Division(s): All

PERFORMANCE SCRUTINY COMMITTEE – 16 March 2017

Report by the Interim Deputy Director for Children's Social Care and Chair of the Case Review and Governance subgroup of the Oxfordshire Safeguarding Children Board (OSCB)

Summary Report on Serious Case Reviews

1. Introduction:

This update is provided by 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 13 months.

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[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 six serious case reviews since the last report to Performance Scrutiny, one of which (Child J) was also a domestic homicide review. Of those six reviews: two were signed off in 2015/6, two in 2016/17, one is active and one has been completed as far as possible, pending other processes. The published reports are Child J (February 2016), Baby L (September 2016), Child Q (January 2017), Child A and Child B (February 2017). They can be read in full on www.oscb.org.uk

[1] Working Together to Safeguard Children 2015

3. National Context

Since the last report national guidance and reforms have been released. In time this will impact on local work. In April 2016 the '*Learning in to practice: improving the quality and use of the Serious Case Reviews*[2]*'* was published, which set out quality markers 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 national 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 intention is that the majority of SCRs will be locally-driven. In May 2016 the national triennial review of case reviews was published. This considered nearly 300 SCRs relating to incidents which occurred over three years to 31 March 2014. Some of the key findings help provide broader context to the work in Oxfordshire:

- There has been no change in the number of child deaths linked to maltreatment and if anything a reduction in all except the older adolescent group. However the higher proportion of reviews on those aged 16 years and over was not a statistically significant increase.
- There has been an overall increase in SCRs, a steady increase in activity across the system and a dramatic increase in children with a child protection plan.
- Once a child is known to be in need of protection and a plan is in place, the system generally works well.
- Only 12% had a Child Protection plan in place at the time of their death or serious harm.
- Pressure points in terms of increased risk or vulnerability are identified at 'step up' or 'step down' in care.
- Fewer than half had current involvement with Childrens Social Care (CSC) and almost two thirds had at some point been involved with CSC.

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

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. Serious Case Reviews are conducted when abuse or neglect are indicated in child death or serious injury. The current Working Together (DfE 2015) guidance is attached at Annex 1.

Since the last report to Performance Scrutiny four new cases were brought to the attention of the OSCB for consideration in 2016/17. One was referred by Thames Valley Police and three were referred by Children's Social Care. Of these four referrals one serious case review was commissioned, one was deemed not to meet the criteria but led to a Partnership Review and two are still pending a decision at the time of writing.

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 (Department for Education 2013). It advises Local Safeguarding Children Boards (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 have been applied correctly. This has led to a tighter focus on the criteria and evidence based decision making. Of two Oxfordshire cases submitted to the National SCR Panel in 2015/16 one was contested. The OSCB reviewed this decision independently and remains of the view that it does not meet the criteria.

5. OSCB SCR Methodologies

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 six cases worked on since the last report one used the systems methodology developed through the Social Care Institute for Excellence (SCIE), two were '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.

6. Family contribution

As reports are written for publication, it is essential to involve families in reviews. Family members have contributed to all reviews which has added a layer of complexity but also provided valuable learning. 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, local Mencap services and probation officers who have facilitated family meetings.

7. Reviews: subject details and safeguarding themes

The details of the cases are:

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

The majority of cases concerned pre-school female children; however the cases concerning adolescents resonated with one another to some extent and highlighted serious issues in supporting vulnerable adolescents with a range of needs. It highlighted that a step change is required as to how we understand and respond to domestic abuse as well as the need to move from 'incident based models' to understanding the nature and impact of coercive control. Over the last year the themes covered by case reviews have been: the long-lasting impact of neglect; physical abuse; self-harm; child and parental emotional wellbeing; peer violence (domestic abuse) and parental substance misuse. The issue of neglect is a repeated theme in terms of the risks it presents to young children and the impact it continues to have as they grow up. In Oxfordshire neglect is the most common reason for a child to be subject to a child protection plan and continues to be a top priority for OSCB.

8. Learning points in common with other Oxfordshire case reviews

The OSCB has conducted a number of case reviews over the last five years and seeks to draw out common themes where possible. From the four recently published these are the most common learning points:

- The importance of thinking carefully about the role of the father in the family system as well as communication with and involvement of fathers and male carers.
- The need for curiosity about the families' past history, relationships and current circumstances that moves beyond reliance on self-reported information.
- There are more challenges faced by professionals working with vulnerable families where neglect is an embedded issue.
- The impact of the parent's mental health problems on the safety and wellbeing of the child.
- Understanding of substance misuse and interventions, the changing levels of risk, and the impact on the child.
- Normalising and misinterpreting children's behaviour - linked to Special Educational Needs.
- Identifying the increased safeguarding risks for children with learning disabilities and Special Educational Needs and the fact that signs of abuse and neglect may be masked by, or misinterpreted as due to, underlying impairments.
- Identification of physical and sexual abuse and following safeguarding processes thoroughly.
- Multi-agency work must be well co-ordinated in order to share planning and to better understand what is happening to the child
- Effective risk management requires systematic planning across the multi-agency partnership.
- The capacity of adolescents, with impaired emotional development, to protect themselves can be overestimated and this can mean that proactive steps to protect them are not always implemented with sufficient authority or rigour.

The OSCB has produced a 'user-friendly' learning summary for each published review and also held learning events picking up on the key themes from the reviews. The learning events have involved: the story / learning from the SCR; the child's perspective; lessons for practice; local resources and networking opportunities for local practitioners. In the last year they focused on – domestic abuse in the family home and between peers; grooming and staying safe online; the importance of building relationships with young people and understanding what 'identity' means as they go through adolescence.

9. Report recommendations and agency actions from case reviews

The four case reviews signed off since the last report led to 26 multi-agency recommendations. At the time of publication progress reports outlining outcomes and actions were published for two of these reports on the OSCB website. Two of the reports had more specialist actions. One concerned communications between and by health agencies on a routine basis as well as out of hours. The other concerned changes to specialist provision such as special guardianship of children. All recommendations form part of the OSCB business plan and drive the direction of work e.g. the OSCB 2016/17 priority to improve practice focuses on working to address neglect and working to safeguard adolescents.

Monitoring of Actions

The recommended actions are monitored through the OSCB Executive Group. Any actions being led by individual agencies are monitored through the OSCB Performance, Audit and Quality Assurance Group (PAQA). Outcomes are then reported into the Executive and are summarised in the annual report of the PAQA subgroup.

Outcomes

The published progress reports provide insight to work on specific recommendations but some broad headlines over the last year would be:

- ***The involvement of fathers in Child Protection care plans*** *is tracked and attendance at conferences by fathers is reported by Independent Chairs of Case Conferences to be at higher levels. A learning summary was produced*

and the OSCB contributed to the recently published 'Future proofing fathers work' by the Oxfordshire Parenting Forum.

- ***Strengthening core groups as part of the child protection planning process****: ensuring meetings take place as planned by arranging a 'deputy' to cover in a social worker's absence; ensuring that there is consistent, good quality administration so that all parties know what has been agreed. This has led to improved attendance (and consistency of support) which is regularly monitored through the OSCB quality assurance subgroup.*

- ***The shared use of tool kits****: The updated Threshold of Needs Matrix and the new Early Help Assessment have drawn on learning from case reviews. They provide clear thresholds and pathways for escalation and de-escalation and more robust approach to early help. These have been reviewed with wide professional, child and family consultation and are the subjects of a full programme of multi-agency training sessions.*

- ***The use of chronologies for children who are on Child Protection plans*** *to ensure shared understanding. This is provided by social workers and is used by core group members. This also forms part of the information provided when cases are being transferred. The effectiveness of handovers is being monitored by Independent Chairs of case conferences and core groups and any concerns escalated through established internal management processes.*

- ***Identification of physical abuse and following safeguarding processes thoroughly.*** *A rolling programme of workshops for Children's Social Care staff commenced in 2016 which has included guidance about the management of incidents on open cases and strategy meetings.*

- ***A review of the 'pathway through services'*** *for vulnerable young people aged 16-24 years, who find it difficult to engage with services in order to keep them safe, was undertaken. Guidance and the pathway on working with young people where there is peer on peer abuse has also been disseminated. The focus on vulnerable adolescents is improving as the numbers supported by a*

child protection plan have increased. The county council is in the process of reviewing the care leavers strategy in line with new legislative responsibilities. An application to the Department for Education's Innovation Programme has been made for grant funding.

- ***A new service for children who have experienced sexual abuse*** *Horizon started in January 2016 and receives an average of 2.5 referrals per week[3]. This service draws on skills from Oxford Health NHS Foundation Trust and local community group Safe! It reports into the OSCB subgroup on child sexual exploitation where safeguarding themes are analysed and take up of the service checked.*

- ***The Complex Case Panel*** *is a multi-agency senior level panel which problem solves for the riskiest children and young people by working collaboratively and by ensuring that issues of high concern are escalated and addressed. This includes high risk domestic abuse or offending behaviour, CAMHS and child sexual exploitation. The panel has developed a policy to determine the most appropriate mechanism for managing risk/concerns for children and young people who do not meet Multi-Agency Public Protection Arrangements (MAPPA) criteria or court orders. This has been tested through case studies and shown to be providing good support.*

In conclusion

The OSCB has two ongoing Serious Case Reviews, one Partnership Review and two current cases that are being considered for a review.

[3] Figures as of Sept 2016

Annex 1

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.

Annex 2

Background information on each published review

(1) Summary:	SCR / DHR for seventeen year old girl who was killed by her ex-partner.
Review commissioned:	January 2014
Review type:	Working Together (DfE 2013), Home Office DHR guidance
Status:	Completed Dec 2015. Published March 2016
(2) Summary:	SCIE review of a baby who died by drowning whilst in the family home.
Review commissioned:	September 2014
Status:	Completed October 2015 and published January 2017
Review type:	Working Together (DfE 2013), SCIE model
(3) 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:	Completed Summer 2016 and published October 2016
Review type:	Reviewer led. No IMRs. No multi- agency practitioner events.
(4) Summary:	Review of two young children who were sexually assaulted whilst in the care of their special guardian
Review Commissioned:	July 2015
Status:	Completed Autumn 2016 and published February 2017
Type:	Reviewer led. Short chronologies. IMRs and interviews.

Annex 3

Glossary

CP	Child Protection
CRAG	Case Review and Governance Group
CSC	Children's Social Care
DfE	Department for Education
FLO	Family Liaison Officer
IMR	Individual Management Review
LSCB	Local Safeguarding Children Board
OCC	Oxfordshire County Council
OCCG	Oxfordshire Clinical Commissioning Group
OSCB	Oxfordshire Safeguarding Children Board
PAQA	Performance Audit and Quality Assurance Subgroup
SCR	Serious Case Review