Report title:	**Case Review and Governance sub group annual report, 2018/19**
Date:	**11 06 19**
Lead Officer:	**Lara Patel**
Contact Details:	**Lara.Patel@oxfordshire.gov.uk**

Introduction:
This is an annual report from the Chair of the Case Review and Governance (CRAG) subgroup – a subgroup of the Oxfordshire Safeguarding Children Board. It covers information on cases considered, cases reviewed and action taken over the last 12 months.

1. Local context

The subgroup comprises members drawn from Thames Valley Police, the County Council's children's services and legal services, the OCCG Designated Doctor and Designated Nurse, OH NHS FT, Public Health and a Head teacher representative. The purpose of the group is to support the OSCB in fulfilling its statutory duty to undertake reviews of cases both where the criteria[1] is met and where it is not met in order provide valuable information on joint working and areas for improvement.

The OSCB has worked on four serious case reviews since the last report to the Board. Of those four reviews: two have been signed off by the Board one is due for sign off by the end of July and one has been completed as far as possible, whilst parallel processes are underway – which have been ongoing since 2013. The OSCB also instigated four partnership learning reviews, which were ongoing at year end. One of these reviews has been stepped down as a local partnership review as it will form part of the first national child safeguarding practice review overseen by the National Panel.

2. National Context

Over the reporting period the OSCB has complied with the DfE Transitional Guidance 2018, introduced in July 2018, and worked with the new arrangements in terms of undertaking Rapid Reviews of all serious incidents. See appendix A for the specific guidance that the CRAG has worked to with respect to notification of serious harm

[1] Working Together to Safeguard Children 2015

ans. The OSCB Chair has established dialogue with the National Panel on all Rapid Reviews led by the CRAG. With the implementation of new multi-agency safeguarding arrangements in 2019 the CRAG will seek to complete and close down all serious case reviews by the end of the calendar year.

3. Cases considered for review by the subgroup

Eight cases were brought to the attention of the CRAG for consideration as a serious case review. Four of them led to further action.

Rapid Reviews
Three cases were notified to Ofsted as serious incidents and became the subject of a Rapid Review. All were referred in by Children's Social Care. These cases were reviewed from the perspective of whether they met the criteria for a SCR and whether the case raised issues which were complex or of national importance.

In only one case were the criteria considered to have been met for a serious case review (see Appendix B for criteria) and the recommendation was made by CRAG that the case raised issues which were complex and of national importance. All Rapid Reviews must be referred on to the National Panel for their consideration of case and the local decision. It was the National Panel's view that the criteria for an SCR had not been met. The National Panel has however commissioned its first National Review on adolescent risk and this same case will be examined in detail for that purpose. The CRAG is therefore not pursuing its own local review. No other decisions were contested by the panel.

Cases considered for a review
Five further cases were considered. They were not notified to Ofsted as serious incidents but were of enough concern to local agencies that they were reviewed by the CRAG. Most of these cases were referred in by Children's Social Care. One case was referred in jointly with health colleagues. Three of the cases resulted in Partnership Learning Reviews.

In all cases CRAG considered if the child was in immediate harm, if any further action needed to be taken, including assurances of good safeguarding practice, and if there were any immediate learning points.

4. Reviews: subject details and safeguarding themes

There were seven ongoing reviews, which involve nine children. At the time that the reviews were commissioned two of the children were aged between 1-5 years and seven of the children were aged between 10-15 years. Four were female and five were male. Two of these children were transgender. Sadly, in two of the cases the children are deceased.

Safeguarding themes covered by case reviews have been cross cutting – neglect plays a part in almost all cases. Broadly speaking additional themes have included: the impact of parental mental health on parenting and the well-being of children; severe emotional and physical abuse; engagement and attendance in education as well as children's emotional wellbeing as they explore their identity and, in doing so, may also become at risk of harm to themselves.

As mentioned, the CRAG considered 8 cases for a potential review this year. An emerging theme from these has been 'contextual safeguarding' e.g. children being vulnerable to abuse or exploitation from outside their families such as online abuse and child drug exploitation.

5. Views of children

Where possible reviewers have met with family and young people. In all cases the review teams have been grateful to family members that contributed to the review as they have provided an important insight into what happened from their perspective.

All cases are unique and generalisations should be avoided with small numbers but some of the points made were about 'being missed' by professionals (children), or 'not being heard' (other family members who wanted to help). Some reviews have identified how the 'voice of the child' was not known consistently, and therefore their lived experience could not be evaluated effectively. For example, reviews have stated:

- *X was "missed in my family" and recalls that professionals who came to their home "only chatted to mum" and "did not spend any time getting to know me*".

There is also a message about when children do disclose information. In some cases when children disclosed information they felt that the outcome 'made it worse' for them (children).

- "*Y feels very let down that nothing happened'* after disclosing a concern at school – the outcome is that this disclosure was shared with carers. Y '*worries that this is still happening today*".

The point was also made that when a child did feel that they were noticed, heard or listened to sympathetically, no matter how small the gesture, this did make a difference to their wellbeing and was remembered.

- *Z* "*Remembers two teachers* (in particular) *that were kind*" and wants them to know that this made a difference at the time.

Due to the number of children directly affected by current serious case reviews the CRAG is introducing a 'life letter' for children. The letter is written by the reviewer

explaining why the review was undertaken and what it found. It will be given to the children or will be kept on the children's case file until they are ready to read it.

6. Learning points from Oxfordshire case reviews

Last year the CRAG summarised the ten most frequently recurring learning points from the three most recently published case reviews. These themes continue to run through the cases that CRAG reviews and have been updated to reflect greater emphasis on some of the points. See appendix C.

Case reviews frequently highlight good practice, where professionals not only do what is expected of them, and excellent practice, where they have gone above and beyond. Current cases highlight Oxfordshire professionals who have done just this: teachers, GPs, health visitors and social workers.

7. Report recommendations, monitoring and outcomes from case reviews

All SCR recommendations form part of the OSCB business plan and drive the direction of work e.g. the OSCB 2018/19 priority to improve practice focuses on: working to address neglect and working to safeguard adolescents. Whilst the current SCRs have not been published there are action plans in place for all four of them, which were monitored through the OSCB Executive group in 2018/19. The four case reviews have over 20 recommendations.

Below are some examples of positive impact resulting from learning from serious case reviews:

- the development of a new 'single point of access[2]' by Oxfordshire CAMHS allowing for much more consultation, advice and support. There has been a 30% increase in activity (consultation, advice and signposting) as a result.
- the production of some short films by CAMHS on some of the most common mental health topics in medias that young people relate to e.g. on YouTube (see Appendix D for the links)
- new CAMHS website with information on service provision, self-help and online referrals www.oxfordhealth.nhs.uk/camhs/oxon.
- good 'access targets' for Oxfordshire CAMHS. It is now in the top three performing Trusts nationally.
- Information sharing through a multi-agency chronology is now compulsory at initial child protection conferences and reviews. Guidance has been issued and training provided.
- The Parenting Assessment[3] Manual is more widely used (revised guidance has been issued) and 16 practitioners have been trained to carry out the assessments.

[2] CAMHS 'SPA' is open 8am-6pm Monday to Friday and will take self- referrals, family/carer and professional referrals

[3] Detailed safeguarding risk assessment of parental ability to care for children properly and, if necessary, the support required to do this

- Private fostering guidance has been updated and reissued and raised at children's social care team meetings. New posters explaining what private fostering is have been promoted.
- The guidance on safeguarding record keeping for schools has been updated and training is available. This is also checked during audits of schools and reported on annually.

8. Publication

It is normal practice to publish serious case reviews for a minimum of one year on the OSCB website. However due to the age, identity and vulnerability of surviving children the OSCB will be making the case not to publish a number of these cases. The CRAG does not consider that it would be in their best interest to have their reviews made public.

8.Communicating the learning from reviews

In 2018/19 the OSCB held two learning events and an annual conference on the following topics:

- Child drug exploitation: information was provided on what this is, how it is presenting in Oxfordshire and what work is being undertaken by local agencies
- Multi-agency chronologies: guidance was given on when, why and how to contribute to a multi-agency chronology along with a 7-minute guide on the process.
- Contextual safeguarding[4]: national and local information was given on this theme as well presentations on the victim's perspective

Learning documents have been produced on Elective Home Education; Lessons from reviews for Health partners; 7-minute guide of Parenting Assessment Manual[5] assessment and a 7-minute guide on Multi-agency chronologies. They are on the OSCB website.

9.Costs and timeframes

Of the three most recently published reviews the costs have ranged from approximately £10,000 to over £20,000. All recently published reviews were signed off by the OSCB within a 12-18 month timeframe. The variation in costs is down to the type of review, its complexity, duration and the level of practitioner and family involvement.

10.In conclusion

[4] Threats to the welfare of children can come from outside their families. These extra-familial threats might arise at school … from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including: exploitation by criminal gangs and organised crime groups such as county lines; trafficking, online abuse; sexual exploitation and the influences of extremism leading to radicalisation.

The OSCB is recommended to maintain a focus on the ten most common learning points from ongoing reviews and to ensure that members of the local safeguarding partnership are fully aware of the learning from the three most recently published summaries.

Appendix A: Serious harm and notifications

16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states:

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if:

(a) The child dies or is seriously harmed in the local authority's area, or
(b) While normally resident in the local authority's area, the child dies or is seriously harmed outside England.

The notification must be within 5 days of becoming aware of the incident. The local authority should also report this to OSCB.

The local authority must also notify the Secretary of State and Ofsted where a looked after child has dies, whether or not abuse or neglect is suspected.

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain.

Any notification of an incident referred to the Panel will also be referred to the Case Review and Governance Sub Group for a local decision on whether the case:

- meets the criteria for a Child Safeguarding Practice Review
- whether the case may raise issues which are complex or of national importance

Appendix B: **Working Together (DfE 2015) guidance**

The Working Together (DfE 2015) guidance requires a Serious Case Review to be undertaken for every case where abuse or neglect is known or suspected[6] and either:

- a child dies; or
- a child is seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard the child.

This includes cases where a child died by suspected suicide. Where a case is being considered where the child was seriously harmed unless there is *definitive evidence that there are no concerns about interagency working*, the LSCB must commission an SCR.

Seriously harmed includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

a. a potentially life-threatening injury;
b. a serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred.

[6] The threshold for 'suspect' should be consistent with s47 Children Act 1989 "reasonable cause to suspect". The following question should be asked: given what we now know should this incident have led to a child protection investigation? If "yes" and the child has been seriously harmed then a Serious Case Review should take place.

Appendix C: Learning points to strengthen working together in Oxfordshire

1. **Understand the 'lived experience' of the child in the family:** use multi-agency chronologies to share information in a cumulative view to weigh up risks over time and keep previous events in mind. Make sure that children's comments are clearly recorded and understood – actual words used and not just the interpretation of them.
2. **Curiosity**: being curious about the family's past history, relationships and current circumstances in a way that moves beyond reliance on self-reported information
3. **Response to physical abuse**: identifying it, listening to children and following safeguarding processes thoroughly; children may sometimes be too afraid to speak or unable to verbalise what they are going through
4. **The role of schools in keeping children safe**
    - effective management of safeguarding records and sharing them when children transfer schools; effective escalation of concerns.
    - children are safest in full time education. Oxfordshire serious case reviews indicate that children on reduced time-tables, children absent from school and children educated at home are at increased risk. School attendance is a critical factor to support opportunity, well-being and safety
    - when the child is not in school being aware of the implications of elective home education and knowing which agencies are in touch with the family and to what effect
5. **Parental wellbeing**: mental health, substance misuse and domestic abuse are recurring themes. With respect to mental health colleagues need to recognise the risks and impact on the safety of the child; don't minimise 'older' information
6. **Fragmented management of health needs**: ensuring effective communication across services for co-ordinated and consistent management of care
7. **Children's emotional wellbeing**: increasing evidence of self-harm by children aged 10 years & above, recognising that, as children explore their identity they may be at risk of harm to themselves
8. **Children's limited capacity to protect themselves** as they move into adolescence after experiencing a lack of consistent, supportive parenting in their early years (long lasting impact of neglect)
9. **Rethinking 'did not attend'** to '**was not brought'**
10. **Understanding safeguarding risks that exist in the child's environment – not just their family** e.g. children being vulnerable to abuse or exploitation from outside their families such as online abuse, peer on peer abuse and child exploitation.

Appendix D: **Oxfordshire CAMHS short films on some of the most common mental health topics:**

Anxiety - https://www.youtube.com/watch?v=WNvKs_I-3kk&list=PLKw7kjGJdcXAYVCP4lhoLzVOeBol1vqfU&index=1
Psychosis- https://www.youtube.com/watch?v=WL5erfC4yE8&list=PLKw7kjGJdcXAYVCP4lhoLzVOeBol1vqfU&index=2
Personality Disorders- https://www.youtube.com/watch?v=oe11chDqbBo&index=3&list=PLKw7kjGJdcXAYVCP4lhoLzVOeBol1vqfU
Neurodiversity- https://www.youtube.com/watch?v=u9ZOqSw9ZLc&list=PLKw7kjGJdcXAYVCP4lhoLzVOeBol1vqfU&index=4

Glossary:

CRAG	Case Review and Governance Group
IMR	Individual Management Review
OCC	Oxfordshire County Council
OCCG	Oxfordshire Clinical Commissioning Group
PAQA	Performance Audit and Quality Assurance Subgroup
SCR	Serious Case Review