Annual report from the Case Review and Governance Group

1. 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.

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. During 2016/17 representation from health providers such as OH NHS FT and OUH has also been recommended. 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 five serious case reviews since the last report to the Board. Of those five reviews: three were published (one of which was signed off in 2015/6 and a further two in 2016/17), one is active and one has been completed as far as possible, whilst a police investigation is underway.

The published reports are Baby L (September 2016), Child Q (January 2017), Child A and Child B (February 2017).

The two ongoing serious case reviews concern adolescents and have not yet been anonymised.

3. National Context

[1] Working Together to Safeguard Children 2015

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 triennial review of case reviews was published. This considered nearly 300 SCRs relating to incidents which occurred over three years to 31.03.14. 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.
- There has been an overall increase in SCRs and a steady increase in activity across the system.
- 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 CP plan in place at the time of their death or serious harm.
- Pressure points 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.

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-

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

agency learning. The current Working Together (DfE 2015) guidance is attached at appendix A.

Since the last report to the Board 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 (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 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. The LSCB has instead commissioned a partnership review to ensure that the work is reviewed and parents are able to inform this process.

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. The OSCB guidance for agency panel members is being strengthened so that they are clear on their roles and responsibilities, especially if linking to another agency not represented on the panel.

6. Parallel processes

A number of case reviews completed by the Board in the last few years have run alongside parallel processes. These range from disciplinary processes, criminal proceedings, complaints proceedings or other professional proceedings such as inquests, internal investigations or other formal reviews such as domestic homicide reviews. This can impact on the terms of reference, stakeholder participation, information sharing, chronology content, review length and cost.

This has led to the subgroup drafting guidance for stakeholders as to how these processes are best managed to ensure they are all completed in a timely manner and where possible achieve the best safeguarding outcomes for children.

7. 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.

8. Reviews: subject details and safeguarding themes

The details of the cases are:

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

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.

9. Ten 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 three recently published these are the ten most common learning points:

1. 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
2. The need for curiosity about the families past history, relationships and current circumstances that moves beyond reliance on **self-reported information**.
3. There are more challenges faced by professionals working with vulnerable families where **neglect** is an embedded issue.
4. The impact of the **parent's mental health** problems on the safety and wellbeing of the child.
5. Understanding of **substance misuse** and interventions, the changing levels of risk, and the impact on the child.
6. **Normalising and misinterpreting behaviour** - linked to Special Educational Needs.
7. Identifying the increased safeguarding **risks for children with learning disabilities** and Special Educational Needs.
8. Identification of physical abuse and **following safeguarding processes thoroughly.**
9. 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.
10. The **capacity of adolescents to protect themselves can be overestimated** and a tendency to view teenagers as adults rather than children can mean that proactive steps to protect them are not always taken.

The OSCB has produced a 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; local resources and networking opportunities for local practitioners. In the last year they

focused on staying safe online; the importance of building relationships with young people and understanding what 'identity' means as they go through adolescence.

10. Learning points in common with the Tri-ennial review

The CRAG summary from the May 2016 triennial review of case reviews stated that the findings are noteworthy and should be reinforced for managers and practitioners. Many findings are consistent with our own local quality assurance work and some have already been taken on board locally, specifically following the SCR into Children A-F. The following points are worth highlighting in particular.

For senior managers

- Coping with limited resources and increased activity and need for senior leaders to identify strategies to manage workloads and sustain acceptable levels through ongoing vigilance.
- Alongside this is the recommendation that there should be long term continuous approaches where maltreatment has been identified and a move away for single or episodic responses.
- Effective structures to be maintained through service change particularly in health and social care. Complexity of health structures noted and need for clear pathways and information sharing across transition points - locally had a potential impact on Baby L.

For practitioners and front line managers

- Step change required with how we understand and respond to domestic abuse and the need to move from incident based models to understanding the nature and impact of coercive control – Child J.
- Disabled children are particularly vulnerable where signs of abuse and neglect may be masked by, or misinterpreted as due to, underlying impairments - Children A and B; Child C.

11. Report recommendations and agency actions from case reviews

The three case reviews published since the last report (Baby L, Child Q, Child A and Child B) led to 19 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.

1. Monitoring

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 in to the Executive and are summarised in the annual report of the PAQA subgroup.

2. 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 CP 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 (CP) planning process****: simple things such as 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 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.*

- ***The use of chronologies for children who have CP 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. The focus on vulnerable adolescents is improving as the numbers supported by a child protection plan have increased.*

- ***A new service for children who are 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 OH NHS FT and local community group Safe! It reports in to the OSCB subgroup on child sexual exploitation where safeguarding themes are analysed and take up of the service checked*

- ***The Complex Case Panel*** *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*

[3] Figures as of Sept 2016

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.

13. Costs and timeframes

Costs of the reviews are reported on in the OSCB annual report. The variation in costs is down to the type of review, its complexity and the level of practitioner and family involvement. All reviews were signed off by the OSCB within a 12 - 18 month timeframe.

14. In conclusion

The OSCB is recommended to consider the ten most common learning points, the local messages that resonate with the findings from the national review of case reviews and to ensure that members of the local safeguarding partnership are fully aware of the learning from the three summaries published this year.

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

Links to learning summaries for each published review

Learning review for Baby L

Learning review for Child Q

Learning review for Child A and Child B

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