Report Title	**Child Safeguarding Practice Review subgroup annual report, 2021-22**
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1. Introduction

This is the annual report from the Chair of the Child Safeguarding Practice Review (CSPR) subgroup. It covers information on all reviews considered and commissioned as well as any action taken over the last 12 months.

2. The CSPR subgroup

The purpose of the subgroup is to support the OSCB in fulfilling its legal duty to undertake reviews where the criteria[1] is met. It has the local duty to undertake reviews where learning could lead to improvements in practice. The aim is to help the OSCB learn from the most serious and complex situations and incidents. The subgroup members come from:

- Thames Valley Police
- Oxfordshire County Council's children, Public Health education and legal services
- The NHS through the Clinical commissioning Group, Oxford University Hospitals FT and Oxford Health NHS FT

The local education community

3. National Context

The Department for Education's National Panel for Child Safeguarding Practice Reviews maintains national oversight of review work. Over the reporting period the National Panel for Child Safeguarding Practice Reviews has completed a review on safeguarding children under one from non-accidental injury. This is pertinent to the OSCB Rapid Reviews. The panel has noted some national trends also reflected in our local reviews: supporting children during Covid-19; keeping children safe who are not seen by schools; domestic abuse; risk assessment processes and multi-agency decision making.

[1] Working Together to Safeguard Children 2018

4. Rapid Review meetings held by the CSPR subgroup

The purpose of a Rapid Review is to decide if the criteria is met for a Review[2] and if one is needed. (If work is already in place or there is no further learning to be gained, then it is not necessary to do a review). Serious incidents are referred for a Rapid Review in line with guidance in Working Together 2018. Appendix A explains how the Department for Education defines a serious incident. The CSPR subgroup also reviews cases referred by board members if they present concerns in how well agencies have worked together to safeguard children. This includes cases which may have met the NHS Serious Incident Framework[3].

4.1 Relevance of Rapid Reviews

Rapid Reviews concern current incidents. They guide us to current learning points.

They do however concern a very small number of children. The population of children in Oxfordshire is estimated to be 140,000. Over 500 children are subject to child protection plan and we care for over 800 children. We know however, that the Rapid Reviews reflect national safeguarding themes. The National Panel's reports cover the same themes.

4.2 Rapid Review facts and figures from 2021-22

- 6 Rapid Reviews, compared to 9 in the previous year (2020-21)
- 1 Rapid Review recommended a CSPR
- 3 referral sources: health, children's social care and a neighbouring partnership
- 2 Rapid Reviews were held jointly with neighbouring safeguarding partnerships
- 0 concerned child deaths
- the National CSPR[4] Panel agreed with all but one of the decisions, where they requested further clarification on specific points regarding the children'

This year there was increased activity with neighbouring safeguarding partnerships. This included the contribution to a Rapid Review from another county. This reflects the ongoing theme of insufficient places close to home and the challenges of keeping children safe where their needs are complex and they move in and out of Oxfordshire.

4.3 Children reviewed

- 8 children were involved in the 6 Rapid Reviews
- they were from 6 families
- half of the children were below 5ys and half were 13ys and above
- of those below 5ys, 2 were babies
- the majority had previous involvement with children's social care e.g., a child in need, subject to child protection planning or a child we care for

The breakdown of children was split by age group, as in 2020-21.

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[2] Review in this context means Child Safeguarding Practice Review

[3] NHS England » Serious Incident framework

[4] The National Panel receives, considers and comments on all Rapid Reviews and can commission national reviews requesting OSCB input as outlined in this guidance

Ages	Safeguarding factors
Children under 5 ys	• physical abuse – in most cases a male abuser • neglect – families were not able to meet the needs of their children • emotional abuse
Children 13 ys & above	• child sexual abuse within the home from male and female perpetrators • harm from outside the home (this is also called contextual safeguarding and is about child exploitation) • mental health and emotional wellbeing

This age breakdown could indicate that primary school is a key time to identify early concerns and offer more preventative support. Most of the adolescents had previously shown early signs of safeguarding concerns that were not always followed up.

4.4 Rapid Review – categories of abuse

For those children under 5 ys physical abuse was a key factor. It was associated with the learning that practitioners need full knowledge of the family background and parenting skills of all carers. In addition, medical staff were reminded of the procedures regarding skeletal surveys where there has been an injury and there are safeguarding concerns. Finally, it led to the repeat reminder regarding safe sleeping. This was also a learning point from the Child Death Overview Panel.

For those children aged 13ys and above sexual abuse within the family network was a key factor. It was associated with learning regarding communication with children. In particular communication with children who have a medical diagnosis, which means that they are non-verbal or struggle with communicating. A child's behaviours will be their way to show they need help. These Rapid Reviews highlighted the challenges of keeping children safe where their needs are complex, especially if they move in and out of Oxfordshire.

The Rapid Reviews showed that actions taken during the pandemic have had an impact. It meant that children have not always been 'seen'. Families' responses to the pandemic have sometimes been to opt for online meetings, decline children being weighed, keep children away from school or reduce contact.

5. Local Reviews

5.1 Purpose

A review is undertaken when we need to learn from the most serious and complex situations and incidents. It will be completed by an independent reviewer. The reviewer works with managers from local organisations to take an objective look as to how well they worked together. They talk to practitioners and to families. The review will lead to a report with findings and recommendations.

5.2 Relevance of Reviews undertaken by the CSPR subgroup

Reviews concern incidents which, usually, will have taken place over the last one-two years. They guide us to learning points that require changes to the way that we work together across the safeguarding partnership. These will be longer-term improvements.

As with Rapid Reviews they concern a very small number of children. However, the learning should lead to changed practice for many children.

5.3 Facts and Figures

The CSPR subgroup has worked on 5 reviews in 2021-22.

- 1 Serious Case Review[5] for Child R (published Dec 2021)
- 3 Child Safeguarding Partnership Reviews[6]
- 1 Partnership Learning Review[7]

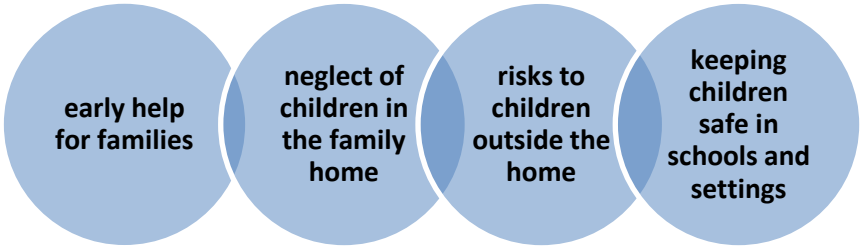
5.4 Children reviewed

The reviews concerned 6 children. Sadly, 1 of the children had died.

- 4 were female, 2 were male
- most were 13ys or older but 2 were below 5ys
- all were white British
- the majority had previous involvement with children's social care e.g., a child in need, subject to child protection planning or a child we care for

5.3 The safeguarding themes from Reviews in summary

Last year the safeguarding themes from case reviews fell under the below 4 headings.



However, there are new repeat factors from the more recent reviews:

child sexual abuse and child sexual exploitation	**sharing of intimate images on-line**	**children's emotional wellbeing and mental health**

These factors had a powerful presence in the reviews. The first two blocks often occurred together.

[5] *A Serious Case Review is the name previously given to an independent review into a case where a child has been seriously harmed or has died and abuse or neglect is known or suspected.*

[6] *Since the updated Government Guidance in 2018 a Child Safeguarding Practice Review is the name given to an independent review into a case where a child has been seriously harmed or has died and abuse or neglect is known or suspected*

[7] *A Partnership Learning Review is the name given to a review not meeting the national criteria but from which we can develop local learning*

6. Learning points this year:

Practitioner skill set

Reviews tell us that our skill sets need to respond and develop to current need. Safeguarding concerns have been as follows.

1. **Child sexual abuse**. We need to know how to recognise it, how to talk about it and how to address it with care. Children need to feel heard and feel safe.
2. **Behaviours demonstrating a child's trauma** and their need for help when they are not telling us using words, in particular if they are non-verbal.
3. **Thinking about how we talk 'to' and 'about' children.** Thinking through what words we use when we respond to children seeking help. Moving from "what is wrong with you" to "what has happened to you". This includes how we write about children.
4. **The long-lasting impact of adverse childhood experiences** which play out as a child becomes an adolescent and then a young person. We need to recognise emotional abuse and emotional neglect and the role that child blame plays within this.
5. **Safe sleeping**. Getting the message out there to all parents and carers, not just mums
6. **Working with fathers and male carers.** In the majority of reviews, where a child was harmed by an adult, the adult was a male and not enough was known or understood about that adult. Attention needs to be given to the whole family and all those who care for the children.

System leader focus

Leadership and organisational culture impact on practice. These are the messages for them

- **Make sure that vulnerable children are seen.** Covid has taught us that any decision not to meet with a vulnerable family in person must be a shared one. The risk of not doing so must be central to that shared decision.
- **Embed the culture of early help** work across everyone working with children
- **Develop a clear understanding of trauma informed** practice across your services and adopt that approach to working with children
- **Develop and invest in plans to keep children close to home** by expanding local residential and foster care provision to meet children's needs.
- **Ensure rigorous commissioning and quality assurance** of placements for the children we care for
- **Maintain oversight of how we record and share information** about children. Set high standards.
- **Ensure greater understanding of the range of mental health and mental wellbeing support** opportunities for adolescents

Messages for the DfE

Some issues require regional or national consideration. This year the OSCB has identified the following:

Child R's Review demonstrated the possible increased risk of harm when children are placed far away from home. National attention should be paid to the national insufficiency of placements to meet children's needs in their local area.

This Review asks the National Panel and the DfE to acknowledge the key learning and findings from Child R's Review including the possible increased risk of harm when children are placed far away from home. The Review asks for particular attention to be paid to the national insufficiency of placements to meet children's needs in their local area and for the learning to inform changes to policy, sufficiency levels and contractual arrangements with independent providers.

A few reviews indicate that the national practice of categorising abuse is out of date and does not work well. This is particularly difficult when there are multiple risk factors or, for many older children, when the risk is from factors outside the family. National attention should be given to the categorisation of risk, to ensure it reflects current safeguarding practice and is achieving its purpose.

7. Publication of Child R in Dec 2021: Report and Learning Summary

Child R was thirteen years and seven months old when she died in an out of county residential placement in 2013. She had previously been in foster care in Oxfordshire and had also been treated in an Oxfordshire in-patient psychiatric unit prior to moving to the residential home. She was part of a large sibling group, who had been supported by services for some time. Safeguarding concerns included neglect, physical harm and sexual harm.

There were 3 main findings. See appendix B for full details.

1. Improvements to our 'early help' work need to be embedded into practice.
2. To make sure that placements are safe for the children we care for, with complex needs, we need:
   - high-quality placements close to Oxfordshire
   - understanding of who is doing what at a professional level
   - systems to check and challenge how well the child's needs can be and are being met.
3. Where there is a risk of suicide, the children we care for should have a clear suicide prevention plan which takes account of all risks

8. The Review Process

8.1 Reflections from Practitioners

Practitioner events give us the opportunity to come together to share experiences and learning. We want to hear practitioners' perspectives and welcome their involvement. It is encouraging to receive feedback to say that the sessions have been, *'powerful and beneficial'.*

8.2 Reflections from independent reviewers

Independent reviewers have given positive feedback on working in Oxfordshire. One reviewer fed back to us**, '***Practitioners from all agencies are always open and willing to reflect on their practice. They are not defensive and are committed to improving the experience of children and young people in Oxfordshire'.*
'There is a high degree of empathy for children and young people, a focus on their lived experience and a desire to understand the impact of practice decisions on them'.

8.3 Family feedback

The OSCB always tries to involve family members and those who have cared for the children. It is so important to hear their perspective. A key message we heard this year was just how important it is for families, especially siblings, to be recognised as 'protective factors' for each other and to not underestimate the support they could provide one another even when they are experiencing really difficult situations. This themes is recognised in the independent review of social care, which refers to the need to recognise relationships and the strengths of families.

8.4 Costs, timeframes and process

Costs vary according to the type of review, its complexity, duration and the level of practitioner and family involvement. They can range from approximately £8,000 to over £20,000.

8.5 Sharing learning

The CPSR subgroup shares learning from each Rapid Review with safeguarding partners such as the Housing Forum and Safeguarding Trainers at regular intervals. Online learning events were run and sessions. For those registered with the OSCB booking system they can still be accessed as follows:
Improving our practice through learning from reviews
The right support at the right time
Introduction to the mental health pathway
Reducing the Risk, The Domestic Abuse Act 2021
Untouchable worlds, learning from the Child Safeguarding Practice Review for Jacob
Updated learning from the CSPR for Jacob

9. Impact of reviews

OSCB Reviews keep recommendations to a minium to ensure they are focused and have impact. The following are examples of change as a direct result of recent reviews:

- ✓ **Updated Thresholds of Needs** to help practitioners make the right decisions about children's level of safeguarding need and plan the right support at an **early** point
- ✓ **Improved Joint Operating Framework for taxi licensing** providing a single set of minimum standards for agencies with responsibilities for transporting children. All districts, the city and county councils and the police are now operating within this framework.
- ✓ **Raising awareness of placement insufficiency** locally leading to careful consideration of placement in relation to distance and proactive monitoring when children are far from home
- ✓ **Improved rigour** when commissioning placements for children with complex needs with improved quality assurance such as guidance on expectations and clarity on professional responsibilities
- ✓ **Keeping children safe in schools** – Guidance is now in place to review decisions would could permanently exclude a vulnerable pupil from school. The aim is to find solutions which reduce any risk of harm.
- ✓ **Improving the screening tool for criminal exploitation** to help practitioners understand whether a child is vulnerable to exploitation and if they need to seek further help
- ✓ **Reflecting on the need for whole-system 'cultural change'** at every level to ensure that we work together to address neglect

10. Conclusion

The CSPR subgroup is how the safeguarding partnership can learn from the most serious and complex reviews.

The OSCB has a leadership role in improving joint working to safeguard children.

Leadership includes knowing what needs to change, where and why to keep children safe.

The ten recommendations from the Child R serious case review published this year are a good reference point on what needs to change.

Appendix A

(i) **Working Together 2018 Guidance**
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

(ii) Serious harm and notifications

The Children Act 2004 (as amended by the Children and Social Work Act 2017) states:
"Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if
(a) the child dies or is seriously harmed in the local authority's area, or
(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England."

The notification must be within 5 days of becoming aware of the incident. The local authority should also report this to OSCB.

The local authority must also notify the Secretary of State and Ofsted where a looked after child has dies, whether or not abuse or neglect is suspected.

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain.

Any notification of an incident referred to the Panel will also be referred to the CSPR Subgroup for a local decision on whether the case:

- meets the criteria for a Child Safeguarding Practice Review
- whether the case may raise issues which are complex or of national importance

Appendix B

Child R: Findings

Finding One
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.

Finding Two
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.

Finding Three
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.

Child R: Recommendations
Findings

Recommendation One
The safeguarding partnership should ensure that there is a cultural shift across universal services so that Early Help Assessments are seen as a helpful multiagency tool, that practitioners are confident to carry them out and that they ask the questions that will help them understand the child's needs within their family context. There should be evidence that when a professional and family have agreed that early help services at Tier 2 can meet the family's needs, this should be followed through to an early help assessment and plan that achieves clear outcomes. The assessment and plan should be implemented by a named lead professional and the practitioners who know the child(ren) and family

Recommendation Two
There should be evidence that the partnership's neglect strategy is being implemented and neglect tools are being used in practice to contribute to effective assessments and plans.

Recommendation Three
There should be a check in the system so that Children's Social Care maintains their current oversight of court orders by the court progression manager to ensure that the 'complex case panel' automatically reviews cases where the order applied for in care proceedings has not been granted by the court.

Recommendation Four
(i) National recommendation:
This Review asks the National Panel and the DfE to acknowledge the key learning and findings from Child R's Review including the possible increased risk of harm when children are placed far away from home. The Review asks for particular attention to be paid to the national insufficiency of placements to meet children's needs in their local area and for the learning to inform changes to policy, sufficiency levels and contractual arrangements with independent providers.
(ii) Local recommendation:
In light of the national and local insufficiency of placements the Council and its partners should continue to develop and invest in plans to keep children close to home by expanding local residential and foster care provision to meet children's needs and report to the Safeguarding Partnership on progress on an annual basis.

Recommendation Five
Work should be undertaken across health and social care to define the meaning of the terms being used to describe the therapeutic (mental health) needs of children in care and the different types of interventions that should be used to meet their needs and the role of risk assessments in identifying the implications of any delay in the provision of therapy. This should be disseminated to all relevant health and social care staff so that a child's needs are understood, and the appropriate support is commissioned and provided within the child's placement, and in the local area of the placement.

Recommendation Six
There should be a clear local system for the commissioning and quality assurance of placements for children we care for, including children placed out-of-county. This system should be known and understood by all practitioners in children's social care, contracts and commissioning. This system should provide clarity for social workers as to where to go if there are concerns that a residential provider is not meeting the needs of a child.

Recommendation Seven
There should be a clear local system of scrutiny and governance of the healthcare of children with most complex needs, including children placed out-of-county. This system should be known and understood by all practitioners working with the children in our care and it should provide:

- Clarity for social workers as to where to go if there are concerns that the therapeutic needs of a child are not being met in placement.
- Commissioning arrangements which formalise the role of the home

- CAMHS service in monitoring of the way in which the therapeutic needs of child in placement are met if they have been involved with Oxfordshire CAMHS.
- Clear expectations as to the specific information about incident within he home that should be shared with the treating CAMHS consultant.
- Oversight by the continuing health care worker which is used to full advantage and integrated into other review systems

Recommendation Eight
All placement plans should set out specific expectations regarding levels of staffing and how often checks should be made on the young person during the day and through the night. The meaning of "waking night cover" should always be clarified.

Recommendation Nine
Where a young person has been identified by mental health and/or social work assessments as being at risk of taking their own life, placement plans should include a specific suicide prevention plan which is distinct from risks of self-harm. This plan should be shared with the Local Authority where the home is situated.

Recommendation Ten
Where a child has self-harming behaviours or suicidal ideation. risk assessments by residential providers must include specific assessments of ligature points throughout the home and most specifically in the young person's bedroom. Placing authorities should expect these risk assessments to be shared with them so that they can be scrutinised by commissioners and integrated with the child's placement plan.