Report from the multi-agency practitioner reflective learning event held on 14th September 2022 following the Rapid Review of child SD

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CONTENTS

1.   Introduction

1.1   The benefits of learning in the safeguarding children environment cannot be underestimated. Sandwell Children's Safeguarding Partnership (SCSP) expects that agencies take every opportunity to learn from their experiences of working together to improve safeguarding arrangements for children and young people.

1.2   When a serious incident becomes known to the safeguarding partners a 'Rapid Review' of the incident takes place, in accordance with Working Together 2018[1]; representatives from statutory and other partner agencies review the information available and decide whether it meets the criteria for a Local Child Safeguarding Practice Review (LCSPR), with an overall purpose of identifying improvements to practice[2].

1.3   Cases will be identified where there is significant learning to be gained across the multi-agency network, but where the criteria for a LCSPR are not met; in these circumstances the SCSP can decide to undertake a different kind of learning review with agencies.

2.   Reflective Learning

2.1   A reflective learning event can establish what lessons are to be learnt from the case about the way in which local professionals and agencies work, individually and together, to safeguard and promote the welfare of children that will impact on *practice beyond the circumstances of the case.*

2.2   The structure of a reflective learning event can vary but will always explore evidence of good practice and lessons learned, including how those lessons will be acted on, who will lead, and what is expected to change as a result. These events do not depend on the completion of complex chronologies and detailed agency reports, but instead invite the most appropriate representative from each agency involved to participate in a reflective review meeting where their knowledge of the case and their agency involvement will enable them to participate in interagency peer scrutiny, review and discussion.

2.4   Where appropriate, the views/experiences of the child/children or young person and their family are sought.

2.5   It is hoped that the process of reflective learning will highlight good practice and stimulate a positive learning culture.

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[1] HM Government (2018) Working Together to Safeguard Children
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

[2] Decisions made relating to Local Child Safeguarding Practice Reviews (LCSPRs) in England is overseen by the Child Safeguarding Practice Review National Panel (National Panel). The National Panel can choose to commission national case reviews and produce national thematic reports on issues which represent national challenges which set out recommendations and findings for safeguarding partnerships to use locally.

3.   Background

3.1   In 2022, a 17-year-old male (referred to for the purpose of this review as 'SD') was seriously injured whilst in the community with friends, leading to a permanent disability. A thorough police investigation has been undertaken however no suspects have been identified and the case has been filed pending any new lines of enquiry arising.

3.2   The family had been known to agencies in Sandwell for over 10 years for complex and entrenched needs relating to criminality/exploitation, domestic abuse, poor parental mental health and a disorganised home environment. This includes four episodes of SD and other family members being subject to statutory plans. SD was last subject to a statutory plan from summer 2020 as a Child in Need, with the plan ending two months before his 18th birthday. At the time of the incident SD was subject to a Youth Rehabilitation order for motoring offences. SD had also recently become a father for the first time.

3.3   The case was discussed at a Rapid Review meeting and a decision made that it met the threshold for a LSCPR. The Rapid Review identified a range of learning and, following feedback from the National Panel, five Key Learning Points were identified as follows:

Key Learning Point 1	Real-time information sharing and analysis, including use of mapping to inform assessments, plans and decision-making.
Key Learning Point 2	Co-ordination of support when multiple agencies are involved with a child or young person.
Key Learning Point 3	The complexity and challenge of engaging with a family involved in criminal activity and exploitation and positively impacting on outcomes for children.
Key Learning Point 4	Transitions between services when young people approach the age of 18.
Key Learning Point 5	The role of 'education' in early prevention through identification of reduced school attendance/presenting behaviour change.

3.4   Through the Rapid Review, a number of single-agency actions were identified, and can be found at Appendix A.

3.5   It was acknowledged by the National Panel and the SCSP that the Rapid Review was thorough and robust, and much of the learning identified had already been acted upon or was in the process of being responded to. It was agreed that commissioning a full LCSPR would be unlikely to provide additional learning for agencies, however, the SCSP decided to hold a reflective learning practitioner event to consider the incident from a practitioner perspective, including any systems-learning that may be relevant to practice beyond this case which may not have been captured during the Rapid Review. Specifically, the event sought to address the following:

a)   What improvements have been made since the incident?

b) Are there further gaps that require focused attention?
c) Are any further actions required (in addition to those identified through the Rapid Review), including timescales for any improvement work?
d) If further gaps in learning or further actions are identified, to devise an action and improvement plan to address them.

3.6 There is an expectation that all Reviews should be completed within 6-months of initiation, unless there are good reasons for a longer period being required. The SCSP will publish a final LCSPR report to incorporate the findings of the Rapid Review, the Key Learning Points and Action Plan, the findings of the reflective learning event, and any associated additional recommendations and/or actions.

4. **Methodology**

4.1 Each agency was sent a template for completion prior to the event, asking for reflections in response to a series of questions relating to each of the five Key Learning Points referenced above, and a final 'sense check' to assess:

- What has already improved in your agency as a result of this incident?
- What still needs to change/improve in your agency and in multi-agency working?
- What else would make a difference for young people like SD?
- How can practitioners be better supported in their practice when working with young people like SD?

A copy of the template can be found at Appendix B. The list of agencies represented can be found at Appendix C.

4.2 Agencies were asked to identify practitioners who had worked with SD between January 2018 and the incident in 2022, and these individuals were invited to attend the event; it was also requested that those practitioners be involved in completing the template alongside someone in an appropriate supervisory role. All completed templates were circulated to the practitioners attending the event, with a request to consider them prior to the session.

4.3 The reflective learning event was facilitated by the Independent Chair of the SCSP and supported by the SCSP's Practice and Quality Review Officer. It was important to create a safe environment at the start of the session and to recognise that feelings and emotions are naturally intertwined with professional reflections when entering the type of discussion that was due to take place. The introduction to the event described the process, recognised the complex circumstances in which professionals work together to safeguard children and explained the desire to understand practice from the viewpoint of practitioners.

4.4 An overview of the case was presented, and practitioners were asked to work in groups to consider the completed template of an agency different to their own and to reflect on that agency's response:

a) as though they were from that agency (i.e. in a different practitioner's shoes):

b) through the eyes of their own agency.

Groups then fed back their reflections and responded to questions, observations and comments from practitioners that were not in their group. Following a high-level summary of the discussion, practitioners were asked whether there was anything else that they wanted to share, ask or discuss. The output from the discussion has been grouped into a themed narrative at section 6 below, including learning points and recommendations where relevant.

4.5 Finally, practitioners were thanked for their honest, constructive and passionate reflections. There was a clear commitment and drive amongst practitioners to do the best job possible for children, young people and families, and a willingness to identify further learning and improvements across the system as well as in their individual agencies. Practitioners demonstrated genuine care and concern about SD, his wider family and hopes for his future.

4.6 Practitioners were informed that the draft report would be circulated to them for comment, and it was hoped that a discussion would also take place with SD and/or his family before the final report was presented to the SCSP and the learning published.

5. **Engagement with SD/family**

5.1 Although SD's mother had indicated via the social worker that she, and potentially SD, would like to contribute to this Review, no response was received following the contact made by the Review author. On reflection, it may have been more appropriate to ask a trusted third party, known to SD, to elicit his views as part of this Review. SD and his family have been informed about publication.

6. **Reflective learning outputs**

6.1 Whilst the discussion was fluid and wide-ranging, several themes regularly emerged, and were related to the Key Learning Points identified in the Rapid Review. The themes, summary points and relevant questions from the reflective discussion are set out below, and drawn into analysis, learning points and recommendations as relevant to the Key Learning Points (KLP).

KLP1: REAL TIME INFORMATION SHARING AND ANALYSIS, INCLUDING USE OF MAPPING TO INFORM ASSESSMENTS, PLANS AND DECISION MAKING

6.2 There was evidence of pro-active good practice amongst practitioners and agencies whilst a frustration that the various case recording systems across

the 'system' can create barriers to swift information-sharing. Practitioners use email and verbal discussions to share information and described the effective use of processes such as MACE, eco-mapping, and MARAC.

6.3 Practitioners introduced a range of considerations into the discussion:
   i. Always remember that individuals and families may have had to tell their story many times to a range of different agencies or new workers and may be weary of the request, and unwilling as a result, or not recognise that support is being offered
   ii. Always consider who else (agency/worker) might need to know when something changes, or when a significant event occurs, and tell them
   iii. Remember to consider risk within a contextual remit in addition to information that is shared at the time of the event and use this to inform assessments, plans and decision-making
   iv. Adult Social Care (ASC) no longer has read-only access to Children's Liquid Logic system. This would enable ASC to see which professionals are involved with the family and make contact to complete assessments and planning
   v. Agencies would benefit from read-only access to the Early Help System so that they can see who is involved in the case and which interventions have been/are being offered to the individual/family. This could ensure that the right agency is offering the right intervention at the right time
   vi. Be aware of unconscious bias in the use of language, e.g. the use of terms such as 'non-engagement' or 'hard to engage/reach' is not helpful and is judgemental: descriptive words to describe SD's appearance may have been open to interpretation
   vii. If SD had been identified as a young carer via an assessment, could other services have supported him in this family role?
   viii. Support for practitioners is not consistent e.g. access to reflective supervision
   ix. Contextual safeguarding meetings that consider more than one child/young person to aid assessment of transferable risk
   x. Work in a solutions-focused way – ask what is the assessment/piece of work trying to achieve? Professionals needed to consider SD as a child and as a parent – fatherhood was a key change in his life
   xi. More challenge is sometimes needed between agencies, particularly around case closures and step up/down
   xii. Individuals and families find it frustrating when workers change - re-telling their 'story', building trust and managing short-term relationships is not helpful to the individual or family.

6.4 Practitioners, and information provided on the completed templates from agencies, identified improvements that have taken place since the incident:
   i. A new alert system is in place in Primary Care that will enable changes of address to be flagged for GPs
   ii. Record-keeping in school nursing has been addressed through training, including ensuring that actions use SMART objectives and that the roles of agencies are clearly described in school health meeting minutes

iii. Was Not Brought guidance for missed health appointments has been developed and launched for all health professionals

iv. WMAS has shared a 7-minute briefing on Young Carers which encourages professional curiosity where there are children present at attendance, and intends to use SD as a case study in training

v. Sandwell Children's Trust is encouraging social workers to be innovative and creative in methods of engaging children, young people and their families

vi. School nursing service holds weekly caseload meetings and has introduced SMART objectives in plans

vii. Adult Social Care is ensuring that staff regularly link records via the relationships tab on the Adult Social Care case record system

viii. Consistency in workers for children and young people following the move to locality working in Sandwell Children's Trust

ix. Face-to-face assessments have been re-established in all agencies

x. All GP practices are IRIS trained which GPs should know how to access

xi. Early Help support has been shared in GP Forums (however is still relatively 'new' to GPs). Encouraging GPs to use Early Help rather than escalating to statutory intervention.

Learning Points

6.5 When children witness several different agencies involved in their families' lives this lived experience can negate the positive opportunities that agency involvement can offer. Practitioners should be encouraged to consider the context of this lived experience and reflect it in analysis and planning to support decision-making.

6.6 Some changes that have been made to read-only access to case recording systems have meant that information sharing across a whole family is more limited between Adult Social Care and Sandwell Children's Trust.

6.7 Agencies could benefit from having read-only access to the children's Early Help System to ensure that the right agency can offer support at the right time, and previous interventions and their impact can be seen.

6.8 Missed appointments are often a trigger for concern and agencies should consider this in assessments and planning.

6.9 The importance of using language that cannot be misinterpreted, does not reinforce stereotypes, and does not promote unconscious bias is vital in record-keeping and file notes, practitioner discussions and in assessments.

Recommendations

6.10 **Recommendation 1:** Within the parameters of GDPR requirements, Sandwell Children's Trust should consider re-instating read-only access to children's case files for Adult Social Care.

6.11 **Recommendation 2:** The Early Help System should consider how best to ensure that all agencies can see who is, or has, been involved with the individual or family, and which interventions have been offered and to what effect (again, within the parameters of GDPR requirements).

KLP 2: CO-ORDINATION OF SUPPORT WHEN MULTIPLE AGENCIES ARE INVOLVED WITH A CHILD OR YOUNG PERSON

6.12 The discussion provided evidence of agencies extensively communicating with each other and trying to avoid duplication, for example, the Horizons Team liaising with the Youth Justice Team to agree who would lead direct work. Many different agencies were involved with individual family members, but no single agency had a full overview of the extent of that involvement, or the various interventions being offered. When seen through the eyes of SD or his family, the plethora of agencies involved may have felt intrusive and may not have felt co-ordinated. Whilst there was evidence of pro-active information-sharing between agencies and regular, meaningful liaison, including joint visits, the co-ordination of support was unclear prior to the need for statutory intervention by services. Practitioners did not refer to the Lead Professional role or the Team Around the Family process to co-ordinate support when multiple agencies are involved with a child, young person or family as part of the Early Help Offer.

6.13 Practitioners introduced a range of considerations into the discussion:

   i. Liaison between professionals and family members was a persistent feature of agency's attempts to engage with SD
   ii. Exploitation, including County Lines, drugs misuse and knife awareness was discussed with SD, and concerns shared with him that he was associating with elder peers and engaging in criminal behaviour
   iii. Opportunities to engage with other family members now rather than waiting for future escalations
   iv. The system needs to help practitioners to understand the bigger picture
   v. Cases don't always meet a threshold and families don't always 'fit into boxes' which means they can be set up to fail if they don't meet set criteria
   vi. Communication – all agencies/professionals need to take responsibility for it and not assume an agency is taking the lead. Real time information sharing is key as are whole family teams of professionals where real time conversations would become part of daily practice
   vii. It is important to identify the best person/agency to complete a piece of work but follow up to make sure it is being done e.g. school nursing handed a piece of work to DECCA but the family did not engage so the piece of work was not completed, but SWBNHS assumed it was;
   viii. It is important for GP records to highlight non engagement especially when family members are registered at the same practice. This is a big responsibility for Primary Care who know families holistically and are pivotal communicators to put the whole picture together.

6.14 Practitioners, and information provided on the completed templates from agencies, identified improvements that have taken place since the incident:

i. Cross-border information sharing and checks regarding 'linked people' take place in the Horizons team
ii. School nursing service undertakes training and reviews to improve outcomes for young people who appear not to be engaging with the service
iii. Introduction of Early Help Police Officers which suggests the system is responding to a need with new roles and services becoming available. These officers can pick up those young people not already subject to orders to try to intervene before the situation escalates
iv. GP system now has a flag if a mother and baby are registered separately and domestic abuse should be recorded on all household records by GPs where it remains on a child's record.

Learning Point

6.15 Co-ordination across agencies has a clear framework for practice when there is a statutory intervention in place, however, there is a need for further clarity and understanding of the 'system' in the Early Help arena.

Recommendation

6.16 **Recommendation 3:** Consider providing briefings for practitioners and managers that make clear the role of the Lead Professional in co-ordinating support across multiple agencies, and the role of the Team Around the Family process in ensuring that the right agencies are providing the right support at the right time.

KLP3: THE COMPLEXITY AND CHALLENGE OF ENGAGING WITH A FAMILY INVOLVED IN CRIMINAL ACTIVITY AND EXPLOITATION AND POSITIVELY IMPACTING ON OUTCOMES FOR CHILDREN

6.17 Practitioners described how they had worked hard to engage the family but the challenge of this was a prominent theme in the discussion. There were examples of SD and other family members engaging in interventions and with agencies, but practitioners felt that the entrenched nature of the family's lifestyle required more regular, longer-term, focused support to build trusting connections with practitioners. This often requires engaging at times that best suit the family rather than fitting into a professional pattern of working hours, and often needs an investment of time or support that cannot be sustained due to the short-term nature of funding for some interventions – practitioners were concerned about these issues. Practitioners described their attempts to steer SD into more positive activities and relationships and described with delight SD's intention to create a more positive future for himself, and to guide other family members towards better choices.

6.18 Practitioners introduced a range of considerations into the discussion:

i. The need to take opportunities to engage as they arise, i.e. act in the moment. For example, WMP referred to using time via a phone call to

discuss matters with the individual rather than arranging a meeting to do the same

ii. The need for more whole family working and the value of intensive interventions

iii. The importance of recognising the potential 'adultification' of children

iv. Concern when the situation doesn't meet statutory thresholds for intervention, and professionals know that support is needed but can't find ways to achieve meaningful engagement

v. How many times does each agency make contact before stopping/closing a case and is this consistent across agencies?

vi. The importance of using numerous and creative methods of contact and for persistence from practitioners

vii. The need to give the individual and the family time to understand how the family functions, respect the family, be clear about the role to support/help, display non-judgemental attitudes, be consistent and recognise that individuals and families have things going on which affect their engagement

viii. The importance of regular, quality supervision with experienced managers who understand exploitation

ix. Upskilling practitioners to be more confident in recognising risk factors, particularly interactive training and in discussing exploitation concerns with young people

x. Consideration of contextual safeguarding and good practice in the use of the MACE process to enable all involved in the case to discuss exploitation concerns

xi. Good practice in Horizons - use of eco-maps of associations and consideration of transferable risks

xii. It can be good for professionals/agencies to use other involved professionals to introduce them to families or complete visits especially when they're trying to engage. Practitioners should try to find a 'hook' – in this case it may have been that SD wanted to be the best dad and not repeat the cycle as he spoke about his dreams. Practitioners felt SD displayed much potential even following this incident

xiii. Difference between statutory and voluntary services – in most cases families prefer voluntary services which are viewed as less-stigmatising. How to better utilise those services and be creative? Practitioners are not always clear what services are available

xiv. Agency concerns remained prevalent for SD but there was never any 'hard' evidence

xv. False appearance that SD was streetwise and not scared but this was not true as people can put up 'facades'

xvi. In this case (and others) there are 'reachable moments' e.g. SD's mother did work with BCWA. Sometimes the impact of statutory involvement affects engagement which becomes a 'tick box' exercise.

6.19 Practitioners, and information provided on the completed templates from agencies, identified improvements that have taken place since the incident:

i. WMP Operation Guardian visits to young people under 25 linked to violence and exploitation

    ii.   Cross-border information sharing and checks regarding linked people via the Horizons Team

    iii.   BCWA Young People's group – this family would have been eligible had the service been available at the time

    iv.   Impact of Domestic Abuse Bill highlights children as victims in their own right; the Domestic Abuse Strategic Partnership has been re-launched and additional services and pathways are being developed.

Key Learning Points

6.20   'Adultification' relates to a child being perceived as older than they are and is not treated with the same level of care and protection that is appropriate for their actual age. Viewing a child as more 'adult-like' may lead to criminalisation[3], higher rates of punishment (in schools and criminal justice systems) and lower levels of safeguarding. This can stem from historic stereotyping and is predominantly discussed as impacting black children (Child Q being the most recent national case[4]), but it can impact all children, in terms of the language used to describe them (calling children 'streetwise' for example).

Recommendation

6.21   **Recommendation 4:** A 'learning offer' should be established by the SCSP and provided to all agencies to increase the awareness and understanding of 'adultification' and its impact on children, young people and families.

KLP4: TRANSITIONS BETWEEN SERVICES WHEN YOUNG PEOPLE APPROACH THE AGE OF 18

6.22   Many agencies have good transition arrangements in place and practitioners discussed good practice within DECCA, the Youth Justice Service and Probation, West Midlands Police and Horizons. Agencies provided evidence of Vulnerable Adults Risk Management meetings being requested. However, the challenges across the 'system' of ensuring good provision for young people aged 16-18, and the continuity of support post-18 was prevalent in the practitioner discussion.

6.23   Practitioners introduced a range of considerations into the discussion:
    i.   Exploitation can impact capacity
    ii.   Soft handovers are helpful
    iii.   Ensuring that a clear plan has been implemented prior to the young person turning 18 was felt vital prior to any case closure

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[3] https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/06/Academic-Insights-Adultification-bias-within-child-protection-and-safeguarding.pdf

[4] https://chscp.org.uk/portfolio/local-child-safeguarding-practice-review-child-q/

iv.   Elements of work with a family may not always fall under the remit of 'your role' but it is important to consider the whole picture, go the extra mile and remove the stance of 'this is what we're commissioned for.'

6.24   Practitioners, and information provided on the completed templates from agencies, identified improvements that have taken place since the incident:
i.   CAMHS is reviewing its Transition Pathway.

Key Learning Point

6.25   In many cases young people have capacity and so do not meet criteria for adult services support, however, a more sophisticated appreciation of 'capacity' may be needed to understand the impact of exploitation on capacity.

Recommendation

6.26   **Recommendation 5:** Consider provision of a 7-minute briefing to expand understanding about the impact of exploitation on a young person's 'capacity' to identify choices and make decisions.

KLP5: THE ROLE OF EDUCATION IN EARLY PREVENTION AND THROUGH IDENTIFICATION OF REDUCED SCHOOL ATTENDANCE/PRESENTING BEHAVIOUR CHANGE

6.27   The practitioners involved in the reflective learning event did not include representation from mainstream primary and secondary schools and focused instead on SD's engagement with education at the time of the incident. SD was enrolled in Alternative Education Provision and was described as 'school-phobic'; it was not clear what interventions may have been provided by mainstream schools prior to him reaching 16.

6.28   Practitioners introduced a range of considerations into the discussion:

i.   SD had been supported through an Outreach Programme at Tipton Library, SD engaged with the Connexions Service and a post-16 plan with a training application made
ii.   Horizons encouraged attendance and transported SD to the learning provider on occasions
iii.   A speech and language assessment in 2019 showed delayed vocabulary skills – this assessment seems late in SD's educational experience
iv   Importance of using a 'trauma informed' lens to understand poor attendance and lack of engagement
v.   Once SD knew he was going to be a father his attitude changed regarding the role of education and employment opportunities in a desire to provide for his family
vi.   Most of SD's offending and arrests took place during the day – education would have provided a positive diversion to lower his risk to exploitation and enable him to see his own capabilities.

6.29   Practitioners, and information provided on the completed templates from agencies, identified improvements that have taken place since the incident:

   i.   The Alternative Education Provider represented at the event now has an Alternative Provision taskforce in place
   ii.   Sandwell's Early Help Strategy and a variety of tools to support the identification of agencies and services that can provide help was launched earlier in the year.

Key Learning Point

6.28   The value of early intervention to safeguard children is widely recognised and supported by evidence. Schools, colleges and other educational providers have a pivotal role to play in safeguarding children and promoting their welfare, addressing problems before they escalate. A briefing from the National Foundation for Education Research (2014)[5] identifies the difficulties that school staff face in identifying and supporting children experiencing neglect: the increased use of the Graded Care Profile 2 tool (GCP2) may help staff in schools to identify neglect. Speech and language delay can be an indicator of risk: Sandwell's Youth Justice System has found evidence of links between poor speech and language/communication development and offending behaviour and introduced a creative arts approach to find new ways to connect with young people.

Recommendation

6.29   **Recommendation 6:** Ensure that education practitioners are trained in the use of GCP2.

7.   Further gaps or actions post Rapid Review

7.1   The strength of the practitioner discussion was that it highlighted a range of good practice and the potential for a range of case studies to support wider multi-agency practice.

7.2   A number of key themes emerged:

- Importance of whole family working, being creative and the need for intensive support
- Information systems – Early Help where everyone can see information is important
- Daily lived experience - what it is like for a child/family when lots of agencies are separately involved and finding the best way to engage, considering what might make it difficult for them
- The 'adultification' of young people and its impact

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[5] https://www.nfer.ac.uk/teachers-want-to-teach-and-not-be-social-workers-key-messages-about-neglect-and-early-intervention-for-schools/

- Support for practitioners – a desire for more reflective practice, supervision, emotional support; a space to reflect and breathe between demands and having capacity to do so
- Use of language e.g. 'non engagement/hard to engage/reach' can create a 'view' from the start of engagement and lead to unconscious bias and stigmatisation
- Clarity and emphasis on the role of a 'lead professional' in coordinating services and support to children/families below the threshold for statutory intervention
- Better understanding of the Early Help pathway for emotional /mental health support for children & young people.

7.3   As an addendum following presentation of the final LCSPR to the SCSP Board, it was agreed that further work is required to ensure the systems and processes for real time information sharing, mapping and analysis for exploited young people is robust, timely and responsive. The following recommendation was agreed:

7.4   **Recommendation 7:** SLPR and CEB subgroups to work together to evaluate the effectiveness of information sharing for exploited young people including their NRM status.

7.5   A number of recommendations are made in this report that complement the actions highlighted by the Rapid Review. They are listed below:

Recommendation 1:

- Within the parameters of GDPR requirements, Sandwell Children's Trust should consider re-instating read-only access to children's case files for Adult Social Care.

Recommendation 2:

- The Early Help System should consider how best to ensure that all agencies can see who is, or has, been involved with the individual or family, and which interventions have been offered and to what effect (again, within the parameters of GDPR requirements).

Recommendation 3:

- Consider providing briefings for practitioners and managers that make clear the role of the Lead Professional in co-ordinating support across multiple agencies, and the role of the Team Around the Family process in ensuring that the right agencies are providing the right support at the right time.

Recommendation 4:

- A 'learning offer' should be established by the SCSP and provided to all agencies to increase the awareness and understanding of 'adultification' and its impact on children, young people and families.

Recommendation 5:

- Consider provision of a 7-minute briefing to expand understanding about the impact of exploitation on a young person's 'capacity' to identify choices and make decisions.

  Recommendation 6:

- Ensure that education practitioners are trained in the use of GCP2 and that evaluation of impact of the training delivery to this cohort of staff is regularly reported to provide assurance of effectiveness.

  Recommendation 7

- SLPR and CEB subgroups to work together to evaluate the effectiveness of information sharing for exploited young people including their NRM status.

8. <u>Appendices</u>

8.1 Appendix A – Single Agency actions identified at Rapid Review

8.2 Appendix B – Reflective Learning Information Template

8.3 Appendix C – List of agencies involved in the Reflective Learning Event

8.4 Appendix D – Table of acronyms

Appendix A – Single Agency Actions identified at Rapid Review

Agency	Identified Learning Need	Action to be taken	Progress Update
Adult Social Care	Need to connect known family members on the system	Training refresher for staff on purpose and need to do this	As this is a whole Adult Social Care update/reminder, enquiries were made with the systems team who did not have a bulletin or similar to circulate to staff. Contact made with Principal Social Worker who is in the process of reviewing and updating the recording policy. Divisional Management Team will ensure that linking relationships is captured.
BCHFT	Use of genograms to link service users and aid 'Think Family' approach	The Safeguarding Training Programme for 2022/ 2023 will be developed and delivered in house as of July 2022. This will include a Think family approach, inclusive of genogram training.	BCHFT confirmed that all children's services use either a genogram or describe the family circumstance/who is in the home which is attached to records as RIO does not at present allow genograms on the system. Training videos used on how to carry out genograms which have been well received. Think Family remains a discussion as part of training with hopefully additional training

			being added now all training is carried out by the in house safeguarding team. An audit of the use of genograms was undertaken and confirmed all services using as above. A Think Family audit was also carried out which was very positive and is due to be shared at the internal safeguarding Operational group.
SCT	-Need for joined up approach when a young person is subject to CIN and MACE processes. -Impact of neglect and quality of assessments in neglect cases	Part of the wider learning through learning events and Team manager reflective sessions. The revised Practice standards have ensured that assessments also take account of the historical information and cumulative impact of Neglect. Learning from specific cases where Neglect is a feature will be shared along with the findings from audits.	During the managers reflective sessions held every two weeks these issues have been discussed. Reflective sessions included looking at Assessments, Plans and permanency planning. The impact of Neglect has continued to be a theme throughout the sessions along with CE. Neglect, CE and their impact is a continual conversation that is also discussed in the Practitioner forum run by the Principle SW. New SWs and ASYEs encouraged to

			attend training around neglect. Practice Reviews and spotlight Reviews continue to evaluate our practice. SCT's "Plans" template has been updated to ensure they are smarter. CYP and their families are spoken to as part of the Practice Review process which enables their feedback to add value to the way in which were work with families.
WMAS	Crews need to record details of children/young people present on call outs	Education/training sessions for paramedics on what/when to record details and possible next steps e.g. safeguarding referral	WMAS safeguarding policy states that information should be collected and documented on the electronic patient report form of all occupants of any premises. However, this is not always possible. As an emergency service, care of a time critical patient will always take priority. Every effort for correct and contemporaneous documentation is encouraged. All frontline ambulance paramedics within WMAS are trained to Level 3 safeguarding adults and children, where

			accurate documentation is covered. A 7-minute briefing document has been produced and released regarding child referrals for ambulance staff and distributed via our weekly staff update.
WMP	Need to make safeguarding referrals for young people who enter the criminal justice system (especially for weapons/violent crime and young people referred to NRM)	WMP to dip sample 10 cases where children arrested for violent crime using weapons to establish whether appropriate safeguarding referrals were made to other agencies at the point of arrest. This can be achieved using the custody systems and appropriate search criteria	Audit completed. All 10 cases involved youth violence or weapons and resulted in arrests. In 6 cases there was evidence of WMP either making a referral to MASH, Domestic Abuse triage, or a social worker already being aware of the matter at the time and referring to WMP for a Strategy discussion. These are all good practice. In one case evidence cannot be seen of a referral, however one must have been made as there are strategy discussions just before and after the incident and there is evidence that SCT are aware of this incident on later reports. In 3 cases there is no evidence of a referral being considered or

			made. For two of these the child suspects were charged, so the Youth Offending Service must be notified but this does not negate or replace the need to consider a referral to SCT at the time of arrest. Referrals should have been considered in all 3 of these cases due to the age of child and/or the fact they were with older suspects at the time of the offence. Once completed the intended next steps is to flag to FCID leadership to remind staff to consider and document referrals to MASH in cases where children are arrested for serious youth violence and knife crime.
YJS	Utilising a whole family approach and mapping to inform assessments and planning	Discussion and agreement of next steps at YJS Partnership Board. Cross referencing with other services e.g. Horizons/Education to gain holistic picture.	There are 2 different types of mapping that are happening. One is a cross reference with partner agencies of our children in custody cohort so patterns and trends can be seen (this will be kept as a running log over a financial year) and this helps us as a partnership to see what work

			needs to be done / to strengthen the work in other agencies to help prevent children coming into YJS. This is new and has just been started – it was undertaken for some cases last year and agreed that this was good to see that School exclusions was a common theme in this cohort.

Appendix B – Reflective Learning Information Template

Agency Information Template for SD Local Child Safeguarding Practice Review Reflective Learning Event

In 2022, a young person known for the purposes of this event as 'SD' was seriously injured. In line with the statutory requirements set out in Chapter 4 of Working Together 2018, this case was discussed at a Rapid Review, attended by partner agencies, and the decision of the panel was that the threshold was met to complete a Local Child Safeguarding Practice Review (LCSPR).

As the Rapid Review identified key single and multi-agency learning, it has been agreed to hold a Reflective Learning Event to consider the following:
- the improvements that have been made since the incident,
- gaps which require focused attention
- to agree the required actions, including timescales for any improvement work
- to devise an action and improvement plan to address the gaps identified

The Chairperson, Facilitator and Lead for the Reflective Learning Event will be the Independent Chair of the SCSP Lesley Hagger. Following the Event, Lesley will produce a report to summarise the discussion and set out recommendations and actions to be taken forward by SCSP and specific agencies as required. All contributions from partner agencies and the family (if applicable) will be anonymised. The final report will be published as is the requirement for all LCSPRs.

Frontline practitioners who have worked with SD and the family **between January 2018 and the incident in 2022** are required to attend the Reflective Learning Event. This process is to reflect openly on the work that took place with SD and family to provide a window on the wider system and practice. It is not about apportioning blame to any agency or professional, but about working together constructively to improve outcomes for children and families in Sandwell.

The template below must be completed by the frontline practitioner and someone with an appropriate supervisory role (i.e. their line manager or a DSL) **before** the event – this is to support the discussion on the day and ensure the time available for the event is maximised. Please reflect on systems and practice in your own agency and as part of the wider multi agency safeguarding landscape in your responses.

Contact details of individual(s) completing this form

Name	AGENCY & DESIGNATION/TITLE	CONTACT DETAILS – Address, telephone number and e-mail address

Reflective Task to inform discussion at the Learning Event

When completing your responses, please refer to events/involvement <u>within the scoping period of January 2018 – the incident in 2022</u>.

For each of the Key Learning Points (KLP) below, please reflect on the following:
- The support your agency provided to SD and his family relating to each point, i.e. how you shared information to inform assessments, plans and decisions
- A general overview of how your agency works relating to each KLP
- How this works as part of multi agency meetings/assessments/plans
- Any barriers and challenges to working effectively
- What needs to change/what support needs to be put in place to improve each area
- Identify further learning for the partnership to make improvements in each area

1. Key Learning Point 1: Real time information sharing and analysis, including use of mapping to inform assessments, plans and decision making
i.e. how your agency used information to make decisions, how you analysed known information to inform assessments, any tools used to gather information e.g. genograms

2. Key Learning Point 2: Co-ordination of support when multiple agencies are involved with a child or young person
i.e. how you worked jointly with other agencies to support the young person, how you ensured visits were not co-ordinated/work was not being duplicated

3. Key Learning Point 3: The complexity and challenge of engaging with a family involved in criminal activity and exploitation and positively impacting on outcomes for children
i.e. good practice to engage young people involved in exploitation, how you worked to overcome/attempted to overcome any barriers/challenges

4.   Key Learning Point 4: Transitions between services when young people approach the age of 18
i.e. how do you transfer support when a young person is approaching 18/when they are reaching the end of their involvement with your service, how do you ensure handovers are robust

5.   The role of Education in early prevention through identification of reduced school attendance/ presenting behaviour change
i.e. contact with school and how information they provided informed work, were you aware of SD's history and issues faced in school?

6.   Sense Check: Final Thoughts/Reflections
Please respond with bullet points in the columns below

What has already improved in your agency as a result of this incident?	What still needs to change/improve in your agency and in multi agency working?	What else would make a difference for young people like SD?	How can practitioners be better supported in their practice when working with young people like SD?

Appendix C – List of agencies involved in the Reflective Learning Event

- SCT - Sandwell Children's Trust
- Horizons Team
- YJS - Sandwell Youth Justice Service
- DECCA - Drug Education, Counselling and Confidential Advice Service
- Education (Alternative Provision)
- SWBNHS - Sandwell and West Birmingham NHS Trust (School Nursing)
- ASC - Adult Social Care
- Child and Adolescent Mental Health Service - CAMHS
- BCHFT (Black Country Healthcare Foundation Trust) Liaison and Diversion Team
- WMAS – West Midlands Ambulance Service
- WMP – West Midlands Police
- GP Practice - Black Country ICB (Integrated Care Board)
- BCWA – Black Country Women's Aid
- Strengthening Families Service

Appendix D – List of Acronyms

- SCSP – Sandwell Children's Safeguarding Partnership
- LCSPR – Local Child Safeguarding Practice Review
- CIN – Child In Need
- CP – Child Protection
- KLP – Key Learning Point
- MACE – Multi Agency Child Exploitation meeting
- MARAC – Multi Agency Risk Assessment Conference
- DA – Domestic Abuse
- GP – General Practitioner
- DASP – Domestic Abuse Strategic Partnership
- TAF – Team Around the Family
- GCP2 – Graded Care Profile 2
- IRIS – Identification and Referral to Improve Safety