OSCB
Oxfordshire
Safeguarding
Children Board

# Child Safeguarding Practice Review (CSPR) subgroup Annual Report 2022-23

# Contents





## Introduction

This is the 2022-23 annual report from the Chair of the Child Safeguarding Practice Review (CSPR) subgroup of the Oxfordshire Safeguarding Children Board (OSCB).

It covers information on all reviews considered and commissioned as well as any action taken over the last 12 months.

## The CSPR subgroup

The purpose of the subgroup is to support the OSCB in fulfilling its legal duty to undertake reviews where the criteria[1] is met. It has the local duty to undertake reviews where learning could lead to improvements in practice. The aim is to help the OSCB learn from the most serious and complex situations and incidents.

**The subgroup members come from:**

- Thames Valley Police
- Oxfordshire County Council's children, Public Health, education and legal services
- The NHS through the Buckinghamshire, Oxfordshire, Berkshire Integrated Care Board, Oxford University Hospitals FT and Oxford Health NHS FT
- The local education community

## National Context

The Department for Education's National Panel for Child Safeguarding Practice Reviews maintains national oversight of review work. Over the reporting period the National Panel for Child Safeguarding Practice Reviews has produced papers on the management of bruising in non-mobile infants, safeguarding children with disabilities and complex needs in residential setting an Annual Report for 2021- 22 as well as good practice examples of completing Rapid Reviews.

[1] Working Together to Safeguard Children (2018)

## Serious Incidents

Serious incidents are referred for a Rapid Review in line with guidance in Working Together 2018. Appendix A explains how the Department for Education defines a serious incident.

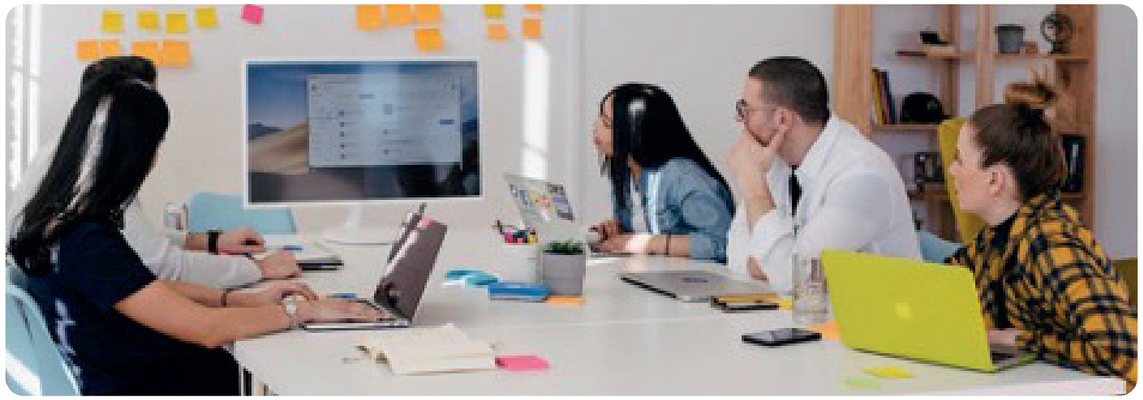
The CSPR subgroup also reviews cases referred by board members if they present concerns in how well agencies have worked together to safeguard children. This includes cases which may have met the (RTH) OUH Serious Incident Framework[2].

This year 6 serious incidents (where abuse and neglect was suspected)[3] were notified to Ofsted and 1 incident was referred for consideration. NB: Following the Rapid Reviews one of the incidents, concerning an infant death, was deemed to have no longer met the criteria. The thorough review removed suspicion of abuse and neglect. This is similar to last year, when there were 6 notifications and the preceding year when there were 9.

## Rapid Review meetings held by the CSPR subgroup

The purpose of a Rapid Review is to decide if the criteria is met for a CSPR and if one is needed.

If work is already in place or there is no further learning to be gained, then it is not necessary to do a Rapid Review. These types of reviews are real-time and provide an insight as to how well the safeguarding system is operating now. Rapid Reviews concern current incidents. They guide us to current learning points.



[2] NHS England » Serious Incident framework

[3] There may be more serious incident notifications but the CSPR subgroup has only considered those, where abuse or neglect is suspected.



## Analysis of Rapid Reviews

When a Rapid Review of a case takes place partners are very proactive in providing information held on the child and their family to ensure that as much information as possible is available to inform the review and ensure the child/ren are safeguarded.

| | 2022-2023 |
|---|---|
| No. of agencies referring incidents for review | 4 |
| Rapid reviews held | 6 |
| Rapid reviews involving safeguarding partners outside Oxfordshire | 3 |
| CSPRs initiated following the Rapid Review | 2 |

Of the six serious incidents reviewed this year 2 were non mobile infants.
Sadly 1 infant died – possibly as a result of parental rollover.
The remainder were all aged between 10 and 16 years.

### Analysis of the seven Rapid Reviews held:

- Two of the Rapid Reviews concerned infants under the age of 1 year
- The next biggest group of children are aged 10-16 years
- One young person was aged 17 years and he was detained in an YOI at the time of the incident
- The largest ethnic group is white British
- The majority of children were subject to chronic harm and did not die but did impact significantly on their development and well-being
- The largest subcategory of serious harm has been by neglect followed by intra familial sexual abuse
- The Rapid Reviews have delivered high quality local learning
- Two Rapid Reviews recommended a CSPR be commissioned, and these have been completed

[4] Review in this context means Child Safeguarding Practice Review

## Serious Incidents

### Child A

- This review was signed off in September 2022.
- The review concerned a child who was seriously self-harming and at risk of suicide. She was accommodated in residential placements out of county.

### Completed actions include:

- The development of the strengths and needs assessment for early help work.
- Communication with the National Panel, the Secretary of State and Oxfordshire MPs regarding placement sufficiency.
- The importance of good working relationships between professionals - keeping the child at the centre.

### Delayed publication of CSPR Child G

- This review was signed off in July 2022. It concerned an adolescent who was sexually exploited whilst living in independent accommodation under the care of the local authority.
- Key pieces of work include the learning events run in November 2022 on trauma informed practice; trauma and parenting; understanding challenging behaviour and secondary trauma.
- Due to changing circumstances in Child G's life it was agreed to delay publication so they would be able to engage with the process.

## Rapid Reviews (including key issues)

| Case | Ofsted notified? | Decision type | CSPR meeting | Presenting issues |
|---|---|---|---|---|
| Child 1 | Yes | Rapid Review | 11 May 2022 | Intra familial sexual abuse – adults and children |
| Child 2 | Yes | Rapid Review | 13 July 2022 | SUDI possibly due to rollover by parent. Issues of homelessness, alcohol use, Domestic Abuse, insufficient pre-birth assessment |
| Child 3 | Yes | Rapid Review | 10 August 2022 | Chronic neglect. Issues of early parenting concerns, cross border movement of parents, large family network |
| Child 4 | Yes | Rapid Review | 8 September 2022 | Intra familial sexual abuse between siblings. Issues of family isolation, underpinned by parental profound religious beliefs, very large family network |
| Child 5 | Yes | Rapid Review | October 2022 | Chronic neglect compounded by the child sustaining serious injuries after falling 40 metres. Issues of previous parenting concerns, large family network, children being Electively Home Educated, families moving across borders |
| Child 6 | Yes | Rapid Review | February 2023 | Non mobile child sustained significant injuries. Issues of parental capacity, homelessness, insufficient pre-birth planning, 3 different men in the child's life by 8 weeks old, domestic abuse |
| Child 7 | No | SIN due to incident in YOI | July 2022 | Notification from a YOI to say an Oxfordshire child (along with 6 others) had been involved in a serious assault of another young person |

## Learning points this year

Rapid Reviews and cases for consideration concern existing incidents. They guide us to current learning points. Over the last 12 months the CSPR subgroup picked up on the following repeat themes for local safeguarding practitioners.

- Moving from "What is wrong with you to what has happened to you"
- Recognise the importance of key adults in a child's life and involve them
- Use non blaming words and language about a young person – they are always the victim
- It is important to understand family dynamics including the history of the family and particularly in large families
- The past can often inform the now
- It is important to understand the impact of historical intra familial sexual abuse
- Think creatively of ways to safeguard a young person – do not be bound by procedures
- Parents may physically chastise a child to manage their presenting behaviours. Whilst it is not illegal to hit a child/young person the impact of physical violent on the child should not be underestimated
- Neglect not being recognised and leading to significant harm of children
- More robust pre-birth assessment and planning is required
- Bereavement of key family members who could have supported parenting
- Understanding neurodiversity and how it may impact on parenting ability
- Knowing the right service to support a parent
- Understanding an assessing individual needs in large families

## Reflections from partners

The focus of the OSCB continues to be inclusive with the partnership and remembering that safeguarding children is everyone's responsibility.

In contrast partners can feel 'done to' as opposed to taken along. Colleagues in Children's Services can feel the responsibility lies with them. None the less, the commitment of partners in Oxfordshire remains strong with a culture of professional challenge, openness, escalation (including the re-launch of Escalation policy now called Resolve) and learning.

Partners value the opportunity of working together to explore cases in depth and ensure that the learning from cases is disseminated throughout the partnership.



## Reflections from independant reviewers

### Jane Wiffin

- *It was a pleasure undertaking my LCSPR in Oxfordshire- Business Office very supportive.*
- *Good communication. well linked in with partner agencies. The review process was a little arduous - the consultation process with all having a slightly different view. Led to many changes.*
- *Professionals were open - lack of defensive willing to learn.*
- *Everyone took LCSPR process seriously. Committed time and effort.*

### Sarah Holtom-Fawcett

- *Excellent business support from the team and paying particular thanks to CB. It really works as a reviewer to have a named support person and CB is super-efficient and very easy to work with.*
- *Able to hear and talk about the difficult things/barriers in agencies and across the partnership and commitment seen from practitioners and senior managers to make the changes to systems and strengthen practice where required*
- *Attention to detail in the draft reports from CRAG - at times there was perhaps a little too much debate over sentences / words in the report in meetings which could have been approached in a more efficient way with email feedback for consideration*
- *Good focus on ensuring family participation. In the Review regarding Sibling Sexual Abuse - I wonder if comment could be made regarding the timing of approaching families as wider learning for the National Panel when they expect certain timeframes. In many situations it is unrealistic to have a 6-month schedule for completion and expect the family to be able to contribute meaningfully when other processes may be ongoing or they family may not be in a psychological space to feel able to think about things*
- *I would also add that KB was a very skilled and experienced Business Manager - she was relational, authoritative when required and kept everyone to task in the Review process. Her knowledge about practice and systems in Oxfordshire across the partnership was impressive. It was clear to see how well respected she was by her Team / seniors and practitioners.*

## Family Involvement

The OSCB always tries to involve family members and those who have cared for the children whose cases are being reviewed.

As highlighted by Sarah Holtam–Fawcett it is important to understand the impact of a serious incident affecting their child and to be led by their ability to process events. It is also important to be available to families should they have any queries.

## Costs, timeframes, and process

Costs vary according to the type of review, its complexity, duration and the level of practitioner and family involvement.

They can range from approximately £8,000 to over £20,000.

## Sharing Learning

The CPSR subgroup shares learning from each Rapid Review with safeguarding partners such as the Housing Forum and Safeguarding Trainers at regular intervals. Online learning events were run and follow up sessions.

For those registered with the OSCB booking system they can still be accessed as follows: OSCB.training@oxfordshire.gov.uk



## Impact of reviews

OSCB Reviews keep recommendations to a minimum to ensure they are focused and have impact.

**The following are examples of change as a direct result of recent reviews:**

- ☑ Raising awareness of 'placement insufficiency' for children with the most complex set of needs through regional work.
- ☑ Improving the online system for 'multi-agency chronologies' (MAC) to build a full picture of what is happening in the life of a child /family who is subject to child protection planning, particularly for neglect.
- ☑ Improving the Thresholds of Needs Document to better capture family background information and make connections between mental health services and children's social care when they are determining what level of needs a child has.
- ☑ Development of a bruising protocol so that practitioners better know how to recognise signs of abuse in older children.
- ☑ Creation of a kit for schools to help them know 'who to call' and what help is available if they are worried that a child is at risk of exploitation.
- ☑ The revised tool for screening the risk of child exploitation will be launched in early Summer 2023.
- ☑ The Resolving Professional Issues between Professionals will be launched early Summer 2023.

## Conclusion

This report evidences the commitment of members of the CSPR subgroup who aim to be dynamic and responsive and to unplanned incidents involving children.

This group meets monthly so that it can respond to urgent issues involving children living in Oxfordshire.

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