# Six Serious Case Review Recommendations

**Note: significant recommendations are in red.**

## Chris – Newham Safeguarding Children Board 2018

## Recommendations

1. Ways to improve professional competence in assessment across services. Emphasis placed on the following:
   - The importance of understanding early years and development in adolescent safeguarding.
   - Engaging young people and families in assessment and decision-making to ensure their voice is heard.
   - Assessment of contextual safeguarding concerns and understanding the impact of environmental/community factors on young people's welfare and wellbeing.
   - The offending/welfare overlap – understanding patterns of offending such as multiple NFA outcomes in the context of risk and vulnerability.
   - Professional curiosity and analytical skills.
   - Risky or challenging behaviour through the lens of trauma.

2. Review of Multi-agency risk and vulnerability panel.

3. Realign work with young people at risk of criminal exploitation with CE and to consider the creation of a contextual safeguarding hub.

4. To ensure there are appropriate policies, procedures, and pathways in place for children and young people at risk of gang affiliation and criminal exploitation, recognising that there is often an overlap.

5. To ensure there is access to Independent Return Interviews after young people return from missing episodes linked to CCE.

6. Specialist work to offer flexible and culturally competent engagement opportunities for gang affected and exploited young people using established and evidence-based practice models.

7. Where multiple risk indicators exist, consider additional transitional support between primary and secondary education with a focus on reducing CCE and gang affiliation.
8. A review of PRU provision to ensure it meets the local need.

9. Ensure a comprehensive professional development offer on CCE is in place.

10. Review local processes for the relocation of young people and families out of the borough, ensuring best practice underpins all decisions regarding the process of relocation.

11. Identification of CCE Champions in key services.

12. Increase awareness across agencies to the role social media plays in gang tensions and violence.
13. Consideration of the commissioning of a young men's service to include casework around harmful sexual behaviour using evidence-based approaches.

14. Access to flexible and responsive trauma-informed debriefing and clinical support available to both staff and volunteers and that self-care and staff wellbeing is embedded in policies, procedures and organisational culture.

## Jacob – Oxfordshire Safeguarding Children Board 2021

## Recommendations

### Criminal Exploitation

1. A relentless focus on disrupting perpetrator and networks to ensure safer communities.
2. Consideration of the child's home in the local community and assess what other places might be needed to ensure their physical and psychological safety.
3. Support professionals to build relationships with children and understand their world.
4. Act upon critical and reachable moments in a child's life.
5. Consider the significance of gender in working with exploited children.
6. Know the risk factors and predictability.
7. Understand the significance of a child's identity with their community networks when assessing levels of risk.
8. Manage risk via multi-agency assessments, plans and contingency.
9. Ensure the right support to help families and manage the risks together.
10. Review the role and function of the NRM.

### The Education System

1. The importance of schools in keeping children safe.
2. An education package is put in place in a timely manner for those children who may show challenging behaviours.
3. Children missing education are known and action is swift.

**Particular attention to be paid to**:

- restorative work to resolve fragmented arrangements between academy schools, alternative provisions and the local authority to ensure collective ownership.
- policy and procedures to track when children are not on roll.
- the function of education panels, education packages for children who may be at risk of exploitation and also present a risk to others.
- local application of the Education Skills Funding Agency intervention.

## Working Together

1. Involve all the local safeguarding system to understand extra-familial risk and harm in a timely manner.
2. Ensure discussion at all levels of seniority result in collective responsibility and ownership which the family understands.

3. Robust systems in place which support all levels when there is a difference of opinion.
4. A shared language across the Partnership.

**Particular attention to be paid to:**

- Ensuring the escalation policy and complex case panel purpose and function are known and used to share and resolve difference of opinion at all levels of the partnership.

## Child C – Waltham Forest Safeguarding Children Board 2020

## Recommendations

1. A national review of current guidance on home education.

2. Procedures, guidance and training to embed the concept of 'reachable moments' in the safeguarding of adolescents.

3. Review the current arrangements for recovering children from outside the Borough.

4. All children who are returned to the Borough are brought back by adults with skills relevant to working with children who are being criminally exploited and that those adults continue in personal contact with the children when they return.

5. Refer and request that the current uncertainties about the catchment area of the 'Rescue and Response County Lines' are rectified by a clear and unambiguous statement made to each Police Force.

6. Raise the issue of the absence of a national system for responding to children who are arrested and detained away from their home areas with the DfE, the Home Office and Ministry of Justice.

7. Safeguarding Partnership to audit the use made of case discussions in order to ensure that multi-agency discussion always takes place where a plan is being developed.

8. Review current arrangements for multi-agency case discussion in safeguarding cases, particularly those arrangements applying to adolescents to ensure that all agencies with a contribution to make are invited and involved.

9. Referring to DfE regarding how it intends to review the current guidance on multi-agency case discussion.

10. Review the references to the involvement of Housing Services in case discussions and meetings in their procedures and either broaden the invitation list to strategy discussions or create provision for case discussions that do involve housing where needed.

**Archie Sheffield 2020**
**Recommendations**

1. Every child arriving from outside the UK and taking a place in the education system should receive an assessment in school to assess their academic ability, level of attainment and other vulnerabilities that may impact on their learning. This assessment should be recorded and should be available to influence future interventions by all agencies.

2. It is the responsibility of all agencies to ensure every child in Sheffield is in an appropriate educational setting every day and that their policies and procedures work to support this. Where agencies do not have a role in education but failing to attend school or an appropriate educational setting is identified, they should have procedures in place to ensure this is referred to the relevant agency.

3. When a parent elects to home educate their child, the Local Authority should seek reassurances that the child is receiving a balanced education which means they are not disadvantaged from children in other education settings. This should include a home visit for an assessment by a trained professional to ensure suitable learning is taking place. The Local Authority has a duty (section 436 Education Act 1996) to make arrangements to establish (so far as is possible to do so) the identities of children in their area who are not registered pupils and are not receiving suitable education otherwise than at a school. If a parent did not comply then established routes for escalation could be considered.

4. The Local Authority must develop and communicate a clear escalation process for children not on school roll.

5. All schools within the City of Sheffield should be reminded of their legal obligations to place a child on their school roll on the day they are notified. Archie was involved in gang related activity. He was initially on the periphery but became more involved and was later identified as making threats of violence and carrying weapons. He was controlled by older associates and thus exploited. The vulnerabilities of his young age, an unstable home life and lack of education provision all contributed to his exploitation through gang culture. Despite several records noting a referral to a gang matrix or gang panel, no such panel ever convened to discuss his case and therefore no plans were made to intervene and remove him from this culture.

6. Sheffield Safeguarding Children Board must be assured that there is an ongoing commitment to maintain and build on the multi-agency response to addressing child criminal exploitation and reducing youth violence in Sheffield.

7. Sheffield Safeguarding Children Board and the Community Safety Partnership should ensure there are structures in place to assess, refer and intervene with

vulnerable people who may be exploited by gangs and Organised Crime Groups operating in the city. The referral pathway should be promoted to all agencies. There were blurred lines for areas of responsibility between agencies. This was particularly evident between the Youth Justice, Children's Social Care and the Community Youth Team.

8. There must be a clear referral route for vulnerable young people who engage in offending. Services should be commissioned to ensure that once a service is engaged with a young person; a lead professional is identified providing a key point of contact for the young person and their family. Irrespective of further offending, the intervention should continue as appropriate. Episodes of being reported 'missing' were frequent. There was confusion both with the family and professionals regarding who was responsible for conducting 'return' interviews. These are a vital component in keeping a young person safe.

9. A review of the arrangements for 'missing' should be undertaken and assurance provided to Sheffield Safeguarding Children Board of the appropriateness of these arrangements in keeping children safe. All practitioners should be aware of the policy and process. Police recorded Archie as a 'medium' risk when he was reported missing. However, this is the minimum risk level for all missing children and young people. He was never escalated to 'high risk' even when in one episode he was missing for 13 days and during several instances when he was clearly involved in violent criminality. His bereavement following the sudden and tragic death of his sister was never fully addressed. He never accessed a professional counselling service.

10. The current Missing Young People protocol should be revised to ensure that all risks are identified at the point of reporting and all levels of risk, responses and actions are reviewed regularly throughout the missing episode. Senior managers and officers should approve and oversee the development of a multi-agency safety plan for all high risk missing young people. The role of the MAST (early intervention) team was ill defined. Individual workers developed a good rapport and understanding with the family, but they became absorbed within the daily problems and therefore were not able to focus on the bereavement.

11. A clear pathway should be developed for children and families to access support following the bereavement of a close family member. This should include a mapping of services for children's emotional and mental well-being.

12. The deployment of resources from MAST is a vital early intervention service. To ensure maximum benefit to the family, their role should be clearly defined with a written plan agreed with the referring agency to include key targets and regular reviews. Archie's mother exhibited a number of vulnerabilities. These included mental health issues, low income, fleeing domestic violence and being a single parent in an unfamiliar country. There were several individual errors in contacts with her which will have added to her frustrations. However, she did receive support from many committed and dedicated professionals across many agencies. The Child Protection Plan was not effective, and the Core Groups were either poorly attended or did not take place at the required frequency. The Review Conference noted the increase in his exposure to violent offending and being reported missing on an almost continual basis. It recorded actions to

progress to a ‘high risk tracker’ to alert senior management as it had reached the highest possible level of risk and required immediate intervention. Yet it failed to implement the actions to deal effectively with the assessed risk. The Child Protection Plan was not working, and the family home was not the right environment in which to base the plan. The danger was on the streets rather than in the home environment.

13. Sheffield Safeguarding Children Board must put mechanisms in place to ensure agencies involved in the safeguarding of children and young people commit to both the sharing of information in a timely manner and their agency’s attendance at Child Protection Conferences.

14. Sheffield Safeguarding Children Board must put mechanisms in place to check agencies identified as having a role in the Child Protection Plan must ensure they send representatives to the Core Groups to ensure the plan is implemented and developed.

15. Sheffield Safeguarding Children Board must ensure that there are clear lines of responsibility on who delivers actions against the Child Protection Plan. This is especially important when escalation to senior management is required.

16. When a young person is subject to a Child Protection Plan, this must be the forum that takes primacy over all other forums. The Youth Justice Service Multi Agency Risk Panel or the ‘gang matrix’ have important roles to fulfil but they must be incorporated into the Child Protection Plan to prevent duplication and ensure a focus of effort to keep the young person safe.

17. Sheffield Safeguarding Children Board to research, develop and assist with the implementation of Child Protection Conferences that assess risk and develop plans in line with our increasing understanding of contextual safeguarding.

18. Sheffield Safeguarding Children Board should commission workforce development for delivery to all front-line professionals on the issues of contextual safeguarding. This training should include recognising the risks of criminal exploitation and sexual exploitation.

19. Contextual Safeguarding should be embedded in all agencies’ considerations, planning and processes linked to safeguarding of children and young people.

## Child C City and Hackney 2020

## Recommendations

1. The secondary school should meet with the family to provide some closure to their unresolved issues.

2. Safeguarding Partners should reassure themselves that all schools within their jurisdiction abide by national and local exclusion policy and promote the use of other interventions designed to address disruptive behaviour as an alternative to PEX.

3. Schools should ensure they have a detailed understanding of the potential safeguarding needs of any child who is at risk of PEX. This should be informed by a robust assessment that includes a clear focus on extra-familial risks and the contextual safeguarding implications for the child.

4. The DfE should review the statutory guidance and non-statutory guidance covering exclusions to ensure safeguarding risks are sufficiently considered as part of the decision-making process for exclusions.

5. To help PRUs / APs manage the potential risk arising from different cohorts of young people placed in their facilities, the CHSCP should make available to all educational settings, regular briefings that include intelligence on youth violence, local gang conflicts and other areas of community tension.

6. The CHSCP should ensure that local guidance covering risk, safety and contingency planning for victims of serious youth violence considers the trauma a young person has experienced, with the plan focussing on both the individual physical and emotional recovery.

7. The CHSCP should ensure that policy, procedure, and guidance is sufficient to ensure the active consideration of racial and cultural identity as part of the safety planning process involving extra familial risks.

8. The CHSCP should ensure the available interventions for responding to extra familial risk, including young people at risk of serious youth violence and/or exposed to criminal exploitation are sufficiently defined within local guidance to promote consistency of best practice.

9. The multi-agency partnership should nominate a named professional or adult who has (or who can develop) a trusted relationship with children who are assessed to be of risk of serious youth violence. This named professional should focus on developing the child to adult relationship and coordinating multi-agency interventions.

10. HCFS should ensure that it follows the Pan London Safeguarding guidance for children who have been victims of serious youth violence, with an emphasis on the need to ensure that managers chair any relevant meetings as defined.

11. HCFS should ensure it exhaust all kinship options as part of a safety or contingency plan for children who are at risk of serious youth violence to help keep them safe.

12. To help families contribute to safety and contingency planning, HCFS should ensure the different methods of family engagement that can be deployed are promoted within HCFS and that relevant practice guidance is sufficient.

13. The CHSCP should review partnership and individual agency processes that involve the application of risk gradings for young people at risk of serious youth violence. Where required, these should be changed to ensure consistency and a clear understanding as to what the judgement means in the context of practice.

14. The CHSCP should review the current guidance relating to the local response to extra familial risk and ensure that this provides sufficient clarity on the ‘status’ of a

case, management oversight and the thresholds for intervention. This should enable practitioners to clearly differentiate when a response is required as part of an early help, child in need or child protection response or one that involves the engagement of contextual safeguarding procedure.

15. The CHSCP should reassure itself that clear minutes, including agreed actions from strategy and/or discharge planning meetings for victims of serious youth violence are accurately recorded, with copies circulated in a timely way to participant agencies and where appropriate, the family.

## Child T Dorset 2019

## Recommendations

1. To ensure the learning from this Review is disseminated across the multi-agency safeguarding partnership to practitioners and managers.

2. To seek assurance that the actions identified by each partner agency, as a result of this Review, have been managed, implemented and embedded in a timely manner.

3. The LSCB to be assured about the arrangements for managing the welfare of high risk and complex adolescents; this to include clarity about the identification and role of the lead professional for each case, the formulation of multi-agency safety and management plan for each case, and the strategic oversight of each case. This should explicitly consider those adolescents that fit two or more of the following categories a) in local authority care, b) who have contact with the criminal justice system, c) access mental health or drug misuse services, and d) have experienced, or are currently, excluded from educational provision.

4. The LSCB to support the implementation of a multi-agency exploitation forum, which has strategic, tactical, and operational levels of activity – addressing all forms of child exploitation including those children that regularly go missing. Ideally, this should include representation from the Community Safety Partnership and considerations about other sources of intelligence and contextual safeguarding data.

5. The LSCB to seek assurance from partner agencies that electronic notification systems and processes are adequate and effective in notifying partner agencies when a child becomes looked after, but also of significant episodes which occur for children whilst looked after i.e., custodial sentence, placement moves, over-dose, suicide attempt, mental health assessment.

6. Dorset Children's Social Care to ensure the appropriate decision-making level of attendance at MAPPA meetings, especially when considering and discussion children that are in the care of the Local Authority.

7. The LSCB to seek assurance from Dorset Children's Social Care that there are systems and processes in place that accurately capture data about individual children who go missing, and that this data can be extracted in a format that supports responsive and effective care and safety planning by the multi-agency partnership. This assurance exercise should include evidenced dialogue with immediate neighbouring local authorities and Police authorities to flag similarities and

differences in approach and to establish any possible common ground in reporting processes.

8. Given the mirroring of findings, the LSCB to seek a position statement from all single agencies that were involved in previous local SCRs conducted in the last four years, about progress against any single agency recommendations and actions plans.

9. The LSCB to examine progress against actions and recommendations from previous local SCRs conducted in the last four years, when formulating the multi-agency action plan from this Review.

10. The LSCB to seek assurance that the Independent Reviewing Officer Service's challenge and escalation policy and procedure is fit for purpose and reflects a more comprehensive set of scenarios for which the IRO may challenge. In seeking this assurance, it will be reasonable to consider performance evidence about the effectiveness and impact of any challenge and escalation. The Lead Cabinet Member for Children's Services to be advised of this assurance exercise and for the Corporate Parenting Board to offer assurances to the Board about the effectiveness of their scrutiny function in relation to this matter.

11. The LSCB to seek a position statement in relation to the quality, performance, and effectiveness of the new arrangements for conducting return home interviews by Dorset County Council staff. This statement should include reference to how widely the new arrangements have been communicated, and received, by all neighbouring authorities (and their interested partner agency representatives who are likely to be involved in the management of missing children i.e., Children's Services and the Police authorities), and an update about any early difficulties in implementing the new arrangements. This position statement should include evidenced dialogue with immediate neighbouring local authorities to flag similarities and differences in approach and to establish any possible common ground in practices.

12. The LSCB to seek assurances from Dorset County Council about the contribution and effectiveness of the Virtual School oversight arrangements of adolescents who fit two or more of the following categories a) in local authority care and have experienced, or are currently excluded from educational provision, b) who have contact with the criminal justice system, c) who access mental health or drug misuse services, and d) who are placed or educated in 'out of county' provision i.e. a provision that is commissioned by Dorset County Council and which may, or may not, be within the geographical boundary of Dorset County.

13. The LSCB to seek a position statement from Dorset Children's Social Care about the use of unregulated placements for children looked after in the last 12 months (for 14 years plus), which should include information about how many unregulated placements are used, type, duration used for and cost, risk assessments undertaken, and authorisation for use of such placements. Where appropriate, this information (particularly in respect of risk assessments undertaken) should be cross referenced with any contact by the Independent Reviewing Officers, to examine the effectiveness of their challenge and scrutiny function. The Lead Cabinet Member for Children's Services to be advised of this assurance exercise and for the Corporate Parenting Board to be offering assurances about the effectiveness of their scrutiny function in relation to this matter.

14. The LSCB to seek regular assurance (bi-annual as a minimum) from Dorset Children's Social Care about the performance, capacity, and procedural compliance of Dorset Children's Social Care Looked after Children's Services in discharging their duties in relation to children who are looked after by the authority. This should include the performance and quality of Pathway Plans, reviews of placement breakdowns (for 14 years plus) and the sufficiency and arrangements to commission and provide accommodation for high risk and complex adolescents. The Lead Cabinet Member for Children's Services to be advised of this assurance exercise and for the Corporate Parenting Board to offer assurances about the effectiveness of their scrutiny function in relation to this matter.

15. The LSCB to seek assurance from Dorset Children's Social Care about the performance, capacity, and quality of 1:1 supervision for all named Social Workers, allocated to working with children looked after.

16. In order to understand the extent of the use of Connected Persons in the Dorset area, the LSCB to seek a position statement from Dorset Children's Social Care about the use of Connected Person's for Looked after Children in the last 12 months which have been used for less than 16 weeks, with a breakdown of categories of connected persons, duration and frequency used, and assurances that arrangements have been made in the child's best interests in line with an informed Care Plan. The Lead Cabinet Member for Children's Services to be advised of this assurance exercise and for the Corporate Parenting Board to be offering assurances about the effectiveness of their scrutiny function in relation to this matter.

17. Dorset County Council to review the offer available to potentially high-risk adolescents, with complex needs, by the Family Partnership Zone at the Early Help level and seek assurances that there is sufficient and good quality supervision and management oversight of case work.

18. Whilst a single IT system may not be currently feasible, Dorset Healthcare NHS Trust should provide the LSCB with assurance that there are adequate mitigating strategies in place to support effective information sharing between health professionals who work across more than one IT system.

19. The LSCB should explore the barriers to the current 'escalation policy' being used. Any amendments should be communicated to all partner agencies, who in turn should cascade to their workforce.