



SERIOUS CASE REVIEW

Executive Summary

REVIEW ON:

Child Y

DATE OF BIRTH:

Young child

Author Name: IM

Post: Independent Author

Date: December 2009

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FOREWORD

Serious Case Reviews can be an important tool for learning lessons from the death of or a serious incident involving a child. Stockton-on-Tees Local Safeguarding Children Board identified the need to undertake a serious case review in respect of Child Y and commissioned an Independent Author and Independent Serious Case Review Panel Chair to oversee the task. A senior and multi agency panel as well as the independent chair and author have been in charge of the process.

This report is a summary of the Independent Authors findings which have been accepted by Stockton –on-Tees Local Safeguarding Children Board and from which an Action Plan will be implemented to ensure the lessons are learned.

As Chair of the LSCB I would like to thank all those involved, including the mother of child Y.



Jane Humphreys

Chair

Stockton-on-Tees Local Safeguarding Children Board

1. SYNOPSIS

- 1.1 This Serious Case Review has been undertaken in respect of events surrounding a young female child who will be called Y throughout this Executive Summary.
- 1.2 Y was living with her family when she was subjected to a serious sexual assault by an adult male who was living as part of the family. At the time of the abuse this adult male was receiving treatment and being supervised by services in two agencies.
- 1.3 The perpetrator had pleaded guilty to three non contact offences against girls outside the family prior to the offences against Y.
- 1.4 Following conviction for those offences the perpetrator was sentenced to a twelve month Suspended Prison Sentence. He was simultaneously made subject to a Suspended Sentence Supervision Order for two years with a requirement of Probation Supervision for two years and ordered to take part in the Northumbria Sex Offender Treatment Programme.
- 1.5 Children's Social Care in both Durham and Stockton on Tees were made aware of these offences.

- 1.6 There were areas where good practice had been identified however there were also a number of areas where agencies did not fulfil their obligation, for example, Information was not shared between agencies and it appears the family were not aware of the full extent of the perpetrators previous offences.
- 1.7 The Registered Sex Offender was being jointly supervised by Cleveland Police and National Probation Service Teesside and Durham at the time of the abuse of Y; however, Y was not being supported or monitored by any of the services, other than the universal services.

2 THE PURPOSE OF THE REVIEW

- 2.1 Local Safeguarding Children Boards are required to conduct Serious Case Reviews where certain specific criteria are met, as set out in the government document Working Together to Safeguard Children (2006). This work was undertaken on behalf of Stockton on Tees Local Safeguarding Children Board by the members of the Serious Case Review Panel detailed below.
- 2.2 As the Overview report contains names and details relating to Y, and others, it cannot be made public. The Executive Summary forms the part of the Serious Case Review that can be made public and seeks to provide public assurance that due process has been followed.
- 2.3 A professional entirely independent of all the agencies involved was appointed to undertake the Serious Case Review. This independent author has used the reports from each agency to prepare her Overview report.
- 2.4 The Overview report examines in detail the contributions of each agency to Y's care; it aims to establish whether there are any lessons to be learnt about the way professionals and agencies work together, and propose recommendations to ensure that any learning is not lost.
- 2.5 In setting the terms of reference for this review the focus was on the agencies involved with Y and her family with particular attention to be paid to the perpetrators previous offending history.

3. MEMBERS OF SERIOUS CASE REVIEW PANEL

Patti Summerfield	Independent Chair
Alastair Simpson	Chief Inspector, Cleveland Police
Dr Agrawal	Consultant Paediatrician Tees
Julia Morrison	Head of Children, Schools and Complex Needs, Stockton Borough Council
Lucia Saiger	Director of Operations, National Probation Service- Teesside
Shaun McLurg	Head of Children and Young Peoples' Operational Services, Stockton Borough Council
Suzanne Welsh	Business Manager, Durham Local Safeguarding Children Board

3.1 Reports from the following agencies were submitted:

Children, Schools and Complex Needs, Stockton Borough Council.
Children, Education & Social Care, Stockton Borough Council.
Cleveland Police.
Durham Constabulary.
Governance and Monitoring, Achievement Services, Durham County Council.
Housing Options, Stockton Borough Council.
Housing Service, Durham County Council.
National Probation Service-Teesside and Durham.
Durham Safeguarding and Specialist Services, Durham County Council.
Tees Health Authority Safeguarding Children, Stockton.

4. FINDINGS

- 4.1 It is important to note that Y's family were not known to any service, other than universal services, prior to the arrest and conviction of the adult male. It is acknowledged that the only factor that would attract the need for services was the fact Y was living with a sex offender but her views and those of her mother were not sought by any professional.
- 4.2 There was evidence of some good practice in every agency. Some aspects of the work undertaken by National Probation Service Teesside and Durham and Cleveland

Police when working with the sex offender himself were good, for example, contact levels were appropriate and frequency of reviews were high and in excess of national standards.

- 4.3 There were clear failures to consider the protection of Y and undertake a full assessment at the point agencies became aware of the original offending.
- 4.4 There is no definitive guidance to say sex offenders cannot live with children whilst attending the Northumbria Sex Offender Programme to which the adult male was directed to do by the Court. An important lesson has been that where there is a possibility of a perpetrator joining the Northumbria Sex Offender Programme whilst living with children, risk to the children should be stringently evaluated and re-evaluated as time progresses.
- 4.5 There was a gap between the original charges and the next date Y comes to the notice of Stockton on Tees Children, Education and Social Care, via National Probation Service Teesside and Durham, some 15 months later, immediately prior to conviction. There is no evidence that consideration was given during this time as to the risks the perpetrator may present to the children living with him despite his being charged with sexual offending.
- 4.6 There was no assessment of Y's family's capacity and willingness to protect Y; such an assessment would ordinarily have been an important step in assessing risks. No assessment was undertaken to clarify the family's understanding of the sex offender's previous offences nor was there any evidence of any support to ensure the risks he presented to Y were fully understood.
- 4.7 Information held within Housing Options, Stockton on Tees and the Governance, & Monitoring, Achievement Services, Durham County Council about the number of moves the family made and early school attendance of Y was not shared with other agencies. Nor was information from these agencies sought by the other agencies involved. The seeking and sharing of information is fundamental to effective child protection.
- 4.8 Following the referral to Stockton on Tees Children, Education & Social Care from National Probation Service Teesside and Durham, there was a failure by this agency

to challenge the main carer's understanding of the offences, and to undertake a full assessment of the risk the perpetrator posed to those living with him.

- 4.9 There was a lack of adherence to procedures within Durham Safeguarding and Specialist Services, Stockton on Tees Children, Education & Social Care, Cleveland Police and National Probation Service Teesside and Durham. There was a failure to seek to involve all appropriate agencies including health, schools and the voluntary group the perpetrator was part of. There was also a lack of appropriate managerial oversight within Durham Safeguarding and Specialist Services and Stockton on Tees Children, Education & Social Care.
- 4.10 Opportunities to clarify and assess risks to those with whom the perpetrator was living, or had close contact with, were not taken by Stockton on Tees Children, Education & Social Care, Cleveland Police or National Probation Service Teesside and Durham; examples of this are when the perpetrator was charged with his previous offences, when agencies were advised of the situation and when the offender himself gave information regarding his living circumstances.
- 4.11 There were a number of occasions when information, for example when the perpetrator himself reports increased contact with Y, should have triggered communication with Stockton on Tees Children, Education & Social Care by Cleveland Police and National Probation Service Teesside and Durham but this did not happen. There were also a number of occasions when opportunities to re-evaluate the risks the perpetrator presented were not taken by Cleveland Police or National Probation Service Teesside and Durham, for example when there were increased concerns about the perpetrator having contact with children from the public.
- 4.12 There were concerns about incomplete recording and sharing of information both within, and between, agencies.
- 4.13 There was a lack of a shared understanding, amongst all agencies, of the risk assessment processes of other professionals which has had significant impact upon professional practice.

- 4.14 There was reluctance by Cleveland Police and National Probation Service Teesside and Durham to challenge Stockton on Tees Children, Education & Social Care about their decision to end involvement with Y and her family.
- 4.15 Every professional has a responsibility to undertake their own assessment of risk and act upon any conclusions they may reach and must challenge other professionals where appropriate.
- 4.16 Every agency has specific roles and responsibilities but there must be effective interagency working if there is to be effective protection for children. There is a lack of interagency working in this matter, as evidenced by the failure to share information and hold appropriate meetings where all the relevant professionals could contribute to the protection process.
- 4.17 The lack of communication and lack of understanding of the roles of other agencies and their individual risk assessment processes meant a holistic approach was not taken with the consequence that the position of those living closest to this perpetrator was not fully considered.

5. LESSONS TO BE LEARNT

- 5.1 Whilst some of the lessons learnt are new, others in effect confirm what is already considered to be good practice but are so important they should be re-stated, and include the following:
- 5.1.1 Competent investigation, assessment and robust analysis is fundamental to effective social work practice.
- 5.1.2 Professionals need to fully understand safeguarding policy, procedure and its application; they need to be clear about the agency's expectation of them in their investigation, assessment, analysis and action.
- 5.1.3 Where there are several professionals involved in the assessment of risk of sexual harm, effective communication and recording channels/mechanisms need to be established drawing on the knowledge base and skills of all

involved; feedback should always be given when the outcome of an assessment is known.

- 5.1.4 The nature and level of supervisory oversight of casework activity needs to be clearly specified with a formally recorded understanding between the worker and supervisor. Significant decisions such as case closure should not be made in isolation.
- 5.1.5 Senior Managers should monitor the effectiveness of decision making audit trails and supervisory processes in a manner that quickly makes them aware if the process is failing.
- 5.1.6 Communication between agencies, and equally important within agencies, continues to be crucial. It is vital that there is proactive information sharing particularly where there are potential safeguarding issues. It is important that any information that is shared is recorded accurately and appropriately, by all involved.
- 5.1.7 Every professional has a particular role and expectations placed upon them; however, they need to guard against an isolated approach to their own role, and be aware of the roles of others, if inter-agency working is to be effective.
- 5.1.8 A holistic approach to safeguarding and willingness to contact other professionals to discuss their actions or decision not to act does not amount to interference. Adherence, by all professionals, to well understood procedures, understanding the need to assess and gather all relevant information, is of fundamental importance when attempting to protect against future offending by sex offenders.
- 5.1.9 Assessing the understanding of those living with sex offenders of nature of the offences and consequently the steps needed to protect should always take place. This assessment should be reviewed regularly.
- 5.1.10 An assessment of risk of possible sexual harm must consider whether it is safe for children to live with or have substantial contact with a sex offender. Information from ongoing treatment of the offender is vital to this

assessment and will mean the assessment is regularly reviewed and new information taken account of appropriately.

- 5.1.11 Whenever there is the possibility of sexual harm to a child any risk needs to be assessed as does the capacity of those non-offending adult carers to protect and there should be an assessment of the possible impact of any proposed treatment. If a decision is made that an offender may live with a child a clear Family Intervention Strategy and Family Safety Contract must be put in place. The strategy should identify the rules the family need to adopt to reduce risk and ensure a child is safe and provide the child and protective carers with strategies and contacts should the risk of harm increase.
- 5.1.12 This case has highlighted important issues with regard to working with voluntary organisations. There are implications when such organisations use property which is accessed by children regularly. Their role in any child protection discussions and strategy meetings and their inclusion in any safeguarding training programme need to be reviewed.
- 5.1.13 There is a national gap in the monitoring of offenders charged with sexual offences, but without previous convictions, between charge and sentence. If an offender is convicted then consideration to monitoring prior to further charges being tried may be given but this was not the situation here. There was a significant gap between charge and conviction in this matter and guidelines to Police in these circumstances would be helpful.
- 5.1.14 Professionals within Housing Services need to be alert to the relevance and value of information they may hold. Other agencies would find it helpful to think more widely and contact agencies such as Housing when considering from whom they may seek relevant information.
- 5.1.15 Information sharing both within and between agencies is crucial if effective interagency working is to be ensured.
- 5.1.16 The advice of a professional in the field of treatment of sexual offending has allowed a useful insight into this review. This amounts to good practice and

is recognised by Ofsted and use of outside experts may be appropriate in the future.

5.1.17 Where experienced professionals fail to follow well established and clear procedures it is possible to identify what they did not do. It is much more difficult to understand, why, they did not do what they should have done. *“The absence or adequacy of procedures is seldom the issue - it is too often staff’s ignorance of them or failure to follow them”* (Learning Lessons from Serious Case Reviews, Year 2)

5.1.18 Human error is a factor to be considered and this means there should be appropriate emphasis by all agencies on establishing fail-safe and improved audit procedures.

6. CONCLUSIONS

6.1 It has been possible to identify a number of areas of concern and issues for consideration and they are summarised below. Many of them have been identified by previous reviews and are familiar issues to professionals.

- i. Inadequate assessment undermines all attempts to protect children.
- ii. Failure to record and share information adequately, both within and between agencies continues to be an issue.
- iii. Management oversight, responsibilities and supervision need to be clear.
- iv. Professionals need to understand risk assessments undertaken by other agencies and must be willing to challenge other professionals if they feel it is appropriate.
- v. Agencies need to guard against isolated approaches if interagency working is to be effective.
- vi. Assessment of risk of harm from sex offenders is a particularly difficult area and requires full information sharing, full assessments to include an assessment of a Carer’s capacity to protect any child and clear interagency working.
- vii. Where a sex offender is living with children and is directed to, or it is felt appropriate that they attend a Sex Offender’s Treatment Programme, clear and detailed consideration must be given to the safety of those children before the Programme commences.
- viii. Failures to follow procedures should never arise.

7. AREAS OF GOOD PRACTICE IDENTIFIED IN THE OVERVIEW REPORT

7. Serious Case Reviews are primarily about learning lessons for future child protection practice and not simply about identifying failure. It is also appropriate to recognise areas of good practice and there is evidence of some good practice by professionals.
- 7.2 For example there was accurate and contemporaneous recording within National Probation Service Teesside and Durham with timescales for assessments met and contact levels appropriate throughout the case. Within this agency there was also offence focussed work with the perpetrator challenge distorted thinking and justification of offences with meaningful and focused interventions.
- 7.3 Another example is the Cleveland Police frequency of reviews which were high and in excess of national standards and there was also evidence of good practice in other agencies too.
- 7.4 That there can be good practice is clearly demonstrated, the challenge is to ensure this good practice is reflected throughout child protection agencies.

8. RECOMMENDATIONS

8.1 Cleveland Police Public Protection

- 8.1.1 The Offender Manager should ensure that the details of their review visit are accurately transferred onto VISOR prior to the destruction of any paper record. The Offender Manager's supervisor should ensure that these entries are clear and do not leave matters open to speculation.
- 8.1.2 The dual system of filing within PPU should be reviewed. If there are to be minutes in paper files then they need to be as accurate as the VISOR computer system. If the paper file is to be used for holding documents only then the use of minute sheets should be discontinued.
- 8.1.3 PPU staff to ensure they receive written feedback on referrals submitted to Stockton-on-Tees Children, Education and Social Care, including details of

any restrictions that have been imposed. This feedback to be included in Police recording.

- 8.1.4 When suspects are charged with sexual offences against children enquiries should be made regarding their access to children, this should be reflected in any bail conditions imposed. Appropriate referrals should be made to Children's Social care.

8.2 Durham Police Recommendations

- 8.2.1 The development of a force wide awareness campaign aimed at all operational police officers involved in the investigation of child abuse cases. The awareness campaign will be specifically designed to encourage officers to look at the extended access to children and the extended risks therefore posed by perpetrators of sexual abuse.
- 8.2.2 All operational officers involved in the investigation of crime will be briefed on the pro-active use of bail conditions for suspects of sexual offences which include residing at an address, reporting to a police station, notifying police of any change of address and no unsupervised contact with children.
- 8.2.3 Every operational police officer will receive level one LSCB training in respect of Child Protection/Safeguarding Children. (April 2010)

8.3 Joint Durham and Cleveland Police Recommendations

- 8.3.1 It is recommended that Durham and Cleveland Police review their supervision procedures to reflect that supervising officers consider whether LSCB safeguarding procedures have been followed for all children who have contact with alleged or convicted sex offenders.

8.4 National Probation Service – Teesside and Durham

- 8.4.1 Where there are other professionals working with an offender, both within NPS and also with external agencies, details of all contacts must be recorded in CRAMS. This will allow effective sharing of information to enable the responsible Offender Manager to respond appropriately to all known information.

- 8.4.2 Offender Managers in conjunction with Northumbria Sex Offender Group Tutors must continually reassess sex offender's attitudes to offending and any implications for risk status and risk management.
- 8.4.3 Information regarding the change of circumstances of an offender assessed as posing a medium risk of serious harm to children must trigger a review of OASys and where appropriate further information sharing with Stockton-on-Tees Children, Education and Social Care. This was also a learning point identified by the Serious Further Offence Review.
- 8.4.4 Where sex offenders are identified as posing risk of serious harm to children and are known to have contact with children, a Section 47 referral must be made to Stockton-on-Tees Children, Education and Social Care.
- 8.4.5 Where offenders are subject to complete a Programme Requirement, continuity of Offender Manager remains a priority and transfer of Offender Manager will only take place in exceptional circumstances.
- 8.4.6 Where the index offence has involved non-family members, the Offender Manager must maintain focus on the potential risks that may be posed to any other children within their family or network.
- 8.4.7 Where an offender is known to be residing with others, Offender Managers must seek consent to undertake a check on Probation internal systems to ascertain any historical or current involvement with the Service.
- 8.4.8 The National Probation Service Teesside and Durham review their procedures in relation to inter-agency planning for offenders who have contact with children when undertaking the Northumbria Sex Offender Group.
- 8.4.9 The National Probation Service Teesside and Durham review their arrangements under Section 11 of the Children Act 2004 to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

8.4.10 Following a review of arrangements under Section 11 of the Children Act 2004 training is provided to relevant practitioners and managers in respect of the interface between sexual offending and safeguarding children from harm.

8.4.11 The National Probation Service Durham and Teesside reviews its policy to ensure that where a sex offender is having contact with children that line manager oversight of the case is maintained.

8.5 Durham Children's Social Care

8.5.1 Managers responsible for chairing strategy meetings and supervising child protection investigations are immediately reminded of their responsibilities and the actions they are required to take to be compliant with Durham LSCB Child Protection Procedures.

8.5.2 Social Care Direct Recording Policy should be followed at all times, Management Oversight should ensure that recording is appropriate, accurate and timely.

8.5.3 Managers and social workers should ensure that when information has been sought from agency partners to inform an investigation that feedback is given when the outcome is known.

8.5.4 Managers, social workers and other multi agency professionals involved in the investigation process should receive regular mandatory refresher training.

8.5.5 Training packages should emphasise the significance of information sharing and the importance of decision making audit trails.

8.5.6 Practitioners should receive training that focuses on the importance of considering emotional, psychological and physical effects of abuse. The training should emphasise the need to ensure extended family are considered when undertaking investigations and assessments.

8.6 Stockton-on-Tees Children Education and Social Care

- 8.6.1 The learning from this review in relation to Stockton LSCB procedures not being followed to be reinforced with operational staff from Team Managers through to support staff.
- 8.6.2 Assessments of risk of sexual harm should be undertaken by qualified social workers who have training and experience in sexual offending.
- 8.6.3 Stockton-on-Tees Children, Education and Social Care undertake an audit of referrals where sex offenders are in contact with children to ensure that section 47 enquiries are undertaken. This audit should consider the quality of the section 47 enquiry and the core assessment and inform future training.
- 8.6.4 Stockton-on-Tees Children, Education and Social Care staff need to be briefed on the risk assessments undertaken by Police and Probation (to include both Risk Matrix 2000 and OASys), and the implication is in relation to a child suffering potential significant harm.
- 8.6.5 A review of audit formats should be undertaken by Senior Management to ensure that ongoing audits address the issues (i) that all recording in relation to cases needs to be completed within the case management system (RAISE), and (ii) all allocated work should be tracked and signed off by an identified Manager, (timescale 3 months).
- 8.6.6 A written instruction is circulated to Team Managers in respect of the procedural requirement that feedback to the referring agency must be in the form of a written communication and a record of this made within the case management system (RAISE), (timescale immediate implementation).
- 8.6.7 Stockton-on-Tees Children, Education and Social Care alongside Stockton-on-Tees Legal Services review guidance in relation to disclosure of sexual offences. (SLSCB, timescale 3 months)
- 8.6.8 Stockton-on-Tees Children, Education and Social Care to ensure that the issues relating to individual members of staff identified in the review are appropriately addressed.

8.7 Health

8.7.1 Stockton-on-Tees LSCB to be asked to review the issue of information sharing about registered sex offenders with Health professionals providing services to the registered sex offender or his/her family and ensure relevant guidance for personnel is developed accordingly.

8.8 Stockton-on-Tees Children, Schools and Complex Needs

8.8.1 The Attendance Service reviews its policy and guidelines in respect of exchange of information between Local Authorities.

8.8.2 All School staff receives child protection training under the safeguarding procedures.

8.8.3 All Schools staff to maintain a dedicated filing system for recording letters from parents / carers in regard to school absences.

8.9 Durham County Council Achievement Services

8.9.1 Advice will be given to schools with services or organisations that operate from the site to ensure that they comply with LSCB safeguarding policies and procedures.

8.10 Stockton-on-Tees Housing

8.10.1 The Council's Housing and Housing Benefits Services and Tristar Homes Ltd will continue to ensure that all appropriate staff receive in-house accredited training around safeguarding and promoting the welfare of children and acting on concerns about their welfare.

8.10.2 All staff within the Council's Housing and Housing Benefits Services and Tristar Homes Ltd will be briefed that if they become aware of children being moved around between family members, this should be flagged up as a safeguarding concern.

8.10.3 Housing professionals should be made aware of their responsibilities in respect of interagency communication around Safeguarding Children.

8.11 Inter-Agency Recommendations

Stockton Local Safeguarding Children Board

- 8.11.1 All authors of Individual Management Review Reports receive up to date, regular and relevant training which includes training on assessment and analysis.
- 8.11.2 All authors of Individual Management Review Reports include a summary of their experience and expertise alongside the statement of their independence from the case.
- 8.11.3 SLSCB Serious Case Review Guidance is reviewed to include the routine consideration of extended family members within the serious case review process.
- 8.11.4 Within the review of the Serious Case Review Guidance consideration of involvement of those families where abuse has taken place but where the victim is not related to the subject of the serious case review is considered.
- 8.11.5 In all serious case reviews consideration is given to gathering information in respect of:
- a. Information about the child's health and development or exposure to possible harm
 - b. Information about a parent/carer that impacts on their ability to care for a child
 - c. Information about others who may pose a risk to the child
- 8.11.6 Where necessary legal advice to be sought in respect of consent for medical records of any adult involved within the serious case review process and where information is required.
- 8.11.7 All agencies to confirm with SLSCB that they have relevant policies and procedures in respect of recording and robust systems in place to ensure compliance with those policies and procedures.

- 8.11.8 SLSCB ensure that all staff from constituent agencies are reminded about their responsibilities in respect of information sharing under Working Together to Safeguard Children 2006 through a programme of training.
- 8.11.9 Relevant Staff from Stockton-on-Tees Children, Education, and Social Care, National Probation Service Teesside and Durham and Cleveland Police Public Protection Officers receive further training in respect of the risk of sexual harm.
- 8.11.10 Training for relevant staff from Stockton-on-Tees Children, Education, and Social Care, National Probation Service Teesside and Durham and Cleveland Police Public Protection, in respect of risk of sexual harm clearly addresses different assessment tools and explores the difference between conviction and risk of significant harm.
- 8.11.11 SLSCB, specifically Stockton-on-Tees Children, Education, and Social Care, National Probation Service Teesside and Durham and Cleveland Police Public Protection review inter-agency policy and practice in relation to assessment, treatment and intervention of a sex offender when s/he has substantial contact with children.
- 8.11.12 National Probation Service Teesside and Durham in conjunction with Stockton-on-Tees Children, Education, and Social Care and Cleveland Police Public Protection review their procedures in relation to inter-agency planning for offenders who have contact with children when undertaking the Northumbria Sex Offender Group Treatment Programme.
- 8.11.13 Relevant SLSCB staff from Stockton-on-Tees Children, Education, and Social Care, National Probation Service Teesside and Durham and Cleveland Police Public Protection receives training in relation to family reunification following sexual abuse.
- 8.11.14 All inter-agency staff should discuss concerns in relation to other agencies handling of a case with their line manager. SLSCB Safeguarding Children's Procedure should be followed in all cases where there is professional disagreement.

Stockton-on Tees and Durham Local Safeguarding Children Board

- 8.12.1 Durham LSCB consider the relevance of learning of all proposed recommendations in respect of Stockton-on-Tees LSCB

- 8.12.2 Durham LSCB to approach the TA to review the TA's safeguarding policies, procedures and training.

Stockton-on-Tees Local Safeguarding Children Board will agree appropriate timescales for the implementation of all recommendations made by the Single Agencies.

9 INTER AGENCY ACTION PLAN

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y1	All authors of Individual Management Review Reports receive up to date, regular and relevant training which includes training on assessment and analysis	<p>Outcome</p> <ul style="list-style-type: none"> • IMRAs understand their role in the process and are able to produce reports that meet local and national requirements. • IMR reports show improvement <p>Action Local Training Programme for IMRAs (New and Refresher Training) introduced.</p>	June 2010	Children's Workforce Development Manager	<p>Attendance at Children's Trust LSCB Training Programme</p> <p>Statistics on uptake of training to be presented at SLSCB meetings on a quarterly basis</p>

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y4	Within the review of the Serious Case Review Guidance consideration of involvement of those families where abuse has taken place but where the victim is not related to the subject of the serious case review is considered.	<p>Outcome SCR Sub committees, when considering the scope of a potential SCR, must consider all victims of abuse linked to the case.</p> <p>Action</p> <ul style="list-style-type: none"> • Proactively contribute to sub regional development of approaches and ensure this is included in sub regional guidance • SLSCB approve sub-regional guidance • LSCB Business Manager ensures that SCR panels are aware of the decision to actively consider all victims of abuse linked to the case 	February 2010 February 2010	LSCB Business Manager	SCR Panel

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y5	In all serious case reviews consideration is given to gathering information in respect of: a) Information about the child's health and development or exposure to possible harm b) Information about a parent/carer that impacts on their ability to care for a child c) Information about others who may pose a risk to the child	Outcome Terms of Reference for future SCRs are explicit regarding gathering of information relating to the child's health, parent / carers ability to care for the child and any potential risk to children Action <ul style="list-style-type: none"> • Checklist of important issues that must be considered by panel to be included in revised sub regional guidance to be approved by SLSCB • Chair of SCR panel ensures appropriate consideration is given and all information included 	February 2010	LSCB Business Manager	SCR Panel and LSCB

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y6	Where necessary legal advice to be sought in respect of consent for medical records of any adult involved within the serious case review process and where information is required.	<p>Outcome Consent obtained from relevant adults in order to access their medical records where appropriate.</p> <p>Action</p> <ul style="list-style-type: none"> Where there are ongoing criminal proceedings relating to any adults associated with the Serious Case Review, Legal Services will be consulted by the Panel Chair / LSCB Business Manager to determine whether and how to obtain the adults consent. 	Commencement of every SCR	SCR Panel Chair/LSCB Business Manager	Correspondence, inclusion of relevant information in reports.

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y7	All agencies to confirm with SLSCB that they have relevant policies and procedures in respect of recording and robust systems in place to ensure compliance with those policies and procedures.	<p>Outcome Improvement in recording is evidenced and action taken to rectify where staff are not complying.</p> <p>Action Quality assurance measures to review adherence to recording policies are included as part of case supervision and management oversight.</p>	Immediate	All Managers and Supervisors in LSCB Partner agencies	Case file audits

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y8	SLSCB ensure that all staff from constituent agencies are reminded about their responsibilities in respect of information sharing under Working Together to Safeguard Children 2006 through a programme of training.	<p>Outcome All staff understands the importance of Information Sharing, perceived barriers are removed and information is shared amongst agencies to safeguard children.</p> <p>Action</p> <ul style="list-style-type: none"> • Multi –agency Information Sharing training is available to all staff on a regular basis. • Staff are released to attend Information Sharing (Integrated Working) training. • Partner agencies have Information Sharing protocols 	<p>Annually.</p> <p>June 2010</p>	<p>Children's Workforce Development Manager.</p> <p>Managers in all agencies</p> <p>Information Governance Officers/LSCB Business Manager</p>	<p>Monitoring of Training Attendance by Children's Trust</p> <p>Agency case file audits</p> <p>LSCB Business Manager in receipt of protocols.</p>

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y9	Relevant Staff from Stockton-on-Tees Children, Education, and Social Care, National Probation Service Teesside and Durham and Cleveland Police Public Protection Officers receive further training in respect of the risk of sexual harm.	<p>Outcome</p> <ul style="list-style-type: none"> • Relevant staff involved in assessing the risk of sexual harm to children are in receipt of up to date and relevant training. • Improvement in understanding of the assessment of risk of sexual harm is evidenced in practice <p>Action</p> <ul style="list-style-type: none"> • Multi Agency Risk of Sexual Harm Training is available for: CESC Social Workers, Team Managers from Duty and Specialist Teams Police, Public Protection Unit Officers and Probation Offender Managers • Staff released to attend training. 	2010/ 11 Programme	<p>Children's Workforce Development Manager.</p> <p>CESC, Police and Probation Managers</p>	<p>Children's Trust LSCB Training Programme</p> <p>Monitoring of Training Attendance</p> <p>Case file audits and supervision</p>

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y10	Training for relevant staff from Stockton-on-Tees Children, Education, and Social Care, National Probation Service Teesside and Durham and Cleveland Police Public Protection, in respect of risk of sexual harm clearly addresses different assessment tools and explores the difference between conviction and risk of significant harm.	<p>Outcome</p> <ul style="list-style-type: none"> • Staff who attend training in respect of assessing risk of sexual harm understand the different elements of risk assessment and the difference between reconviction rates, risk of re-offending and the risk of sexual harm as determined by the balance of probabilities. • Improvement in understanding of the risk of sexual harm is evidenced in practice <p>Action</p> <ul style="list-style-type: none"> • Training that raises awareness and understanding of risk of sexual harm clearly addresses different assessment tools and explores the difference between conviction and risk of significant harm. 	20/10/11	CESC, Police and Probation Managers	Monitoring of Training Attendance Case file audits and supervision by Managers

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y12	National Probation Service Teesside and Durham in conjunction with Stockton-on-Tees Children, Education, and Social Care and Cleveland Police Public Protection review their procedures in relation to inter-agency planning for offenders who have contact with children when undertaking the Northumbria Sex Offender Group Treatment Programme.	<p>Outcome Where a sex offender is to undertake the Northumbria Sex Offender Treatment Programme, inter-agency planning is informed by assessment which considers potential increase of risk of sexual harm to any children the offender may come into contact with.</p> <p>Action</p> <ul style="list-style-type: none"> • Inter-agency procedures in respect of offenders who have contact with children when undertaking the Northumbria Sex Offender Group treatment programme is reviewed and developed. • Inter-agency guidance is endorsed by SLSCB. • Information and criteria circulated to all LSCB Partners 	<p>June 2010</p> <p>July 2010</p>	<p>CESC Head of CYP Operations, Asst Director Offender Management and Detective Chief Inspector Cleveland Police (Crime / Child Protection)</p> <p>LSCB Business Unit</p>	<p>Procedures in place</p> <p>LSCB Minutes</p> <p>Copy of Email evidencing action</p>

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Y13	Relevant SLSCB staff from Stockton-on-Tees Children, Education, and Social Care, National Probation Service Teesside and Durham and Cleveland Police Public Protection receives training in relation to family reunification following sexual abuse.	<p>Outcome</p> <ul style="list-style-type: none"> • Relevant staff involved in assessing the risk of sexual harm to children are in receipt of up to date and relevant training in respect of family reunification. • Improvement of understanding of the risk of sexual harm and assessment of family reunification is evidenced in practice <p>Action</p> <ul style="list-style-type: none"> • CESC Social Workers, Team Managers from Duty and Specialist Teams Police, Public Protection Unit Officers and Probation Offender Managers are released to attend training in relation to family reunification following sexual abuse. • Staff released to attend training 	2010/11	<p>CESC, Police and Probation Managers</p> <p>Managers</p>	<p>Case file audits and supervision by Managers</p> <p>Monitoring of Training Attendance</p>

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y14	All inter-agency staff should discuss concerns in relation to other agencies handling of a case with their line manager. SLSCB Safeguarding Children's Procedure should be followed in all cases where there is professional disagreement.	<p>Outcome</p> <ul style="list-style-type: none"> • Staff are supported to follow through their concerns in respect of safeguarding children. • Staff are empowered to discuss matters with their managers and positively challenge other agencies to improve safeguarding arrangement for children and young people. <p>Action</p> <ul style="list-style-type: none"> • Staff of all LSCB Partners are reminded of the LSCB Safeguarding Children Procedures section 13.6 – Resolution of Professional Disagreement. • The encouragement to make staff feel empowered to speak up will be through team meetings, case supervision. • Staff will also be reminded of the Whistle Blowing Procedure 	February 2010	LSCB Board Members	<p>Email, Team Meeting Minutes, Internal briefings.</p> <p>Case file audits and supervision by Managers</p>

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y15	Durham LSCB consider the relevance of learning of all proposed recommendations in respect of Stockton-on-Tees LSCB	Durham LSCB considers development of local action plan based on the Y Multi agency Action Plan.	January 2010	Durham LSCB	Durham LSCB Minutes

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y16	Durham LSCB approach the TA to review the TA's safeguarding policies, procedures and training.	TA Safeguarding Policy is endorsed by Durham LSCB. Safeguarding Children Training is made available to the TA and other voluntary organisations to improve the safety and wellbeing of children.	2010/11 Programme	Durham LSCB	Monitoring of Training Attendance

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y17	Single and Multi-Agency Action Plans are implemented and monitored for impact.	Recommendations are implemented. Lessons are learned and acted upon.	May 2010	LSCB Leads	Progress Report to LSCB

ACTION POINTS FROM ORIGINAL SCR SUBMISSION

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y18	There to be specific interagency training to ensure a clear understanding of each agency's risk assessment procedures and to raise awareness of the risks of perceptions of demarcation within the safeguarding arena.	Staff in all agencies understand the risk assessment tools used to identify and analyse the level of risk, in particular that relating to sexual harm and how the outcome of the assessment is used to determine and plan services required to protect children.	July 2009	CESC (Children's Trust) - Children's Workforce Development Manager	Training Records and Evaluation Reports

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y19	A system of spot checks for CESC cases that do not proceed to Initial Child Protection Conferences to be introduced where there are referrals from Probation and Police about children living with or having regular contact with sex or violent offenders.	Appropriate investigations, analysis and action takes place to ensure children are not at risk.	June 2009	Head of Children's Services	Audit Reports

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y20	When suspects are charged with sexual offences against children inquiries should be made regarding their access to children, this should be reflected in any bail conditions imposed. Appropriate referrals should be made to CESC.	To provide an opportunity for early intervention and assessment when an individual has been charged with sexual offences with children and s/he may be living with or have access to children.	May 2009	Police	Spot checks of records and liaison with appropriate agencies.

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y21	A meeting to be arranged between Manager of Review and Development / Designated Manager for Child Protection, Safeguarding Operations Manager and Manager of First Contact to ensure referrals are appropriately actioned. This meeting to consider the introduction of a failsafe system to receive referrals from Probation and Prisons to ensure appropriate decisions are made immediately.	Safeguarding Child Offender Management (Probation & Prison) Notification Protocol developed and accepted by LSCB Procedures are enhanced, followed and where required strategy meetings are held.	May 2009	Chair of Procedures Task Group	Record in LSCB Minutes Spot checks undertaken by Performance & Quality Task Group

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y22	Durham Children's Services to be advised of the conclusions of this serious case review regarding the failure to consider other children at their strategy meeting on 28-4-06. Any response from Durham to be submitted to Stockton Safeguarding Board.	Durham Children's Services / LSCB to be provided with a copy of the SCR to enable them to reflect on their involvement with the family and to identify any learning points as necessary.	May 2009	LSCB Chairs	Records of communication.

REF (Childs Initials) No of Action	RECOMMENDATION	INTENDED OUTCOME & ACTION	TIME-SCALE	AGENCY / LEAD PERSON	METHOD OF AUDIT
Y23	SLSCB to consider the recommendations of the single agencies, to determine appropriate timescales and review the progress of their implementation.	Single agency recommendations implemented.	July 2009	Respective LSCB Board Members	Evidence Reports to Chair of Performance & Quality Task Group. LSCB minutes.