Annual report from the Case Review and Governance subgroup

1. Introduction

This is the annual report of the Case Review and Governance (CRAG) subgroup. It covers information on cases considered, cases reviewed and learning achieved as part of the OSCB's learning and improvement framework[1].

2. 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 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[2] is met, and where it is not met, in order provide valuable information on joint working and areas for improvement. Cases include death and serious injury associated with abuse or neglect. The CRAG produces a short learning summary for practitioners and ensures multi-agency learning events take place following each review.

The OSCB has worked on five serious case reviews over the last year, one of which is also a domestic homicide review. Of those five reviews: two have been signed off in 2014/15; one was signed off in July 2016, one is active and one is complete as far as possible, whilst a police investigation is underway.

3. National Context

In recent months national guidance and reforms have been released which will impact on local work. In April 2016 the '*Learning in to practice: improving the quality and use of the Serious Case Reviews*[3]*'* was published, which set out quality markers

[1] Working Together to Safeguard Children, 2015, Chapter 4, sets out the requirement for LSCBs to maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

[2] Working Together to Safeguard Children 2015

[3] Serious Case Review Quality Markers – supporting dialogue about the principles of good practice and how to achieve them. SCIE &NSPCC 2016

and principles of good practice in case reviews. In May 2016 the government published 'The Children and Social Work Bill', which includes a set of clauses that set out arrangements for a new Child Safeguarding Practice Review Panel. The Panel will identify a number of serious or complex child safeguarding cases which raise issues of national importance and will review cases which they believe will result in learning. The Secretary of State will also be able to set up arrangements for the Panel, including arrangements relating to the criteria for reviews, reviewers and reports. However, the intention is that the majority of SCRs will continue to be managed by local boards. Further government guidance has been released following the 'Wood Review of LSCBs' commissioned in December 2015. In addition we are awaiting the publication of the Triennial Review of Serious Case Reviews from 2011-14 from the University of Warwick and the University of East Anglia, which will bring together a national analysis of this and previous biennial reviews to provide child protection practitioners with evidence of key issues and challenges across the sector and learning to ensure children are kept safe. A national repository of all case reviews is held by the NSPCC, which also produces learning documents based on thematic findings.

4. Cases considered for review by the subgroup

The decision making criteria for serious case reviews has changed over time to permit different types of reviews and strengthen the conditions which apply to inter-agency learning. The current Working Together (DfE 2015) guidance is attached at appendix A.

Five new cases were brought to the attention of the OSCB for consideration of a review, in 2015/16. Of these five referrals one serious case review was commissioned, one led to no further action and the remainder had a series of quality assurance actions to be reported back in to the subgroup. This included a case which did meet the criteria for a domestic homicide review (DHR). The CRAG has remained involved with this DHR and reviewed the proposed recommendations and actions as it reaches its conclusion. In all cases reviewed by the CRAG further local actions have been considered in order to test the effectiveness of agency work and

hold them to account. If they are significant they have been referred in to the OSCB Executive for consideration.

All cases considered by the CRAG must be referred to the National SCR Panel. This independent expert panel of four colleagues was established through Working Together (DfE 2013). It advises LSCBs and the DfE on aspects of SCR procedure and reviews *all* decisions. The panel members will challenge LSCBs where they do not feel the criteria has been applied correctly. This has led to a tighter focus on the criteria and evidence-based decision making. Of five Oxfordshire cases submitted to the National SCR Panel in 2014-15 none were contested.

5. OSCB SCR Methodologies in 2015/16

Working Together (DfE 2015) gives LSCBs permission to be innovative in the range and types of reviews commissioned and proportionate with respect to the scale and complexity of the issues being reviewed.

OSCB reviews have been completed using a range of approaches. Of the five cases worked on in 2015/16 one used the systems methodology developed through the Social Care Institute for Excellence (SCIE), one was 'reviewer-led' and three were the Working Together (2010) style of serious case review. The CRAG has not arrived at one recommended approach but considers the best approach for each case based on the scale and complexity of issues. Below is a commentary on the component parts of reviews, which have varied with each approach.

- **SCR Reference Panel**

In all instances the OSCB has used an SCR reference panel to support the reviewer. Only one of the reviews involved an additional SCR panel chair, which has been appropriate for the case. In all cases either the designated nurse or doctor now forms part of the panel. Learning this year has been to clarify the role of the 'link SCR Panel Member'. This panel member has the role of representing their own agency and also providing a link to a second agency, if that agency is not directly represented. The CRAG has set out these additional responsibilities so that all

partners in the review are kept abreast of its progress and able to input and sign up to actions and recommendations.

- **Chronologies**

All reviews have required a chronology of some type. The practice has been to request summarised information, based on significant events, in preference to detail, with further detail provided on request of the reviewer e.g. copies of core assessments or meeting minutes. Thames Valley Police have continued to produce full chronologies for their own reference. The feedback has been that chronologies are essential and helpful when in a summarised format.

- **Analysis**

Agency self-analysis has been an essential element in all reviews, but the methodology and depth has varied across these models. The SCIE model and the reviewer-led approaches have required summarised agency information and analysis with the scope and focus determined according to the case, by the SCR panel and reviewer. Thames Valley Police have continued to produce individual management reviews (IMRs) for their own reference. The feedback from most agencies has been that they welcomed the reduced report-writing burden. Where agency reports and IMRs have been produced the reviewers have commented on the high quality of the submissions.

- **Practitioner involvement**

The Working Together (DfE 2015) encourages practitioner involvement as a means of analysis and learning. Practitioner involvement has been central to the SCIE review, the joint SCR/DHR and to the most recent reviewer-led reviews. In all cases practitioners have valued feedback sessions before the review is finalised. At these sessions the reviewer has tested out their initial findings and learning points. The CRAG has reflected that this is good practice in any case review.

- **Average time taken**

Working Together (DfE 2015) recommends that reviews are undertaken within a six month timeframe of the decision. Influencing factors tend to be parallel processes

such as criminal investigations or Independent Police Complaints Commission (IPCC) enquiries, which may mean that practitioners or families are not able to contribute until these are concluded. Publication is also affected by timescales for criminal prosecutions, as it is only after the conclusion of a trial that the contents of the review can be placed in the public domain. Most reviews take 15 – 30 days of a reviewer's time (dependent on how much time is given to family contribution and practitioner involvement).

Of the reports signed off this year, timeframes ranged from 12 to 24 months. One review has been ongoing for 3 years due to continuing criminal investigations which have prevented any further work being undertaken whilst key individuals could be called on to give evidence in a trial. The independent Chair is discussing with the National SCR Panel what actions the safeguarding board should take, given the unprecedented delay.

- **Costs**

Costs tend to increase with the complexity of review; family contribution, practitioner involvement and preparation for media interest. These costs are reported in to the OSCB budget monitoring at year end.

6. Subjects of the reviews

- The five different serious case reviews have concerned six children.
- Four of the children were under the age of four years – one was a baby. Two were adolescent children.
- Four were female. Two were male.

7. Family contribution

It is essential to involve subjects and families in reviews. Family members have contributed to all reviews which has added a layer of complexity but also provided valuable learning.

Further meetings with families are undertaken to prepare for publication and to offer support to withstand the media attention they may receive. The OSCB has valued the support of the family liaison officers (FLOs) at Thames Valley Police, social

workers from the County Council, the engagement team at the County Council and probation officers who have facilitated family meetings.

8. Themes and learning

Over the last year the themes covered by case reviews have been: the enduring impact of neglect; child sexual abuse; physical abuse; self-harm; child and parental mental health; peer and familial violence (domestic abuse) and parental substance misuse.

The issue of neglect is a repeated theme in terms of the developmental damage it does to young children and the impact it continues to have as they grow up. The issue of 'damaged and difficult' lives of young people and their capacity to protect themselves has also become a repeated theme in recent years.

The two case reviews signed off in 2015/16 have highlighted themes in common with other serious case reviews; practice learning points and multi-agency learning points. Some of these messages resonate with the reviews in production and these are outlined below:

Themes in common with other serious case reviews

- Challenges in dealing with inconsistent and neglectful parenting
- Professionals' lack of challenge or curiosity in relation to self-reported explanations of harm to the child/ren
- Loss of continuity of service (and records) when families move across boundaries
- Effective risk management supported by systematic planning across the multi-agency partnership.
- The capacity of adolescents to protect themselves can be overestimated and a tendency to view teenagers as small adults, rather than children, can mean that proactive steps to protect them are not always taken
- Young people can 'slip through the net' by not meeting criteria for a number of services, leaving them in need of help but without support

Multi-agency learning points

- Agencies should feedback to Children's Social Care when they do not receive minutes of formal meetings (CP Conferences and Core Groups, and Strategy Meetings) within the required timeframe.
- Where the criteria are satisfied for holding a professionals' meeting without parental attendance, an involved professional from any agency should be able to request this.
- Effective multi-agency work requires careful planning, so that services do not overwhelm the family.

Learning points for practitioners

- When assessing: always make an assessment of what a father/male partner and his family can offer to a child (positives), as well as of the risks he/they may pose.
- Remember: the quality of assessment can impact on all your future plans. Be sure to review and reappraise those assessments over time.
- When responding to incidents: ensure that you speak to a child alone in relation to any allegation of harm or physical signs of harm.
- When you are working with complex adolescents seek out proper management support
- Remember: the risk to a young person is not necessarily reduced if they are not living with the perpetrator and is likely to be exacerbated at the point of separation

Learning points for managers

- Assessment: Comprehensive thoughtful assessment which is reviewed over time is fundamental to the success of future safeguarding. Ensure that systems for support, supervision and challenge are effective.
- Supervision: Ensure that reflective supervision is carried out in neglect cases, with a focus on the lived experiences of the child/ren.
- Management: Ensure that neglect cases have clear plans – with desired outcomes, timescales, etc. – which are reviewed robustly on a regular basis

- Risk Management: Make use of the multi-agency risk assessment and management plan (MARAMP) and support inter-agency colleagues to reduce risk and impose boundaries on dangerous behaviour.
- Working with adolescents: Damaged and dangerous young people are often well known to services. Ensure that your service collates risk information so that it is easily accessible in records. Working with adolescents: Consider what contribution you should be making to improving your organisation's approach and services for working with adolescents.

Learning

The OSCB disseminates learning from SCRs in a range of ways e.g. through the annual conference, learning summaries from practitioners, learning events and training. This year three learning summaries have been produced. In 2015/16 the OSCB has produced a learning summary for the published review and also held learning events picking up on the key themes from the reviews. The learning events have involved: a narrative of the case; professionals' learning from the SCR; the child and parent's perspectives; opportunities to address difficult challenges; local resources and networking opportunities for local practitioners. These events are well-attended by hundreds of multi-agency practitioners and managers.

9. Report recommendations and agency actions from case reviews

On publication of a review the OSCB will produce a progress report or a statement on learning to date. The OSCB Performance, Audit and Quality Assurance Group (PAQA) monitors agency actions on a quarterly basis and the OSCB Executive monitors the recommendations made to the OSCB, at every meeting. It has been agreed that once a review is completed a closure report is compiled by the PAQA. The PAQA subgroup has the remit to test out how well the learning is embedded through audits and self-assessment frameworks such as the 'section 11' self-assessment.

10. Recommendations agreed by the Board

- The OSCB has supported the appointment of a permanent Learning and Improvement post and Training post to ensure effective learning and practice improvement in Oxfordshire
- The OSCB is to be kept appraised by CRAG of developments in the commissioning and undertaking of SCRs by a national panel.

Appendix A

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[4] 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.

[4] 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 B

Background information on each review

(1) Summary:	Review of a girl who died whilst living in an out of county therapeutic placement. There is an on-going police investigation in North Wales.
Review commissioned:	March 2013
Status:	The review is on hold until criminal investigation completed.

(2) Summary:	SCR / DHR for teenage girl who was killed by her ex-partner.
Review commissioned:	January 2014
Status:	Published March 2016

(3) Summary:	SCIE review of a baby who died by drowning whilst in the family home.
Review commissioned:	September 2014
Status:	Report completed and will be published following criminal trial.

(4) Summary:	Review of a baby who died having suffered an impact to the head using review model developed by Jane Wonnacott
Review commissioned:	January 2015
Status:	Report completed and due for publication.

(5) Summary:	Review or two young children who were sexually assaulted whilst in the care of their special guardian
Review Commissioned:	July 2015
Status:	Report in draft format.

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