Serious Case Review - Adam & Anna

Learning and Improvement Report

June 2019

Preface

This review highlights the barriers to safeguarding two children, known as Adam and Anna, from child sexual abuse within the family. The Review covers the period from October 2013 when fresh concerns regarding neglect triggered child protection concerns, to July 2017 when the children were received into the Local Authority's care. It explores how effectively agencies worked together to identify and address the risk of child sexual abuse within the family and what is need to improve future professional practice.

Southampton LSCB would like to acknowledge the good work and persistent efforts of key agencies that tried to keep Adam & Anna safe, for the resilience of Adam & Anna and all children that suffer this kind of abuse.

The Case Review highlights a range of issues including child sexual abuse within the family, neglect, isolation and poor home conditions and provides key learning for agencies working with children. The LSCB is also implementing training to ensure that professionals from all agencies understand the signs of symptoms of sexual abuse, and feel confident in acting upon their concerns to keep the children safe.

Southampton LSCB is committed to working alongside partners in order to ensure that the recommendations are implemented and understood by professionals.

Keith Makin - Independent Chair
Southampton Local Safeguarding Children Board

Introduction

Child sexual abuse within the family (also known as Intra-familial child sexual abuse or 'IFCSA') is sexual abuse perpetrated or facilitated in or out of the home, against a child under the age of 18, by a family member or someone otherwise linked to the family context or environment. Perpetrators may be close to the victim (for example a parent, or extended family member) or less familiar (for example a family friend or babysitter). Child sexual abuse within the family is possibly one of the most difficult contexts in which to identify children at risk. Many of the strategies and techniques used by perpetrators to target, isolate, groom and abuse children may be obscured within 'normal' activities that that one would expect a parent or carer to engage in with their children.

In September 2017 the LSCB received a referral regarding the sexual abuse of two children, known as Adam and Anna, by a family member.

Adam and Anna's paternal uncle (known as 'PU') was convicted in July 2017 for multiple counts of abuse against the children which took place from around December 2015 until his arrest. The abuse took place within the family home and at the paternal uncle's home where the children had also lived.

The purpose of this review is to understand the barriers to safeguarding Adam and Anna from sexual abuse and to better understand the correlation between neglect and child sexual abuse within the family. The review also explores how effectively agencies worked together to identify and address the risk posed to the children, what the barriers were and what can be learned to improve future professional practice. The period under review is October 2013, when concerns regarding neglect of the children were raised, to July 2017 when the children were received into the Local Authority's care.

This Learning and Improvement Report has been produced by the LSCB as an overall response to the recommendations made within the overview report. It describes how the LSCB partnership in the city are responding to the recommendations made in the review. It identifies how lessons have been learned and the improvements that have already been made, and outlines how we will work to maintain the highest possible standards and safeguard children in the future.

The Children: Adam and Anna

Adam and Anna lived at home with their parents in Southampton. They were subject to sexual abuse by an extended family member during their time living at home and subsequently their time living with that person. The time period covered by this Serious Case Review is from October 2013 when concerns regarding the neglect of Adam and Anna triggered child protection concerns, to July 2017 when the children were received into the Local Authority's care following confirmation they had also been subject to sexual abuse.

Review Format

Southampton LSCB appointed Fiona Bateman as the Independent Lead Reviewer for this Serious Case Review.

The Serious Case Review (SCR) followed a thorough methodology to ensure the practice and policy applied to each case was robustly analysed. This consisted of the reviewer receiving individual agency reviews and chronologies from those closely working with the family in each case. A learning workshop was convened with practitioners who had worked with Adam and Anna. The lead reviewer has produced a six step briefing which summarises the background, issues raised in the SCR and the recommendations made to ensure similar cases are prevented in future.

Adam and Anna's parents were invited to participate in the review but have declined to take part.

Careful consideration was given about how to best secure Adam and Anna's voices within the review. The children were not asked to directly contribute because of their age and level of understanding and the level of trauma that they have endured. There was also the desire that they have the best opportunity to develop strong bonds within their new family placements and therapeutic support networks. The reviewer was however able to meet with practitioners who had been involved in supporting the psychological recovery of the children.

The Review's Recommendations

Recommendations and learning have been circulated to partner agencies and NHS England for dissemination to staff. Progress against actions for each of the following recommendations will be monitored by the LSCB Serious Case Review Group.

The report makes the following recommendations:

Training

1. The LSCB set up a task and finish group and/or host a practitioners' workshop to explore whether protocols for increased inter-agency work or joint training could be developed to respond to a perceived risk of inter familial child sexual abuse. The focus should be to develop a shared understanding of the legal framework and empower practitioners across partner agencies by providing clarity on:

- the full victimisation profiles of children at risk of neglect and IFCSA in order to address the cumulative impacts of harm;
- the legal powers that could be employed when supporting families to ensure that perpetrators find fewer opportunities to target and abuse children. [pg 1.13 and 5.34]
- the services available locally to support children, families and practitioners (including school and health staff) working with children who are at risk of IFSCA recognise and report such abuse [pg 5.22];
- the role of parents in protecting children at risk of IFSCA [pg 5.50]

- legal powers and expectations when collating and sharing information so as to assist lead agencies (social care, the police and CPS) to progress matters into Court in a timely manner. [pg 5.4]
- the evidential burden required to arrest for offences that might arise where there is neglect and a risk of IFSCA, including complicity offences, so that a child is supported through specialist interview techniques and any criminal investigation can commence at the earliest opportunity. [pg 5.34]

2. The LSCB seeks assurance that staff from relevant agencies, including designated safeguarding leads within schools, school nursing staff and health visitors, receive learning from this review and the LSCB give consideration to how to measure the impact of that training, e.g. review of referral data, audit or professional surveys. Any training offer should include guidance on retention of records, compliant with GDPR, Data Protection and Freedom of Information obligations. [pg 4.11]

LSCB Response

Training is key in enabling practitioners to identify signs and symptoms of child sexual abuse and this SCR has highlighted a need for training in this area, and to ensure that practitioners understand the legal processes available to keep children safe. As such the LSCB has commissioned a Task & Finish group to look at the Review's recommendations including training. The Task & Finish Group is expected to be complete by October 2019 and will bring together partners from Southampton City Council Children's Services, Housing Services, Legal Services, Solent NHS Trust, the Clinical Commissioning Group and Hampshire Constabulary, and will be chaired by a Detective Inspector from the Hampshire Constabulary Child Abuse Investigation Team. As well as addressing the issues raised by the Serious Case Review it will create a group of subject experts from existing staff who are available to provide extra support to practitioners who are concerned that children may be subject to sexual abuse. In addition this the Task & Finish group will address the best way of evaluating training to ensure that it covers the key issues for frontline staff.

Pathways and Processes

3. Where there is reasonable cause to suspect intra familial sexual abuse may occur, this must be recorded as the principle category of risk and evidence of other types of abuse carefully considered against the Finkelhor's four preconditions model so that plans and contingency plans adequately reduce risk through early detection or disruption as with other forms of child sexual exploitation. [pg5.15]

LSCB Response

Practitioners must be confident in identifying signs and symptoms of child sexual abuse in the family and confident in recording where this is the principle category of risk. In Adam and Anna's case, the poor home conditions in which they lived and the neglect that they suffered were key concerns, and the sexual abuse was subsequently discovered. Southampton City Council's Children and Families Service have ensured that the principal category of risk is now recorded

clearly in local child protection processes and systems. There is a multi-agency focus on training, support and supervision of staff to ensure effective risk assessments and plans that robustly address child sexual abuse within the family, alongside other risks.

4. LSCB to explore opportunities for Child Protection Conference Chairs to secure advice from agencies with expertise in management of offending behaviours on the possible risk reduction measures they can lawfully employ as part of a CP plan and when failure to comply with any protective measures could indication reasonable grounds to believe a child may be experiencing significant harm [pg4.27].

LSCB Response

The LSCB recognises that staff working with children for whom they have concerns about sexual abuse within the family may benefit from extra support from multi agency partners with expertise in managing offenders and reducing risk. As part of the newly convened Task & Finish Group, Southampton City Council Children and Families Service will create a group of subject experts from existing staff who are available to provide extra support to practitioners who are concerned that children may be subject to sexual abuse. The Task & Finish Group will also strengthen links with partners such as the Probation Service, who have expertise and experience in managing offenders. Finally, the Task & Finish group will address the best way of evaluating training to ensure that it covers the key issues for frontline staff.

5. LSCB give consideration to reviewing multi-agency guidance so as to clearly indicate that CP and PLO processes are not linear, but require exercise of professional judgment having regard to the thresholds set out in legislation. This should also make explicit that it is expected practice that a RCPC is held whenever there is a significant change in the protection plan, including a conclusion by the lead practitioners that proceedings should commence. [pg5.36]

LSCB response

Safeguarding is everybody's responsibility[1] and as such the LSCB is clear that all agencies working with children should understand thresholds and the need for professional judgement in Child Protection and Public Law Outline Planning. As such the Southampton City Council Children and Families Service Task & Finish Group will be required to clarify Child Protection and Public Law Outline processes to clearly show that processes require professional judgement, particularly around thresholds. The new training under development also by this Task & Finish Group will clearly convey that a Review Child Protection Conference should be held whenever there is a significant change in a Child Protection Plan, including a conclusion by lead practitioners that proceedings should commence.

[1] Working Together to Safeguard Children, July 2018

Quality Assurance

6. LSCB review mechanisms used for securing assurance from all member agencies that they:

    - actively implemented supervision within practice including how the escalation policy works within agencies. [pg4.12]
    - effective processes of case reallocation / handover when active risks are being managed [pg4.25] or when the child[ren] have been subject to a CiN or Child Protection process previously [pg4.9].
    - pathways are widely understood and that any practitioner who believes there is reasonable cause to suspect a child could be at risk of IFCSA raises this in line with the referral mechanism through MASH

LSCB Response

The LSCB recognises the importance of supervision for front line practitioners and the need for understanding and confidence in escalation procedures to enable practitioners to take concerns 'higher' if they feel they have not been adequately dealt with. Where cases are reallocated or handed over to a different staff member there should be a full handover between staff members to ensure that all information is transferred – and this is particularly key when active risks are being managed or when the children have been subject to Child in Need or Child Protection processes previously. Where practitioners have concerns about child sexual abuse within the family, they should be clear about the pathway to follow. In accordance with this, Southampton City Council Children and Families Service will undertake a comprehensive audit of child protection and child in need cases to provide assurance of current practice; alongside a review of child protection systems and processes and a focus on supervision. The LSCB will receive a six monthly report on child protection including responses to interfamilial sexual abuse in order to monitor and evaluate the implementation of this. The LSCB Task & Finish Group will also look at the possibility of creating a new pathway for concerns about child sexual abuse within the family to ensure that they are dealt with as key concerns for the safety of children in that family. Lastly, the LSCBs across the four areas of Hampshire, Isle of Wight, Portsmouth and Southampton are also revising new safeguarding supervision standards that will ensure a consistent approach.

7. LSCB to seek information on commissioned therapeutic support/services locally to work with perpetrators and cascade details of referral pathways to the multi-agency. [pg5.12]

LSCB Response

Working with perpetrators is key in preventing the recurrence of child sexual abuse. The LSCB Task & Finish Group will consider commissioned and local services and their promotion to ensure that work with perpetrators is coordinated and robust. The LSCB has sought assurance that referral pathways are re-cascaded to all agencies to ensure that practitioners are aware of available services. The Integrated Commissioning Unit has assured the LSCB that all commissioned services are asked to refer perpetrators (where appropriate and safe to do so) to relevant services. Information will made available through intranet/internet sites locally to publicise the pathways available as therapeutic intervention for child sexual

abuse within the family as this is a specialist area of work. The LSCB will monitor and evaluate the success of this work during the coming year.

8. LSCB to seek assurance from NHS England and/or the CCG regarding support services for children and young people who have experienced IFCSA. LSCB to seek assurance that the access to therapeutic services is included and monitored as part of the children's LAC planning. [p5.53]

LSCB Response

This Review is clear that children who have experienced sexual abuse must have access to a range of therapeutic support services to help them with long term recovery from the trauma they have experienced. The LSCB has sought assurance that health care planning for looked after children includes all aspects of emotional health and wellbeing. The LSCB will raise the issue of therapeutic support for children who have experienced sexual abuse at a national level, seeking assurance from NHS England and more local Clinical Commissioning Group as to the range of services available and also seek assurance that the recommendations from this report are implemented and acted upon. Similar assurance will be sought from Southampton City Council Children & Families Services regarding this within looked after children planning.

Supervision and management oversight

9. The relevant lead person from CSC provide assurance that oversight of assessment process and decision making is robustly monitored by team managers. Also that service managers have oversight of decision making trends and that decisions are 'dip sampled' as part of the service Quality Assurance processes. [pg4.9] Focus must be given to:

- Those child/ren who have been subject to a CiN or Child Protection process previously.
- Where there is reasonable cause to suspect IFCSA is a risk; or
- Continuity of practice- especially when an outgoing lead professional believes there are reasonable grounds to believe a child is at risk of significant harm to ensure managerial oversight is consistent. [pg4.25]

LSCB Response

The supervision and management of front line staff is key to enable full discussion around issues and concerns, and to assist practitioners in dealing with these appropriately. Southampton City Council Children and Families Service will conduct a comprehensive audit of child protection and child in need cases is being undertaken to provide assurance of current practice; alongside a review of child protection systems and processes and a focus on supervision. The LSCB will receive a six monthly report on child protection as part of the LSCB annual schedule to enable monitoring and evaluation of progress.