SSCP
SOUTHAMPTON SAFEGUARDING CHILDREN PARTNERSHIP

Child Clare Learning Report

Lead Reviewer
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Contents **Page No**

1. Reasons for the review and synopsis of the case

1.1 On the recommendation of the Southampton Serious Case Review Group, a decision was taken by the Independent Chair of the Southampton Local Safeguarding Children Board in July 2018 to commission a Serious Case Review into the death of a child (hereafter referred to as Clare). The recommendation was based on the decision that the circumstances of Clare's death met the criteria for a Serious Case Review under Chapter 4 Section 17 of Working Together to Safeguard Children (2015)[1].

1.2 Clare was 13 years old when she died as a result of multiple stab wounds. A man was convicted of her murder and is serving a life sentence. Prior to Clare's death, the perpetrator had been staying with the family intermittently for almost twelve months.

1.3 Clare lived with her mother, her mother's partner, and her three siblings, two of whom were half siblings. The family had been known to statutory agencies because of past incidents of domestic abuse. Throughout her short life, Clare and her siblings witnessed frequent arguments and incidents of domestic abuse between her parents and subsequently between her mother and her partners.

1.4 Following a private court hearing, mother was given care and control of the children, with their father allowed regular contact. The ruling was against the recommendation of Children's Social Care and after the hearing their father had little contact with the children. Concerns about the care and emotional wellbeing of Clare and her siblings began to emerge when they started school, resulting in the children being made subject to Child Protection Plans. Clare and one of her siblings were referred to Children and Adolescent Mental Health Services (CAMHS). The Local Authority considered removing the children from mother's care, however the proceedings were delayed and did not progress further than the Public Law Outline (PLO) stage.

1.5 Concerns were raised with Children's Social Care by teachers at both secondary schools, which Clare attended, that she had an older boyfriend whom it was believed could be sexually exploiting her. The referrals were investigated, however, because of assurances given by Clare's mother that there was no foundation to these concerns, no action was considered necessary. Information subsequently emerged that Clare had been sexually abused by the perpetrator since the age of 12, when he began to stay with her family.

2. Key Themes arising from the Review

2.1 A number of key themes have emerged from this review, which are important to the improvement of practice.

- **Parental discord, domestic abuse and the emotional impact on children**

2.2 There is growing evidence that children who live in families where there is domestic abuse can suffer serious long-term emotional effects. A child's fear and anxiety will affect their self-

[1] Working Together to Safeguard Children (2015) - NB this guidance was updated in 2018, however this Serious Case Review was commissioned prior to the update. The update to the guidance included the fact that Local Safeguarding Children Boards should become Local Safeguarding Children Partnerships.

confidence and often make them depressed, withdrawn or violent.[2] Research by The Children's Society found that children experiencing domestic violence and abuse could see a negative impact on their mental health and wellbeing, school attendance and achievement, emotional development and physical safety.[3]

2.3 Clare and her siblings witnessed ferocious verbal arguments and violence between their parents and between mother and another partner throughout their childhood. The impact of exposure to prolonged periods of parental discord, which was prevalent during Clare's short lifetime was manifest in her exhibiting insecurity, anxiety and vulnerability, particularly whilst at primary school. The children were at the very centre of parental arguments which resulted in them experiencing significant emotional harm, and at times physical abuse.

2.4 As a consequence, the children were subject to Child Protection Plans and the PLO process was initiated. Despite these measures, outcomes for the children were inconsistent in ensuring their safety and emotional wellbeing. There was a well-intentioned belief, on the part of those professionals involved that the situation would improve, however, this resulted in a lack of focus on the needs of the children.

- **Disguised compliance and hostility towards professionals**

2.5 The engagement of parents with safeguarding professionals is key to the assessment of risk to children. From information provided to the review, by multiple agencies, Mother was described as being at times 'defensive', 'controlling', 'aggressive' and 'intimidating'. She was able to influence professional judgement in her engagement with health, school and Children's Social Care, and indeed the court, in ways similar to those she affected with the fathers of her children. For example, Mother was determined that Clare and her siblings remained in her care, and on succeeding in an application to the court for care and control, ensured that it would prove difficult for Father to maintain contact with his children and they with him.

2.6 It is apparent that Mother was largely able to manage situations involving the children on her terms in her involvement with all agencies, which proved to be detrimental to the well-being of the children. The review recognises the difficulties faced by professionals in attempting to engage with parents presenting in this way. However, such behaviour should not be allowed to detract from the need to focus on the safety and wellbeing of children. Thus, professionals need to be aware of disguised compliance, be resilient when faced with hostility, and confident in understanding when to escalate their concerns.

- **The role of CAMHS and diagnosis of children with ADHD**

2.7 Mother believed that both Clare and one of her siblings had Attention Deficit Hyperactivity Disorder (ADHD). She was persistent in this belief when meeting with teachers, Primary Care clinicians and with CAMHS practitioners. However, in respect of Clare both the school and the GP considered that she did not present as a child with ADHD. On receipt of referrals assessments were undertaken, which resulted in both Clare and her sibling being assessed by CAMHS clinicians as requiring medication to ameliorate their behaviour.

2.8 The review found that the standard pathway for ADHD assessment in respect of Clare was not followed. A number of screening tools and assessments which were part of the usual

[2] Barnardo's https://www.barnardos.org.uk/what-we-do/helping-families/domestic-abuse
[3] The Children's Societyhttps://www.childrenssociety.org.uk/mental-health-advice-for-children-and-young-people/domestic-violence

procedures were largely bypassed, the reason being that the family was known, Clare's sibling already having been assessed as having ADHD, and the insistency by mother that Clare's behaviour at home and at school was indicative that she had the condition.

2.9 The review has been informed that a clearly defined pathway for ADHD is now in place, consisting of four appointments and completion of various screening tools. Solent NHS Trust has confirmed to the review that this ADHD pathway document has been disseminated.

- **Male partners in the family environment**

2.10 The importance of agencies sharing known information concerning the background of males who become involved with children and families cannot be underestimated. Clare and her siblings had experienced different male partners coming to live in their home, after father had left. This resulted in the children witnessing the distress of parental discord, argument and violence and led to them being made subject to child protection plans because of the risk of emotional harm. The arrival of a male who was allowed to stay as a semi-lodger with the family, however presented a different risk of harm.

2.11 Mother informed the review that she was unaware of this man's history of violence and if she had, she would never have allowed him into her home. He was well known and appeared to be well liked and trusted in the local community. This man was however, also well known to Police and Children's Social Care did have knowledge of elements of his background. Before being sentenced to life imprisonment for Clare's murder the perpetrator had numerous previous convictions, which included theft, battery, criminal damage, domestic violence and possession of cannabis.

2.12 Agencies, including Children's Social Care, were aware of the perpetrator's criminal history. The referrals by Clare's secondary schools detailing concerns about Clare's involvement with this man did not progress further than the 'Front Door' to the Multi Agency Safeguarding Hub (MASH), which resulted in no multi-agency sharing of information held by Police, the School and Children's Social Care. The referrals needed to be treated as one of child protection. If this had happened, a Strategy Discussion under Section 47 of the Children Act, 1989 could have been convened concerning the risk this man posed to Clare and her family. This did not happen and was a missed opportunity.

- **The importance of the Public Law Outline & the need for robustness in the Child Protection Process**

2.13 Concerns about the welfare and safeguarding risk posed to the children resulted in Children's Care appropriately requesting that a legal planning meeting being convened. This resulted in a decision that the children were suffering from emotional harm, which met the threshold for a PLO.

2.14 The PLO process should not take any longer than 16 weeks from the time of commencement. In this case, it continued for fifteen months after the decision was taken to commence the process. During this time, Capacity to Care Assessments were undertaken on mother, father, and the father of one of Clare's half-siblings. Clare and her sibling also underwent therapeutic assessments. There is no documentation available to the review as to the outcome of those assessments informing any decisions made about the future of the children.

2.15 The PLO had been in place for ten months, when a solicitor in the Local Authority Legal Services Department questioned why the process was taking so long. A decision was then taken that as the process had been going on for many months and the prospect of care proceedings being successful was remote, the PLO should be withdrawn. The PLO was not however withdrawn for a further five months. During this period Legal Services sought instructions on several occasions from Children's Social Care as to how to proceed. However, the lack of timely decision making which would have ensured that the PLO process progressed appropriately and efficiently, meant that this process was allowed to drift. This can only be described as poor practice, which resulted in the court not being given the opportunity to decide what was in the best interests of the children.

2.16 In response to questions raised as to why this case was allowed to drift, the Lead Reviewer has been informed that there was no designated business support for Children's Services to support the Legal Gateway process, as such services are shared across departments in Southampton City Council. Given the demands on Children's Social Care to fulfil their statutory duty to care and safeguard children, it is seriously concerning that such support was not in place. It is recognised that business support provide administrative assistance in this process, and not the management of cases which remains the responsibility of Children's Services. It can be said that the welfare and best interests of Clare and her siblings were compromised by the system for review of PLO processes, and has resulted in a recommendation arising from this review. (Recommendation 2).

2.17 The children remained subject to Child Protection Planning until February 2016 when a Review Child Protection Conference decided that the case be stepped down to one of Child in Need. This was a split decision and the outcome to proceed to Child in Need plans was one endorsed by the chair of the review conference. Within months of the Child in Need planning being closed the perpetrator moved into/began to stay in the family home.

2.18 The importance of clear, comprehensive child protection planning, and child focused decision making, is a finding of many Serious Case Reviews. Unfortunately, this case is not an exception. The children were subject to Child Protection Plans on two occasions over a three year period. They remained on Child Protection Plans for almost another three years thereafter, and for a year on Child in Need plans. The question needs to be asked, not only why the children were subject to Child Protection Plans for so long, but also whether by the time the decision was taken to remove them from plans, full consideration had been given that the risk to their wellbeing had diminished and that they were no longer considered to be at risk of significant harm. The decision, at a Review Conference, to remove them from child protection planning was not a unanimous one and would indicate that there were concerns amongst some agency representatives that the children remained at risk. The crucial importance of comprehensive information being available at Child Protection Conferences, the need to challenge decisions which are not unanimous and the recognition of safeguarding risk by professionals from all agencies cannot be underestimated and is a finding of this review.

- **Lack of Professional Curiosity**

2.19 Lack of professional curiosity is a frequent theme emerging from Serious Case Reviews. It has been illustrated in this report that there was lack of further investigation by Police into the perpetrator's background when he came to their attention, prior to Clare's death, not least when it became known he was tattooing under-age young people. Similarly, there should have

been an escalation from the Front Door to the MASH of the concerns raised by the schools about Clare's involvement with an older man.

2.20 Whilst it is acknowledged that as a male, known in the community and to mother and her partner, the perpetrator was able to inveigle himself into the family home; the significance of recognising what constitutes a safeguarding concern and seeking additional information when a safeguarding referral is made to statutory agencies is a fundamental requirement of professional practice. By not following up on the concerns expressed about this man, an opportunity was missed to consider the risks he presented to Clare and other young people.

- **Listening to Children**

2.21 Whilst Clare did not share that she was being abused by the perpetrator with her mother, she did disclose to friends at school that she had an older boyfriend. The two secondary schools she attended took appropriate action and referred this information to the Front Door of the MASH. This showed that both schools had a good understanding of child sexual exploitation and sought to protect Clare from this situation by escalating their concerns.

3 Learning Arising from the Review

3.1 The most significant learning arising from this review can be summarised as follows:

3.2 **Parental Discord and domestic abuse**: The impact of parental discord and domestic abuse on the emotional health and wellbeing of children must be recognised and given sufficient importance by professionals involved in safeguarding children.

3.3 **Disguised compliance and hostility towards professionals:** Parents can be intimidating and at times aggressive to health professionals, teachers and social workers. However, such behaviour cannot be allowed to detract from the necessity to keep the best interests of children and their safety at the centre of all professional practice.

3.4 **The role of CAMHS and the diagnosis of children with ADHD:** The need to recognise that ADHD can arise as a result of attachment disorders and parental relationship difficulties is a learning point arising from this review. Whilst it is often not possible to explore underlying issues such as relationship difficulties until a child has been treated with medication to manage their behaviour and thereby be able to focus on such issues, the need for appropriate assessment and proportionality in the prescribing of medication by clinicians is vital.

3.5 **Robustness of the Child Protection Process:** the importance of clear, comprehensive child protection decision making, and planning is crucial, if children are to be safeguarded and cases are not allowed to drift. It is of note that in 2015, a new system was implemented within Primary Care in the City of Southampton to support the Initial and Review Child Protection Conference process coordinated by Children's Social Care.

3.6 **Information sharing amongst agencies:** as so many statutory reviews into the death and serious abuse of children have found, the importance of information sharing by and within agencies cannot be underestimated.

3.7 **Lack of professional curiosity:** the significance of recognising what constitutes a safeguarding concern and seeking additional information when a safeguarding referral is made to statutory

agencies is a fundament requirement of professional practice. The recognition by the Local Authority that the use of a particular methodology to assess referrals to the MASH, which was in place prior to Clare's death, was not in the best interests of safeguarding children is a finding of this review.

3.8 **Listening to children:** the need to listen to children, whether they speak directly to professionals or indicate worries and concerns indirectly by their actions and behaviour is an important lesson arising from this review.

4 Good practice

4.1 The care and concern shown to Clare and her sibling by the staff at their primary school is commended and is an example of good practice, as is their escalation of safeguarding concerns to Children's Social Care.

4.2 The therapy offered by the Behaviour Resource Service (BRS) to Clare and her sibling positively contributed to their wellbeing and emotional health. It is commended as an example of good practice.

4.3 The referral of concerns about Clare and her involvement with the perpetrator by both secondary schools is also commended as examples of good practice.

5 Conclusion

5.1 As a result of this review a number of partner agencies who have been involved in the process have changed procedures to enhance the way in which children are safeguarded. This includes changes to management responsibility for PLOs, a review of MASH procedures, a clearly defined pathway for ADHD and a new system in Primary Care in the City of Southampton to support Initial and Review Child Protection Conferences. Further learning arising from the review is reflected in single agency action plans and recommendations. This is in addition to the recommendations arising from this Serious Case Review.

6 Recommendations

The following recommendations are for the consideration of Southampton Safeguarding Children Partnership:

Recommendation 1

(a) When referrals are received into the MASH investigations are undertaken to ensure that all relevant information is gathered from agencies to make an informed decision as to the risk of harm to a child.

(b) It is recommended that an independent audit of current MASH procedures is undertaken to reassure the Partnership that referrals are receiving appropriate priority and adequate investigation by appropriate information gathering.

Recommendation 2

(a) It is recommended that an independent audit is undertaken of Public Law Outline cases to ensure that required procedures and timescales are adhered to and cases are not subject to drift.

(b) **The system whereby no designated business support is available to strengthen the legal gateway process requires urgent review.**

Recommendation 3

(a) **All agencies are to be reminded of the impact of domestic abuse on the health and emotional wellbeing of children, and support offered to professionals to adopt a trauma informed approach.**

(b) **Intimidating and aggressive behaviour by parents and carers cannot be allowed to detract from the importance of professionals focusing on the safety and protection of children. The Partnership should seek assurance that the provision of safeguarding training to raise awareness of disguised compliance, and regular, reflective supervision is being delivered and accessed by professionals. If this is not happening, then action should be taken to ensure that the situation is addressed.**

Recommendation 4

It is recommended that an independent audit is undertaken of CAMHS to ensure that the pathway for children diagnosed with ADHD introduced by Solent NHS is adhered to, and that children are not being medicated unnecessarily to enable them to remain in education.

Recommendation 5

It is recommended that a formal procedure is developed to ensure that where siblings attend different schools, information is shared between each individual school to ensure that an overall picture of a child and their family is available to teachers and education professionals.

Recommendation 6

It is recommended that Southampton Children's Safeguarding Partnership gives consideration to launching a campaign to raise awareness amongst parents and carers of the need to be curious about the background of males who are invited into their homes. The toolkit used by Hampshire Safeguarding Children Partnership may assist this recommendation.

https://www.hampshirescp.org.uk/toolkits/understanding-unidentified-adults/practical-tools/