re-examine the quality and purposefulness of professional contact. Keeping parents/carers on board with change is critical to successful intervention.

In summary, notwithstanding the challenges associated with assessing and intervening in this case due to the uncertainty about the origins of child sexual abuse there is strong evidence of the multi-agency machinery around formal child protection processes being ineffective. The complexity of relationships within the family and then between the family and professionals impacted on the ability of the professional network operating as a coherent whole. Coupled with the wider system challenges faced by services in Southampton during this timeframe it is possible to understand cause and effect of drift and the pathway to ongoing harm for Freddie. Had the partnership's decision making and interventions been more effective the strength of the response by the safeguarding partnership may have resulted in a more robust intervention in Freddie's life .i.e. consistent attendance at meetings by all agencies, consistency in those who had oversight and scrutiny roles, greater professional curiosity, information sharing, challenge and escalation, and the timely follow-through on actions.

1 – Hood, R., How professionals experience complexity: An interpretative phenomenological analysis. Child Abuse Review Vol 24: 140 – 152, 2015, Wiley.
2 -Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, p. 175, University of Warwick & University of East Anglia, May 2016).

The use of family history to inform assessments & decision making

Professional curiosity is the ability to think, and communicate, with children, families and professionals in a way that explores what is happening rather than making assumptions or accepting things at face value. Sometimes it can be described as 'respectful uncertainty' – applying critical thinking skills to information received and maintaining an open mind.

Learning from this case review highlights;

- Taking the time to be curious, analyse information and forming a set of working hypotheses about the impact of adverse events that have occurred in a child's earlier life can be an important step in setting the professional network on a pathway that offers protection to the child.

- When concerns emerge about a child's safety and welfare, it is always good practice to review previous chronological involvement with the child and family and apply professional judgement about current needs and risks in the context of known history and relevant research about child development. Statutory guidance (3) states '*… a high quality assessment is one in which evidence is built and revised throughout the process and takes account of family history and the child's experience of cumulative abuse …'*. - It is important that the feelings and biases of professionals and managers towards parents do not hamper judgements, prevent challenge and undermine decision making. Balancing support with authoritative scrutiny is a key requirement when making decisions about a child's best interests.

3 - *Working together to safeguard children, 2018, HM Government.*

The recognition & response by professionals to actual or potential harm

' … child sexual abuse is a minefield for all concerned … it is genuinely a multidisciplinary problem, requiring the close co-operation of a wide range of professionals with different skills …'. (4)

Learning from this case review highlights;

- Management oversight offers the opportunity to exercise quality assurance, scrutiny of professional standards, sense check risk management and safety planning and provide a 'one-step' removed perspective. It is important for managers to have the time and space to provide reflective feedback on these issues.

- Gaining legal advice offers the opportunity to seek a fresh perspective about how to manage concerns about a child's safety and welfare. In cases that are particularly entrenched or complex a legal perspective may be invaluable to assist with untangling what may be viewed as messy and thorny problems faced by the professional network. It is crucial that legal advice is properly recorded and that a clear rational is also recorded when the advice given is not followed.

- When any specific type of assessment has been commissioned it is reasonable to expect professional challenge and escalation when it is not completed or if agreed processes have not been followed in terms of information exchange or commissioning arrangements.

- When seeking specialist input into cases where there are child protection concerns it is important to remember that sitting behind the need for specialist input is a statutory framework requiring agencies to safeguard children's welfare. When cases have already reached a child protection threshold this means being mindful of the options open to professionals. Specialist input therefore has to be seen in the context of statutory intervention and one which still requires the professional network to keep children safe.

4 - Furniss, T., The multi-professional handbook of child sexual abuse: Integrated management, therapy & legal intervention, p.81, 1995, Routledge.

Current practice challenges raised relating to the findings of this case

In order for this review to assist with learning and improvement activity it is helpful to place the findings in the current operating context for practitioners. On this basis the review has had access to the findings of recent audit activity which have examined many of the practice issues highlighted in this report. Whilst it is important to not draw conclusions about the quality of practice across all cases which may have a similar profile to this case there is value in noting that some themes remain a significant challenge for the safeguarding partnership. The audit work clearly demonstrates ongoing challenges around some of the core aspects of child protection work and the effectiveness of the multi-agency machinery around formal child protection processes.

Good practice

The focus of this Review is to learn and improve services. As such, it is important to capture good practice which supports positive outcomes for children. The following aspects of good practice have been captured.

- It is evident that the Health Visitor understood the family's complexities and had a focus on the impact of this on Freddie.

- School A held a detailed chronology and notes regarding a range of incidents. There is evidence of positive attendance at statutory meetings such as Core Groups and Child Protection Conferences with shared reports highlighting concerns. Staff commented in interview that they allocated support to Freddie; he was happy in school; the staff worked as a team and shared concerns with each other; and that Freddie had made progress.

- The GP Practice communicated with other agencies (Health visitor, Social worker) in a timely and useful manner to further discuss what was known about the family, and these contacts were well documented. This Practice currently holds monthly Safeguarding Meetings with Health Visitors in attendance.

- GPs continued to refer Freddie to CAMHS when the Mother continued to have concerns about his behaviour.

- The Police use of Out of Court Disposals for dealing with Sibling 2 was a positive approach to responding to his behaviour.

- The Police use of the Neighbourhood Police Team single point of contact for engaging with the family

- Pro-active multi-agency working by the Police via the MAPPA arrangements which recognised Sibling 2 as both an offender but also a vulnerable child.

- The clear advice given by Legal Services to Children's Services.

As a result of this review agencies that have contributed have been able to identify learning that can be taken forward internally, and as such have submitted single agency action plans reflecting their internal learning and recommendations for improvement. It is the role and responsibility of the Safeguarding Partnership to scrutinise and challenge progress against single agency action plans. A number of recommendations have been made for Southampton Safeguarding Partnership.

For a copy of the full overview report and recommendations please follow this link:
http://southamptonlscb.co.uk/seriouscasereviews/

For information on what to do if you are worried about a child please visit https://sid.southampton.gov.uk/kb5/southampton/directory/service.page?id=gLu7KI9grCY or if you would like information about safeguarding or policies and procedures https://hipsprocedures.org.uk/