



Report title:	Case Review and Governance sub group annual report, 2017/18
Date:	14 06 18
Lead Officer:	Lara Patel
Contact Details:	Lara.Patel@oxfordshire.gov.uk

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.

1. 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, OH NHS FT, Public Health 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 criteria¹ 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 four serious case reviews since the last report to the Board. Of those four reviews: two are active and two have been completed as far as possible, whilst parallel processes are underway. One of the cases affected by

¹ Working Together to Safeguard Children 2015

parallel processes was initiated in 2013. The OSCB has also instigated one management review which is currently ongoing.

2. National Context

In May 2017 the 'The Children and Social Work Act', came in to power, 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.

3. 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.

Since the last report to the Board three cases were brought to the attention of the OSCB for consideration as a serious case review. One was referred by Thames Valley Police and two were referred by Children's Social Care. Of these three referrals two serious case reviews were commissioned, one was deemed not to meet the criteria. A further case was discussed by the group. This complex case led to a request for a case summary and assurances of safeguarding practice and multi agency working.

All cases considered for a serious case review 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. Of the three Oxfordshire cases submitted to the National SCR Panel in 2017/18 none were contested. However, there was one case that was contested at the end of the previous year. During 2017/18 the OSCB reviewed this decision independently and

remained of the view that it does not meet the criteria. The National SCR Panel accepted this point of view although they did not share it.

4. 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. The three new cases worked on since the last report have all been 'reviewer-led'. The case initiated in 2013 was based on 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. A set of principles were developed in 2016 which have been further strengthened in 2017/18 to include guidance for agency panel members as well as parallel processes which have had a significant influence on OSCB case review work.

5. 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.

Attached at appendix B is guidance on 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.

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, probation officers as well as social workers from the County Council all of whom have facilitated family meetings.

7. Reviews: subject details and safeguarding themes

The details of the cases are:

- The four different serious case reviews have concerned five children.
- One of the children was between 1-5 years. Four of the children were aged between 10-15 years.
- One was female. Four were male.
- One of these children is transgender

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; engagement and attendance in education. 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. The OSCB has a Task and Finish Group to co-ordinate work to address neglect.

8. Learning points from Oxfordshire case reviews

Last year the CRAG summarised the ten most frequently recurring learning points from the three most recently published case reviews. A lot of work was undertaken to promote the learning including 3 learning events. Some examples of work undertaken to address those points is set out in section 13. The OSCB has not published any reviews in the last year but the themes coming through ongoing reviews are worth summarising as the consequences are so serious to children.

1. **Curiosity:** being curious about the family's past history, relationships and current circumstances in a way that moves beyond reliance on self-reported information
2. **Responding to physical abuse:** professionals identifying it, listening to children and following safeguarding processes thoroughly; children may sometimes be too afraid to speak or unable to verbalise what they are going through
3. **The role of schools in keeping children safe**
 - effective management of records and sharing them when children transfer schools; effective escalation of concerns.
 - children are safest in full time education. Oxfordshire serious case reviews indicate that children on part time time-tables, children absent from school and

children educated at home are at increased risk. School attendance is a critical factor to support opportunity, well-being and safety

4. **Professional understanding of the implications of elective home education:** actively knowing which agencies are in touch with the family and to what effect
5. **Taking a cumulative view when working with children:** not seeing events in a linear way but weighing up risks over time and keeping previous events in mind (using chronologies)
6. **Parental wellbeing:** mental health, substance misuse and domestic abuse are recurring themes. With respect to mental health colleagues need to recognise the risks and impact on the safety of the child; don't minimise 'older' information
7. **Fragmented management of health needs:** ensuring effective communication across services for co-ordinated and consistent management of care
8. **Children's emotional wellbeing:** increasing evidence of self-harm by children aged 10 years & above
9. **Children's limited capacity to protect themselves** as they move into adolescence after experiencing a lack of consistent, supportive parenting in their early years (long lasting impact of neglect)
10. **Rethinking 'did not attend' to 'was not brought'**

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.

9. Report recommendations and agency actions from case reviews

The three most recently published case reviews (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. All recommendations form part of the OSCB business plan and drive the direction of work e.g. the OSCB 2018/19 priority to improve practice focuses on: working to address neglect and working to safeguard adolescents.

10. Monitoring

The recommended OSCB actions are monitored through the OSCB Executive group. A decision was taken by the Performance, Audit and Quality Assurance Group (PAQA) in 2017 that individual agency actions should be monitored internally and comments / key outcomes from them could be provided in the single agency annual report of its quality assurance work to that group.

11. Communicating the learning from reviews

In 2017/18 the OSCB held three learning events which focused on the ten learning points from serious case reviews. The CRAG Chair and members led the first event which covered each of the ten points using the case reviews as examples and involving practitioners in relaying the narrative of these cases. The second event covered the learning point regarding fathers. The third event covered the learning point regarding neglect. Health, education and social care professionals led this event which had a big impact on attendees.

12. Outcomes

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

- *Think Family training (free online learning) has been developed and launched by the OSCB partners so that colleagues think about all family members when working to support and protect children*
- ***The involvement of fathers in CP care plans is tracked and attendance at conferences by fathers is reported. The Think Family operational group are taking this work forward in 2018/19.***
- *Guidance produced and circulated for headteachers on effective supervision for safeguarding work in schools so that school staff are better supported in their decision making when working with children*
- ***A co-ordinated and improved focus on keeping children safe in education which has included the development of an additional County***

Council post to work with education providers to ensure that children are in school

- *Development of targets for education providers to ensure that children are in full time education and are safe. This includes guidance and data on attendance, exclusions and elective home education.*
- ***Development of locality panels on children going missing which link in to the child exploitation work for better management of care and support to children***
- *A checklist has been developed by the Independent Reviewing Officers for children with complex needs and are escalated if timeframes for children's placements and 'permanency planning' are not met*
- ***Introducing the use of chronologies for children who have Child Protection plans to ensure shared understanding of how to contribute to a shared chronology***

13. Costs and timeframes

The variation in costs is down to the type of review, its complexity, duration and the level of practitioner and family involvement. Of the three published reviews the costs have ranged from approximately £10,000 for Baby L through to over £20,000 for child Q. All recently published reviews were signed off by the OSCB within a 12 - 18 month timeframe.

14. In conclusion

The OSCB is recommended to maintain a focus on the ten most common learning points from ongoing reviews and to ensure that members of the local safeguarding partnership are fully aware of the learning from the three most recently published summaries.

Appendix A

The Working Together (DfE 2015) guidance (*current at time of writing*) requires a Serious Case Review to be undertaken for every case where abuse or neglect is known or suspected² 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.

² 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

OSCB Principals for completing safeguarding reviews



OSCB operating principles and guidance

Appendix C

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