Report title:	**Case Review and Governance sub group annual report, 2019/20**
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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. CRAG is the means by which the board can learn from the most serious and complex situations and incidents that we work on jointly in Oxfordshire. The paper covers information on children considered, reviews commissioned 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 NHS is represented by the Designated Doctor (OUH & OCCG) and Designated Nurse (OCCG), and Head of Community Services (OH NHS FT), Public Health, Education and a Head teacher representative. The purpose of the group is to support the OSCB in fulfilling its statutory duty to undertake reviews both where the criteria[1] is met and where it is not met in order to provide valuable information on joint working and areas for improvement.

The OSCB has worked on ten reviews since the last report to the Board. Six have met the criteria for serious case reviews and/or Child Safeguarding Practice Reviews. The remaining four are local reviews. Two have been signed off, two were completed as far as possible, whilst parallel processes are underway and two are ongoing. The OSCB has worked on four partnership learning reviews, three of which were near completion at year end. The OSCB has also been involved in the Government's first National Child Safeguarding Practice Review on child exploitation.

2. National Context

Over the reporting period new multi-agency safeguarding arrangements have come into place. The OSCB has complied with Working Together 2018[2] and is now

[1] Working Together to Safeguard Children 2015
[2] Link to guidance is attached at Appendix B

initiating Child Safeguarding Practice Reviews. It has sought to complete and close down all serious case reviews (just two remain).

During this time frame the National Panel for Child safeguarding Practice Reviews has completed its first review on adolescent risk (see **Appendix B**). The OSCB contributed to this review which examined 21 children who had died or were seriously harmed, in which criminal exploitation was a factor. The review identifies areas of innovative good practice and contains recommendations at local and national level. It also provides helpful findings in terms of service development in response to child exploitation which CRAG has recommended for use by the local partnership.

The Panel has also completed an Annual Report for 2018-19 (see **Appendix B**). The report highlights patterns in practice they have gleaned from over 500 Rapid reviews notified to the Panel since it was established in July 2018. From this analysis, teenagers and infants appear most at-risk of death and serious harm in the context of abuse and neglect, which is reflected in Oxfordshire's reviews.

In addition, a triennial analysis of serious case reviews from 2014-2017 has been produced (see **Appendix B**). It is entitled 'Complexity and challenge' and CRAG has recommended that this is considered by board members to inform their own safeguarding training programmes as well as the OSCB portfolio of training. Many of the national trends and patterns are reflected in our local reviews.

3. Incidents considered for Rapid Review by the subgroup

Five[3] incidents concerning six children were notified to Ofsted by the local authority as 'serious incidents' and became the subject of a Rapid Review. These were reviewed from the perspective of whether they met the criteria for a Child safeguarding practice review (CSPR) and whether they raised issues which were complex or of national importance.

The CRAG considered that two of the five Rapid Review cases met the criteria for CSPRs. The National CSPR[4] Panel agreed with these decisions but considered that a further one also met the criteria. The OSCB did not agree that a CSPR was necessary but confirmed that its local work could be formalised and made available as a case study for the National Review on non-accidental injuries.

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. These were always dealt with promptly and included issues such as ensuring risk assessments and genograms were completed as well as updates on the ongoing safety of the children being reported back to the group.

[3] This figure denotes serious incidents which occurred between 010419 and 310320

[4] The National Panel receives, considers and comments on all Rapid Reviews and can commission national reviews requesting OSCB input

With respect to Rapid Reviews half of the six children were under 1 year and for all of these children non-accidental injury was a concern. Half of the children were adolescents whereby substance misuse was a theme as well as children being vulnerable to abuse or exploitation from outside their families, missing from home and school and not engaging well in school life.

4. Reviews: safeguarding patterns and trends

The OSCB worked on ten reviews, which involved twelve children. At the time that the reviews were commissioned three of the children were aged under 5 years and nine of the children were aged between 10-15 years. Four were female and six were male. Two of these children were transgender. Sadly, in three of the cases the children are deceased. Three of the reviews on adolescent children raised concerns regarding suicide (or attempted suicide). In two of the three reviews on children under 5 years the child suffered physical abuse.

Despite the small number that are reviewed the patterns and trends of maltreatment do reflect those noted in the 'Triennial analysis of SCRs: 2014 – 2017'. It is worth highlighting some of those common trends:

- Responding to **neglect** and protecting children from its harmful effects is a perpetual and growing challenge for all those working to keep children safe. It plays a part in almost all reviews and a recurrent theme is how it is identified and dealt with at an early stage. It requires a system response.

- Reviews frequently show **difficult parental and family circumstances**. Often there is not one single issue but a combination of different parental and environmental risk factors which built up over time including mental health, domestic abuse and drug and alcohol misuse.

- The nature of **vulnerable adolescents**' behaviour can detract from its underlying causes. The presenting issue can overshadow multiple concerns. Experiencing and perpetrating abuse are often closely related and risks are often outside the home. Going missing is often a sign that there are other problems in their lives. Consistent relationships are key to supporting adolescents. Relationships are key to supporting adolescents. Most of the adolescents did not have good mental wellbeing.

- **Schools** are key to noticing potential harm; to keeping children safe; to alerting other agencies for a child protection response and to challenging decisions. They do not always understand how to (or feel empowered to) challenge decisions.

5. Learning points from Oxfordshire case reviews

The learning from recently published reviews has been summarised by CRAG. The group has a clear view on what can be changed and improved. See **Appendix C** for the OSCB poster on **'***Ten learning points from case reviews'* to share with practitioners.

In 2019/20 the OSCB held two learning events, three workshops and an annual conference on themes which have arisen from reviews:

- 'Understanding my world'
- Gangs and violence
- Child Exploitation
- Multi-agency chronologies

Learning documents have been produced on (1) Physical Abuse (2) Parental Vulnerability (3) key points for strengthening working together in Oxfordshire poster and (4) Safeguarding Conversations / Supervision poster. They are on the OSCB **website**.

Reviews highlight where professionals have gone above and beyond what is expected of them. CRAG has seen examples of local teachers, GPs, health visitors, social workers and police to keep children safe. The OSCB has introduced a commendation system this year to recognise good practice within the safeguarding system.

Many recent reviews have involved children who are still in need of support and continue to be vulnerable due to their life experience. CRAG has therefore maintained a degree of contact with managers to ensure immediate as well as ongoing safety of children who have been subject to reviews.

6. Views of children and families

Wherever possible reviewers have met with the children and their families. As ever this input provides a valuable perspective on 'what has made a difference' and 'what worked well' for children and what could be done differently to better understand what it means to be that child.

All children are unique and generalisations should be avoided but some of the points made to the reviewers were as follows:

- Understand what life is like for **all** children in the family – give all the opportunity to talk
- Build a relationship with me – it might take time
- Talk to me first before checking out with my parents

These are helpful reminders for all partners in the system and sit alongside positive feedback as follows:

- “She really listened to me and I knew I could go and sit with her & chat. That helped me; knowing there was someone.” Child talking about Designated Safeguarding Lead in a school
- “If they didn’t know, they asked me to explain what it meant and we thought about it together – she was really amazing!” Young Person

The OSCB has been able to work with some families about their experiences. They raised a message which was important for us to consider as a board about how we communicate with individuals. How as a partnership we remind others in day-to-day life that we should do something if we are worried about a child. It relates back to the message of the children’s act that ‘safeguarding is everybody’s business.

The OSCB knows that what is written about children is just as important as what is said and can have a long-lasting impact on their life journey. As a result the CRAG wherever possible is writing ‘life letters’ to children following reviews which are both given to the child and also saved on file so that they can be accessed as they grow up to understand why a review was done and what it found.

7. Views of practitioners

Feedback from practitioners has been that they value prompt review work and that it is challenging for families and practitioners to return to emotive times after the event. As a result of this CRAG made clear decisions about how to take forward review work under the restrictions imposed by Covid-19 to avoid delay.

Further feedback was received regarding the complexity of cases and the fact that a number of reviews have involved children who are still in need of support. CRAG now includes reflection after each meeting to consider emerging / recurrent themes and how learning might be passed on to other fora e.g. Training subgroup, Complex case panel or the Neglect task and finish group.

The CRAG will be developing its work in the coming year to take more time for reflection and recognise the impact on partners where organisations are still working with children and families. It will also ensure that reviews are completed in a prompt manner, especially when parallel processes are underway or children are still in receipt of support, and that the needs of families and practitioners are considered at all points

8. Report recommendations, monitoring and outcomes from case reviews

All SCR / CSPR recommendations form part of the OSCB business plan and drive the direction of work. This is why the current plan includes the issues of ‘neglect’, ‘keeping children safe in education’ and child exploitation. All completed reviews have action plans in place, which are monitored through the OSCB Business Group.

On average OSCB reviews have 8 recommendations. The OSCB is keen to keep these to a small number and ensure they are specific, contextual and targeted. The CRAG wants reviews to lead to improvements. Feedback has been that fewer actions lead to clearer learning.

9. Publication

It is normal practice to publish serious case reviews for a minimum of one year on the OSCB website. In the last year the OSCB was able to publish one review on **Child M**, which included themes of parental mental illness and the effective sharing of information between agencies where families move or treatment/ support is completed. This was published alongside a **Domestic Homicide Review** into the same case.

The CRAG has taken learning from this parallel process to improve its operating principles and to consider ways of enhancing family engagement in the conclusion of the review process.

9.Costs, timeframes and process

Costs vary according to the type of review, its complexity, duration and the level of practitioner and family involvement. They range from approximately £10,000 to over £20,000.

10.In conclusion

CRAG is the means by which the safeguarding partnership can learn from the most serious and complex reviews and improve joint working.

Safeguarding themes have been highlighted in this report and links have been given to learning resources. The OSCB has a leadership role in terms of taking forward learning and improvement.

The following recommendations are made:

- Board members are recommended to champion joint-agency learning by ensuring that the key messages from reviews and the practice improvement guides and tools are shared within their own agency's professional development workstreams.

- Board members are recommended to ensure that they understand and participate in 'System Responses' to keeping children safe in education; a universal approach to neglect and the challenges of contextual safeguarding.

Appendix A: Serious harm and notifications

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: **Government guidance**

CSPR Panel Practice Guidance – on website as background document

Working Together 2018 Guidance
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

The National Panel for Child safeguarding Practice Reviews has completed its first review on adolescent risk.
It Was Hard to Escape: Safeguarding children at risk from criminal exploitation,

The National Panel for Child safeguarding Practice Reviews has completed an annual report for 2018-19 – on website as background document

Complexity and challenge: a triennial analysis of SCRs 2014-2017
Final report March 2020 – on website as background document

Appendix C

OSCB publication on ten learning points from case reviews in Oxfordshire

Glossary:

CRAG	Case Review and Governance Group
CSPR	Child Safeguarding Practice Review
OCC	Oxfordshire County Council
OCCG	Oxfordshire Clinical Commissioning Group
OH NHS FT	Oxford Health NHS Foundation Trust
OUH NHS FT	Oxford University Hospitals NHS Foundation Trust
PAQA	Performance Audit and Quality Assurance Subgroup
SCR	Serious Case Review