GLOUCESTERSHIRE SAFEGUARDING CHILDREN PARTNERSHIP SERIOUS CASE REVIEW RECOMMENDATIONS

The recommendations set out in this document relate to a number of serious case reviews completed during 2019 / 2020 that the partners are not in a position to publish at this time due to ongoing criminal proceedings.

2019 – 2020

During 2019 / 2020 the partnership instigated and published two Serious Case Reviews

1. 0319 Liam SCR June 2019 Published 18th June 2020
2. 0219 Lauren SCR May 2019 Published 14th December 2020

Publishing three other Serious Case Reviews:

1. 0215 Megan SCR Published May 2019
2. 0118 Children of Family Y Published May 2019
3. 0116 James SCR Published April 2019

All Published SCRs can be found Here

Context:

Working Together 2018 sets out:

"..Where other proceedings may have an impact on or delay publication, for example an ongoing criminal investigation, inquest or future prosecution, the safeguarding partners should inform the Panel and the Secretary of State of the reasons for the delay.

Safeguarding partners should also set out for the Panel and the Secretary of State the justification for any decision not to publish either the full report or information relating to improvements..

..Every effort should also be made, both before the review and while it is in progress, to capture points from the case about improvements needed, and take corrective action and disseminate learning".

The GSCE has therefore decided that whilst the SCR reports cannot be made public the recommendations along with the partnerships response from those reports should be made available.

Serious Case Review Recommendations:

	Recommendation	Response
1.	It is recommended the GSCE ensure Safeguarding Partners involved in the serious case review remind practitioners of their duty in safeguarding cases to ensure the voice of the child is captured and safeguarding cases are children focused as identified in learning from previous serious case reviews.	*Response to Recommendation 1* • Section 11 assurances and a themed response where the S11 standard 4 "the voice of the child" is a focus for 2020. S11 Report to the Board will set such assurances and monitoring of S11 responses can be undertaken throughout 2021 by the partnership.
2	Local guidance regarding complex abuse inquiries to be clarified to explicitly state that all relevant agencies should be represented at a senior level from the outset.	*Response to Recommendations 2* • Local guidance is in place and forms part of the South West Child Protection Manual. It has subsequently been reviewed and used successfully.
3	The Constabulary and children's services should review the numbers of ABE trained staff and commission new training programmes to train new staff but also to refresh those who may have undertaken the training some time ago.	*Response to Recommendation 3* • The Constabulary and Children Social Care have a comprehensive development plan to ensure staff are trained in ABE and have refresher training. This plan was produced following commentary from the family court in relation to the case and directly addresses this recommendation.

4	The safeguarding partners - constabulary, children's services and health should review how both strategy meetings and child protection medicals are carried both more rigorously and holistically.	*Response to Recommendation 4* • Detailed data is now collected which is allowing us to question our outcomes, ensuring we remain focussed on the right cases. This approach is shared across the partnership. Medicals have been discussed with all partners and are now always considered where any injuries are reported. Data is kept for auditing purposes, to ensure this remains under review and part of our decision making and information gathering processes. Following the implementation of the findings during 2020 A joint review of Strategy Meetings has commenced. Multi-agency workshops are planned and scheduled with the aim of delivering a more consistent approach whilst improving service delivery.
5	The GSCE should undertake a thematic review of cases where there have been concerns about sexual abuse. This should include how professionals work with suspected perpetrators and also listen and respond to children.	*Response to Recommendations 5 to 9* • LSCB Independent Chair David McCallum wrote to the DFE in 2018 highlighting concerns. National guidance is more readily available and the GSCE has clear guidance in the South West Child Protection Procedures online and available to all practitioners • GCC and CCG have commissioned CAMHS to provide expertise on HSB both advising and defining the strategy for HSB in the county. CAMHS are setting out a strategy; guidance and training for the partnership and currently are providing advice on request to practitioners on HSB. • The PPU business and partnership officers have developed a Quality Assurance Framework to thoroughly audit child protection cases in line with our Approved Professional Practice and HMICFRS/SCR/IOPCC recommendations. The process examines cases in detail with certain themes on a bimonthly basis and with the "Child's Journey" underpinning it. • CSA as a theme within the GSCE Multi Agency Training Curriculum has been reviewed and revised and whilst embedded in the CPIA training it will now be available for practitioners in a
6	In light of the historically low numbers of children in England subject to child protection plans under the category sexual abuse the chair of the LSCB (2018 Action) should write to DfE highlighting the findings of this and other relevant reviews with regard to sexual abuse; reporting on the lack of guidance for staff managing sexually harmful behaviour in primary schools. "Peer on	

	peer abuse" is not appropriate for children of this age group.	virtual classroom, eLearning and practice briefing format in 2021.
7	The GSCE to develop and circulate local guidance for practitioners in all agencies in managing sexually harmful behaviour.	
8	The GSCE to identify appropriate assessment tools for children demonstrating sexualised behaviour.	
9	The GSCE to ensure that working with sexual abuse and harmful sexualised behaviour are part of the Boards inter agency training programme.	
10	The GSCE to monitor recent developments regarding the escalation policy in order to ensure its efficacy.	*Response to Recommendations 10 & 11* • Escalation remains a priority for the GSCE and is part of a detailed and robust programme of challenge and assurance with all partners. Awareness seminars have been delivered across the partnership with more recent Webinar available in 2020 as part of the training curriculum. The foundation of a Task & Finish Group instigated in 2020 following the 'Children of Concern in the Community' report that was recently presented by the interim Director of Children's Safeguarding and Care to the GSCE. It was agreed that a small group of strategic safeguarding partners would form and meet on a regular basis to: ○ Identify children of concern ○ Share information and confirm the nature and level of concern
11	It is recommended the GSCE are assured by all safeguarding partner agencies to the review, staff are reminded of the need to comply with National and Local	

	Safeguarding policies and procedures ensuring effective communication, sharing of information, with professional curiosity displayed to escalate concerns and where necessary, call a multi-agency professionals meeting or strategy discussion to look at the wider picture, in order to protect children and young people.	○ Create a safe forum within which to offer professional challenge and support ○ Work together to problem solve identified multi-agency partnership issues ○ Agree clear lines of communication to clarify and confirm key messages ○ Provide advice, guidance and direction to front line practitioners and teams • The safeguarding partnership representatives were discussed at the Executive meeting and are Interim Director for Children's Safeguarding & Care, Detective Superintendent, Designated Nurse Safeguarding Children and Integrated Commissioner CCG and GCC. • It is entirely possible that the partnership group outlined above could be asked to review specific children of concern and related partnership issues prior to any disputes and difference needing to be escalated. • Professional curiosity remains a feature of reviews and as a result of the SCRs highlighting it as an issue multi-agency training has been reviewed and includes professional curiosity throughout. Practice briefings are in place and available as a resource to practitioners.
12	Chairs of local safeguarding children's and adults' boards to review how cases are managed when there are concerns about both children and vulnerable adults.	*Response to Recommendation 12* • The GSCE and GSAB have a working protocol in place in addition secured links to Safer Gloucestershire and the Health and Wellbeing Board. Clear mental health and care act guidance has been promoted to Childrens practitioners including sharing of adult safeguarding advice line. The Public Protection Unit holds oversight responsibility for both child and Adult At Risk investigations thus facilitating a joined up approach in such cases.
13	It is recommended the GSCE are assured by the agencies and organisations involved in the serious case review that their staff are made aware to always	*Response to Recommendation 13* • 2020 S11 Assurances to the GSCE that practitioners are undertaking safeguarding training appropriate to their roles and that key identified themes are prioritised including training that

	consider manipulation, disguised and veiled compliance of a carer of children and young people. To assess their presentation and to ensure action taken, advice and comments made of the health and wellbeing of the child is not just plausible but factual after the circumstances are verified	matches findings from case reviews. • Disguised compliance has been included in GSCE Multi Agency Training during 2020, including the writing and sharing of practice briefings. Both areas have been reviewed in light of this and other SCRs both locally and nationally. Disguised compliance remains a feature in Rapid Review and LCSPR with further work required across the partnership.
14	GSCE to monitor the implementation plan for revised pre-birth protocols across agencies including further audit of purposive sample of vulnerable young parents including care leavers	*Response to Recommendation 14* • Revised Pre Birth Protocols implemented March 2020 with a Multi-Agency Sampling Audit being conducted January 2021, setting a benchmark to conduct a planned full Pre Birth Assessment Multi-Agency follow up audit later in 2021 enabling the partnership to measure improvement in the use of the revised Pre Birth Protocol.
15	The leadership team within Children's Services to appraise effectiveness of the improvement plans currently being implemented in the leaving care service (now being managed exclusively by the Local Authority)	*Response to Recommendation 15* • Children's Services continues to update and refresh its Accelerated Improvement Plan AIP and presents this to the independently chaired Improvement Board on a monthly basis. The AIP focuses on agreed priorities including "To achieve permanence for children at the earliest appropriate opportunity to improve their life chances and overall outcomes" which focuses on children in care and care leavers. There is a service specific improvement action plan for the Leaving Care Service which is monitored and reviewed in the GCC CSC monthly Strategic Performance Meeting and reported in the AIP to the Improvement Board.

16 It is recommended the GSCE are assured by all safeguarding partner agencies to the review that supervisors will consistently review practitioners' standards and safeguarding practice ensuring all staff record their actions to ensure compliance with the following: -

- Statutory Reviews and assessments, awareness of the consistency of practice and support provided.
- Allocated SWs and Health Visitors, to ensure there is regular contact with LAC and foster carers in a placement and any contact and communication is recorded expediently to an acceptable standard.
- Any illness or injury to a child or young person in a placement must be thoroughly reviewed to ensure the information and reasons given are verified and challenged.
- Ensure risk assessments are readily carried out as circumstances change for LAC within a placement. If there are repeated reported health concerns, a professionals meeting should be called.

Response to Recommendations 16 & 17

- Partners have maintained a focus on the importance of supervision from a practice and performance perspective to provide challenge and support for practitioners in order to improve outcomes for children and young people. Quality assurance monthly auditing and dip sampling activity regularly evaluates the quality of supervision practice and where practice doesn't meet the required standards this is escalated and addressed promptly.
- The standards and expectations within the Leaving Care Service are the same as all other service areas. To strengthen supervision arrangements CSC has promoted a number of initiatives. These include a review of the Supervision Policy, development of Management Oversight standards as part of the whole service Essential 2.0 Programme, additional training and support for supervisors, changes to the electronic recording system which align with the Essentials 2.0 Programme framework and principles as well as more robust performance reporting arrangements. The Practice Fundamentals quality control tool which is designed to promote individual and collective professional accountability includes the following standards for supervision and management oversight to:
    - Promote and govern excellent practice and develop excellent practitioners.
    - Shape and influence the practice system, and use power and authority effectively.
    - Ensure managers understand and track the needs and risks for children; and provide confident analysis, direction, and decisions.
    - Offer guidance, challenge and support to practitioners so that their interventions are purposeful and effective.
    - Be regular, reflective and clearly recorded (and filed in the 'Forms' section on Liquid Logic).
    - Clearly show the impact of the manager's 'foot print' throughout the journey of the child.
    - Ensure the voice of the child, their story and lived experience is known, understood and taken into account.
    - Analyse the child's circumstances and the impact of protective factors, needs and

17	Leaving care service to develop and revise supervision policy to ensure supervision not only takes place but offers sufficient guidance and challenge for practitioners	risks, and longer-term consequences. ○ Define the threshold and consider the likely, significant and imminent risk of harm for the child. ○ Include specific actions about what needs to change for the child (with realistic timescales). ○ Confirm how management direction will be reviewed. ○ Evidence critical challenge and address poor practice, drift and delay. ○ Be used proactively by staff to work professionally, reflectively and reflexively.
18	Leaving care service to provide training for all staff regarding pre-birth assessments and when working with care leavers the importance of holding both the adolescent and their unborn child in mind.	*Response to Recommendation 18* • GCC CSC has invested in pre-birth practice learning, development and training for all social workers, including those within the Leaving Care Service. An Improvement Advisor has led on pre-birth team-based workshops so all staff are familiar with the Pre-Birth Tool Kit, including use of the Risks and Vulnerabilities Matrix as a screening tool and the Pre-Birth Assessment, both of which are now built into the CSC electronic data, work flow and reporting system (Liquid Logic).
19	The GSCE to consider guidance on identifying and working with invisible family members in training and practice development activity.	*Response to Recommendation 19* • Work on significant adults, particularly hidden men, in a child's life has been embedded into GSCE multi-agency training, practice discussion and practitioner briefings as a key consideration regards understanding and managing risk particularly for Non Mobile Infants.
20	Children's Services to look at how early help services can work with the leaving	*Response to Recommendation 20*

	care services to ensure that robust early help assessments and plans are implemented. These plans should be framed in such a way that their purpose is to provide greater support for care leavers who become parents.	• As a result of the Risks and Vulnerabilities Matrix, there is improved identification and screening in relation to the needs, risks and circumstances of Care Leaver's who have children and become parents. This determines whether there a need for an Early Help or Social Care assessment and any plan for support, protection or care.
21	Findings of this and other reviews to be shared and to contribute to wider debates regarding how services respond to vulnerable adolescents and the meaning of the corporate parent to young people who have left care.	*Response to Recommendation 21* • Childrens Social Care recently prepared and presented a paper to the GCSE focusing on Children of Concern in the Community. This focuses on the vulnerability of adolescents and the need for the safeguarding partnership to exercise its 'shared and equal duty'. The paper focused on the needs, risks and circumstances of ten young people, all children in care and care leavers, and identified several key themes and issues that develop the wider debate about service provision for vulnerable adolescents. This is a continuing debate which is being formalised as part of an on-going process whereby members of the safeguarding partnership will meet regularly to identify vulnerable adolescents of concern, share information, clarify issues and concerns, problem solve and confirm advice, guidance and support for front line managers and practitioners.
22	Leaving care service to develop links with housing advice agencies and providers regarding the young people who may come into contact with their services.	*Response to Recommendation 22* • The Leaving Care Service improvement action plan includes a focus on housing and accommodation. There are now established links with the District Council Housing Leads. During the CV19 pandemic the needs of young people at risk of homelessness have been identified, supported, tracked and reported on a weekly basis to ensure young people receive the support that they need. The Leaving Care Service also has designated housing advice and support workers to work directly with and on behalf of young people in respect of responding and meeting their accommodation needs. Responsibility for commissioning accommodation provision for young people is now manged within the integrated commissioning hub in order

		to strengthen the relationships with housing providers and a designated housing representative now sits on the Panel which considers requests for accommodation support. Quality assurance monthly auditing and dip sampling activity regularly evaluates the quality of supervision practice and where practice doesn't meet the required standard this is escalated and addressed promptly.
23	It is recommended the GSCE are assured by all safeguarding partner agencies to the review, all staff are reminded to comply with legislation, National and Local Child Protection Policies and Procedures and guidance and utilise the available Neglect and Risk Framework Assessment tools to assist in the health and wellbeing of children and young people in the management, assessment and reassessment of risk as changes develop in a safeguarding plan.	*Response to Recommendations 23 & 24* • The GSCE has set up a multi-agency Neglect working group under the Quality and Improvement in Practice (QiiP) subgroup. The working group have reviewed and monitored the launch and landing of a Neglect toolkit for the partnership. During September and October 2020 the GSCE undertook a Neglect Audit to understand and test the partnerships understanding of neglect and its ability to respond. The Audit Report was submitted to the Neglect Working group for consideration and to the QiiP in December 2020. Actions from the QiiP will see neglect remaining a priority for 2021 including a review of the county strategy, neglect toolkit and a focus on targeted training and learning dissemination. This will be followed up by a further Multi Agency Neglect Audit in the autumn of 2021. • 2020 S11 Assurances to the GSCE setting out that practitioners are undertaking safeguarding training appropriate to their roles and that key identified themes are prioritised including training to ensure confidence and competency in the use of specific safeguarding toolkits
24	It is recommended the GSCE are assured by the Safeguarding Partners involved in the serious case review that their staff are aware of local and national guidance and neglect strategies. This is to ensure they consider and are able to recognise the signs and symptoms of neglect, including physical and emotional abuse and to take the necessary action to	• Gloucestershire Health Trusts hare a key partner in the Neglect Working group and support a review of the Neglect Strategy that encompasses adolescent neglect. In October 2019 the counties GP Forum focused on neglect and CSA. And within the Trusts findings from safeguarding reviews continue to be shared at safeguarding supervision. Level 1 & 2 training packages are regularly reviewed to incorporate new learning and recommendations. Specialist Safeguarding Children Nurses being intrinsic to the neglect training delivery, with a commitment to maintain that footing. The Trusts Section 11 report for 2020 highlights Neglect training as a key priority within the Trusts with Specialist Safeguarding Practitioners

	ensure the health and wellbeing of any child or young person.	encouraged to raise the profile of adolescent neglect and indicators of neglect as part of the Neglect Training programme, along with a continued focus on the promotion and use of the Neglect tools available through the GSCE.
25	It is recommended the GSCE are assured by Health Services and Childrens Social Care they will agree a memorandum of understanding to ensure all arrangements for the discharge of a Vulnerable Mother and a child is safe, supportive and at the time in their best interests.	*Response to Recommendation 25* • The GSCE have reviewed developed and published its Hospital Discharge process and published it in March 2020 on the GSCE website. The pre Birth Assessment sample will initially test the landing of the process with a full Pre Birth and Hospital Discharge Audit planned for 2021
26	There was a delay and drift in legal proceedings. In a recently published 2020 Gloucestershire SCR for Family Y there was a similar recommendation made regarding delay and drift. This addresses communication therefore there is no requirement to make a recommendation.	*Response to Recommendation 26* • Family Y SCR action completed relating to this finding. A case progression officer is now in post. Additionally, the DCS and Director of Safeguarding regularly meet with the Head of Legal Services and Principal Lawyer to review all issues related to Care Proceedings and minimise delay.
27	It is recommended the GSCE are assured by Gloucestershire CC Commissioning the following: - • All placements within the County must be considered before a placement can be considered out of area of a vulnerable LAC mother and	*Response to Recommendations 27 & 28* • Standard placement commissioning practices ensure all suitable in-house parent and child placement provision is considered first and foremost. Currently no in-house residential parent and child placement provision exists however the Placement Sufficiency Strategy is seeking to develop residential parent and child placement provision in county, which will be commissioned by GCC, as part of the Council's capital programme. Currently, requests

	baby, and not without the supervision and agreement by Head of Service or Senior Management and the rationale recorded. • Independent commissioned agencies should provide evidence of up to date and current reviews and inspections prior to commissioning. • The experience of the commissioned carer and placement must be assessed and matched with the mother and baby to be placed.	for out of area parent and child placement provision are routinely made by the relevant operational social work team to the Placement Commissioning Team using the established placement request process (P1 and P2 placement profile request). These are routinely reviewed and approved by the relevant Head of Service before they are submitted to ensure management oversight. In many instances these requests will have been generated as part of the Public Law Outline pre-proceedings process or as part of Family Court Proceedings which will provide an additional layer of oversight and scrutiny. • Established Quality Assurance commissioning arrangements within the Placement Commissioning Team includes 'due diligence' checks which routinely include reviewing the most recent Ofsted regulatory and inspection reports and references from Local Authorities who have recently used the service. No placements are used prior to satisfactory 'due diligence' checks being confirmed by the Commissioning Quality Assurance Team.
28	It is recommended the GSCE are assured by Commissioning that commissioned provider agencies quality assess: - • Their carers experience and their ability matches the needs of a placement within a supportive and suitable environment. • Analysis of single parent carers with young children and the likely impact on their ability to foster. • Provide continuous assessments of carers and the provision of accommodation supplied for the placements. • No new foster carers without proven	• The purpose of the P1 and P2 placement request process is to ensure that the needs, risks and circumstances of the child and parent are suitably matched to available in-house foster carers who are approved to provide a parent and carer placement as well as available independent fostering agency and external residential parent and child placement provision. • The placement planning process for placing parents and children with Independent Fostering Agencies (IFAs) is an established process which allows for careful matching through use of the placement profile (P1 and P2) and the 'due diligence' checks completed by the placement commissioning quality assurance processes. Additional placement support needs are identified and responded to as part of the matching and placement planning process to ensure that the assessed needs, risks and circumstances for the parent and the child are addressed appropriately at the point of placement, or subsequently if these emerge subsequently or change once placed. • The relative strengths and merits of single foster carers with young children of their own is a consideration at the matching stage when considering how the needs of any parent and child placement will be met. • The on-going assessment of any parent and child placement is a shared responsibility and

	experience should be allowed to foster a LAC mother and baby with known vulnerabilities.	one that all professionals who have contact with the parent and child placement are responsible for. Any observations should always be reported to the allocated social workers for the parent and the child and any concerns should always be reported to GCC's Commissioning Service so that the placement commissioner and quality assurance team can consider this information, make enquiries and take further action if required. The GCC Independent Reviewing Officer (IRO) also has a role to play to ensure the quality of the care planning and placement provision is in accordance with agreed plans. Where required, the IRO has access to a formal escalation protocol to resolve any outstanding matters of concern. • No new in-house foster carers without proven experience are permitted to provide a parent and child placement for a parent who is themselves a child in care (or care leaver) with a baby that has known vulnerabilities. This position has been reiterated with the Assistant Director (Integrated Commissioning) as it relates to IFA parent and child placement provision. This position has also been confirmed with the relevant Head of Service for the in-house Fostering Service by the interim Director (Children's Safeguarding and Care).
29	It is recommended the GSCE are assured by all partners that supervisors and staff can access and utilise the recently implemented Liquidlogic Children's System (LCS) for Child Protection – Information Sharing, CP-IS Alerts regarding the improvement to case management and record keeping of sharing of information for children and young persons who present in a health setting. The presentation will be communicated to the case worker if involved in a child protection case or is a	*Response to Recommendation* 29 • Liquid Logic is GCC's electronic client data base, work flow and reporting system. Subject to user access permissions this can be routinely scrutinised by GCC Children's Services staff to check and verify data about children and young people known to the service. Children's Services staff within the Multi Agency Safeguarding Hub (MASH) have full access and use of the Liquid Logic system to check all new incoming contacts about children and young people. Where contacts are received about children and young people who have previously been known these records can be checked and for children and young people currently allocated elsewhere within the service this information can be uploaded and forwarded directly onto the allocated social worker, or professional advisor in the case of a Care Leaver, in order for it to be responded to.

	LAC, for their information and attention.	
30	It is recommended Children's Social Care review their Lead Professional guidance and to remind their staff of the requirement that a Lead Professional must be appointed where necessary. They must be assured the appointed Lead Professional has the necessary skills, competence and knowledge to carry out the role, following National and Local good practice guidance and models. This is particularly important with Look After Children (or Child Looked After), ensuring there is a single point of contact to represent and ensure the best interest of the child and young person and family is obtained.	*Response to Recommendation* 30 • From a Children's Social Care perspective, the lead professional role is routinely undertaken by the allocated practitioner for the child or young person. In respect of addressing needs, risks and circumstances that meet the statutory threshold, the allocated social worker for a child or young person 'in need' of support, protection or care will act as the lead professional. Care leavers may have an allocated personal advisor instead of an allocated social worker, who will also act as their lead professional. When a child in care or a care leaver is a parent they will have their own allocated social worker or personal advisor to act as their lead professional and their child or children will have their own social worker as their lead professional if they are 'in need' of support, protection or care themselves. In this way both the needs of the child in care or care leaver who is a parent will be assessed and supported from their individual perspective as a young person but also from the perspective of being a parent. The allocated social workers for the child in care and care leaver who is a parent and for their child or children will work together, and with others, to ensure all identified and assessed needs are met in accordance with the paramountcy principle, as per the Children Act 1989.
31	The GSCE to request a review of how cases where children are subject to child protection plans are "stepped down" and reassert the rigour with which children in need plans need to be managed.	*Response to Recommendation* 31 • GCC Children's Services has reviewed and updated the children's social care 'step down' arrangements. Changes have been made to relevant procedures which are included in Tri-X the on-line procedures manual. Staff communication and updated user guidance for Liquid Logic has also been issued. Further quality assurance exercises, including an externally commissioned thematic audit, have been undertaken to review 'step down' arrangements for children ceasing to have a child protection plan. The findings and outcome of this activity has helped to update and refresh the 'step down' arrangements,

		including an additional review of children in need practices. Child in need review meetings are now held more regularly and are now chaired by Team Managers at regular intervals to ensure improved management oversight.
32	The midwifery service to review recording systems and provide appropriate training to ensure that necessary detail relating to the child is captured in case records.	*Response to Recommendation 32* • As of the 1st November 2020 following the Trusts receipt of children in care notifications, an alert is placed onto the hospital patient administration system (Trakcare). These alerts are visible to clinical staff throughout the hospital including maternity, whenever the child or young person presents and will be on the electronic record of all new children entering the care system.