Civic Offices, New Road, Grays
Essex RM17 6SL

Dear Councillor,

Children's Services Overview and Scrutiny Committee - 10 March 2015

I enclose for consideration at the Children's Services Overview and Scrutiny Committee meeting on 10 March 2015, the following reports that were unavailable when the agenda was printed.

9	**Multi-Agency Action Plan - Serious Case Review**	**1 - 26**

Yours sincerely,

Graham Farrant, Chief Executive

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10 March 2015	ITEM: 9
Children's Services Overview & Scrutiny Committee	
Multi-Agency Action Plan – Serious Case Review	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Andrew Carter, Head of Children's Social Care	
Accountable Head of Service: Andrew Carter, Head of Children's Social Care	
Accountable Director: Carmel Littleton, Director of Children's Services	
This report is Public	

Executive Summary

The Multi-Agency Action Plan in response to the Serious Case Review is included for Members scrutiny and comment, following the request of the Children's Services Overview and Scrutiny Committee on 10 February 2015.

The extract of the Multi-Agency Action Plan, included in appendix 1, details the progress that has been made in Children's Social Care and Education in response to the findings of the Serious Case Review.

Members are advised that appendix 1 is an extract of the full multi-agency plan, which includes Police and Health contributions.

1. Recommendation(s)

1.1 That Members be invited to scrutinise the Multi-Agency Action Plan and provide any feedback.

2. Introduction and Background

2.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for Local Safeguarding Children's Boards to undertake reviews of serious cases where:

(a) abuse or neglect of a child is known or suspected; and
(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board Partners or other relevant persons have worked together to safeguard the child.

2.2. This case was referred formally to the Thurrock Local Safeguarding Children Board Serious Case Review Panel to consider the case under Regulation 5. The Panel found that this case met the criteria for a Serious Case Review and agreed the commissioning arrangements in order to meet the requirements of such reviews as laid out in HM Government 'Working Together to Safeguard Children, 2013.

2.3 A Serious Case Review Team was established and although Julia and her family had been known to Universal and Specialist Services for many years, the SCR Review Team agreed that the period to be reviewed would be from November 2010 to February 2013 when Julia became subject to a Child Protection Plan.

2.4 The review was commissioned in May 2013 and completed in May 2014 and the subsequent findings presented at a series of Safeguarding Board meetings and presented to the recently initiated National Serious Case Review Panel (new requirement) before going before the LSCB Full Board for final ratification and agreement in September 2014.

2.5 The review was officially published on 15th December 2014 and will remain on the LSCB website for a period of 18 months in accordance with guidelines (Working Together 2013).

2.6 The review identified seven findings for the Safeguarding Board to consider.

2.7 The board conducted an initial assessment of progress made during the course of the review and this is reflected within the final document.

2.8 A detailed multi-agency action plan has been developed and agreed by the partner agencies to monitor progress of each of the seven findings and outcomes from this review.

2.9 The governance and monitoring of the action plan has been tasked to the Safeguarding Board's Audit Group and overseen by the Serious Case Review group and subsequently reporting to the LSCB Full Board.

3. Issues, Options and Analysis of Options

None.

4. Reasons for Recommendation

4.1 It is a statutory requirement for Local Safeguarding Children Boards to publish all Serious Case Reviews. It is good practice for these reviews to be submitted to Overview and Scrutiny.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The document was circulated in draft for consideration and comment to all partners of the LSCB and the various LSCB sub committees prior to ratification.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The review calls upon the authority to review the findings against existing policies and procedure and to consider making any changes reflected in the review.

7. Implications

7.1 Financial

Implications verified by: **Kay Goodacre**

Finance Manager – Children's Services

The delivery of the LSCB Business is undertaken within existing budgets. Those budgets are established through annual partnership funding and specific budgets allocated for training and serious case reviews. All agencies contribute to the LSCB budget.

7.2 Legal

Implications verified by: **Lindsey Marks**

Principal Solicitor

This serious case review fulfils the requirements of Regulation 5 of the Local Safeguarding Children Boards Regulations 2006.

7.3 Diversity and Equality

Implications verified by: **Teresa Evans**

Equalities and Cohesion Officer

The annual report covers the safeguarding needs of all children in Thurrock. The plans and policies of its board and sub committees reflect the diverse needs which are supported through implementing and developing equalities impact assessments as appropriate.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- SCIE Serious Case Review Report "Julia"

9. Appendices to the report

- Appendix 1 – Multi Agency Action Plan

Report Author:

Carmel Littleton

Director of Children's Services

Children's Services

Thurrock LSCB SCR under SCIE Methodology

Child A – 'Julia'

Review Findings and Questions to the Board and its Partner Agencies

Children's Social Care

	Red Progress not on track – remedial action required
	Amber Progress will need monitoring to ensure it remains on track
	Green Progress on track no additional action

Report as at 23.02.15

Finding 1: There is a pattern whereby national and local policy agendas have driven practice in relation to underage sexual activity to have a stronger focus on sexual health and teenage pregnancy rather than sexual exploitation

The principal finding of "If only someone had listened" − the Final Report of the Inquiry of the Office of the Children's Commissioner into Child Sexual Exploitation in Gangs and Groups (CSEGG) was that despite increased awareness and a heightened state of alert regarding child sexual exploitation children are still slipping through the net and falling prey to sexual exploitation. Research published by Barnardos and the evidence provided to the Home Affairs Select Committee suggest that gaps remain in the knowledge, practice and services required to tackle this problem. Part of an effective response will be to ensure that there is a professional balance between appropriate advice regarding sexual health and a heightened awareness that this might be an opportunity to consider the potential for sexual exploitation.

Questions	Agency	Response	Actions	RAG	Constraints/Problems	Target Date/Evidence	Lead Person	Desired Outcome
1a. Does the Board recognise that this is an issue within Thurrock?	Children's Social Care (CSC)	Agreed that this has been an issue nationally. This case and others nationally have challenged professionals awareness & perception. This needs to continue and be addressed with all professionals who have a key role giving sexual health / contraception advice.	Ensure that multi-agency training is addressing the impact of Child Sexual Abuse (CSA), Peer on Peer abuse & CSE in a format that is accessible to sexual health workers. Develop countywide CSE strategy.	G		Completed - Countywide CSE Group established and action plan in place. Local CSE group is established and strategy in place. Training is on track re: sexual health workers.	NL/AC	To ensure that there is a consistent, appropriate and timely response to CSA; Peer on Peer abuse and CSE across the whole partnership.

	Education	This case indicates that there is a need to ensure that all staff working across education have the support and training to ensure that the supportive approach to young people with regard to their sexual health and contraception includes clear opportunities to reflect on and question the young person concerning their behaviours and their capacity.	Ongoing training and support for school staff to ensure appropriate pupil access to sexual health information and promotion, within a framework that identifies and addresses abuse and exploitation.	G		Training and Awareness raising for Headteachers and Safeguarding leads on track.	NL/ LSCB	To ensure that there is clear awareness of the risks of CSE and a consistent, appropriate and timely response to CSE by all Schools, Colleges and Education agencies.
1b. Does this Board have any further information about what is getting in the way of enabling professionals to strike a balance between advice around sexual health and an awareness of sexual exploitation?	Children's Social Care (CSC)	The Board should obtain further information from multi-agency audits; staff questionnaires across partnership; Single agency CSE audits & feedback from staff training	CSC staff to complete CSE awareness training. Single agency audits to be undertaken. Staff questionnaires to be developed and feedback obtained from staff training. National Peer on Peer, MsUnderstood training to be offered to key managers.	G		On-line CSC training provided to CSC staff. Learning from Julia and CSE briefings at CSC Service Morning on 30.1.15. Audit of CSE cases Dec 14, Feb 15 - April' 15. Staff questionnaire on track and feedback obtained from staff training. Managers have attended or are booked to attend Home Office sponsored MsUnderstood training.	LSCB Audit Group / CSC-SMT/AC / NL	Increased awareness leading to appropriate focus and challenge where required.

	Education	Schools, carry out programmes of sexual and relationship education and are required to have regard to the Sex and Relationship Guidance (DFE 2000).	Schools need to ensure that their PHSE is not focused solely on sexual health but encompasses issues of consent & exploitation.	G		Walk Online' road shows and COP programmes across schools in Thurrock as part of LSCB and multi-agency provision. Multi-agency training and briefing for school staff re: CSE; CSA; peer on peer abuse and neglect.	NL/AC/LSCB	Ensure that schools are addressing CSE within their PHSE curriculum. Continue to promote work by schools re: online safety.
1c. What are the options available for tackling this issue?	Children's' Social Care	Ensure that the CSE strategy is revised. Make CSE training compulsory part of induction and NQSW /ASYE modules. Ensure all agencies are providing effective CSA training	Ensure staff are completing CSE training. Revise CSE strategy. Continue to provide appropriate Child Sexual Abuse (CSA) training.	G		Whole service briefing held on 30.1.15. Staff have and are completing CSE training. Training is in place for NQSWs as part of ASYE academy. CSE training is compulsory. CSE champions training in place for March 15 re: all frontline managers. Revised CSE strategy is in place. Ongoing CSA training is provided.	AC	Increased awareness leading to early identification of and effective risk management of CSE;CSA and Peer on Peer abuse. The appropriate level of plan is in place and cases are escalated to legal proceedings where sufficient change is not made or maintained.
	Education	Targeted advice to schools as part of ongoing safeguarding training with regard to exploitation.	Ensuring all staff across the partnership including schools undertake on-line CSE awareness training as a minimum.	G		Julia' briefing to Strategic Partnership Board. Briefing for Head Teachers. Roll-out of briefings to school governors (summer term). On-line CSE awareness training. Ongoing CSA awareness training.	NL/ AC/ LSCB	Equip schools staff / bodies to quickly identify patterns and risks re: CSE, CSA and peer on peer abuse. Enable staff to refer appropriately, challenge and escalate.

Finding 2: If professionals record the language used by young people and their parents regarding early sexually exploitative experiences without clear analysis and challenge it has the potential to leave children and young people without an adequate response or protection

Issues for the Board to consider

Sexual exploitation is a serious issue and one that has a profoundly negative effect on young people's lives and their wellbeing. It is essential that all professionals feel able to recognise young people who are being sexually exploited and that they are able to respond effectively. This response must be child centred and all professionals must take a critical approach to the use of language in this complex area of practice, so that risks are recognised and young people are not held responsible for the harm perpetrated by others.

Questions	Agency	Response	Actions	RAG	Constraints/Problems	Target Date/Evidence	Lead Person	Desired Outcome
2a. Does the Board recognise that this is an issue that it should be concerned about?	Children's' Social Care	This is an issue that the board should be concerned about given potential to undermine effective responses to CSA, Peer on Peer abuse & CSE.	Expectations that board agencies will challenge any inappropriate language / use escalation process where necessary. Training for CSC staff and peer monitoring. Spot-checks on case notes.	G		CSC audits and spot checks in Dec 14 & April 15. Checks to be embedded in audit processes and supervision from May '15 onwards	NL/ RM /AC	To ensure that CSC & the professional network uses language which appropriately reflects abuse and exploitation.
	Education	This is an issue that the board should be concerned about. Evidence of inappropriate use of language to describe young people's sexual behaviour must be challenged and escalated.	Expectations that board agencies will challenge any inappropriate language using formal escalation process where necessary.	G		Advice to schools through information as part of Headteachers Bulletin; online CSE training; 'Julia' briefings & LSCB conference on neglect.	NL/ AC/ LSCB	To ensure that schools and all agencies supporting them uses language which appropriately reflects the abuse and not minimising it by language which shifts the blame and responsibility
2b. How can the Board ensure that this issue is addressed within its Child Sexual Exploitation strategy?	Children's' Social Care	CSC is committed to embedding the CSE Strategy; challenging language and practice as necessary.	Revise strategy to ensure there is reference to language used by professionals. Ensure all agencies aware of escalation process for raising concerns.	G		Completed	Strategy sub-group. JW/ NL /AC	Clear processes to monitor and address the use of inappropriate language

	Education	Children's Services are committed to embedding the CSE Strategy; challenging language and practice as necessary.	Review strategy to ensure there is reference to language used by all staff in schools and ensure safeguarding leads are in a position of sufficient influence to ensure appropriate challenge takes place.	G		Completed	AC/NL/LSCB	Clear processes to monitor and address the use of inappropriate language
2c. Are there other opportunities or levers at the Boards disposal for changing professional practice and language in this area?	Children's Social Care	The board and partner agencies should require universities and professional training bodies to address the use of language within qualifying courses.	Address with providers of SW training / include in all ASYE modules.	G		Completed re: ASYE and on track re: providers of social work training.	NL/AC/ WA	Increased professional awareness and competency.
	Education	Advice to schools following the SCR to include specific reference to the need for analysis and challenge with regard to the reporting of sexual behaviour in schools.	Lesson learnt from 'Julia' SCR briefings to be rolled out across schools. On going development of AIM programme with Children's Social Care as lead agency.	G		Multi-agency training offer in place via LSCB.	AC/NL	Ensure that sexually harmful behaviour is identified and addressed in relation to both the victim and perpetrator

2d. How will the Board know if it is being effective in addressing this issue of language?	Children's Social Care	Audits and thematic case audits of CSC files.	Evidence through file audit that appropriate language is being used and inappropriate language is being challenged by managers through supervision.	G		Questions in relation to CSE have been introduced to the audit tool. Thematic audit in place and ongoing.	NL/AC	Increased professional awareness and competency as evidenced by records showing an appropriate use of language.
	Education	Statutory Safeguarding reporting by schools	Focus group activity with school designated child protection staff, feedback from schools statutory safeguarding reports.	G		Ongoing	NL/AC/LSCB	Increased professional awareness and competency as evidenced by records showing an appropriate use of language.

Finding 3: Is there a pattern whereby the Child in Need procedures are not routinely being used leaving children and young people without formal plans and review?

Effective processes to support children, young people and their families are essential. The Child in Need processes are intended to build on good quality assessments, by developing a plan of action , which is owned and developed by the multi-agency group, and is reviewed regularly to see what progress is being made to promote children and young people's outcomes. If these processes are not used, interventions are unlikely to be clearly focussed on children's needs and are unlikely to provide effective help and support.

Questions	Agency	Response	Actions	RAG	Constraints/Problems	Target Date/Evidence	Lead Person	Desired Outcome

3a. Are the Board aware that Child in Need processes are vulnerable to pressures on Social Work teams, and of a potential mis understanding of when Child in Need meetings should be convened?	Children's Social Care	Constant vigilance is required across agencies to ensure that Children in Need processes operate to improve outcomes for children and families.	New CIN processes / guidance has been issued to staff. The document was re-circulated again to all teams.	G		In place & ongoing	RM/SMT	CIN cases regularly reviewed and robust step up/down process in place
			CIN surgeries set up across Family Support Teams chaired by Service Manager, to review all cases ,ensuring robust /SMART plans are in place.	G		In place & ongoing	RM/SMT	CIN cases regularly reviewed and step up/down processes in place
			AST to set up CIN challenge surgeries	**G**		In Place	JW	CIN cases regularly reviewed and step up/down processes in place
	Education	Safeguarding leads to be reminded of the role of schools in CIN procedures and escalation routes available to them following a decision by social care.	Renewed advice/guidance to school safeguarding staff on follow up routes available to schools following a MASH or other safeguarding concern and their duties in relation to CIN.	G		Further clarification advice to be delivered as part of Headteachers' briefing on SCR and follow up to be delivered as part of safeguarding training in summer term 2015.	NL/AC	Schools fully aware and empowered to seek further clarification and where appropriate challenge decisions made by partner agencies.
3b. Is there more the Board could do to establish the extent of this issue, e.g. case audit?	Children's Social Care	Multi-agency focus on threshold	Regular peer audits	G		completed	CS	Cases appropriately escalated/deescalated when risks and needs change.

audit?			CP surgeries established; challenging CP plans over 12 months	G		completed	AC/ NL/ RM	
			Audit of 30 S47 decisions undertaken	**G**		completed	NP/RM/JW	
3c. What can the Board do to address this?	Children's Social Care	Establish multi-agency LSCB Performance Panel to challenge single agency performance and outcome data	Establish multi-agency LSCB Performance Panel to challenge single agency performance and outcome data	G		Completed - LSCB Performance Panel is operational	AC	Evidence of effective risk management of CIN cases- step up and step down
	Education	Ensure feedback is in place from schools to the LSCB on the involvement of school in CIN meetings.	Ensure feedback is in place from schools to the LSCB on the involvement of school in CIN meetings.	G		Feedback and actions from school survey on CIN to be reported to LSCB following data gathering in summer term 2015	MT/NL	Evidence of effective inclusion of schools in CIN meetings; challenge and escalation.
3d. How will the Board know they have been successful in ensuring that Child in Need processes is embedded in multi-agency practice?	Children's Social Care & Education	Through multi-agency audits and single agency audits.	Re-issue threshold document to agencies and schools. Complete multi-agency audits and single agency case file audits.	G		Threshold documents have been re-issued and audits are on track.	CS/ AC	Thresholds are clearly understood across agencies
Finding 4: The lack of engagement with services by parents takes professional energy and attention away from the needs of children /young people and leaves them with an ineffective response								

The non-engagement of parents in services aimed at promoting the well-being of their children/young people is a significant issue. It has an impact on young people's wellbeing and their outcomes, and causes more pressures on over stretched professionals. It is also costly for services. A lack of recognition of this as a safeguarding issue means that children and young people are not always effectively protected.

Questions	Agency	Response	Actions	RAG	Constraints/Problems	Target Date/Evidence	Lead Person	Desired Outcome
4a. Are the Board aware of this as an issue facing professionals?	Children's Social Care	Working with parental resistance / passive resistance is a national issue.	Requires focus by staff & managers on purposeful intervention / regular review and robust supervision. Introduction of case discussion audit to focus on resistance and disguised compliance.	G		Case Discussion Tool has been introduced (Feb'15). Disguised Compliance PowerPoint discussed in all teams during Feb & March '15. Ongoing support and monitoring to be provided in supervision.	SMT/AC/ CS	Non-Compliance and Disguised Compliance is recognised and appropriate actions taken to safeguard children and young people.
	Education	Schools are a key point of contact for agencies parents and families. Pastoral support teams in schools are used to engage parents on a range of issues .	Requires close working between social care teams and school based staff to ensure the existing contacts in school are used to best effect.	G		Process of developing close working relationships to be supported through post SCR briefing to headteachers in March 2015 and further work directly with safeguarding leads	MT/NL	Close links between school based staff and social care teams to ensure opportunities for parental engagement are achieved
4b. Does the LSCB know if staff locally have been equipped to work with resistant parents both in single agency and partnership working?	Children's Social Care	CSC staff have been and continue to be provided with training and support to work with resistant families.	Review all open CIN cases for SMART plans. Where cases are open for longer than 6 months review purpose of continued intervention.	G		First wave completed Sept'14. Second wave to be completed by July 15 and third wave by Jan' 16.	RM/JW/NL	To ensure that cases are effectively managed and appropriately stepped up or down based on a clear assessment of risk.
			Workshop undertaken with staff regarding SMART plans. See above CIN Surgeries	G		Sept 14	CS	To ensure that cases are effectively managed and appropriately stepped up or down based on a clear assessment of risk.
	Education	As above re: 4a						

4c. How might the LSCB help practitioners overcome this obstacle to effective practice?	Children's Social Care	Multi-agency training for staff working with resistant families.	Provide multi-agency training for staff and managers on effective working with resistant families	G		2015/16 Training Plan	LSCB	Staff are able to quickly identify and address resistance.
	Education	Advice to schools on working with hard to reach / resistant parents to be included as an area of school safeguarding training.	Provide multi-agency training for staff and managers on effective working with resistant families	G		Training plan in place	NL/AC/MT	Staff are able to quickly identify and address resistance.
4d. How will the Board know when this has been effective?	Children's Social Care (CSC) & Education	Audits; reports to board and LSCB Challenge Panel.	CSC to undertake and present findings from audits to LSCB. CSC to provide performance data to LSCB re: Challenge Panel. Regular performance reports to be presented to LSCB. Statutory safeguarding reports from schools to clearly address neglect across all age groups.	G		Audit process embedded. Challenge session held with LSCB. Regular performance reports submitted to LSCB	NL / CS / AC	Staff are able to quickly identify and address resistance.

Finding 5: Is there is a lack of a developed understanding and awareness of adolescent neglect across the multi-agency network leaving young people at risk of harm

Adolescent neglect is a significant issue which has a profound effect on young people's lives. Recognising and responding to adolescent neglect is a critical part of addressing sexual exploitation, and an ineffective response leaves young people at risk of significant harm.

Questions	Agency	Response	Actions	RAG	Constraints/Problems	Target Date/Evidence	Lead Person	Desired Outcome

5a. Are the Board aware that adolescent neglect is a significant issue facing professionals?	Children's Social Care & Education	Thurrock has a high prevalence of neglect cases across all age groups.	Focus on neglect within LSCB Conference. Adolescent 'neglect toolkit' to be rolled out within Adolescent Team	G		LSCB conference 'Spotlight on Neglect' completed. Adolescent 'neglect toolkit' on track re: March '15 target date. .	JW/ AC	Earlier identification of adolescent neglect and affirmative action taken to risk manage and address.
5b. How can this be tackled by the Board?	Children's Social Care & Education	By addressing adolescent neglect within the LSCB multi-agency and single agency training plans.	Provide appropriate training and ensure robust auditing / monitoring to evidence that learning is being translated into improved practice.	G		Auditing process in place training plan in place	JW/CS/ LSCB	Impact of training can be evidenced in practice improvements. Feedback from service users.
5c. How can professionals be supported to develop a more effective response to adolescent neglect?	Children's Social Care	By using adolescent neglect tool kits.	Rolled out to all Adolescent Team staff & managers	G		In place & re-launched	JW	Staff can consistently identify neglect and respond appropriately.
			Evidence of toolkit used in supervision	G		Mar-15	SMT / JW	Managers can consistently support workers in identify neglect and responding appropriately.
	Education	By training support.	On going training and support for school based staff, through signposting by LA staff to appropriate training and direct support in individual cases.	G		On-going	MT/NL/AC	School staff can identify neglect and respond appropriately.
5d. How will the Board know its response has been effective?	Children's Social Care	Neglect is quickly recognised and addressed.	Frequent review of CP Plans.	G		Frequent CLA surgeries are being held as additional scrutiny.	AC/ RM / NL	Fewer children subject of a plan for two years or more
			Frequent review of CIN cases.	G		Frequent CIN surgeries are being held as additional scrutiny.		

	Children's Social Care & Education	Neglect is quickly recognised and addressed by school staff	Increase in referrals to EOH and Troubled Families	G		Compare 2013/14 rate with final rates for 2014/15- target for completion June 15.	MT/NL/AC	Families are effectively 'turned around' inline with Troubled Families criteria.

Finding 6: Is there a pattern whereby Multi-agency working has become overly focussed on information sharing, at the expense of a shared analysis, face to face meetings and shared plans to meet the needs of children and young people?

Issues for the Board to consider

Information sharing is a critical component of multi-agency safeguarding practice, but if multi-agency processes are to be effective there is a need to move beyond the provision of information to sharing and exploring a professional analysis of a child or young person's circumstances. Assessments and plans need to be developed and reviewed by the multi-agency network. If this does not happen children and young people are left at risk of harm, and plans become one dimensional. Drift is not challenged, and the lack of progress not noted.

Questions	Agency	Response	Actions	RAG	Constraints/Problems	Target Date/Evidence	Lead Person	Desired Outcome
6a. Does the Board accept this Finding?	Children's Social Care (CSC) & Education	There is a danger that agencies can believe that their duty is complete by sharing concerns with CSC and not taking responsibility for their own actions in the safeguarding arena.	All agencies to be frequently reminded of their safeguarding responsibilities and the need for shared analysis. Best practice models to be promoted based on the strength of practice within the MASH.	G		March '15 and ongoing	AC/ NL/ LSCB	Shared analysis leading to increased early intervention, drawing on strengths of MASH partnership
6b. How will the Board establish whether this is a significant issue?	Children's Social Care & Education	By undertaking multi-agency thematic audits.	Multi-agency thematic audits are completed by the LSCB audit group	G		Jun-15	LSCB / AC	Audits show evidence of effective information sharing and shared analysis.
6c. What can the Board do to address it?	Children's Social Care & Education	Promote effective multi-agency ownership of risk and risk management.	Review and strengthen LSCB work plan for 2015-16.	G		Mar-15	LSCB	Agencies appropriately manage risk and constructively challenge each other in the best interests of children.

6d. How will the Board know it has been successful?	Children's Social Care & Education	Audits show evidence of effective information sharing and shared analysis. Children and young people receive timely interventions.	Audit programme linked to LSCB single agency challenge sessions. Audit of MASH contacts from schools and feedback from school safeguarding leads.	G		Single agency challenge session have taken place and are planned for the rest of the year.	NL/ AC	Children and young people receive timely multi-agency interventions.

Finding 7: Is there a pattern whereby GP's in Thurrock are not recognised by other professionals or themselves as an integral part of the safeguarding network?

GPs are a critical part of the safeguarding network. It is essential that any barriers to their effective engagement in safeguarding processes are actively addressed. This is particularly important in the context of underage sexual activity and sexual exploitation, where GP's are likely to be a key point of contact for young people

Questions	Agency	Response	Actions	RAG	Constraints/Problems	Target Date/Evidence	Lead Person	Desired Outcome
7a. How will the Board establish whether this is a significant issue and which needs addressing?	Children's Social Care & Education	This is a local & national issue.	Review local and national data, SCRs and research.	G		Ongoing	N/L	Improved engagement is facilitated for GPs.

7b. How will the Board explore the engagement of GPs in the safeguarding network?	Children's Social Care	CSC managers and LSCB members to regularly attend GP Forum.	CSC managers and LSCB members to regularly attend GP Forum.	G		Dates proposed for CSC Head of Service to attend GP Forum	AC	Effective partnership with GPs lead to early identification of CSE; CSA and peer on peer abuse.
	Education	Education are aware that schools often have important links with GPs and may therefore be in a position to provide further information on this concern through contact with safeguarding leads	Schools to feedback on contact with GPs as part of their safeguarding audit.	G		Ongoing	NL/AC	Effective partnership with GPs lead to early identification of CSE; CSA and peer on peer abuse.
7c. What are the options for addressing this issue?	Children's Social Care & Education	As suggested by GPs the following proposal are being explored by CSC and the CCG	Children Social Care to consider changing case conference time/venue	**G**		To be progressed at GP Forum meeting	YA/ AC/ NL	Increase ability of GPs to manage their surgeries and attend CP conferences & CIN meetings.
			Explore other ways of engaging GPs in conferences/ CIN meeting e.g. telephone conferencing.	**G**		To be progressed at GP Forum meeting	YA/ AC/ NL	Increase ability of GPs to manage their surgeries and attend CP conferences & CIN meetings.
			Holding some CIN meeting/ Case conference/ at GP practices.	**G**		To be progressed at GP Forum meeting	YA/ AC/ NL	Increase ability of GPs to manage their surgeries and attend CP conferences & CIN meetings.

		An educational MASH Video is being made to assist GPs and other professionals in making referrals to CSC	G		Filming is complete and video is being edited on track for March '15 completion target.	YA/ AC/ NL	Increase awareness of referral pathways

Chapter 4 of Review Report – ADDITIONAL LEARNING

1. The importance of holistic assessments

Historically national guidance regarding Initial and Core Assessments encouraged Social Workers to be incident focused and only analyse the circumstances of the referred child, leaving other children in the same family without a clear analysis of their needs or a plan

There were two referrals regarding Julia's sibling during the period under review and both focussed on the sibling rather than Julia. The Review Team recognised that the existing processes regarding Assessments did not support a holistic whole family approach. This is in the process of change with the development of the Single Assessment process.

In September 2011 Children's Social Care received a referral from the hospital regarding Courtney who had been seen in A&E with burns caused by her sister throwing water from a boiling kettle on her back whilst she was in the bath. The referral also said that the hospital was concerned because Julia's mother had told them that Julia "*had been sexually active since she was 11- 12 years old*". A referral was opened regarding Courtney, but not Julia.

The completed Assessment contained a lot of information and family history. The focus was on Courtney and her circumstances, but there was also information provided about Julia. Information was provided about Julia not having contact with her father because her mother said that he is a risk to children and was allegedly involved in the sexual abuse of a child. The School were said to have raised concerns about Julia who was refusing to follow instructions, truanting from class, being disruptive and had hit another student in class. In the context of the two previous disclosures of rape and the allegations made in the referral, these were worrying issues, which indicated that Julia had significant needs.

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Crucially the conclusion of the assessment focussed almost exclusively on Courtney and the incident which led to the referral. This meant that the referral was not considered to have met the threshold for services because the incident had been dealt with. Julia's needs were not analysed and no formal plan of action was put in place, beyond continued support from school for her.

The lack of any Assessment of Julia's needs during the majority of the period under review meant her needs were not well understood, the issues of sexual abuse not explored fully and the need for Child Protection processes to be put in place not fully discussed.

Questions	Agency	Response	Actions	RAG	Constraints/Problems	Target Date/Evidence	Lead Person	Desired Outcome

8a. Does the Board recognise that the quality of assessment in Thurrock is an issue for the safety and wellbeing of children and young people?	Children's Social Care	The awareness and quality of assessment re: CSE has improved but as is the picture nationally, ongoing work is taking place to continually improve the consistency of high quality assessments in this area. Assessments are holistic and continued challenge is required re: any assessment that fails to take into consideration the needs of all children in the household.	Thematic audit of CSE cases and ongoing staff training. Managers to monitor assessments for potential CSE risks before approving. Managers to equally ensure that all children within the household have been considered as part of any C&F assessment. Senior Managers to monitor compliance and evidence of appropriate managerial oversight.	G		Completion in April '15 of thematic audit of current and historic CSE cases/ medium to high risk cases over a period of the last 5 yrs from 2014. Ongoing individual case feedback from auditor to improve any areas of immediate practice. Ongoing management oversight of C&F assessments re: ensuring these adequately cover all children in the household.	AC/NL/RM	Assessments clearly identify and lead to prompt actions re: risks of CSE & CSA. Staff feel confident, well trained & supported to assess and address CSE, CSA & neglect.
Page 21	Education	Schools will require ongoing advice and support to ensure that all information relevant to individual children and their families is appropriately recorded in school giving a long term picture of needs which is included in assessments.	Ongoing training support in schools regarding their role in information gathering	G		Advice to Headteachers through bulletin and briefing March 2015, Training for schools in summer term 205	NL/AC	Effective & holistic assessment and information sharing by school staff.
8b. Does the introduction of the Single Assessment provide an opportunity to improve the quality of assessments, and ensure that a holistic approach is taken?	Children's Social Care & Education	Single Assessment was introduced in April 2014 in Thurrock. The principle objective of SA is that it captures and reflects on child's journey starting from early intervention (CAF) through to Children Social Care with a holistic approach to consider the family as an unit rather than the assessment only focusing on the subject child.	Strengthen assessment processes by MASH (Multi-agency safeguarding hub) undertaking initial CSE risk assessments (where appropriate) to increase capacity for early identification of CSE risks.	G		Audits in Dec 14; March 15 & June 15 - ongoing spot-checks and periodic thematic audits	RM/NL	Evidence of an initial CSE screening assessment by MASH being completed on relevant cases and leading to appropriate further assessment and initial actions.

8c. Does the Board have any evidence about the quality of Assessments locally and what the barriers to effective practice might be?	Children's' Social Care & Education	Quality of CAFs to be monitored and improved within single and multi-agency audits. Audit outcomes to be feed into training needs analysis.	Complete single and multi-agency audits periodically throughout 2014/15 and embed into audit cycle for 2015/16	G		CSC single agency audits Dec 14; Jan 15 & March 15 - Multi-agency audits by LSCB	RM/ CM/NL	Assessments where appropriate clearly consider CSE. Training is offered to multi-agency network to improve quality of assessments
8d. Does the Board have an awareness of the key issue for effective assessment of young people who are being sexually exploited and what needs to be put in place to optimise assessment practice in this area?	Children's' Social Care	CSE risk assessment to be undertaken on all young people over 10 who go missing.	Complete & review CSE risk assessments on current missing cases.	G		Nov 14 & Audit March 15	NL/JW/PC/RM	All children who regularly go missing have effective CSE risk assessments.
	Education	Schools need to be fully aware of the risks of CSE	Multi-agency support to be provided to schools in identifying CSE risk factors / indicators	G		Ongoing	NL/LSCB/AC	Schools are able to consistently identify & address CSE risk factors.
8e. How will the Board know it has been successful?	Children's Social Care	Evidence on LCS of clear identification of young people understood to be at risk of CSE; CSA & peer on peer abuse	Complete CSE Risk assessments on current cases.	G	LCS ability to flag cases, discuss with Liquid Logic and consider upgrade to CSE workspace when available in June 15.	March 2015 and ongoing as new cases identified.	JW/NL/PC/RM	CSE risk assessments are embedded into practice and regularly reviewed

	Education	Statutory safeguarding reports from schools & multi-agency audits	Statutory safeguarding reports from schools & multi-agency audits	G		Ongoing	NL/AC/LSCB	CSE screening and appropriate referrals are embedded into practice

2. Difficulties in escalating to concerns about Adolescents to Child Protection

Over the period of the review the Case Group told the Review Team that adolescents were less likely to be subject of Child Protection processes and the social work team charged with meeting the needs of teenagers found this frustrating. This has changed over time, and there is now better recognition of the importance of Child Protection processes for this age group.

Given the seriousness of the concerns regarding the disclosure of sexual assault by Julia from the ages of 12 – 14 years, and her mother's unresponsiveness, it would have been expected that she would have been subject to Child Protection procedures. Julia made four disclosures of rape in a two year period. Rape of a child is sexual abuse, yet somehow this was not recognised. The police undertook extensive criminal enquiries to establish the facts of each case and to seek a prosecution of the perpetrators identified by Julia. The lack of a criminal prosecution should not have meant that there was no assessment of significant harm and a decision made about whether a Child Protection response under Sec 47 of the Children Act 1989 was required.

Questions	Agency	Response	Actions	RAG	Constraints/Problems	Target Date/Evidence	Lead Person	Desired Outcome
9a. How will the Board know that these changes have occurred and are embedded in practice?	Children's Social Care & Education	Strengthen SET procedures regarding sexual exploitation and use of CP procedures. Monitor CP rates in relation to teenagers.	Review & update SET procedures. Undertake multi-agency audits of adolescent CIN cases against thresholds.	G		Revised SET procedures have been completed. Audits are ongoing.	NL	Updated procedures that incorporate learning from 'Julia'; Jay Report and Ofsted Thematic on CSE. Thresholds are applied appropriately and cases escalated where necessary using full legal powers open to the LA.

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