Divisions Affected – All

PEOPLE OVERVIEW AND SCRUTINY COMMITTEE - 17 February 2022

Serious Case Review for Child R

Report by Corporate Director for Children's Services

RECOMMENDATION

1. **The committee is recommended to note the findings and recommendations of the Serious Case Review for Child R and to note the actions taken to date.**

Executive Summary

2. The Serious Case Review (SCR) concerns child R who was 13yrs old when she took her own life in 2013 in an out of county residential establishment. An SCR was commissioned at the time, however, complex and protracted concurrent police, Health & Safety and social care investigations meant that only a summary report could be completed. Immediate learning was identified by the Oxfordshire Safeguarding Children's Board (OSCB) at the time. The Health & Safety investigation concluded in September 2020 when the home pleaded guilty to a breach of Health & Safety legislation. The SCR was prepared for publication at this time, however, further information from the Health & Safety prosecution papers led to an updated report. Child R's family were kept informed throughout the process.

3. The SCR report was published in December 2021 and was focussed on learning and explaining what happened. The findings of the SCR are:
    a. Working to keep children safe within their families continues to be a challenge and there is the need to ensure that improvements made since child R was a child are embedded into practice**.**
    b. Placement Planning and managing the complex needs of Children in Care needs sufficient placement availability, clarity of role across the professional network and systems that scrutinise and challenge how well the child's needs can be met.
    c. Where there is a risk of suicide, Children in Care should have a clearly articulated suicide prevention plan which takes account of emotional, behavioural and situational risks.

4. The SCR makes ten recommendations which are being progressed through a multi-agency action plan overseen by the OSCB. Progress made against the findings and recommendations to date include:

5. Early Help:
   - Senior leadership strengthened to maintain year on year increase in use of early help assessments
   - Improved community responses to 'Team around Family' and Early Help Networks established to improve multi agency problem solving
   - Revised Threshold of Needs framework to advise all staff when and how to act early and Early Help Core Offer reviewed and enhanced
   - Increased supervision in school to help staff to engage early with families
   - Joint activity pathway in place to ensure shared understanding across adult and children's services to meet children's needs
   - Training and induction in early identification delivered across the workforce has resulted in increased numbers of assessments across the partnership

6. Tackling neglect:
   - Senior leadership of revised strategy and action plan across health and children's social care
   - Peer Review in 2018 identified strengths in leadership, tools, strategy and performance framework
   - OSCB Challenge Event in Sept 2021 identified progress in development of services, systems and process together with multi-agency shift in perception and response and understanding of role and responsibilities

7. Court orders:
   - Where a court order applied for in care proceedings has not been granted by the court, a system is in place to ensure each child's needs are overseen by a senior level multi-agency panel

8. Placement monitoring and review:
   - Improved placement commissioning and monitoring – specialist children's brokerage team; well established panels in place to provide assurance and oversight of: children's entry to care, what is being commissioned and how it is being delivered and any safeguarding concerns. Embedded Valuing Care needs assessment for all children in care to ensure that what we commission is meeting children's needs.
   - Multi agency risk assessment and management includes risk of suicide
   - Placement monitoring protocol in place and staff trained, including risk assessments for ligature points in residential homes and prompts regarding staffing levels
   - Register of all placement providers completed

9. Placement insufficiency
   - Letter sent by OSCB Independent Chair to DfE, the National Child Safeguarding Practice Review Panel and Chair of the Care Review regarding local concerns in relation to the impact on children of placement insufficiency
   - Local sufficiency strategy developed with an action plan underway to increase local fostering and residential placements

10. Health care of children with most complex needs

- Clinical supervision is provided to social workers for children we care for, to help develop the child's needs assessment and inform the child's plan
- NHSE have created a pledge for Children and Young People that they will receive equitable CAMHS services regardless of where their home is. This has raised the profile of the mental health needs of children nationally.
- Robust escalation processes are providing improved management of situations where CAMHs engagement is problematic

Kevin Gordon
Corporate Director for Children's Services

Annex: None

Background papers:

2021-12-09-Child-R-Serious-Case-Revew-Report.pdf (oscb.org.uk)
2021-12-09-Child-R-Learning-Summary.pdf (oscb.org.uk)

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