6 October 2020	ITEM: 7
Children's Services Overview and Scrutiny Committee	
Items Raised by Thurrock Local Safeguarding Partnership Board – Serious Case Review	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Jane Foster-Taylor, CCG – Statutory Partner of the Local Safeguarding Children's Partnership (LSCP)	
Accountable Assistant Director: Joe Tynan, Interim Assistant Director, Children's Social Care and Early Help	
Accountable Director: Sheila Murphy, Corporate Director of Children's Services	
This report is Public	

Executive Summary

This report is to inform Members of the Overview and Scrutiny Committee about the outcome of a Serious Case Review (SCR) which was published by the Local Safeguarding Childrens Partnership (LSCP) on 30th July 2020. The subject children were called 'Sam' & 'Kyle' for the purposes of the SCR, their real names being anonymised.

Sam was born in January 2016 and sadly died in January 2018 at home. There is a sibling, Kyle, born in October 2012. There was no presumption of non-accidental injuries or harm and Essex Police took no further action in relation to Sam's death. The SCR was agreed by the LSCP and the remit was to cover the period of time from when Kyle was born through to Sam's death.

Serious Case Reviews were established under The Children Act (2004) to review cases in which a child has died and where abuse or neglect is known or suspected. Serious Case Reviews are also sometimes carried out where a child has not died, but has come to serious harm as a result of abuse or neglect. The aim of a SCR is to establish learning for agencies and professionals to improve the way that agencies work together to safeguard children.

A Local Safeguarding Children Board (LSCB) can commission a SCR for any case where it suspects there may be multi-agency learning outcomes which will improve local practice. Since this SCR was commissioned, new safeguarding arrangements have come into place under the Children and Social Work Act 2017 and Working Together to Safeguard Children 2018. Accordingly, a Local Safeguarding Children's Partnership (LSCP) has been in place in Thurrock since May 2019, (led by the three

statutory partners - Police, Health and Children's Social Care). Serious Case Reviews are now replaced by Learning Practice Reviews. This Serious Case Review has been undertaken in line with the revised Working Together guidance and subsequent guidance from the National Child Safeguarding Practice Review.

The SCR report of Sam and Kyle has been provided to Members of the Overview and Scrutiny Committee, to supplement this item and is available on the LSCP website. The SCR provides an overview of the services offered to the family, work undertaken by all agencies, progress made and concerns raised during this period of involvement. The SCR provides an analysis of the key lines of enquiry within the review, and learning points are identified with five key recommendations.

The Local Safeguarding Partnership has developed an Action Plan in response to the recommendations within the Serious Case Review report. The Action Plan is attached as Appendix 2.

1. Recommendation

1.1 That the Overview and Scrutiny Committee accept the recommendations of the Serious Case Review and the resulting Action Plan.

2. Introduction and Background

2.1 The Serious Case Review report is written by an Independent Author, and the review was chaired by an Independent Chair. At its commencement, this Serious Case Review was commissioned under the previous safeguarding arrangements and therefore there was an independent chair of the Local Safeguarding Children Board at that time. The SCR report is based upon the information provided by involved agencies in the form of chronologies and individual management reviews. The report's author also offers to meet with the relevant adults in the family (usually the parents) and the final report is shared with them prior to publication. This SCR was informed by a practitioner event where staff and managers involved in the case were invited to contribute perspectives on the case and help draw out key conclusions.

The publication of this Serious Case Review has taken longer than anticipated due to delays in meeting with the family, combined with the impact of restrictions resulting from Covid-19.

2.2 The Serious Case Review report had key lines of enquiry (page 3 of the report) that relate to;

1. How well agencies co-ordinated; including universal services, shared information, understood threshold and escalated concerns.
2. Dealing with neglect; use of tools and training.
3. Professional confidence and curiosity, management oversight and the support offered to vulnerable parents.

2.3 The recommendations from the Serious Case Review are as follows:

1. *"Thurrock Safeguarding Children Partnership should review within the next six months its procedure for the escalation of concerns and for resolving differences of view between professional and agencies. This should especially consider where there are challenges to the thresholds applied to cases which involve a number of agencies, and where there are persistent concerns about either neglect and/or parental engagement.*

2. *"Thurrock Safeguarding Children Partnership should develop a series of practice workshops to be run between agencies to explore and build on better co-operation and understanding of handling complex or persistent cases. Case studies should be used – such as this Review - and the development of joint or group supervision approaches should be explored. This should be viewed as an opportunity to strengthen understanding between services and encourage wider joint working and sharing of relevant information about concerns.*

3. *"Thurrock Safeguarding Children Partnership should, using the principles within the Signs of Safety approach, review interagency procedures for establishing agreement with families of written care plans involving all those working with a child, with shared, clear and practical objectives that can be monitored– especially in persistent cases of poor parenting and neglect.*

4. *"Thurrock Safeguarding Children Partnership should consider auditing the operation of the Prevention and Support Service programme to establish the extent to which the positive evaluation in the 2019 Ofsted report has been sustained and strengthened*

5. *"Thurrock Safeguarding Children Partnership is recommended to encourage the continued development of the Signs of Safety approach, and the use of the Graded Care Profile 2 for use across agencies and professional groups."*

3. Issues, Options and Analysis of Options

3.1 The Serious Case Review report and Action Plan are attached as appendix 1 and 2.

4. Reasons for Recommendation

4.1 The Serious Case Review report has been commissioned and agreed by partner agencies and recently published.

4.2 The options available to the Overview and Scrutiny Committee are to either accept the Action Plan which has been developed by the Local Safeguarding Children Partnership in response to the recommendations within the report, or to request that the Local Safeguarding Children Partnership reviews the

Action Plan taking into account any specific questions or concerns raised by the Overview and Scrutiny Committee.

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

5.1 None

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

6.1 None

7. Implications

7.1 Financial

Implications verified by: **David May**

Strategic Lead Finance

None.

7.2 Legal

Implications verified by: **Judith Knight**

Interim Deputy Head of Legal (Social Care and Education)

The review was conducted by the LSCP to support the development of practice across the partnership. The Committee has a role in supporting the partnership in taking the learning from this review and using this in developing practice.

The statutory powers relating to the review are detailed in the report, there Are no other specific legal implications from this report.

7.3 Diversity and Equality

Implications verified by: **Roxanne Scanlon**
Engagement and Project Monitoring Officer

None.

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

None.

8. Appendices to the report

Appendix 1 – Serious Case Review – Sam and Kyle
Appendix 2 – Action Plan

Report Author:

Jane Foster-Taylor

Statutory Partner of the LSCP