SANDWELL SAFEGUARDING CHILDREN'S BOARD

7 Minute Briefing – SSCB Table Top Review

01 – Aim of the Review:

Sandwell Improvement Board highlighted the case of 'Michael' as being one that needed investigation due to the escalation in risk and lack of progression. There are several contextual safeguarding concerns including criminal exploitation and county lines activity.

Agencies involved with young person and family were asked to complete a chronology, returns were received from all partner agencies, including Children's Trust, Education, Health and Police. All partner agencies were also invited to a table top review.

02 – Overview of Case:

Involvement with Early Help services since 2012 displaying aggressive and inappropriate sexualised behaviour at a young age. Several problems at school resulting in exclusions from both Primary and Secondary education and attendance at a PRU. From 2016-2018 there have been many arrests for serious violent and/or drug offences, and a large number of missing episodes that have increased in frequency and length. There have also been 3 attacks on this young person and their home, one resulted in him being hospitalised. There has been little progression, and the risk has not decreased since statutory agencies became involved. They still appear to be involved in gang activity.

03 – Key Questions:

- Has the history of involvement been considered?
- Were thresholds understood and applied?
- Was there missed opportunity for statutory interventions?
- Were multi-agency assessments and meetings effectively used?
- Quality of the work with the family
- Quality of the work with the young person
- Was there effective safety planning?
- Was there an effective review process?
- Overall what was the quality of multi-agency working, and what can we learn from this case?

04 – Learning from Review:

7. **Understanding and implementing thresholds –** It was clear from discussion that either practitioners did not understand thresholds for significant harm and/or did not have confidence that cases would be accepted by statutory agencies
8. **Dispute Resolution and Escalation Process –** Agencies were trying to manage risk themselves rather than using the 'Managing Professional Disagreement' Policy which has an escalation process for agencies if they have concerns about risk to a child and/or decision relating to risk
9. **Understanding of multi-agency approach –** lack of confidence in multi-agency working resulted in a lack of co-ordinated interventions
10. **Effective safety plans** – CIN plans were not robust and did not effectively safeguard young person
11. **Responding to disguised compliance –** agencies need to look at reasons for families disguised compliance, work with that, or escalated the case if families are still not engaging

05 – Learning from Review:

1. **Assessments –** were often weak and failed to include history of case, or other agencies views
2. **Supervision of Elective Home Education** – was not robust and led to long periods of unsupervised time for a young person who was vulnerable to exploitation
3. **Cultural Understanding** – lack from some agencies of understanding diversity and cultural difference
4. **Implication of low level emotional neglect** – lack of boundaries and low level emotional neglect, makes young people vulnerable to exploitation
5. **Direct work –** little direct work was carried out which meant that opportunities to engage the young person were missed – good direct work from YOS and MST
6. **Perpetrator vs. Victim –** criminal and sexual exploitation victims can engage in criminal behaviour, and need to be held accountable for these actions. However, they must still be recognised as victims and treated as such

06 – Recommendations for Frontline Managers/Practitioners:

1. Agencies to be aware of the 'Managing Professional Disagreements' Policy and the escalation process, and feel confident to use the process if they have concerns about the risk to a child, and/or the escalation/de-escalation of a case
2. All practitioners/managers to attend exploitation training which will be available through SSCB from April 2019
3. All practitioners/managers to be trained in use of Sandwell threshold documents, feel confident in being able to recognise thresholds for significant harm, and when identified cases that met the threshold require a referral to Children's Social Care
4. Need to understand the complexities of the victim/perpetrator status for both those at risk of exploitation and involved in gang activity
5. All practitioners need to understand how to develop and monitor signs of success as outcomes of safety plans

07 – Recommendations for Strategic Leads:

1. Strategic leads in Sandwell need to develop a robust multi-agency offer for families with children at risk of criminal exploitation

2. There needs to be a linking together of all different strategic exploitation groups, and one comprehensive plan developed

3. There needs to be consideration to the development of a local safeguarding framework to consistently respond to request for elective home education (EHE) and prevent misuse of the arrangement for EHE, which identifies early those children at risk of exploitation, abuse and neglect