Freddie Serious Case Review

Learning & Improvement Report

In January 2019 the Southampton Local Safeguarding Children Board commissioned a serious case review to consider the circumstances of agencies involvement with a child who for the purposes of this review is known as Freddie.

Freddie was under 8 years old. His family had a long history of contact and involvement with statutory services. There were concerns about neglect and harmful sexual behaviours which led to Freddie being taken in 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.

The independent review brought together the contributions of a number of agencies and professionals that were involved with the children and gained the perspective of Freddie's mother. The report captures a number of points of learning and improvement and has made recommendations for Southampton Safeguarding Children Partnership to continue to take forward.

The Southampton Local Safeguarding Children Board transitioned to the new Southampton Safeguarding Children Partnership (SSCP) in September 2019 in accordance with the new statutory guidance, Working Together to Safeguard Children 2018. The SSCP, under the joint leadership of the new Safeguarding Partners, have overseen the completion, publication and response to this Serious Case Review.

The safeguarding partners in Southampton endorse the recommendations made by the review author and will continue to work to ensure the recommendations are implemented and understood by practitioners.

This document provides the responses by the Southampton Safeguarding Children Partnership and individual partner agencies to any recommendations made to them.

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

The recommendations and learning from this review have been circulated to partner agencies for dissemination to colleagues. A learning synopsis has been produced to be shared across the workforce. This is available on the Southampton Safeguarding Children Partnership website. The learning from the serious case review will inform the ongoing work in relation

to Child Sexual Abuse within the Family Environment (CSAFE) to ensure the learning is captured in multi-agency training moving forward.

Individual partner agencies will also share learning from this review through a variety of mechanisms, including, but not limited to:

- **Primary Care**- the Southampton City Clinical Commissioning Group, Safeguarding team will ensure that learning from this review is disseminated across the primary care network in Southampton via virtual/face to face training updates and tutorials as appropriate regarding the lessons learned.
- **Solent NHS Trust** will continue to disseminate learning across the Trust workface in line with the Solent Safeguarding Team pathway for sharing learning.
- Named Nurse 6 minute Tutorials have already been cascaded to the staff in relation to themes from this case including "invisible" males within the home, record keeping and child sexual abuse.
- Solent NHS Trust own internal recommendations from this review have all been completed or have made appropriate progress.
- **Hampshire Constabulary** identified single agency learning as a part of the organisations contribution to the review. The single agency actions that stemmed from this learning have all been actioned. Action taken has included; auditing the quality and response to safe and well checks (now referred to as Prevention Interviews) following missing episodes involving children. Furthermore the force has been looking at gaps in the system regarding the submission of Police Protection Safeguarding Notifications including when a call has not resulted in a deployment and has been held within the control room. This scenario has been rectified by the implementation of a triage hub within contact management. There has also been ongoing scrutiny of decision making within MASH to ensure consistency and accuracy combined with ongoing scrutiny of police information sharing within child protection conferences.
- **Education** professionals will continue to access the 'Learning from Practice Reviews' network meetings to access disseminated learning.
- **University Hospital Southampton Foundation Trust** will ensure learning from this review is disseminated to the safeguarding governance group divisional governance groups, to the wider workforce through the safeguarding children champions and safeguarding link leads and is included in divisional reports. Safeguarding training is under review to ensure learning is included and internal recommendations are monitored to ensure progress and completion.

Southampton City Council's Children's Services have already implemented and communicated many of the changes which address the learning review recommendations.

  - Child Protection Conference Team:
    - Mid- way case tracking for all child protection conferences by conference chairs to ensure the effectiveness of plans;
    - Attendance by Child Protection Advisor at team meetings of the Protection and Court Service in order to build relationships and

understand challenges and issues relating to child protection planning;
    - Child protection chairs now ensure that all plans include the actions required to achieve the desired outcome, the risk, clear timeframe and who is responsible for delivering the required action.
- Development of a strategic framework for Child Sexual Abuse within the Family Environment (CSAFE) for Children Services and associated training.
- Quality Assurance:
    - Monthly dip- sampling by Service Managers, Heads of Service and Child Protection Advisor of conference minutes and plans to review consistency across the team, the appropriateness of plans in addressing risks and the decision making regarding children starting and ending child protection plans;
    - Child protection plans are scrutinised through the monthly manager audits within the quality assurance framework;
    - Core group recording on the IT system is audited within mid-way reviews and monthly audit process
    - A range of practice standards documents are available for staff within the department's intranet including a process for case escalation;
    - Practice standards form part of supervisions, via feedback sessions with the principle social worker, via independently chaired review meetings and by the audit of cases quality assurance process;
    - All outputs from the quality assurance framework audit process are reported regularly to **Southampton City Council's** Children's Services Improvement Board;
- Protection & Court Teams
    - Changes were made to the core group template in response to the March 2018 audit, to ensure a standardised process is in place;
    - Developed a weekly tracker to monitor the timeliness of core group meetings taking place;
    - Implemented a tracker to monitor that core group meetings are recorded on the IT system
    - A standardised framework for recording legal decision making on children's files within two weeks of the meetings occurring;
    - Implemented trackers to support the monitoring of the Public Law Outline, which includes Public Law outline meetings and letters before proceedings are tracked and filed within two weeks;
    - All decisions not to go to legal planning meeting are recorded on the social care IT system within the legal planning section;
    - Decisions by Team Managers are recorded in supervision;
    - Decisions from all legal planning processes are fed back in core groups to the network;

- The Building Resilience Service (BRS)
  - Specification has been strengthened to clarify the service offer and was widely consulted and communicated at the time;
  - The BRS now has a clear escalation process for case concerns within the service protocols and SCP escalations procedure;
  - A mechanism is in place to ensure effective multi-agency governance via the Multi-agency Children's Board (MACB);
- Viability assessments:
  - The policy has been strengthened to ensure that there is a clear process and structure. The viability assessments are now undertaken by the friends and family fostering service;
  - Viability assessments standards now include prescribed timescales for completion and a quality assurance process to ensure consistency in the standard of the assessments;
- Staff wellbeing
  - The Employee Welfare Line is already available for all Southampton City Council practitioners and regularly publicised and referenced in supervision sessions;

Southampton City Council will ensure that all learning from the review is communicated across the workforce including all actions already taken and developments underway.

Recommendation 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.

Individual agency actions identified as part of this review are monitored and quality assured through the Serious Incident Learning Group (SILG) on behalf of the Southampton Safeguarding Children Partnership as part of the action plan for this review. This process ensures agencies are accountable for the actions taken to address the recommendations and provide assurance both to SILG and to the executive group of progress.

Recommendation 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.

There was an unprecedented increase in children being subject to Child Protection Planning in 2019 and this was sustained in 2020. Additional agency staff were recruited by

Children's Social Care to assist with the chairing of conferences. This impacted on the consistency of chairs for conferences, and therefore measures were put in place by the Child Protection Conference Chairs in order to address any inconsistencies, issues of drift within plans, and provide oversight of progress and impact of plans, including:

- Mid- way case tracking for all conferences, where issues or good practice were identified in between conferences by independent oversight;
- Attendance by Child Protection Chairs at team meetings of the Protection and Court Service in order to build relationships and understand challenges and issues relating to child protection planning;

These measures have raised awareness of specific issues within cases, identified themes around areas of practice development, and provided insight into practice variations between chairs that have then been addressed individually or as a team.

Additional child protection chairs are now in place on fixed term contracts, to assist in ensuring consistency. A review of the number of permanent child protection chairs needed will be undertaken within the next 4 months.

Child protection plans are scrutinised through the monthly manager audits within the quality assurance framework, and within learning circles attended by Heads of Service, Service Managers for Quality Assurance, Protection and Court, the Assessment service, and the Child Protection Advisor.

Child protection planning was examined through the Ofsted Inspection in November 2019, where it was found "the quality of child protection and child in need plans varies widely. Some include broad overarching outcomes that are too vague, or irrelevant outcomes and gaps in identified needs. Timescales for completing actions are not always stipulated. Other plans are more focused and goal orientated." This finding immediately informed the team's approach to the recording of plans so that clear actions are identified that relate to specific outcomes which address the risks outlined in the conference.

Child protection chairs now ensure that all plans include the actions required to achieve the desired outcome, the risk, clear timeframe and who is responsible for delivering the required action. This is monitored via the quality assurance process including the dip sampling of cases and midway reviews by conference chairs.

Recommendation 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.

Following the March 2018 audit, an improvement plan was implemented to address the audit recommendations, which were:

a. One template is used by all Teams across the Protection and Court service.

b. All progress is tracked on the plan with a grid that includes a specific column for further timescales for each of the actions that have not yet been addressed.
c. The template does not include a separate section for analysis of the impact of the interventions on the desired outcomes, including the views of the professional network and family on the progress. However, this is commented on within the plan grid.

All recommendations were implemented.

The Ofsted inspection in 2019, concluded: "Core group meetings take place regularly, are well attended and are largely effective in developing and reviewing plans to ensure they reduce risks and address children's unmet needs".

The Children's Service, Protection and Court Teams have developed a weekly tracker to monitor the timeliness of core groups taking place.

There is ongoing work to ensure timely recordings of the meetings on the social care IT system to reflect the core group activity. An advanced practitioner has been identified to monitor this and identify patterns within teams and specific workers to target specific support with this issue.

There is a tracker in place to monitor that core groups are recorded on the system. Core groups are audited within the case tracking and conference audits undertaken by child protection conference chairs. They are also audited within the monthly management audits.

Consideration is being given to more effectively utilise partner agencies to support the practical arrangements of core groups.

A review is underway to identify additional business support requirements to ensure swift and effective administration of core groups.

Recommendation 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.

The April 2018 audit included recommendations relating to increasing the knowledge of the workforce in responding to Child Sexual Abuse within the Family Environment (CSAFE). Therefore, the child protection advisor within the Quality Assurance service became the specialist lead for CSAFE and launched evidenced based training sessions, using Research in Practice material, for staff highlighting responding to the relevant indicators. The Child Protection Advisor went on to commission experts in the field to develop a further, more detailed offer to staff featuring specialist advice, support and

training. Further work in this area indicated that a strategic framework for this range of interventions and services was needed.

Southampton City Council's Children's Service's Child Protection Advisor has written the strategic framework for Child Sexual Abuse within the Family Environment (CSAFE) for Children Services.

Work is underway with key agencies, within the safeguarding children partnership to:

- Develop a multi-agency one day training package on CSAFE;
- Develop e-learning modules;
- Develop specific training for practitioners on assessing perpetrators, assessing non-offending parents, direct work and interventions with victims and other children in the household.

The framework also covers safety planning and direct work with non-offending parents.

Southampton City Council's Children's Services quality assurance framework is being reviewed and will include regular thematic audits which will be monitored through the Children's Services Improvement Board.

Recommendation 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.

Southampton Children's services have in place robust systems which include:

- Legal decision making meetings are recorded on children's files within two weeks of the meetings occurring;
- Use of a central tracker and team tracker to support the monitoring of the Public Law Outline. Public Law outline meetings and letters before proceedings are tracked and filed within two weeks;
- Decisions not to go to legal planning meeting are recorded on the social care IT system within the legal planning section;
- Decisions by Team Managers are recorded in supervision;
- Decisions from all legal planning processes are fed back in core groups to the network.

The quality assurance framework includes thematic reviews of the public law outline process.

The quality assurance framework is currently subject to independent review and will be monitored through the Children's Services Improvement Board.

Recommendation 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.

Since February 2019, the Building Resilience Service (BRS) has changed its service offer and this was widely consulted and communicated at the time, both in service and across the partnership.

The BRS is a jointly commissioned service between Southampton Clinical Commissioning Group (SCCG) and Southampton City Council. The senior commissioner within SCCG confirms the service offer is now based solely on the needs of all children and young people instead of being exclusively focussed on the needs of Looked After Children. The service specification has been updated and clarified. The service also offers consultation to professionals and foster cares and will advise accordingly on the impact of abuse and neglect. Escalation of case concerns are now set within service protocols and exist also within the SCP escalations procedure.

Quarterly updates from the service are provided to Multi-agency Children's Board (MACB) – there is also a monthly Partnership Management Group where, alongside other integrated professional services, outcomes of the BRS are reviewed and assurance checks are undertaken within this governance process.

Recommendation 8

To raise awareness of the professional challenge and escalation protocol.

As part of the learning shared from this review the professional challenge and escalation protocol will continue to be highlighted. Awareness of this will be assured through the Keeping Children Safe Partnership audit planned for autumn 2020. This includes a practitioner survey which will provide assurance of awareness. The protocol remains referenced and highlighted in training provided by the SSCP.

In addition, individual partner agencies note the following**:**

- **Hampshire Constabulary** has direct links to the relevant policies and guidance shared by the partnership and this includes access to the escalation protocol. The

details of these policies and the updated hyperlinks are contained within the Standard Operating Procedure document that is used by the MASH coordinators and Sgts in terms of their work.

- It has always been the intention to publish this document as a Forcewide document for all staff to be aware of it, however, it does require updating every so often. The most recent document is currently being redrafted with some updated guidance on CCE and CSE. Once approved it will be sent out Forcewide to senior leaders with explanatory notes and for them to share with their frontline teams.
- Previously, this document has been shared with the Child Abuse Investigation Teams and the Senior Leadership within each of the Police Investigation Centres where cases were managed that had not gone to specialist child investigators.
- Additionally, links to the 4LSAB (Hampshire, Isle of Wight, Portsmouth and Southampton Safeguarding Adults Boards) have previously been circulated to some colleagues as specific notifications about issues.
- **Solent NHS Trust** delivers a successful level 3 professional challenge and curiosity training available to all staff that require level 3 competencies. This training has been updated in March 2020 to include a stronger emphasis on the escalation protocol.
- Solent Safeguarding Supervision policy is in the process of having amendments to include links to the escalation protocol.
- **University Hospital Southampton Foundation Trust,** staff are reminded of the escalation protocol through training, and case discussion.
- **Education** professionals are reminded of these protocols through the Guidance for Safeguarding policies and the School Safeguarding self-evaluation that should be completed by each setting at least annually.
- **Southampton City Council's** Childrens Social Care services have a range of practice standards documents available to staff within the department's intranet. Within this there is a process for case escalation. Practice standards form part of supervisions, via feedback sessions with the principal social worker, via independently chaired review meetings and by the audit of cases quality assurance process. All outputs from the quality assurance framework audit process are reported regularly to Southampton City Council's Children's Services Improvement Board.

Recommendation 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.

Southampton City Council's Children's Social Care have led the development of multi-agency training, which will continue to be provided to increase knowledge and confidence of front-line practitioners, in assessing and working with children and families where child sexual

abuse and exploitation may feature. This multi-agency training has been created and will be reviewed by the Centre of Expertise on Child Sexual Abuse**.**

In addition, the Child Protection Advisor within Children's Social Services has completed the strategic framework for Child Sexual Abuse within the Family Environment for Children Services. Work is underway with key agencies within the safeguarding partnership to develop a multi-agency one day training on CSAFE, as well as e-learning modules. This is a cross-service framework with further exploration with the Building Resilience Service.

Hampshire Constabulary have both a specialist Child Abuse team (CAIT) and a specialist Missing, Exploited and Trafficked Team (METT) who have enhanced training and skills to respond to cases involving sexual abuse and exploitation. The METT have also had a recent refresh of their terms of reference and have an action plan in place to continue to develop and evolve the force's approach to exploitation. Supplementary to this Child Abuse is a priority within the Force Control Strategy and is subject to regular senior management scrutiny and oversight.

In addition prior to Covid-19 Hampshire Constabulary were supporting the partnership to develop a training package for frontline practitioners to enhance their skills in identifying and responding to indicators of child sexual abuse within the family environment.

Solent NHS Trust provides on-going training opportunities with a half day level 3 child exploitation course that includes sexual exploitation. It is not currently mandatory for School Nurses to attend this training but would be responsibility of their managers to promote this as part of intercollegiate requirements. Solent NHS Trust also advocates staff completing the Seen and Heard sexual exploitation course online, developed for health professionals as part of their blended learning.

At present Solent NHS Trust are keen to support access to the partnership training on child sexual abuse which when completed and ratified can be either be delivered by in-house safeguarding staff or promoted to school nurses to undertake this training via the SSCP.

Solent NHS School Nurses are required to gain enhanced level 3 safeguarding competency in line with the intercollegiate guidance.

Education professionals can access a variety of training where child sexual abuse and exploitation may feature.

University Hospital Southampton Foundation Trust have access to a variety of safeguarding training , including a specific course on child exploitation and are working in partnership with children social services on multi-agency training on CSAFE

Primary Care- the Southampton City Clinical Commissioning Group, Safeguarding team will ensure that learning from this review is disseminated across the primary care network in Southampton via virtual/face to face training updates and tutorials as appropriate regarding the lessons learned.

Recommendation 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.

The Child Sexual Abuse within the Family Environment (CSAFE) framework has been developed by Southampton City Council's Children's Services, which includes support for managers overseeing cases with CSAFE, and additional oversight from an independent specialist assessor who has been appointed. This is alongside more reflective supervision provided through the BRS.

Cases where CSAFE have been identified will be tracked by the Child Protection Advisor to consider the impact of the work being undertaken with all family members.

The Employee Welfare Line is available for all Southampton City Council practitioners and regularly publicised and referenced in supervision sessions.

The services has mechanisms to monitor access to and take up of professional supervision sessions where staff welfare issues are discussed. A range of reflective supervision and learning circles are in place.

Management oversight and supervision are looked at by Child Protection Conference Chairs within the audit process for all review conferences and within the Quality Assurance Framework of monthly case file audits.

Recommendation 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.

Southampton City Council's Children's Services have reviewed the policy for viability assessments. The policy has been strengthened to ensure that there is a clear process and structure for the viability assessments. The viability assessments are now undertaken by the friends and family fostering service. Service standards now include prescribed timescales for completion and a quality assurance process to ensure consistency in the standard of the assessments.

Recommendation 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.

The SSCP members recognise the importance and necessity of ensuring learning from reviews is implemented as swiftly as possible. The partners note the opportunity in the transition from Serious Case Reviews to Child Safeguarding Practice Reviews. This has resulted in a review of systems and procedures as required by this recommendation. Members of the Serious Incident Learning Group on behalf of the SSCP are critical to this work and progress will be reported to the main partnership in December 2020

ENDS