Item No. 10.	Classification: Open	Date: 21 October 2015	Meeting Name: Health and Wellbeing Board
Report title:		Southwark Safeguarding Children Board – Serious Case Review	
Wards or groups affected:		All	
From:		David Quirke-Thornton, Strategic Director of Children's and Adults' Services (Vice-Chair, Southwark Safeguarding Children Board)	

RECOMMENDATIONS

1. The board is requested to:

   a) Note the Serious Case Review Report at appendix 1.

   b) Comment on the key learning points from the Review at paragraph 10; their relevance for Health and Wellbeing Board member organisations; and the action that could be taken across the health and social care system to address them.

BACKGROUND INFORMATION

2. In March 2014 the Safeguarding Board considered a serious incident affecting a young person, Child R, and decided to undertake a Serious Case Review (SCR).

3. This is the first SCR in Southwark for five years and the first informed by *Working Together to safeguard Children 2013/15* and the new requirements in relation to SCR placed upon Safeguarding Children Boards.

4. The Serious Case Review took place between April 2014 and February 2015 when it was signed off by the SSCB subject to further anonymisation of the child's circumstances. Following careful consideration by the review panel, a police colleague and council lawyer to ensure it protects Child R's identity, the SCR report was published in August 2015.

5. Child R is a 15 year old girl who came into care aged 10 and has been looked after by the London Borough of Southwark for the past five years. Currently she lives with foster carers in Greater London and attends school locally.

6. In early spring 2014, R was invited to meet an older, predatory male at a hotel, where he allegedly raped her. The alleged assault was reported by R to her carers the same day and police action was taken to find and arrest the man. A criminal investigation and court process have concluded, in which the perpetrator was found guilty of a separate, lesser sexual offence against another young person.

7. This incident initiated the SCR. It was agreed to use the Welsh Governments Guidance for arrangements for multi agency child practice reviews as a methodology. This guidance complies with Working Together as it is systems based and offers a collaborative approach with agencies to surface the key themes and issues to develop an action plan to take forward the learning points arising in the case. The methodology included senior managers comprising a review panel considering agency chronologies and summaries, a learning event bringing together staff and managers involved across the partnership to consider the themes and issues emerging and informing the learning points.

8. The report has been shared at a number of events led by the SSCB, to take the learning to different parts of the borough and ensure that as many staff and volunteers are able to consider the messages of the report for their agency and their own practice.

KEY ISSUES FOR CONSIDERATION

9. The key points of learning from the Serious Case Review of Child R's case can be summarised as follows:

    1. Knowledge of a child's psycho-social history is essential for effective assessments and planning for children.

    2. In any agency, high turnover and sickness among workers and managers in a team carry the risk of loss of knowledge about cases and potential failure to carry out statutory duties.

    3. Many looked-after adolescents find it hard to trust and communicate with professionals who are tasked with planning for them, and helping to keep them safe – especially when their key worker changes frequently. This can significantly constrain the ability of workers (and the local authority, as 'corporate parents') to respond to the young person's wishes and feelings, and to meet their needs.

    4. Effective care planning for looked-after children requires input from all partners in the form of either attendance or appropriate reports for the LAC Review process. However, LAC Reviews, as smaller, child-centred meetings, do not provide a suitable forum for the full professional network of those who know about and are working with the child. Thus, there may be no regular opportunity for this network to share significant information and concerns.

    5. In addition, the LA needs to ensure that foster carers and the professional network are given full and good information about the determined needs of the child and the current plans, as well as relevant history. These actions can become more difficult for children placed out of borough.

    6. Partners in safeguarding networks continue to struggle with the timing and appropriate use of escalation procedures, often leaving unsatisfactory situations going on for too long.

    7. The choice, and timing, of local authority placements available for looked-after children does not always allow a matching of the child's needs to the

ability of the carers, especially for more complex and 'hard to place' adolescents.

8. Children and families cases will inevitably transfer to a number of different social workers and managers over time. For their work to be effective, case records need to include a genogram, an up-to-date chronology and a transfer summary.

9. The systems for sharing and transferring information about a looked-after child who moves schools do not always operate in a transparent and timely way.

10. Children missing from care are at greater risk of sexual exploitation, not only because of being outside of (corporate) parental control, but also because of the power and reach of social media.

11. There are potential tensions between Police and Children's Social Care, regarding their respective roles and responsibilities in relation to a looked-after child at high risk of harm. This can result, as in this case, in an impasse and an outcome which is not appropriate for the child, even in the short-term.

12. The power and lure of electronic social media carry a risk of harm, particularly to vulnerable young people, which cannot be removed by professionals working with these young people.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children	See link below	SSCB@southwark.gov.uk
Link: https://www.gov.uk/government/publications/working-together-to-safeguard-children		
Protecting children in Wales: Guidance for arrangements for multi agency child practice reviews	See link below	SSCB@southwark.gov.uk
Link: http://www.nspcc.org.uk/preventing-abuse/child-protection-system/wales/child-practice-reviews/		

APPENDICES

No.	Title
Appendix 1	Serious Case Review Report – Child R

AUDIT TRAIL

Lead Officer	David Quirke-Thornton, Strategic Director of Children's and Adults' Services (Vice-Chair, Southwark Safeguarding Children Board)	
Report Author	Rachel Flagg, Principal Strategy Officer	
Version	Final	
Dated	9 October 2015	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		9 October 2015