One minute guide

Learning from a Southampton Serious Case Review

November 2020

Overview

'Freddie', a child under the age of 8, had a history of involvement with statutory services due to concerns of neglect and his own sexualised behaviours. He was judged as no longer being safe living with his family and was taken into local authority care where he made several statements about sexual abuse by family members and within the family.

The review investigated the time from January 2014 through to Freddie being made the subject of a final Care Order in October 2016.

Prior to the review, Freddie's older half siblings (1 & 2) had been known to Children Services since 1999. There had been verbal statements of a sexual nature by Siblings 1 and 2 in in respect of the Father and a person posing a risk to children with whom the Mother had entered a relationship. Numerous contacts were made to Children's Services reporting the mother as struggling, and Sibling 2 was reported to the Police for numerous incidents including being charged with rape / sexual assault.

In November 2013 Freddie's Pre-school contacted Children's Services showing concern about his behaviour and pre-occupation with genitals (aged 4), commenting on the inappropriate sexualised behaviour by his father towards him. The Behaviour Resource Service judged this as 'normal and exploratory' however were concerned about the frequency and persistence of the sexualised behaviours.

In June 2014 there was a s.47 investigation due to Freddie making statements about both his mother and father behaving towards him in an inappropriate sexual manner. Freddie had also touched or tried to touch other children and he would later be excluded from school in 2015. There was agreement for an Initial Child Protection Conference (ICPC) in respect of all three children.

All 3 children were made subject of a Child Protection Plan (CPP) from June 2014 until May 2016 when Sibling 1 & 2 were stepped down to 'Child in Need' and Freddie remained subject of the CPP, later being moved into specialist placement. Siblings 1 and 2 remained with their mother due to their age.

Findings

- Freddie was subject to a CPP for over 18 months that was ineffective and the lack of pace and purpose between reviews resulted in continued exposure to harm for himself and his siblings.

- Inadequate management oversight was evidenced by frequent references that the CPP had not achieved any changes and frustration was voiced by various professionals attending including the Chair. However, no challenge or escalation was made and there was evidence of limited curiosity.

- Conferences and Core Groups encountered significant problems including:
    - Cancellations and delays in assessment work being completed.
    - No Social Worker allocated or attending, with high turnover being a noted issue.
    - Lack of attendance by other agency representatives, or new unfamiliar agency reps.
    - No minutes being available.
    - Fragmented Core Groups with little opportunity to reconcile their differences.

- There was a lack of information sharing across the professional network, with transitions from paper to electronic records leading to information loss and no shared multi-agency chronology.

- Sympathy for the mother distracted the professional view on children's safety and unwittingly resulted in a loss of focus on the children. Emphasis was placed on impact of the children's actions on the Mother and she was often given the opportunity to speak on behalf of the children rather than practitioners seeing and allowing the children to speak themselves. The mother did not confidently understand the process and felt it was not explained.

- The Mother did not accept responsibility for Freddie's sexualised behaviour and instead blamed Sibling 2 or the Father. The origin of Freddie's behaviour was never established and would have been critical to creating an effective safety plan given the high possibility that Freddie continued to live in the same household as his abuser.

- There is no evidence of a formal viability assessment or referral for a full assessment of the maternal grandparents, or any other family members to be considered for looking after Freddie until some months after it was known that they had taken on a greater role in his life. The conclusion was that they would not be able to meet his complex needs and indicates there was little focus or grasp of what was really happening for Freddie.

Learning Points

- 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 likely to increase and the multi-agency plan made less effective. Professional challenge and escalation are reasonable and necessary if agreed processes have not been followed in terms of information exchange or commissioning arrangements.

- 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, resulting in more cooperation and information sharing. It is good practice review previous chronological involvement with the child and family and applying professional judgement about current needs and risks in the context of known history.

- Receiving regular high-quality management support and supervision is important when working with intra-familial child sexual abuse. Seeking additional input from specialised services help professionals remain objective, child focused and attentive to unconscious processes which may impact on assessment and decision making. It is important that the feelings and biases of professionals and managers towards parents do not hamper judgements, prevent challenge or undermine decision making. Balancing support with authoritative scrutiny is key when making decisions about a child's best interests.

- It is important parents/carers understand why professionals are involved in their lives and are kept on board with change.

- 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.

Key Contacts and Further Information

Please find a copy of the full review here:
https://www.careknowledge.com/media/48511/2020southamptonfreddieoverview.pdf

Coventry Safeguarding Children Partnership website - https://www.coventry.gov.uk/lscb