Agenda Item No: 5

SERIOUS CASE REVIEW ACTION PLANS

To:	**Children and Young People Committee**
Meeting Date:	**30th June 2015**
From:	**Adrian Loades, Executive Director: Children, Families and Adults Services**
Electoral division(s):	**All**
Forward Plan ref:	**N/a** ***Key decision:*** **No**
Purpose:	**The purpose of the report is to share with the Committee learning from recent Serious Case Reviews undertaken in Cambridgeshire and the actions Cambridgeshire County Council Children Families and Adults Services have taken in relation to these.**
Recommendation:	**The Committee is recommended to consider and comment on Children, Families and Adults response in relation to the learning from the Serious Case Reviews.**

	Officer contact:
Name:	Sarah Jane Smedmor
Post:	Head of Safeguarding and Standards for Children's Social Care
Email:	Sarah-jane.smedmor@cambridgeshire.gov.uk
Tel:	01480 379445

1.0 BACKGROUND

1.1 Cambridgeshire Local Safeguarding Children Board have initiated three serious case reviews over the last eighteen months. Each review takes on average of six months to complete from the point of commissioning. Each case is anonymised and are referred to as Child H, Child J and Child K.

1.2 The publishing of these reviews has been delayed due to a number of reasons. In two cases criminal trials needed to be concluded prior to the review being published and in one case the results of a post mortem were awaited. This is a similar picture across the country and is a national trend and while six months is always the aspiration to complete the review and publish, it is rarely the actual timescale. Hence, three reviews have been completed and published in Cambridgeshire over the last few months.

1.3 Every Local Safeguarding Children Board (LSCB) has a statutory responsibility to undertake a serious case review when a child dies from abuse or neglect or where agencies have failed to work together to protect a vulnerable child. The primary purpose of such a review is to see what lessons can be learnt to mitigate a similar event occurring in the future. Any death of a child is a tragedy and all agencies must do everything they can to ensure they are working together as effectively as possible. However, we must also acknowledge child deaths are not always either predictable or preventable.

1.4 The purpose of a serious case review is for professionals and organisations with a responsibility for protecting children to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so there is a growing understanding of what works well. Conversely, when things do go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

1.5 These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases as everyone across the county has an interest in understanding both what works well and also why things can go wrong.

1.6 Serious Case Reviews are not only conducted when a child dies but also in some instances of significant harm such as a serious sexual assault as in one of the recent Serious Case Reviews published in Cambridgeshire - Child J.

1.7 Actions for the County Council and the Children, Families and Adults Directorate were identified in the report for Child H and Child K but none in the case of Child J.

2.0 MAIN ISSUES

2.1 Child J

2.2 Child J was seriously sexually assaulted by her mother's partner, who has subsequently been sentenced to seventeen years in prison for the assault. Child J was four years old at the time of the assault.

2.3 A serious case review was commissioned by the LSCB serious case review group to consider if there were any systemic failures within the safeguarding network leading up to the assault of Child J. The review concluded that no individual or organisation could have predicted or prevented the assault and they there were no systemic failures in the system.

2.4 Good practice was identified within the Children's Social Care Integrated Access Team (IAT) for robust follow up after a 'What if Conversation' from the hospital paediatrician who treated Child J on her first admission to hospital.

2.5 On her second admission to hospital, when the sexual assault on Child J was evident, Children's Social Care and the police were recognised to have worked well together to safeguard child J and her brother in a timely manner and for identifying foster carers who spoke in the children's first language.

2.6 The review made three recommendations for the LSCB. There were no recommendations for the Local Authority.

2.7 Child H

2.8 Child H was two years old when she was murdered by her mother's partner. He is now serving a life prison sentence for this crime.

2.9 The LSCB serious case review group commissioned a serious case review to consider if there were any systemic failures within the safeguarding network leading up to the death of Child H. The review concluded that no individual or organisation could have predicted or prevented her death and there were no systemic failures in the system.

2.10 Child H and her family had been an active case to Children's Social Care for twenty five days prior to her death and in this time it was identified that all assessments were undertaken in a timely way and the social work unit had made visits to the children five times in this timeframe, making sure the children were seen alone where appropriate.

2.11 The Children's Social Care Integrated Access Team (IAT) followed up on a 'What if' conversation from the school when a referral was anticipated in respect of Child H and this was acknowledged as good and robust practice.

2.12 Learning opportunities were identified for all partner agencies. For the Local Authority there was one recommendation for Children's Social Care and one recommendation for education settings.

2.13 Children's Social Care was asked to consider procedures in regard to verbal agreements and to define expectations regarding good practice in their use of written agreements. The social worker made a verbal agreement with Child H's mother that she would undertake the sole care of her children and not leave their care to anyone else. This was to ensure that her parenting abilities could be fully assessed by the social work unit. The agreement remained verbal for the initial assessment period and was also verbally shared with partner agencies. It would have been good practice to move this agreement to a written agreement after the initial agreement which is reflected in the recommendation for Children's Social Care.

2.14 This recommendation has been completed and guidance has been updated. These agreements are short term as they will be superseded by a child in need plan, a child protection plan, a court care plan or a looked after child care plan. The guidance has been cascaded to staff in written form and verbally in the form of briefings. The briefings have focussed on the good practice identified within the serious case reviews recently undertaken in Cambridgeshire, shared the lessons learnt and the actions taken by Children's Social Care in response regarding the updating of the verbal and written agreement guidance. The briefing also provided an opportunity to discuss themes from the recently published Serious Case Reviews regarding Child Sexual Exploitation and raise awareness of work undertaken locally too.

2.15 Education settings were asked to review their recording processes and ensure there are not parallel reporting and recording systems which impact negatively on the effectiveness of seeing a full picture of the circumstances and needs of a child and their family.

2.16 The Learning Directorate has developed a checklist and guidance on reporting and recording for schools and settings. Training has been updated and provided via Governor's meetings and the Education Child Protection Service. This information has been disseminated across the county and passed onto the designated persons within schools and settings. The message will be communicated to Governors through their regular briefing sessions.

2.17 **Child K**

2.18 Child K was two years and five months old when he died unexpectedly at home. At the time both child K and his sibling had been subject to a child protection plan for a month.

2.19 Child K was born prematurely at 24 weeks and as a result of this had very complex needs. A bleed in his brain led to Child K developing cerebral palsy.

2.20 The LSCB serious case review group commissioned a serious case review to consider if there were any systemic failures within the safeguarding network leading up to the death of Child K.

2.21 The review concluded that although the professionals were aware of and were actively seeking to support this vulnerable mother and child, a number of key lessons for agencies were identified that would improve

safeguarding arrangements.

2.22 Learning opportunities were identified for all agencies involved with Child K and their family. There were two recommendations for Children's Social Care, one recommendation for Enhanced and Preventative Services and Early Support, three recommendations for the LSCB and one recommendation for Cambridgeshire Community Services.

2.23 Children's Social Care was asked to ensure the changed remit of the Disabled Children's Service is embedded and that the system for sharing their specialist knowledge to support social workers across Children's Social Care is defined and understood.

2.24 The serious case review acknowledged that significant advances have been made in the Disabled Children's Service over the last eighteen months. These have included embedding the Early Support Service for disabled children and their families, awareness raising amongst the professional network of the role of Lead Professional for Early Support and the role of the disabled children's social worker incorporating safeguarding responsibilities in conjunction with social work units.

2.25 Children's Social Care was recommended to review the current systems for the provision of legal advice.

2.26 The issues raised within the review was the child protection conference chair not being aware of the fact that the unit had taken legal advice in respect of Child K and what this legal advice was. There is now a robust mechanism in place to ensure the Conference Chair has this information, which is monitored through case file audits and audits of child protection conferences. Children's Social Care are satisfied that legal advice is taken and acted upon in an appropriate way.

2.27 Arrangements were requested to be reviewed between Early Help Services, Early Support Services and Children's Social Care so that plans can seamlessly transfer between the various Model of Staged intervention (MOSI) levels.

2.28 Transfer arrangements have been reviewed across the services. This has included the review of the allocation meetings within Enhanced and Preventative Services, enhanced understanding of the role of Early Support and detailed recording by Children's Social Care on closure summaries when a case is stepped to Enhanced and Preventative Services. The child's plan and the transitions between services is monitored through single agency audits and in the future will be monitored thorough joint Children Social Care and Enhanced and Preventative Services Audits.

2.29 See Appendix A for Child H and Child K action plans.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.2 There are no significant implications for this priority.

3.3 **Helping people live healthy and independent lives**

3.4 There are no significant implications for this priority.

4.0 SUPPORTING AND PROTECTING VULNERABLE PEOPLE

4.1 The report details the responsibility of the LSCB and Childrens Services in protecting vulnerable children. This is defined with the legislation Children Act 2014 and the revised Working Together 2015. Applying the learning from Serious Case Reviews is intended to reduce the risk to children and young people in the future.

4.2 **SIGNIFICANT IMPLICATIONS**

4.3 **Resource Implications**

4.4 There are no resource implications arising from the action plans. Guidance has been updated and the messages shared with the workforce. Safeguarding training has been updated across CFA and the messages from this serious case review are being shared as part of these established packages and briefings.

4.5 **Statutory, Risk and Legal Implications**

4.6 The Local Authority, as part of the Safeguarding Children Board, has legislative responsibilities under Working Together to Safeguard Children 2015 to partake in the serious case review process and to implement the recommendations and monitor the impact of these.

4.7 **Equality and Diversity Implications**

4.8 Equality and Diversity considerations have been addressed within the serious case reviews. The initial scoping of the reviews and the terms of reference ensured the process addressed how the families of Child J, Child H and Child K could be involved and the most sensitive way to engage them. The children's ethnicity and the families' cultural backgrounds were considered, as were any complex needs of the children or their families.

4.9 **Engagement and Consultation Implications**

4.10 For the three Serious Case Reviews the practitioners involved and the parents of the children have been consulted and involved in the formulation of the report and are aware of the recommendations made.

4.11 The Local Safeguarding Children Board has been consulted about the content of the report and the recommendations. Adrian Loades, Executive Director Children, Families and Adults, Niki Clemo, Service Director Children's Social Care, and Joan Whitehead are members of the LSCB.

4.12 **Public Health Implications**

4.13 There are no public health implications.

4.14 **Localism and Local Member Involvement**

4.15 This report has been brought to Members for information.

SOURCE DOCUMENTS GUIDANCE

Source Documents	Location
• Working Together to Safeguard Children 2015 Department of Education • Child J Serious Case Review Overview Report- Cambridgeshire Local Safeguarding Children Board • Child H Serious Case Review Overview Report- Cambridgeshire Local Safeguarding Children Board • Child K Serious Case Review Overview Report- Cambridgeshire Local Safeguarding Children Board	The documents can all be found on Cambridgeshire Local Safeguarding Children Board website. www.cambslscb.gov.uk