Serious Case Review

Child R

SSCB Response

Agreed By the SSCB February 2015

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The Southwark Safeguarding Children Board received the Serious Case review at a meeting dated 24 February 2015 and endorsed the findings of the review. Further guidance was given at this meeting as to preparing the report for publication given the sensitivity of the issues and the report needed robust anonymisation to protect Child R

A criminal investigation and court process have now concluded, in which the perpetrator was found guilty of a separate, lesser sexual offence against another young person. The offence of rape against R remains untried, but is held on the man's records as a not-guilty plea.

Southwark Safeguarding Children Board and its partners have sought to learn from Child R's experience. This response should be read alongside the Serious Case review which gives fuller detail of the background in the two years leading up to the serious incident, the methodology of the review and its findings.

The review found that no one could have predicted that this serious incident would have happened when it did. The review also found that the professionals responsible for R's care as a looked-after child have not had a sufficient understanding of her history and of her level of vulnerability – a vulnerability which continues to expose her to significant risk of harm, especially when she is missing. One consequence has been a lack of alertness by these professionals about the risk associated with R's patterns of going missing in this period.

Child R is a young person in care who has struggled with the status of being 'looked after'. She entered care as an older child, with a complex history which included neglect and abuse by her parent, and which left her with powerful feelings of rejection and blame by her family. She went on to have a series of 10 different social workers and 7 placements – a difficult and increasingly unsatisfactory experience of being looked-after and cared about.

The methodology of the review involved as many of the practitioners and their managers as possible in a 'learning event' where themes emerging from agency reports and chronologies were used as discussion and challenge points. The event was based on a systems model and looked at whether the findings were unique to this case or could be used as a 'window' on the local child protection and care system. The 'learning event' was well attended and the Board is grateful to the practitioners for their openness in the review process. The process also sought to engage Child R and her mother although the family felt they could only be involved in a limited way.

The Serious Case review identified eighteen learning points. An action plan has been implemented to address these points.

The learning points are highlighted below:

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 about 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.

In the period of the review agencies started to address the concerns they identified as part of the review process. Notably Children's Social Case has commissioned a service to offer return interviews to young people who are missing from care, research was commissioned to understand the barriers to young people who go missing from care returning back to their

carer, health have increased their resources offered to looked after children, the CCG undertook a review of arrangements for looked after children's services.

The learning points have been shared in a cascade event with partner agencies and this will be repeated in September and in further cascade events later in the year.