Serious Case Review

Freddie

Review report

Independent Reviewer: Kevin Ball

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1. Introduction to the case & synopsis of the review

1.1. Based on statutory guidance[1] Southampton Safeguarding Children Board concluded that it was appropriate to conduct a Serious Case Review examining the circumstances of agency involvement with a child under eight years old who, for the purposes of this report, will be known as Freddie.

1.2. Freddie had a long history of contact and involvement with statutory services due to concerns about neglect and harmful sexual behaviours. 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 this stage no further action was to be taken.

1.3. 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; this was mostly ineffective, 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.

1.4. 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.

1.5. This 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.

2. Process for conducting the Serious Case Review

2.1. Southampton Safeguarding Children Board commissioned Kevin Ball as the Independent Reviewer[2]. The approach taken has adhered to the principles set out in statutory guidance[3] and has applied systems thinking ideas to the findings and analysis. As such, the process has been able to capture and identify opportunities for professionals and organisations to learn and improve safeguarding practices from a whole system perspective.

[1] Working Together to Safeguard Children, HM Government, 2015.

[2] Kevin Ball is an experienced independent safeguarding consultant from a children's services background, an independent Scrutineer and has specific experience of chairing & authoring case reviews.

[3] Working Together to Safeguard Children, HM Government, 2015.

2.3. At the time of the decision in July 2018 by the Independent Chair of the Board to commission this review there was a Police investigation into the statements made by Freddie. As a result, there was an agreed delay by the LSCB initiating the review. Consequently, the review did not begin until January 2019. The following steps were then taken;

- Terms of reference for conducting the Review were then set by the Case Review Sub-Group[4],
- Single agency reports and chronology were requested and submitted[5]. This process provided each agency with the opportunity to reflect on their involvement with Freddie and his family, from both a single agency viewpoint but also from a wider, and more interactive systemic perspective. As a result, agencies have been able to consider actions required of themselves in order to make improvements to practice,
- The contribution of practitioners that had contact with Freddie and his family has been gathered through the process of completing each single agency report. Given the course of time a number of practitioners, managers and relevant personnel are no longer in post. Practitioner contribution to this review has therefore been limited and best efforts have been made where-ever possible.
- The LSCB Case Review Sub-Group determined that the approach to this review should be proportionate especially given the passage of time and the need to position learning and findings within current practice. On this basis, the review has comprised mainly of a documentary review and analysis by the Independent Reviewer following the receipt of single agency reports.

2.4. It was agreed that the timeframe for the Review would be from January 2014 through to Freddie being made the subject of a final Care Order in October 2016. Relevant information prior to this timeframe is also included.

2.5. Limitations to this review:

- The focus of this review is to examine the quality and effectiveness of multi-agency arrangements in respect of Freddie. This report does refer to Freddie's siblings, notably Sibling 2, however he is not the subject of the review.
- Information was submitted to this review that explicitly described some of the sexualised behaviours that Freddie is reported to have been subject to and which he disclosed to professionals at the time whilst he was in his mother's care. On balance, recognising that this report will be placed in the public domain, and the need to be respectful and sensitive to Freddie and not cause further harm, the general consensus of those responsible for commissioning the review, was that the explicit references should not be used. On this basis, Freddie's voice is lessened and potentially limits the impact of the review.

3. Family structure

3.1. For the purpose of conducting this review the following individuals are relevant;

Individual	Identified as	Individual	Identified as
Subject child	Freddie	Mother to Freddie	Mother
Older half-sibling	Sibling 1	Father to Freddie	Father
Older half-sibling	Sibling 2	Father to Siblings 1 & 2	Father 2

[4] The Case Review Sub-Group is a sub group of the Southampton Safeguarding Children Board.

[5] Single agency reports were submitted from the following agencies;

- Southampton City Council Children's Services
- Southampton City Council Education SEND Service
- University Hospital Southampton Foundation Trust
- Primary School A
- Behaviour Resource Service (Health/Children's Services service)
- Hampshire Constabulary
- Southampton City Clinical Commissioning Group
- Southampton City Council Legal Services
- Solent NHS Trust

4. Summary of relevant case history

4.1. Summary of relevant case history prior to the timeframe under review (prior to January 2014)

4.1.1. Sibling 1 and 2 had been known to Southampton Children's Services since 1999 due to concerns about neglect, physical abuse and punitive parenting, social relations and harassment of the Mother from an ex-partner.

4.1.2. In 2004 the Mother and Father 2 separated, and the Police investigated a report by the Mother that Sibling 1 and Sibling 2 had experienced inappropriate sexual behaviours from their father. This information was shared with Children's Services. As no forensic evidence of sexual abuse was available it was agreed the matters were filed and remain on record.

4.1.3. In 2007 there was an allegation of indecent assault on Sibling 2 perpetrated by his father, Father 2. There was insufficient evidence to pursue this matter.

4.1.4. In 2008 the Mother entered into a relationship with a Schedule One offender[6]. The offender was spending most of his time at the family home, which resulted in a Child Protection Plan being agreed in August 2008 as the Mother initially chose to continue her relationship with the offender above that of her children's safety. Sibling 1 went on to make an allegation of sexual assault by the offender, which was proven by medical evidence. The Child Protection Plan ended in March 2009 on the basis that the Mother had subsequently ended the relationship and the offender had been charged and remanded for offences.

4.1.5. During 2011 there were 17 contacts to Children's Services reporting the Mother as struggling to manage Siblings 1 and 2 and Freddie. In 2012 there were a further seven contacts, including directly from the Mother who was struggling to manage the children. A CAF[7] was completed identifying the need for support for the family; but with no role for Southampton Children's Services.

4.1.6. In 2013 the Mother requested further help with Sibling 2. The Child & Adolescent Mental Health Service (CAMHS) noted the following factors; the inconsistency of the Mother's parenting; not managing boundaries; being reliant on Sibling 2 to parent the younger siblings; blaming Sibling 2 for Freddie's behaviours; and lack of concern about the individuals Sibling 2 was associating with and his potential drug use. In November 2013, when Freddie's Pre-School provision contacted Southampton Children's Services concerned about his behaviour and pre-occupation with genitals (aged 4 years), commenting on the inappropriate sexualised behaviour by his father towards him.

4.1.7. In 2014 Sibling 2 was charged and convicted of rape offence however this conviction was successfully appealed with a lesser offence substituted.

4.1.8. From 2013 - 2014 the Police responded to a high volume of reports from the Mother relating to anti-social behaviour, assaults and criminal damage. Seven referrals were made to CAMHS at the request of the Mother, insisting that Sibling 2 had a mental health issue or learning disability. He was later diagnosed with ADHD and ODD[8].

4.2. Summary of relevant case history during the timeframe under review (January 2014 – October 2016)

4.2.1. Accounts of Freddie displaying sexually inappropriate behaviours whilst at Pre-School and then into school continued throughout the timeframe. Throughout the time period under review there were reports and incidents of

[6] A Schedule One offender is someone who is convicted of an offence listed in the first schedule of the Children and Young Persons Act 1933. The term Schedule One offender has now been replaced and is now known as a 'person posing a risk to children'.

[7] CAF – Common Assessment Framework which provides an opportunity to assess a child/family circumstances.

[8] ADHD - attention deficit hyperactivity disorder, and ODD - Oppositional Defiant Disorder.

anti-social behaviour from the local neighbourhood, common assaults relating to Sibling 2, and public order incidents. Sibling 2 was also reported as going missing for short periods of time on a number of occasions.

4.2.2. In April 2014 Children's Services confirmed that there was no role for them but that an early help (Families Matter) worker would continue to offer support and advice to the family. However later in April 2014 there was a section 47[9] investigation, following referral from the Families Matter worker due to further concerns Freddie was displaying inappropriate sexualised behaviour in Pre-School. This resulted in a single agency investigation by Children's Services and then Freddie and Sibling 1 being managed via Child in Need[10] procedures. Following a consultation by the Behaviour Resource Service (BRS)[11] it was concluded that Freddie's behaviour was judged as *'normal and exploratory'* however the assessment expressed concern about the frequency and persisting nature of the sexualised behaviours, that they may become harmful and that services with statutory responsibility should take action, as necessary, to safeguard Freddie if judged appropriate.

4.2.3. In June 2014 there was a section 47 investigation due to Freddie making statements about both his mother and father behaving towards him in an inappropriate sexual manner. Freddie was also reported as behaving inappropriately with a Social Worker. The school had a catalogue of incidents where Freddie had touched or tried to touch children. There was no clear disclosure to pursue a criminal investigation however there was agreement for an Initial Child Protection Conference (ICPC) in respect of all three children. Also in June 2014 there was a further rape allegation against Sibling 2. No further action was taken by the Police in this matter due to the evidential threshold not being met. As part of the investigation taking place in June 2014 concerning Freddie, BRS agreed to undertaken an AIM assessment[12] of Freddie and the Youth Offending Service to complete an assessment of Sibling 2.

4.2.4. All three children were made subjects of Child Protection Plans under the category of sexual abuse in June 2014.

Date	Comment
June 2014 Initial Child Protection Conference	All children were made subjects of Child Protection Plans under the category of sexual abuse[13]. The Chair noted that *'… it is important to recognise that it is not known where the risk is coming from and it is a crucial part of the plan that this is explored quickly …'*[14]. All relevant professionals were present at the ICPC other than the Health Visitor and GP, but both sent reports.

[9] A strategy discussion is held under Section 47 of the Children Act 1989 which provides the local authority with a duty to make enquiries as considered necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare, where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm

[10] Child in Need - Section 17 of the Children Act 1989 imposes a general duty on the Local Authority to safeguard and promote the welfare of children who are 'in need' and to promote the upbringing of children in need by their families by providing a range and level of services to meet those children's needs. A child in need is defined as a child: i) who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services; ii) or a child whose health or development is likely to be significantly impaired, or further impaired, without the provision of services; iii) or a child who is disabled.

[11] The Behaviour Resource Service is a jointly funded health/children's services resource that (at the time) offered a service to high risk and complex cases.

[12] AIM assessment is a specific assessment tool for understanding sexually harmful behaviours towards other children.

[13] Sexual abuse is defined as *' … forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children …'*. Working together to safeguard children, 2015, HM Government.

[14] Southampton Children's Services: documents submitted to the review.

July 2014 Core Group	Freddie's new school, and the School Nurse were absent from this initial meeting; there was no allocated Social Worker. Exchanges between Children's Services and BRS suggest that a referral to the BRS was expected but that safeguarding concerns should be pursued as a priority given the significant risks identified about possible sexual abuse.
August 2014 Core Group	Records indicate the Core Group meeting did not go ahead. In August 2014 a MAPPA[15] meeting assessed Sibling 2 as high risk, with ongoing risks identified. As a result of concerns a decision was made in September 2014 that Sibling 2 could be accommodated[16]. A placement became available however records indicate that this was never pursued by Children's Services. No suitable alternative placements were found for Sibling 2 and he remained in the family home. Sibling 2 was however found a more appropriate school placement. In August an adolescent female with learning difficulties, reported to the Police that she had been inappropriately touched by Sibling 2. Despite attempts, it was not possible to take the matter any further.
September 2014 Review Child Protection Conference 1	The Chair commented *'… there has been very little progress since the ICPC … there has only been one Core Group meeting … and visits within every ten working days have not been achieved … specific protective work is still required to be carried out by the parents … assessments specified in the CP plan have not yet been undertaken …'*[17].
November 2014 Core Group	No minutes available – it is unclear whether this meeting took place. The Police received information that a registered sex offender had been having sexual contact with Sibling 1 breaching his SOPO[18]. The individual was arrested and charged. In October it was agreed that BRS would become involved with Freddie despite him not meeting the criteria for the service (the risk was judged as high). This may have been endorsed at Director level.
December 2014 Core Group	This meeting highlighted that the Social Worker had not visited in four weeks due to absence, protective parenting work had not started and Freddie was on a waiting list for CAMHS. The referral information relating to the BRS work, despite being requested in October, was not received until December.
January 2015 Core Group	Meeting cancelled due to Social Worker sickness; the school were reporting incidents of Freddie displaying sexualised behaviour. The Health Visiting Service were not invited to this meeting.
February 2015 Core Group	Core group held in family home, which school attended but no other professionals. Delays in the BRS receiving information from the Social Worker were identified. In February 2015 there were allegations by an adolescent female that Sibling 2 had touched her inappropriately. Due to lack of evidence no further action was taken.
March 2015 Review Child Protection Conference 2	The children remain subject to a Child Protection Plan. A family assessment was being undertaken by the BRS however they awaited outstanding information before the assessment could be completed. The Mother was engaging with professionals, no concerns identified by the Social Worker regarding the home conditions or supervision of Freddie. No protective parenting work or post abuse work with Sibling 1 had started, no progress in assessing Freddie or identifying the source of sexualised behaviours.

[15] MAPPA – Multi-Agency Public Protection Arrangements.

[16] Section 20 of the Children Act 1989 - Every local authority shall provide accommodation for any child in need within their area who appears to them to require accommodation as a result of (a) there being no person who has parental responsibility for him; (b) his being lost or having been abandoned; or (c) the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.

[17] Southampton Children's Services: documents submitted to the review.

[18] SOPO – Sexual Offences Prevention Order.

April 2015 Core Group	Highlights that the Youth Offending Service and Family Matters were no longer part of the Core Group. Some progress identified in respect of Sibling 1.
May 2015 Core Group	Progress was reported about statutory visiting, the Mother engaging with services, yet no update on protective parenting work. School maintain concerns about Freddie's sexualised behaviour.
June 2015 Core Group	Freddie had been excluded from school having displayed aggressive and sexualised behaviours. The Mother never mentioned Freddie's sexualised behaviour when attending support sessions.
July 2015 Core Group	There was no representative at the meeting to discuss Siblings 1 or 2. Despite still waiting for outstanding information, some details of the BRS assessment were shared during this meeting; there is no indication of how this information was used by members of the Core Group. In July 2015 during a contact session with his Father, Freddie (aged under 6 years) was sexually inappropriate with a three year old child. This was reported to the Police, the Father minimised the incident and Freddie made comments about sexually inappropriate behaviour with his mother. The Police made attempts to discuss this information with the Emergency Duty Team of Children's Services however it was stated that there was no manager available and the matter was never followed through.
September 2015 Review Child Protection Conference 3	No Social Worker for 5 weeks. Freddie continued to display sexualised behaviour and services were still waiting for the final BRS report. The Chair remarked *'… I can't see the changes in the family that have been impacting on any improvement of Freddie's behaviour. The aggressive and sexualised behaviour of Freddie is a massive concern. If things can't change in the family home to improve this situation we are going to be here is three or four years' time. We need to consider whether home continues to be protective for Freddie …'*[19]. The children remained subject to Child Protection Plans but the decision was divided about Sibling 1 and 2; the Chair made the decision to maintain the Plan due to ongoing allegations and lack of progress. An emphasis was placed on the need to conduct a formal review of Freddie as there had been no progress for Freddie; Freddie's behaviour was becoming increasingly worrying.
November 2015 Core Group	The outcome of the Family Day assessment report are reported as still outstanding (conflicting with the report from July). The BRS were due to start holding play sessions for Freddie.
January 2016 Core Group	Concerns persisted about Freddie's sexualised behaviour. Sibling 1 disclosed that her ex-boyfriend sexually assaulted her but due to lack of evidence the matter was not pursued.
February 2016 Review Child Protection Conference 4	This RCPC involved a different Chair and new Social Worker. The BRS report was completed however it was viewed as not addressing the issues that needed exploring. The Chair identified that *'… despite being subject to child protection planning for 2 years (a third of his life) it is still unclear what the root causes of Freddie's sexualised and aggressive behaviours were …'*[20]. Siblings 1 & 2 were stepped down to Child in Need; Freddie remained subject to a Child Protection Plan.
May 2016	Freddie was accommodated section 20 and an Independent Reviewing Officer was allocated.

4.2.5. In March 2016 the Mother reported that she no longer felt able to manage Freddie; the Maternal Grandparents had been supportive over the last few weeks and had offered to care for Freddie. This resulted in a decision the following month to issue legal proceedings to take Freddie into local authority care – it appears this was due to neglectful parenting and not risks associated with sexual abuse. A fostering placement was deemed necessary whilst considering extended family members as possible carers. In early June 2016 a care planning meeting was held where

[19] Southampton Children's Services: documents submitted to the review.

[20] Southampton Children's Services: documents submitted to the review.

it was noted that *'… no sexual abuse assessment has been done on the family. BRS did a family day assessment last year but work was outstanding …'*. A final Care Order was granted four months later on Freddie. He was unable to stay in foster care due to sexualised behaviour and was moved to a specialist placement; from this point he began to talk about his experiences. Given their ages, Siblings 1 and 2 remained in the family home with the Mother.

5. Findings & analysis

1. As outlined in section 2.3, by providing each agency with the opportunity to submit an individual report it has allowed agencies the chance to examine their own practice against the terms of reference. In turn, agencies have identified learning for themselves, and made recommendations to strengthen practice. The following sections provide an analysis of multi-agency involvement and, as such, provide us with the greatest insight into the quality and effectiveness of the response to Freddie. Where possible, an explanation of why events occurred as they did, has been provided. Learning points for use by all practitioners and trainers have been emphasised.

2. The report will examine five key areas in order to better understand the quality and effectiveness of safeguarding arrangements across the partnership, these are;

- The quality & effectiveness of multi-agency working and child protection processes.
- The use of family history to inform assessments & decision making.
- The recognition and response by professionals to actual or potential harm.
- The assessment of the grandparents to provide a safe place for Freddie.
- Practice challenges raised relating to the findings of this case.

3. By way of a summary, the following features have been identified as contributing to agencies not working together as effectively as required in order to safeguard and promote Freddie's welfare;

- Whilst subject to a Child Protection Plan there was considerable drift in progressing actions that may have offered safeguards to Freddie. The lack of pace and purpose resulted in Freddie's continued exposure to harm.
- The drift was influenced by multiple factors which included; staff changes resulting in a lack of continuity; inadequate oversight of case progression; delays in initiating and completing assessment work; and a collective professional uncertainty about how to manage the risks to Freddie and respond to the whole family situation.
- A wholesale lack of effective challenge and escalation across the partnership allowed the situation to drift.
- Some professionals felt sympathetic towards the Mother, thereby losing focus on the children's day to day experience and their safety and welfare.
- Children's Services experienced multiple systemic challenges during the time period which impacted on their capacity to effectively fulfil their responsibilities as the lead agency responsible for the Child Protection Plan.

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

5.1.1. Statutory guidance relevant at the time[21] states of assessment and analysis *'… decision points and review points involving the child and family and relevant professionals should be used to keep the assessment on track. This is to ensure that help is given in a timely and appropriate way …'.* Freddie, and both his older siblings were subject to a multi-agency Child Protection Plan for two years from June 2014 until July 2016. This two year window allows us an opportunity to focus on the quality and effectiveness of multi-agency working arrangements.

5.1.2. Local procedures in Southampton set out the expectations of a Child Protection Plan with the purpose being *'… to facilitate and make explicit a co-ordinated approach to: a) Ensure that each child in the household is safe and prevent them from suffering further harm; b) Promote the child's welfare, health and development; c) Provided it is in the best interests of the child, to support the family and wider family members to safeguard and promote the welfare of their*

[21] Working together to safeguard children, 2015, HM Government

child …'[22]*.* The lead agency, in all cases of children subject to a Child Protection Plan is the local authority Children's Services, with a named Social Worker. The Social Worker has a pivotal role in coordinating and facilitating the multi-agency protection plan.

5.1.3. Analysis of the review and decision points, as detailed above, over this two year period reveal significant problems;

- Four Review Child Protection Conferences were held within expected procedural timescales but documentation consistently reflects a lack of pace and purposeful activity between each Review.
- 13 Core Group meetings were held and which appear to be within expected procedural timescales. Records indicate however that the first five Core Groups encountered significant problems (July 2014 – February 2015), which included; cancellation, no Social Worker allocated or attending, and lack of attendance by other agency representatives and no minutes being available (suggestive of either the meeting not going ahead, minutes not being distributed or taken). The effectiveness of the Core Group as a mechanism for driving forward the multi-agency Child Protection Plan, in the first eight months, is therefore negligible.
- The first RCPC highlighted that statutory visits to see the children had not happened in accordance to expected practice standards. Subsequent RCPCs make no reference to statutory visiting patterns. The effectiveness of having a lead professional offering oversight of day to day protection arrangements for the three children is also negligible given there is no evidence to support any other way of thinking.
- Records highlight that at each Conference an outline Plan had been documented. At each subsequent RCPC there appears no explicit reference to checking progress against previously agreed actions, and the Plan shifting each time despite limited identifiable progress. There is an emphasis on a narrative update between the intervening period of time since the last Conference; in effect more story telling rather than scrutiny and action tracking. The effectiveness of RCPCs acting as an opportunity to keep assessments on track is very limited.
- Over the course of two years, four different Chairs lead the five Conferences, with three different Social Workers attending. Representation from the School Nursing Service and the Police is inconsistent; however this has to be balanced with the agreed protocol that School Nurse and Police attendance at RCPCs is only likely if there is an ongoing Police investigation or significant new information and significant relevant health needs requiring the involvement of School Nurses. Representation from these two services will therefore always be inconsistent given the operational demands[23]. Attendees from other agencies fluctuated, most notably around September 2015 and February 2016. As the consistency of agency representation is often lacking it follows that each new person attending will have to familiarise themselves with the case history and form an opinion on the basis of the information presented on the day whilst at the Conference.
- Throughout both Conferences and Core Groups there are several references to progress not being made, with the Chair of the September 2015 Conference stating *'… there continues to be evidence of extreme behaviour from Freddie and a display of sexualised behaviour which has no apparent root cause. Sibling 2 is also known to show sexualised behaviour and remains of Police bail for an alleged sexual assault … The risk for all children exposed to potential risk of harm of a sexual nature continues to be evident in the home, school and in public. It is a significant issue of which professionals continue to express their concern for Freddie in particular. No progress has been made since the ICPC and observations indicate that behaviour from Freddie is increasingly worrying …'*[24]*.* During the February 2016 School A report to the RCPC that *'… This is an extreme area of concern. We do not believe that the support from social care has been robust enough in order to address any of the issues in the family home. The issues which are on-going have been issues since [Freddie] joined in 2014 and do not show any signs of*

[22] Southampton LSCB procedures: Child Protection Plans

[23] The Hampshire Constabulary receive an average of 165 invitations to Child Protection Conferences per week.

[24] Southampton Children's Services: documents submitted to the review.

improvement …'[25]. Records indicate this being the strongest and clearest challenge to date by any agency represented in the two year process.

- Other than the challenge in February 2016 by School A about the lack of progress, there is no other obvious evidence to indicate any challenge or escalation about the lack of progress, other than statements of frustration by various professionals attending including the Chair. There is reference in the September 2015 to Siblings 1 & 2 being stepped down and managed via a Child in Need Plan rather than via a Child Protection Plan. This is however not agreed until the February 2016 with the following statement *'… a Child in Need plan for Sibling 2 and Sibling 1 which needs to be well thought through particularly regarding the sexual risk ...'*. A Child Protection Plan remained in place for Freddie. The assessment of Siblings 1 & 2 being managed via a Child in Need plan conflicts with information presented at the Conference highlighting ongoing risks. The idea of a *'… well thought through plan …'* fails to acknowledge that this was precisely what was needed in the preceding two years.

5.1.4. Whilst the formal RCPC may be more procedurally driven the Core Group can support opportunities for closer working relationships with professionals and parents. Evidence submitted confirms that the effectiveness of the Core Group as being limited, lacking pace, purpose and authority.

Learning point: 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.

5.1.5. There is evidence within the records from Solent NHS Trust of health agencies *'… working in apparent silo, such as CAMHS documenting no contact from social care for child protection meetings without any plans to address this. Frequently health practitioners recorded outcomes from child protection proceedings without considering and therefore challenging the length of time or lack of change for the children. An example being Freddie's sexualised behaviour in preschool, with no apparent escalation or conversation from health to social care ...'*[26].

5.1.6. A further example of agencies not working effectively together can be seen by the Police's response to Sibling 2's episodes of going missing – which were frequent. Review of records shows that although incidents were appropriately dealt with as a single agency, information was not shared with partner agencies in a systematic way alongside a broader consideration of holistic risk management i.e. alongside information about concerns for Sibling 1 being exploited and concerns about Freddie. Operating context is important. At the time the multi-agency response to children going missing and exploitation was not as well developed in Southampton as it might be now. Alongside these concerns was intelligence about the family increasingly becoming linked to a number of concerning individuals know to the Police as perpetrators of child sexual exploitation. Using Police intelligence to feed into contextual safeguarding issues and working with partner agencies was still evolving practice. The ability to effectively use Police intelligence and share with partner agencies was also compromised due to local arrangements limiting capacity. This episode does show that a considerable amount of activity and knowledge was held by Police and there were missed opportunities for the professional network to join up and consider information holistically. Developments in contextual safeguarding[27] is an area worth exploring to support more timely and effective interventions.

Learning point: 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

[25] Southampton Children's Services: documents submitted to the review.

[26] Solent NHS Trust submission to this review.

[27] Contextual Safeguarding Network

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

5.1.7. The professional network clearly debated and understood the implications of the information being presented to the Initial Child Protection Conference, judging abuse to have taken place. When working with cases of child sexual abuse, Furniss[28]discusses the importance of the professional network surrounding the family to work in a tight and coordinated manner. He refers to mirroring where *' … the professional network enacts the family dynamics; for example showing splitting and fragmentation and reflecting in the professional network the way the family sees itself …* [with] *… case conferences* [being] *the most typical places in which mirroring of the family process is enacted visibly in the professional network …*[where*] we often find ourselves locked into mirroring the family's dysfunctional ways of relating and their inability at problem solving and conflict resolution … '.* It is possible to see potential of the professional network being split in the decision making notes from the ICPC in June 2014 and then the September 2015 RCPC where differences of opinion about how the case could be managed are apparent. Given the fragmented follow through by the Core Groups there was little opportunity for the professional network to reconcile their differences, come together as a tight unit and consider their tactics and strategy for working with this family.

5.1.8. This is also somewhat brought to light in a Children's Service management oversight note from July 2015 *'… it is possible that Freddie is being abused within the home by a number of people or it is possible that Freddie is not being sexually abused but is being subject to inappropriate sexual content via a number of outlets … there is no clear evidence either way, and no disclosures have been made by Freddie or any other party … it is very difficult to accurately assess the risk … the social worker has raised that professional anxiety in this case is a driving factor in how agencies respond to this family and this response could well be perpetuating the situation …'.* Importantly, Furniss goes on to state that *'… mirroring does not happen because of incompetent professional conduct. Mirroring is the result of the striking influence families are able to exert even on very competent and highly skilled professional networks …'.* This dynamic (including professional anxiety) is an inevitable consequence of working with complexity in families where child sexual abuse features and emphasises the importance of good quality supervision and support, and high performing child protection processes. Records and discussions confirm that there was sufficient professional suspicion about Freddie being sexually abused. The direct statements by him of inappropriate behaviour from family members offered a clear opportunity to form a view that he was not being protected by a Child Protection Plan and that his current care arrangements were ineffective in keeping him safe. On the basis of the evidence available in August 2014 a more assertive plan could have been adopted earlier.

Learning point: 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.

5.1.9. Placing the above findings of this review in context of the wider system in which professionals were operating at the time is important; this allows us to better understand the behaviours of individuals in context. In 2012 Ofsted[29] highlighted some aspects of inadequate practice by Southampton Children's Services particularly relating to the quality of safeguarding work i.e. social work and management turnover, the quality of assessments and Core Group activity. A self-assessment conducted the following year, in 2013, highlighted insufficient progress had been made on some of these areas despite efforts to make improvements. In 2014 Ofsted[30] noted positive improvements in respect of the

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

[29] Ofsted & the Care Quality Commission, Inspection of safeguarding and looked after children services Southampton, 2012.

[30] Ofsted, Southampton Council Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the local safeguarding children board, Inspection date: 8 July 2014 - 30 July 2014 Report published: 15 September 2014

Council's work with children subject to Child Protection Plans and Conferences and a 2018 inspection[31] noted further improvements across the system. Appreciating the contextual journey that spans the timeframe under review is an important aspect to understanding the quality and effectiveness of the response to Freddie. This highlights systemic problems that have taken a number of years to identify and address, and which has included significant changes in managers, re-structuring and transformations – all of which have impacted on front-line practice.

Learning point: 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.

5.1.10. From a system thinking perspective the concept of emergence is relevant. Emergence[32] is a key property of complex systems – of which the multi-agency child protection mechanism is one example. The strength of a complex system can often be tested against its ability to respond to emerging issues which cannot be controlled, predicted or easily managed. Emergence as a concept is therefore relevant as it allows us, often with the benefit of hindsight, to better examine system weaknesses – rather than purely concentrating on the efforts, or errors, of individual practitioners. Research about other case reviews[33] confirms that this can have a negative impact of front line practice. It is clear that practices had emerged prior to the timeframe under review which had become embedded in the wider multi-agency working arrangements in Southampton. The earlier Ofsted reports confirm this. Evidence submitted by Southampton Children's Services, Solent NHS Trust and the Police supports the fact that at those times when information could have been brought together to inform a holistic assessment and safety planning for Freddie, it was not. Some of these emergent practices created what might be described as organisational pathways to harm[34] or failure. The combined effect was that the multi-agency response, in the form of Child Protection Conferences and Core Group activity for Freddie, was not an effective mechanism to offer protection.

Learning point: Research 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 …*'[35].

5.1.11. For those children that are subject of a Child Protection Plan for more than 18 months questions are often raised about the effectiveness of the plan in bringing about change and improvement. In the 2015 - 2016 period Southampton City Council had 3.9% or 13 children of the total cohort of children (333) subject to Child Protection Plans on Plans for two years or more[36]. In 2016 - 2017 this had dropped to 2.2% or 6 children of the total cohort (276). During the 2016 – 2017 reporting period Freddie and his two siblings would have accounted for 3 of this total number. Whilst the number of children being subject to a Child Protection Plan for longer than two years is not necessarily indicative of a deeper problem in a local area, it can provide a useful proxy measure about the quality, pace and

[31] Ofsted: Children's Services focused visit - Southampton - 2018

[32] Seel, R., Emergence in organisations, 2006.

[33] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, p. 149, University of Warwick & University of East Anglia, May 2016

[34] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, p. 24, University of Warwick & University of East Anglia, May 2016

[35] 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

[36] Department for Education statistics, 2015 – 2016, Characteristics of children in need: 2015 - 2016

purpose to multi-agency child protection work being undertaken with individual children and families. Typically such cases may reflect situations whereby child maltreatment and neglect are entrenched and difficult to un-stick; they may however also reflect a lack of assertive assessment, intervention and decision making. In this particular context, it has already been highlighted that there were embedded system wide challenges being tackled during the timeframe under review – highlighting testing times for multi-agency safeguarding practices. This case has highlighted a lack of pace and purpose to assessment work whilst known, and knowable risks, were in plain sight. This is reflected somewhat by a comment from the Mother during RCPC in February 2016 noting that *'… the Mother recognises that she has lost focus on what the issues around her children are any more – including the purpose behind the CP process and the work undertaken and how it all links …'.*

Learning point: 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.

5.1.12. 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. When coupled with the wider system challenges faced by services in Southampton during this timeframe, as outlined above 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.

5.2. The use of family history to inform assessments & decision making

5.2.1. Given the breadth and extent of worrying history outlined in section 4, which has purely been extracted from agency records, it would be reasonable to conclude that it is likely to represent the very tip of professional awareness about Freddie's day to day experiences in the family home.

5.2.2. Section 4.1 has outlined information about family history which was relevant and of interest to the professional network during the timeframe under review. When conducting assessments and making decisions the use of historical information is critical to effective safety planning.

5.2.3. Risk can be categorised into those factors that are currently presenting themselves as a concern, for which it may be possible to manage i.e. situational risks, and those where there is less likelihood of effecting change and which occurred prior to the current concerns and circumstances i.e. pre-disposing risks. For Freddie there were a significant number of pre-disposing risks that formed part of his family history, which the professional network had no control or influence over, but were known or knowable. These included;

- Information about concerns about parenting of Siblings 1 and 2 since 1999,
- Verbal statements of a sexual nature by Siblings 1 and 2 in 2004 and 2007,
- The Mother's concerning relationships or associates.
- Concerns about the Mother's ongoing ability to manage all three children,
- Sibling 2 being charged with rape/sexual assault in 2013,
- Police persistently being called out to anti-social behaviour, assaults and criminal damage incidents.

5.2.4. Therefore, when the professional network was faced with the emerging concerns about Freddie's sexualised behaviours in 2013 awareness and consideration of this history would have been highly relevant in helping them

manage risk and make decisions. Research[37] relating to childhood adversity and trauma highlights maltreatment (including abuse or neglect), violence and coercion, and household or family adversity as potential pathways to further harm that can impact negatively on development and life chances. For Freddie to benefit from a safe pathway through childhood and into adulthood, the time given by the professional network to recognising the weight and significance of his family history and family functioning would have been critical.

Learning point: 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.

Learning point: 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[38] 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 …'*.

5.2.5. From a Children's Services perspective it has been noted that the previous interventions, concerns and sexual risks including the child protection planning from August 2008 until March 2009 were not consistently referred to within decision making and management oversight later on. Whilst it is mentioned in some single assessments undertaken, the Mother's failure to protect is not weighed against the current concerns due to her perceived engagement with the professional network. Despite the Mother embarking on new relationships in 2013 and 2014, some of which resulted in the male partner residing in the family home leading to child protection concerns, the Mother's *' … lack of capacity to safeguard and prioritise the safety of the children is not discussed. Instead, decision making is based on Mother mainly being able to meet the basic needs of the children ...This decision does not appear to take into account that Sibling 2 is being investigated for sexually assaulting a peer, or the risks this poses for Sibling 1 and Freddie, and whether Mother is equipped to manage this ...'*[39]. This is reflected by a management oversight note at the time in April 2014 that highlights a level of sympathy for the Mother rather than a focus on the children's welfare *'… It is clear from the assessment although there are ongoing issues regarding the children and their behaviour their mother does her best to offer the best care to all of them'.*

5.2.6. Further examples of where family history is inconsistently applied to inform assessment and decision making includes a) when the family are re-referred in April 2014 following Sibling 2 being found guilty of rape of a peer, b) the sexual abuse of Sibling 1 by Mother's partner in 2008, and c) the allegations the children made about Father 2, which occurred in 2007. Additionally, the disclosure that Freddie had been sexually touched by the Mother and Father is clearly stated in one document but is then not referred to throughout the rest of the involvement by Children's Services, even during discussion about where the sexualised behaviour may have stemmed from.

5.2.7. The inconsistent consideration and use of history by Children's Services is worrying given that for two years Freddie and his Siblings were subject to a multi-agency Child Protection Plan, for which the local authority Children's Services were the lead and responsible agency. This information was known and there is no evidence to indicate it was extracted in a coherent way to inform multi-agency decision making or early advice being sought from Legal Services (see section 5.3).

5.2.8. From a Solent NHS Trust perspective, who were responsible for the provision of health visiting, school nursing, speech & language therapy services, paediatric and child mental health services, a similar inconsistent picture

[37] Young Minds & NHS Health Education England: Addressing childhood adversity and trauma

[38] Working together to safeguard children, 2018, HM Government.

[39] Southampton Children's Services submission to the review.

emerges. This review has highlighted that there was considerable historical information held within the electronic records which could have informed practice, such as Sibling 2's convictions and Sibling 1's involvement with an older man, Mother's partners and their history. The Trust has acknowledged that there was inconsistent recording, which resulted in unreliable analysis on which to base planning and intervention, noting that with the benefit of hindsight *' … it could be seen that lack of detailed analysis and plans potentially contributed to the longevity of the abuse suffered by all three children ...'.* The Trust has also noted that *'… family history was referred to within many of the assessments undertaken within the time frame of the review however it would appear that these were not analysed regularly or adequately, such as; the noted sexualised behaviours and history of older brother's offences. These are known indicators of sexual abuse but there is little reference made within the records that would evidence that practitioners were concerned enough that these children had, or possibly were being sexually abused …'*[40].

5.2.9. As with Children's Services, Solent NHS Trust also note a professional empathy for the Mother above the focus needing to be on the children. One example cited relates to decision making being more about the mothers needs based on the perceptions of some professionals about community harassment in February 2016 and seeing the *' … children as perpetrators rather than victims … suggesting it was the children's behaviour as the cause, and therefore no questions were raised as to the underlining reason for this behaviour ...'*[41]. Research into other Serious Case Reviews[42] examines the need for authoritative practice when dealing with complexity and ambiguity in individual cases *'… the quality of empathy embraces considering both the voice of the child and the needs of the family. It must be grounded in the centrality of the rights and needs of the child, while being sensitive but not colluding with the needs and views of the parents …'.*

Learning point: 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.

5.2.10. One reason cited for this inconsistent practice and deficits by Solent NHS Trust relates to recording systems which, at the time were continuing to change from paper to electronic records. Information contained about Siblings 1 and 2 in paper records is likely to have been lost at the point of transfer. This is an issue that has been identified in other local Serious Case Reviews conducted recently.

5.2.11. From Primary School A's perspective, which Freddie began attending in 2014, it is noted that there is limited evidence of history in the chronology on record. They recall that there was no contact from the Social Worker at the point that Freddie transferred from the Pre-School.

5.2.12. The Clinical Commissioning Group has noted, on behalf of the GPs involved with Freddie and his family, that there are significant gaps in the GP's understanding – or at least their capacity to understand – family history due to the inconsistent use of electronic database systems, but also limitations of its use at the time. They have reflected that '*… there is no reference made in Freddie's notes to his mother's history as a victim of sexual and domestic abuse, nor to her capacity to protect her children from abuse as perceived by other agencies. There is also no reference made to Sibling 2's history of sexual assault, nor Sibling 1 having been a victim of sexual assault which resulted in them both being on a Child Protection Plan …'*[43]. A contributing factor to these deficits relates to the cross referencing of significant issues within a family across the individual family members medical notes. In this case, there was no information cross referenced linking, for example, the Mother's notes to Freddie's. Prior to 2014 it was not compulsory

[40] Solent NHS Trust submission to the review.

[41] Solent NHS Trust submission to the review.

[42] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, p. 202, University of Warwick & University of East Anglia, May 2016

[43] Clinical Commissioning Group submission to the review.

for GP Practices to scan whole documents relating to safeguarding issues into the records of the index child i.e. in this case Freddie. Information, potentially pertinent, could be stored separately to the medical record but accessible to staff if needed. Best practice guidance[44] produced by the Royal College of General Practitioner and the NSPCC advises that children's records should be linked in some way to parents (even if at different addresses), siblings and others in the household. It recommends that safeguarding information received by the Practice should be handled by a designated, administrative, member of staff who should scan CPC reports into the child's records with an appropriate coding system to flag safeguarding issues. The local GP Practice supports the use of this guidance and best practice toolkit including the expectation that a GP should read and have oversight of relevant information. The CCG have noted that in this case *'… it is evident in Freddie's medical record that safeguarding documents were scanned by an administrator but no GP comments were associated with them.* [The CCG] is … *assured by the interim Practice Safeguarding Lead that, since the Practices merged in April 2015, all documents are coded by a trained and competent administrator and seen by a GP …'*[45].

5.2.13. Notwithstanding the lack of historical information about the family in the GP records, there was information available about Freddie following the section 47 enquires and information relating to Sibling 2's arrest on the rape charge. Freddie was seen by a GP shortly after this information came to light as the Mother took Freddie for a routine consultation. Not unreasonably, information about the wider safeguarding issues was not discussed given the distinct nature of the issues being consulted about. Later in 2014 information was received by the GP Practice regarding the children being subject to Child Protection Plans. This information was coded correctly and resulted in a telephone call between the GP and Health Visitor in October 2014 regarding a rejected CAMHS referral and ongoing concerns about his mental health and emotional well-being. There is no information that indicates this pro-active step taken by the GP in discussing the concerns with the Health Visitor resulted in a change of decision by CAMHS.

5.2.14. When the Mother attended an appointment with Freddie in January 2015 feeling exhausted due to his sleeping difficulties the GP Practice at that time, was unable to offer a permanent GP for patients. On the basis of the presenting concerns, but with the benefit of hindsight, this might have provided the GP with an opportunity to probe further and be more curious about family history and circumstances. Given that the issues to be discussed were sensitive it is reasonable to argue that it was not appropriate for this to be achieved in one single, short consultation. However a follow-up consultation could have been suggested to explore underlying contributory factors and make a more thorough assessment of the family and household structure, and other adults or partners involved. A similar opportunity presented itself in April 2016 when the Mother saw the GP, concerned about Freddie and how she was coping and requesting another CAMHS referral. GP records for Freddie do not document what other agencies were involved with the family, how Freddie was being supported, and how the Mother's ability to protect Freddie was being assessed or managed. These episodes reflect an inherent challenge GPs for who may see patients on an intermittent basis for very short slots of time and are often forced to focus on the immediate and presenting issue.

5.2.15. From a system thinking perspective, the challenges faced by the GP can be described as a trade-off[46]. Trade-offs are a system thinking concept. Work in complex systems is impossible to assign, predict and prescribe completely. Demand fluctuates, resources are often limited and goals often conflict. Frequently, the choices available to us are not ideal and we are forced to make trade-offs and choose sub-optimal courses of action. Trade-offs, such as these, help us understand system behaviour and system outcomes. The trade-off in this case was that the GP chose to respond to the presenting physical health related issue in the short consultation slot, over pursuing enquiring into the mire of dysfunctional family dynamics and possible sexual abuse.

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[44] RCGP & NSPCC - 2014: Safeguarding children toolkit for General Practitioners

[45] Clinical Commissioning Group submission to the review.

[46] Trade-off - as cited a) Learning into Practice: improving the quality and use of serious case reviews, Masterclass 2: Systems thinking, SCIE & NSPCC, 2016 and b) Systems thinking for safety: Ten principles – A White Paper, Eurocontrol, 2014.

5.3. The recognition & response by professionals to actual or potential harm

5.3.1. Recognising actual or potential harm to a child or children is the first step to responding. Harm arises in many forms, and in this case the focus is on sexual harm; however emotional harm and neglect are also important to consider and were known worries for professionals at the time. The consequence of the professional network not effectively intervening with children who have been sexually abused are likely to be severe and enduring for those individual children[47]. The assessment and response to child sexual abuse can be challenging for professionals who may face a series of perplexing problems; *' … 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 …'*[48].

5.3.2. Research[49] by the NSPCC highlights that 90% of sexually abused children were abused by someone they knew and children who have been abused or neglected in the past are more likely to be open to re-victimisation and experience further abuse. Further research shows that the majority of allegations of sexual abuse are against fathers, stepfathers or new male partners'[50]. Bentovim[51] discusses some of the specific challenges associated with safeguarding children who have been sexually abused, specifically highlighting that for interventions to be effective any therapeutic work needs to take place in a context of safety for the child.

5.3.2. From Southampton Children's Services perspective, Freddie had explicitly informed the staff at school, Police and Social Workers in 2013 and 2014 that his Mother and Father were behaving in a sexually inappropriate way towards him. This review has been unable to identify any evidence to indicate that the risk of sexual harm by either parents was discussed any further by the Social Worker in supervision, strategy discussions or elsewhere during the timeframe. When the Mother suggested that Freddie's Father may be the cause of these problems, there is very limited recognition that he had supervised contact fortnightly, for which the Mother was responsible for supervising. The origins of Freddie's and Sibling 2's sexualised behaviour is never established, and decisions appear to focus on how to manage or change this behaviour rather than understand the origins. Understanding the origins of Freddie's sexual abuse (as best as possible) was critical to creating an effective safety plan given the high possibility that Freddie continued to live in the same household as his abuser. The possibility of any therapeutic work taking place in a context of safety was therefore impossible at this time for Freddie.

5.3.3 The September 2015 RCPC minutes lists strengths/protective factors with one being *'… family … assessment in March 2015 … no clear outcome as yet from this assessment …'.* This form of words or what it describes cannot be viewed, at-all, as a strength or protective factor as it refers to not knowing the outcome. The outcome of this family assessment was clearly not known about by the professional network attending the RCPC and therefore could not be considered and used to inform safety planning. It is not until the February 2016 RCPC, almost two years after the children first became subject to a Child Protection Plan, that the minutes refer to this assessment of Freddie but of it being of limited value. The RCPC record goes on to state that *'… there is no understanding as to why all three children have displayed inappropriate sexualised behaviours (aside from the fact that it is known that Sibling 1 was sexually abused by the Mother's previous partner …'.* Records indicate that it was not until March 2016 when a different Social

[47] NSPCC Signs, symptoms and effects of child abuse

[48] Furniss, T., The multi-professional handbook of child sexual abuse: Integrated management, therapy & legal intervention, p. xvi, 1995, Routledge.

[49] NSPCC Sexual abuse research

[50] Parkinson, P., Child sexual abuse: assessing the risk, 2014, Paper for the Independent Children's Lawyers Conference, Independent Children's Lawyers, Child sexual abuse: assessing the risk, and accessed 29/04/19.

[51] Bentovim, A., Safeguarding and promoting the welfare of children who have been sexually abused: The assessment challenges, in Horwath, J., The Child's World, second edition, 2010, Jessica Kingsley.

Worker was allocated that there was a conversation with Mother about the possibility that Sibling 2 has been sexually abused; something that the Mother is reported to have stated she had not considered previously.

5.3.4. Practice from Southampton Children's Services appears to have been one where the focus was on the Mother's needs with a failure to respond to the risks of sexual harm faced by Freddie. Given the explicit lack of recognition of actual, or likely, sexual harm to Freddie it follows that the response was equally lacking. This is evidenced by comments such as … *Despite consistent concerns in the quality of information provided by mother to the professional network, the social worker believes Mother when she reports that she is "in a better place" (November 2015) and reports there are "no concerns about her care of the children, only her behaviour management"*[52]. This further reinforces the point made above about professional empathy for the Mother, and a loss of focus on the child's day to day experiences.

5.3.5. Throughout the timeframe under review records indicate there was management oversight or supervision by Children's Services, however it appears to collude with the circumstances at the time and offer no challenge or direction. This is evidenced by frequent references to the fact that the Child Protection Plan had not achieved any changes for the children. A further contributing factor was the frequency and quality of management supervision for the Social Worker; '… *The social worker allocated to Freddie and his family in July 2014 did not received case supervision until April 2015. This supervision is poor quality and does not explore the risks for Freddie or the work plan required to assess and create an effective safety plan for him. Following a change in team manager, it was noted that there was a significant improvement in the quality of recording of supervision and the content of discussions ...''*[53]. This however continued to result in a lack of authoritative social work practice and drift. Significant practice issues were identified with the management oversight and supervision at this time, accounting for the quality of management oversight not being to the standard expected. Issues connected to this are being addressed via a separate single agency process.

Learning point: 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.

5.3.6. There is further evidence of collusive practices between professionals and the Mother which, albeit unwittingly, resulted in a loss of focus on the children. There is also evidence of limited curiosity and a lack of challenge across the professional network. Examples of this include:

- A letter sent to the GP from CAMHS in January 2014 suggesting that the children were the instigators rather than the victims of their behaviours and circumstances.
- During a telephone call in early 2014 between CAMHS and the Mother, the emphasis was on the impact of the children's actions on the Mother.
- The Mother was often given the opportunity to speak on behalf of the children rather than practitioners seeing and allowing the children to speak for themselves.
- In May 2014, continuing sexualised behaviours were noted, but plans and actions focused on parenting programs/support for the Mother.
- In Core Group meetings Freddie's behaviours were rarely challenged or explored.
- Practitioners recording not being invited to child protection meetings but no evidence of a plan, or no attempt to contact social work team to correct this, or open the channels of communication. This lack of challenge and escalation colluded with ineffective multi-agency arrangements.
- The Mother continued to be seen as a protective factor for the children with nothing to indicate that any practitioners were considering the family members, or known and unknown associates, as potential abusers.

[52] Southampton Children's Service submission to the review.

[53] Southampton Children's Services submission to the review.

5.3.7. Potential signs of neglect are also frequently reflected in the records of all three children held by Solent NHS Trust. These include;

- Freddie's constant dribbling which was discussed in an assessment by Speech therapy in June 2014, advice was provided on two separate occasions, with no apparent recorded consideration of dental health forming part of that assessment. Since coming into local authority care Freddie has required several dental extractions due to decay – one indicator of long term neglect.
- In April 2015 where Sibling 1 presented with poor hygiene, being visibly dirty, and having head lice. Sibling 1 was referred to the School Nurse who was also informed by the school and Social Worker that Sibling 1 was in a relationship with an older man who was a registered sex offender. The School Nurse promptly saw Sibling 1 the next day in school, where the focus was on self-care and personal hygiene. This could have been a good opportunity for the School Nurse to explore with Sibling 1 her relationship and risk of sexual exploitation. There is also little documentation about her presentation at this contact, or any discussion regarding her being vulnerable to abuse. There is no recorded communication back to the Social Worker regarding the outcome of this contact. The significance of Sibling 1's relationship and her vulnerability to abuse and neglect is not fully considered within the health records.
- At the Core Group meeting in June 2015, the School Nurse identified that Sibling 2 had hit Freddie, and that the Mother had brought charges against Sibling 2 as a result. There is no obvious curiosity about the approach taken by the Mother to criminalise her son.

5.3.9. It is clear from the above findings that over the duration of there being a multi-agency safety plan in place, there was a limited use of information and an over-optimistic mind-set to safety planning. There is no evidence of a multi-agency chronology, for example, making its way into the Initial or Review Child Protection Conferences. This resulted in safeguarding partners not having access to full information. Concerted attempts to make sense of the origins of sexual abuse for Siblings 1 and 2 and Freddie are not evident and continue to remain a mystery throughout the timeframe under review despite potential lines of enquiry being exposed; this resulted in the creation of an un-workable safety plan. References in the Initial and Review Child Protection Conferences to the children *'needing to feel safe'* and the need for therapeutic work are misguided given that there was no certainty that the children were free from further abuse.

5.3.10. Records do however indicate that the Health Visitor made clear reference within their child protection report about needing to consider why Freddie was presenting with sexualised behaviour, alluding to the fact that remained at risk of sexual harm. This sensible contribution had no impact on outcomes or arrangements.

5.3.11. Solent NHS Trust have advised that safeguarding supervision is offered on a regular basis to practitioners who work with children i.e. Health Visitors, School Nurses and CAMHS practitioners. During the timeframe under review there are no supervision sessions recorded by those practitioners working with the family. This suggests an inconsistent understanding about recognising indicators of actual or potential harm to children. Given that all three children were subject to a Child Protection Plan it is concerning to think that the use of worrying information was not taken advantage of and explored in a safe and supportive environment such as that which could be provided by safeguarding supervision. One of the contributing factors to this not happening was that during the timeframe under review the model of safeguarding supervision arrangements for Health Visitors changed from 1:1 to being a mixture of 1:1 and being in a group setting. No group supervision is recorded as being sought either. A high proportion of the caseloads held by Health Visitors at the time had safeguarding concerns and the change in arrangements meant that workers had to prioritise which cases they brought to group supervision. The need to select cases inevitably meant that those with the most pressing, immediate and identifiable worries were prioritised. A factor which will have impacted on prioritising will have been the knowledge that Freddie's case was open to Children's Services; which would have been perceived as a reassuring factor.

5.3.12. Southampton City Council's Legal Services had four episodes of contact with the professional network during the timeframe under review. Their contributions are important when exploring the quality and effectiveness of actions taken by Southampton Children's Services in recognising and responding to indicators of actual or potential harm. These episodes include;

5.3.13. ***August 2014 MAPPA meeting*** – A Legal Services representative was asked to attend a MAPPA meeting in response to a request by Southampton Youth Offending Service regarding Sibling 2. The advice back from attending this meeting was that a legal planning meeting should be convened in respect of Sibling 2 as a matter of urgency. This clearly demonstrated that Legal Services at the time recognised and responded to indicators of actual or potential harm. This advice was followed.

5.3.14. ***August 2014 legal planning meeting*** – An initial legal planning meeting was convened and attended by representatives from Children's Services. Records indicate that those attending the meeting were aware of the issues with Sibling 2 and that Pre-School had raised concerns that Freddie was exhibiting sexualised behaviour. Given the attendance at the MAPPA meeting it was known that MAPPA were very concerned and that Sibling 2 had been described as a *'… predatory and dangerous man …'*. The concerns at this legal planning meeting focused on Sibling 2, the risk he posed to others and the Mother's difficulty in controlling him. Whilst there is reference to the current concern about Freddie's sexualised behaviour records show that Freddie was not the main focus of the legal advice sought. The outcome of this meeting was for the children to *'… remain subject to CP planning. CAHMS referral for Freddie regarding sexualised behaviour. Options need to be explored to keep both himself and others safe …'.* The advice given also included *' … plan - possible issue on Sibling 2 - ICO plan to place in a residential … assessment of the mother- capacity to care/change assessment to be undertaken … and the Social Worker to continue weekly visits …'*[54]. The fact that the legal advice acknowledged that legal proceedings could be initiated in respect of Sibling 2 and to seek an Interim Care Order indicates that there was a legal opinion that the threshold of actual, or likely, significant harm had been met and that this was attributable to the current care arrangements. Records indicate that details of residential placements were considered (pending management agreement) and one suitable placement was found however there was a lack of follow-through on pursuing the matter, with no response to questions posed to the Fostering Placements Team and no further management oversight, decision or escalation. As well as highlighting potential shortage of suitable placements (which is known to be a persisting national issue[55]), this episode highlights a system issue which created a pathway to failure; emails were not responded to and there was no checking back to seek a response nor any management oversight of this.

5.3.15. ***July 2015 legal planning meeting*** – This meeting was requested by Children's Services. Records indicate that the meeting had been called as there had been a lack of progress under a Child Protection Plan. Case history was also presented at this meeting including further information about Freddie's sexualised behaviours. Importantly the notes highlight that the recommendations from the legal planning meeting held in 2014 had not been pursued, that the Social Worker was confident that the Mother was not allowing unsupervised contact between Freddie and Sibling 2 and that the Mother was engaging with services *" … and doing everything asked of her…".* On this occasion, Legal Services advised against legal proceedings in respect of Sibling 1 and 2 in 2015, a year after they had advised that there may be grounds to seek an Interim Care Order in respect of Sibling 2 – it seems the rationale behind this decision was based on their ages (16 & 15 years at the time) and potential for disruption. Again, there was no challenge at this second legal planning meeting about why the actions in respect of Sibling 2 had not been followed through in 2014.

5.3.16. ***February 2016 and issuing of legal proceedings –*** A legal case note refers to a Legal Planning Meeting being held in February 2016; records of this Legal Planning Meeting cannot be found despite efforts. The case note indicates

[54] Southampton City Legal Services submission to the review.

[55] ADCS: What is Care For – Alternative Models of Care for Adolescents, April 2013, b) ADCS press release 9 August 2017, c) ADCS press release 13 June 2018

that the Public Law Outline process should have been initiated in February 2016 but was not because the Social Worker went on extended sick leave. A similar pattern is repeated with a further request for a Legal Planning Meeting in April 2016 in relation to Freddie. Freddie was not then accommodated using section 20 of the Children Act 1989 until May 20016 and legal proceedings were not issued until June 2016 with Freddie being initially placed in foster care before then moving on to a residential placement. The reason given for this delay and drift is that the Social Worker went on an extended period of sick leave and there was no re-allocation of the case. The drift is worrying and was not child focused especially given that the management oversight at that time was consistent.

5.3.17. On the basis of records examined the advice provided by Legal Services was clear and sound. It advised a systematic and evidenced based pathway for Children's Services to follow so as to build a case to support legal intervention into safeguarding Freddie's welfare. Clear advice was given that a further meeting should be convened once the required actions and recommendations had been completed. The legal advice was not followed through for either Sibling 2 or Freddie in a timely way, and this was not pursued or challenged. At the time of the advice being sought in 2014 the focus was on Sibling 2, however it later shifted to include a focus on Freddie; there is little consideration about Sibling 1 who continued to live in the household. This may be due to gender bias – being the only other female in the household and her behaviours somehow seeming more acceptable, her appearing to pose no risk compared to Sibling 2, and her being viewed as contributing to the household in a caring role as opposed to a perpetrating role.

5.3.18. Monitoring of whether legal advice and agreed actions were followed is an important learning point of this review. The responsibility for this rests across two parties; Legal Services but also Children's Services management.

Learning point: 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.

5.3.19. The Clinical Commissioning Group, on behalf of the GPs have considered their contribution to the recognition and response to indicators of actual or potential harm to any children in the household. They have usefully reflected that although the concerns about Freddie and the family were well documented in correspondence the GPs received (as outlined in section 5.1) gaining a sense of the Mother's parenting style, her interactions with the children and her parenting ability was not something that was easily extracted from the various documents held. The Mother had told her GP that she had attended parenting courses but that they had not helped; the reasons for this lack of improvement do not appear to have been evidenced by any agency in documentation. This is a helpful reflection highlighting the importance of good minute taking but also the need to produce a coherent record of a meeting that can be shared with those professionals unable to attend.

5.3.20. A further example where there is limited recognition of Freddie's worrying sexualised behaviour can be seen in June 2014 when there was a request for a specialist assessment to be undertaken by BRS, a multi-agency team within Children's Services. This is a service that is part funded by health and Children's Services where specialist services such a child-psychologist and psychiatrists can be accessed and that specifically works with children who are Looked After. The initial meeting concluded that only Sibling 2 would benefit from a specialist assessment and that it would not be appropriate to assess Freddie however the Service would review documentary information about Freddie in order to then make a recommendation about what might be appropriate for him. Records suggest a level of concern so high that access to a service ordinarily provided solely to Looked after Children is disregarded because of the risk levels. The September 2014 RCPC states that the referral to CAMHS was rejected but that the BRS may be able to assist – reflecting drift between June and September 2014 when the original request was submitted. The RCPC record of March 2015 then states that there had been a family assessment by the BRS but the outcome was not yet known – reflecting further drift from the original point that some action was agreed nine months earlier. The account

given by the BRS for the delay in producing a final assessment report is that they were waiting for information to be submitted which would enable them to correctly complete their assessment work, alongside staff sickness for an extended period of time. This drift appears unchallenged resulting in no pace and little purposeful activity. The BRS did not escalate their concerns about missing information at any time and given their own views about the levels of risk this was a missed opportunity. Nor was there any escalation by the Child Protection Chairs or other members of the professional network responsible for the Child Protection Plan; this too, was a missed opportunity. Records indicate that a year after the original request was submitted (July 2014) the Service had in fact completed an assessment and report but that it had not been shared with the Social Worker. It is not until the February 2016 RCPC that we see reference to the BRS assessment and comments that it did not address the issues that needed to be explored. This reflects a mismatch in expectations about what such an assessment might be able to achieve and what it might have been able to offer the wider professional network.

Learning point: 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.

5.3.21. Whilst the recommendations from the BRS focus on gaining more understanding, management strategies and support it does make reference to the Mother not accepting responsibility for Freddie's sexualised behaviour and instead blaming Sibling 2 or the Father. The Mother also minimises Sibling 2's offences and behaviours and appeared happy to criminalise them. Shifting the responsibility for the root causes deflects attention away from the Mother and further complicates the professional network's search for trying to understand the origins of Freddie's sexualised behaviours. This may account for some of the frustration and disappointment expressed by the network in that the BRS assessment did not pinpoint the origins of abuse, does not provide them with the magic solution and perpetuates a notion of the situation having to be maintained through management strategies rather than endorsing a view that a more interventionist approach could be followed. Furniss[56] discusses the use of the 'expert' in such situations which is how the BRS was perceived *'… to accept the notion of experts in child sexual abuse creates the false expectation that somebody who knows could tell others who do not know …the debate is not between the ones who can see and the ones who cannot … the tasks, the skills and the responsibilities in the overall intervention are larger than any single professional or agency can cover …'*. The BRS's report concludes, correctly so, with a recommendation that *' Freddie is also subject to a Child Protection Plan and within this framework consideration should be given to whether [the Mother's] parenting is good enough and is meeting Freddie's needs …'.*

Learning point: 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.

5.4. The assessment of the grandparents to provide a safe place for Freddie

5.4.1. It is understood that Freddie had been cared for by his Maternal Grandparents on a regular basis from around January 2016 onwards. This informal arrangement is one that evolved over time and towards the latter part of the timeframe under review became one whereby the Maternal Grandparents took on a greater role. On this basis it would be reasonable to expect to see some reference to an assessment of the situation as it evolved by Children's Services, but also an assessment of the Maternal Grandparents' ability to care for Freddie. Given that the entire professional network had not formed a view, or obtained any evidence, about the origins of any sexual abuse it would be reasonable to take a view that anyone with unsupervised contact with Freddie could be viewed as a potential

[56] Furniss, T., The multi-professional handbook of child sexual abuse: Integrated management, therapy & legal intervention, p.260, 1995, Routledge.

perpetrator. Keeping the possibility of inter-generational abuse in mind at this point should have been an important consideration[57].

5.4.2. There is no evidence of a formal viability assessment[58] or referral for a full assessment of the maternal grandparents, or any other family members to be considered for looking after Freddie until May 2016 – some five months after it was known that they had taken on a greater role in Freddie's life. This indicates there was little focus or grasp of what was really happening for Freddie by Children's Services at this time.

5.4.3. Much of the groundwork for this assessment work could have been achieved whilst Freddie was subject to a Child Protection Plan. Exploring family networks and support would ordinarily form part of the assessment process when a child becomes subject to a Child Protection Plan, and certainly ongoing assessment work whilst on such a Plan. Exploring options about who might be best placed to care for Freddie would have been an entirely appropriate course of action as part of a coherent and systematic plan; as the notes of the legal planning meeting cannot be found it is impossible to comment on whether it was an option explored by Legal Services with Children's Services in February 2016 but it would have been a reasonable recommendation from the July 2015 legal advice given.

5.4.4. The September 2015 RCPC makes a cursory reference to the grandparents and great grandparents being a good support to the whole family. Other than this, extended family members are not referenced at-all over the duration of the timeframe under review in any of the Conferences records and there is no reference to the Maternal Grandparents being involved in Freddie's care at the February 2016 RCPC (when one might expect to see something).

5.4.5. The lack of assessment by Children's Services is confirmed by Solent NHS Trust who have very little reference to the Maternal Grandparents in their records. Good practice standards expect assessment work to consider information from other agencies and professionals and there is no evidence to indicate that health professionals involved with Freddie at the time were contacted to consider the Maternal Grandparents capacity to care for a young and vulnerable child. Health professionals only became aware of the Maternal Grandparents involvement towards the end of the timeframe under review. There had been no known statements by the children of the Maternal Grandparents being abusive or inappropriate with them.

5.4.6. It is not until May 2016 when there is reference to the Maternal Grandparents being considered for long term care does any assessment work take shape. The conclusion reached was that although they cared a great deal for Freddie they would not be able to meet his complex needs.

5.4.7. It has not been possible to ascertain any specific reasons for the lack of assessment work on the grandparents other than those factors which have already been identified in the preceding pages.

5.5. Current practice challenges raised relating to the findings of this case

5.5.1. 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 following evidence supports this;

- An audit was conducted in April 2018 of concerns raised about cases of intra-familial sexual abuse between January 2017 and April 2018. Findings were made about the quality of protective parenting work, sexual abuse

[57] Intergenerational Patterns of Child Maltreatment: What the Evidence Shows, August 2016, U.S. Department of Health and Human Services & Children's Bureau.

[58] A viability assessment is a formal and specific type of assessment to consider the suitability of alternative carers when a child is unable to remain with the parent and members of the extended family have put themselves forward as carers.

had been missed with professionals focusing on other forms of abuse, and the quality of assessment work completed. These issues are reflective of what occurred in this case.

- An audit of referrals and case progression was conducted in March 2018 looking at cases at the three month and nine month Child Protection Review Conferences. Findings were made about core group activity at three months *'… core groups were more likely to occur than not, but there were cases where no multi-agency core groups occurred, and some where only one occurred during the 12 week period of planning. When core groups do occur, the success depends of the professionals and family attending and the quality of the recording and tracking of progress in the plan. On the cases where there has been drift, no core group minutes reflected how this had been challenged or discussed …'* noting that *' … the first three months of a child protection plan is a key time to engage and effect change within a family …* [and] *the delay in starting key pieces of work to achieve the outcomes in the CP plan has a fundamental impact on the effectiveness and therefore duration of the plan ...'* The finding at nine months *was ' … there is still a pattern of core groups not occurring or not being recorded …'.* Again, the issues are reflective of this case.
- An audit was conducted in September 2018 of cases where children were subject to a Child Protection Plan for more than 18 months. Findings concluded that there was a lack of clear and adequate assessment of the circumstances and parents ability and motivation to make and sustain change, plus most of the cases had periods of drift and delay due to social worker absences or the Plan not being progressed, and that RCPCs were more effective when there is a consistent Chair. The findings are similar to those of this review.
- An audit was conducted in January 2019 about children that come off a Child Protection Plan after more than 12 months. The findings concluded that risk assessments were often not completed in appropriate timescales with no clear explanation why, protective parenting work not being undertaken within agreed timescales and there being a lack of analysis in assessment work.
- In discussion with workers from CAMHS it was noted that during the timeframe under review CAMHS were often not invited to Child Protection Conferences; reports suggest that this still remains an issue with short notice often being a barrier and CAMHS needing to find cover for scheduled clinic appointments.
- The quality of management oversight and supervision in Children's Services has come under the spotlight in this case. Whilst it may be possible to place the findings of this review against rogue practice current concerns remain about the overall quality and consistency of this important area. This is an area that is currently under review in the broader programme of improvement activity.

5.5.2. The audit work and examples cited above clearly demonstrate 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. From the audit activity it is unclear what specific recommendations and actions have been taken forward to drive improvement activity.

5.5.3. Also of note, the time taken to initiate and conduct this case review has been a concern to the Independent Reviewer. The decision to conduct a review was taken in July 2018 yet there were delays in beginning the review of over six months despite it being possible to run case review processes in parallel to criminal proceedings. Further delays in receiving information were then experienced, in part due to staff sickness but also delays in information being submitted. Case reviews can be a valuable mechanism to provide feedback into the safeguarding system however in order to be effective there has to be an element of pace and momentum. The issues highlighted in this case, when placed alongside the findings of audit activity illustrate the high value of reviewing those cases where learning and improvements can be captured and then responded to in a timely manner; the danger being otherwise the system has no effective feedback loop to reduce the likelihood of recurrence.

6. Family contribution to the review

6.1. Seeking the contribution of family members has been an important consideration. The Independent Reviewer met with Freddie's mother towards the end of the review process despite good efforts to engage her earlier. The mother

continues to have statutory agencies involved in her life but spoke about some of her frustrations with the professional contact during the time frame under review. These included;

- Not understanding why a decision had been made to find alternative accommodation for Sibling 2 in 2014 but then not pursuing the matter further and Sibling 2 remaining in the family home.
- Despite having many professionals involved with her, and the children, feeling like that she was not actually receiving any support, or at least not the right kind of support. The mother expressed a view that she would have valued further advice and guidance about how to be a more protective parent to Freddie.
- During the time when Freddie was subject to a two year Child Protection Plan the mother was unclear what it was achieving and often felt it to be very messy; in part she confirmed that she was not finding life easy around that time herself, which fits with the offer of support not feeling enough for her.
- During meetings, the mother expressed a view that she often felt intimidated by professionals, sometimes not knowing who people were or what they did.
- A strong theme for the mother was her frustrations that professionals were not listening to her, especially when she was struggling to manage Sibling 2 and being worried about the impact of his behaviour on Freddie. Examples of her feeling like she was not being listened to include during meetings, professionals using information from the past and basing judgements on what this will mean for the future, and not being given sufficient time to make changes and professionals not hearing how challenging it was to make those changes.
- The mother was complimentary about a Family Support Worker and one of the more recent Social Workers; due to them taking the time to understand her situation, spend time with Freddie and make good decisions. She was also complimentary about some of the actions of the Police in trying to manage Sibling 2's behaviours.

7. Good practice

7.1. 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.

8. Conclusion

8.1. This Serious Case Review has examined the circumstances of agency involvement with an eight year old child who is suspected of being sexually abused in his family. The review has highlighted that the family were well known to

agencies and professionals and that all the children in the family were subject to a multi-agency Child Protection Plan for two years.

8.2. The review has benefitted from the contributions of agencies involved with the child and highlighted that work undertaken by professionals involved was largely ineffective in reducing the risks to the child. Attempts were made to gain the contribution of the Mother and children to the review however these offers were not taken.

8.3. The ineffectiveness of this work was due to a number of factors. These include;

- The multi-agency Child Protection Plan had no pace and had little purpose.
- 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 – who held lead responsibility for the Child Protection Plan.
- Challenge and escalation by professionals across the partnership was limited.
- The ability of Children's Services to effectively fulfil their statutory functions as the lead agency were compromised due to multiple system issues whilst Freddie was subject to a Child Protection Plan.

8.4. The review has also exposed information that indicates ongoing challenges for the professional network in responding to cases that have a similar profile as this case.

8.5. The review has captured points for learning and improvement and concludes with recommendations for the Safeguarding Partnership to take forward.

9. Recommendations

9.1. 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. The following recommendations are for Southampton Safeguarding Partnership.

1. To ensure the learning from this Review is disseminated across the multi-agency safeguarding partnership to practitioners and managers.

2. To seek assurance that the actions identified by each partner agency, as a result of this Review, have been managed, implemented and embedded in a timely manner.

3. To request information about the consistency of Chairs for Child Protection Conferences over the last 12 months, and, where there has been inconsistency i.e. more than one Chair, seek assurance that the Plans for children subject to Child Protection Plans are fit for purpose and have pace.

4. To seek assurance about the quality, effectiveness and compliance with Core Groups when children are subject to Child Protection Plans and an update on actions taken to remedy the points raised in the March 2018 audit conducted by Children's Services.

5. To seek an update about progress on actions arising from the April 2018 audit conducted by Children's Services which looked at cases of intra-familial child sexual abuse, and to examine blocks and barriers to effective multi-agency work around the issue of child sexual abuse.

6. Southampton Children's Services to assure the Safeguarding Partnership that there is a robust system for seeking legal advice, sharing information, recording legal planning meetings and tracking outputs – all on a timely manner.

This should include a process for monitoring any gatekeeping which may act as a barrier to gaining a legal perspective on a case where there may be threshold disagreements.

7. To ensure the commissioning arrangements for specialist services such as the Building Resilience Service (formerly the Behaviour Resource Service) are unambiguous and that all potential referrers are clear about expectations of what the service can offer. This should include a clear set of expectations about the need for professional escalation to be built in to contractual arrangements particularly when there are concerns about child protection, risk and safeguarding. Assurances should also be provided to the Safeguarding Partnership about the timeliness, pace and purpose of assessments and reports commissioned.

8. To raise awareness of the professional challenge and escalation protocol.

9. To increase the knowledge and confidence of front-line practitioners, in particular social workers, school nurses, and police in assessing and working with cases where child sexual abuse and exploitation may be a feature.

10. To seek assurance from Southampton Children's Services about the quality of management supervision and employee welfare, plus management scrutiny and oversight in Children's Services for cases where child sexual abuse and exploitation are features.

11. To seek assurance from Southampton Children's Services that the decision making process and practice around viability assessments is robust and that decisions and assessments are completed in a timely manner.

12. The Safeguarding Partnership to review the systems and procedures around decision making, commissioning and business processes for conducting statutory reviews. This would be with a view to ensuring the necessary agility, rigour and pace and whilst confirming that learning from case reviews is implemented and embedded in a timely manner.