SUMMARY OF BOLTON SAFEGUARDING CHILDREN BOARD

RESPONSES TO LEARNING AND RECOMMENDATIONS ARISING FROM CHILD SB SERIOUS CASE REVIEW

May 2016

Bolton Safeguarding Children Board would like to express its sympathies to the family and friends of SB who very sadly took his own life at such a young age; when someone takes their own life, it deeply affects all those who have known or loved them.

SB was described as a calm, quiet and well-mannered child, who could occasionally be stroppy and defiant but not in a way which raised concerns. SB had one particular friend who lived close by and for a couple of months, was 'going out' with another pupil who went to the same school. SB liked sport and had academic potential but this was hampered by poor attendance at school over the years. From late 2014, SB seemed more reluctant to socialise and to leave the house. It seems SB began to stay up late at night and slept more during the day. When teachers or school attendance officers tried to talk with SB, there was a polite but assertive refusal to attend school, or to offer any explanation.

1. Background

1.1 Bolton Safeguarding Children Board received the Serious Case Review report and endorsed the findings of the review fully on 27 November 2015. The Board and its partners have sought to learn from SB's experiences to further develop safeguarding responses. This report summarises the action taken to date to respond to the lessons learned and to ensure we build on the good practice that was highlighted in the review.

1.2 The methodology of the review involved as many of the practitioners and their managers as possible in a series of 'learning events' where themes emerging from agency reports and chronologies were used as discussion and challenge points. The review methodology was based on a systems approach and looked at whether the findings were unique to this case or could be used as a 'window' on the local safeguarding systems in Bolton. The Board is grateful to the practitioners for their openness and contributions in the review process.

1.3 This document should be read alongside the Serious Case Report view which provides a more detailed account of the background in the two years leading up to SB's death, the methodology of the review and its findings. The review found that no one could have predicted or prevented this serious incident.

2. Response to the Lessons Learned

2.1 During the review process agencies began to address areas for development they had identified. The table below summarises multi-agency responses to the recommendations and the next steps required to continue to ensure that lessons are integrated within frontline practice.

LEARNING POINT	RECOMMENDATION	RESPONSE TO DATE August 2015-April 2016	NEXT STEPS May 2016-Nov 2016
Patterns in assessments and decision-making **(Finding 1, 5 &10 of the SCR)** • Despite the family's social history, poor school attendance was continually perceived as being the 'problem' within this family, rather than it being considered as a symptom of what was happening in SB's life. The sole focus on school attendance obscured and hid the effects of cumulative adversity, which SB experienced, and this left the child vulnerable. • Effective recording systems support good practice by the inclusion of succinct and updated chronologies, sound assessments, regular summaries of the work undertaken with families. This was not evident in this review. • Persistent failure to send children to school is a clear sign of neglect and every effort should be taken to work with parents to address this issue. When a decision is taken by the local authority to escalate intervention to 'aggravated proceedings', the current processes rely on custom and practice and do not take into account the need to safeguard children who may be affected by these proceedings	**Recommendation 1** The Board needs to be assured that when there are significant concerns about school attendance: • Assessments are always undertaken which take into account the family background and history and include an assessment of the motivation, capability and willingness of parents to change their behaviour to support their child back into school. • Plans to support children and young people not attending school are robust, smart and child focussed and do not focus solely on symptomatic behaviours and these plans, together with the assessments are recorded and regularly reviewed.	Since the re-launch of Bolton Safeguarding Handbook and Threshold Document – the 'Framework for Action' - in October 2014 there is clear evidence that Early Help processes are being used to assess and respond to children's needs, including non-school attendance – at year-end 2016, 129 services are using the process and 2882 open Early Help at year end 2016, cases compared with 1935 on the same day in 2015 and 495 in 2014 Termly evaluations of the quality of Early Help assessments, plans and reviews, most recently March 2016, provide evidence to BSCB that they collate good, in-depth information during the assessment and this is developed via the review process September 2015 - In response to this review a service manager from the Early Intervention Team (EIT) joined the Early Help Quality group to ensure learning is shared and early help processes are fully integrated within the EIT service The EIT service have introduced a '***transfer of case handover summary***' template in response to learning from the review From July 2015 BSCB commissioned delivery of dedicated SMART Action Planning Training – 9 sessions have been delivered to social workers and other practitioners – audits by Children's Social Care and the Early Help Quality group provide evidence that this area of practice is continuing to improve July-September 2015 School 1 reviewed and updated their attendance policy to integrate thresholds to initiate Early Help assessments; Early Help assessments are completed at an early stage to involve EIT in persistent absence cases December 2015 - School 1 reviewed all persistently absent children to ensure co-ordinated responses and needs being met – findings reported to Senior Leaders	SMART Action planning training will continue throughout 2016-2017 June 2016 – Early Help Quality audit will be completed with a specific focus on non-school attendance – findings will be reported to BSCB in August 2016 July 2016 - Quality audits of children's plans will be completed in to ensure training continues to drive up quality of planning for children in Bolton – findings will be reported to BSCB in August 2016

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Patterns in assessments and decision-making **(Finding 1, 5 &10 of the SCR)** • Despite the family's social history, poor school attendance was continually perceived as being the 'problem' within this family, rather than it being considered as a symptom of what was happening in SB's life. The sole focus on school attendance obscured and hid the effects of cumulative adversity, which SB experienced, and this left the child vulnerable. • Effective recording systems support good practice by the inclusion of succinct and updated chronologies, sound assessments, regular summaries of the work undertaken with families. This was not evident in this review. • Persistent failure to send children to school is a clear sign of neglect and every effort should be taken to work with parents to address this issue. When a decision is taken by the local authority to escalate intervention to 'aggravated proceedings', the current processes rely on custom and practice and do not take into account the need to safeguard children who may be affected by these proceedings	**Recommendation 2** The Board needs to produce procedures for professionals about responding effectively to non-school attendance to ensure there is clarity about roles and responsibilities especially where decisions are taken to move to 'aggravated prosecution'. These procedures should stipulate that a referral to or contact with Children's Social Care is required to determine if a further assessment is needed to safeguard the child given a possible outcome of those proceedings could be a custodial sentence for the parent.	School 1 have reviewed and re-developed their internal Attendance Policy to reflect the lessons learned – the revised policy integrates thresholds to initiate Early Help assessments and access additional support A review of persistently absent students was completed by School 1 in January 2016 evidenced Early Help assessments were completed for all students meeting Persistent Absence threshold BSCB has reviewed current pupil absence data over two academic years – September 2013 to July 2015 to seek to establish whether there are any other children in Bolton who have high rates of unauthorised absence; this data shows that for primary school in 2015 1.1% of sessions were missed as result of unauthorised absence and 1.4% for secondary schools. This is broadly in line with statistical neighbours and the England average. However this research has been unable to identify rates of unauthorised absence for individual pupils BSCB has also sought assurance from the EIT service that they are using Early Help processes to assess and respond to those children who are persistently absent and are referred to their service. The most recent data indicates that in April 2016 there were 21 pupils identified as having four weeks continuous absence – all bar one had an Early Help assessment	Building on the work undertaken by School 1 it has been agreed that a Bolton wide practice guide for responding to persistent absence will be progressed - this will include clarity about service roles and responsibilities as well as triggers for implementing early help processes and stepping up into statutory services The practice guide will be developed in partnership with schools pastoral clusters with progress reported to BSCB in September 2016. This guide will seek a solution to the data gap identified for unauthorised absence The practice guide will also take account of the impact of children's home circumstances and its impact on children's attendance at school The neglect strategy will recognise the potential for non-school attendance to be an indicator of neglect

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Patterns of gaps in provision (Finding 3 of the SCR) • There is a mismatch between available resources and the needs of young people who need access to mental health services but who do not or cannot meet the criteria for CAMHS support.	**Recommendation 3** The Board needs to ensure that CCGs are giving sufficient priority to the development of mental health services for those children who do not meet the threshold for CAMHS or who for whatever reason are unable to access that service.	BSCB Independent Chair has written to Bolton CCG in March 2016 to request assurance and supporting evidence of the range of emotional support available to young people	November 2016 - Bolton CCG to present to BSCB members an overview of current emotional health support for young people, an analysis of gaps and plans to address these
Patterns in communication and collaboration in multi-agency working (Finding 6 & 9 of the SCR) • The failure to collaborate within a multi-agency context means that key information is not shared or discussed. This leaves professionals working in isolation and highlights vulnerability in multi-agency systems designed to safeguard children. This was evident in this review. • Where there are a number of significant transitions happening in families, professionals need to ensure information pertaining to history and its significance to current concerns and future harm is carefully maintained and purposefully shared with colleagues. This is especially important when different professionals begin working with families.	**Recommendation 4** The board needs to be confident that there are management systems in place to ensure and encourage recourse to multi-agency processes to facilitate better information sharing and more effective ways to work with families where professionals are 'stuck'	September 2015 - Bolton Integrated Drug and Alcohol Services (BIDAS) have now ensured that all assessments contain early help questions in respect of adults childcare responsibilities (a practitioner prompt sheet has been developed), all staff have copy of Bolton's threshold diagram and staff have received level 2 training to support their understanding of their role to safeguard children within the multi-agency system, including when and how to share information BIDAS have reviewed their internal risk assessments in relation to children to ensure it includes an assessment of the wider developmental needs of the child and positive protective factors this informs front line staff of when to seek additional information and initiate safeguarding procedures and the threshold level at which these should take place (e.g. Early Help, Child in Need, Child Protection) September 2015 - EIT have introduced a process to review all pupils where there is persistent absence – 'Pupils Causing Concern' – this review is carried out by service managers; this supports improved decision making, identification of risks and additional action required Bolton Children's Services – Children's Social Work are re-delivering training on chronologies to ensure they are well maintained and used to inform the child's assessment and decision making	May 2016 - BSCB will share learning from the Review to ensure it informs the development of Public Service Reforms for complex lifestyles; in particular Phase 2 of the multi-agency hub June 2016 – Early Help quality audit will be completed with a specific focus on non-school attendance and include a review of management decision making – findings will be reported to BSCB in August 2016 August 2016 - Bolton Children's Services – Children's Social Work will report findings from audits of chronologies

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Patterns in family-professional interactions (Finding 2, 4, 7 & 8) • Children who live in families where there is co-morbidity of parental substance misuse and violence within the home are known to be at risk of significant harm. This review has highlighted that when the 'child' is a young adolescent, the impact of these adversities can be overlooked or minimised by professionals who are then less likely to refer their concerns to children's social care. • A lack of knowledge among professionals about the evidence base related to risk indicators for adolescent suicide could leave them ill equipped to discuss and/ or recognise signs and respond accordingly. • Parental hostility and lack of engagement impacted on professional confidence and hampered the ability to safeguard or work effectively with SB. This led to work with the family drifting and left SB vulnerable. • Where it is not possible to build a cooperative relationship with parents, workers need good quality reflective supervision to explore and establish what actions or intrusive measures should be undertaken to protect a child from harm.	**Recommendation 5** The Board needs to develop an authoritative mandate for professionals who need to engage with hard to reach and hostile parents and ensure that whatever their role, professionals have access to quality supervision to support them in this work.	September 2015 - EIT have further developed their internal supervision arrangements to ensure that where practitioners face parental/child challenge or resistance this is recorded in supervision, feeds into the 'Pupils Causing Concern' process and informs further interventions – including the need to 'step-up' to statutory processes BIDAS have introduced joint quarterly supervision sessions across its providers – this is to promote effective communication and joint working	June 2016 - Evaluate supervision arrangements across the partnership via the Section 11 Audit – report the findings to BSCB in September 2016
	Recommendation 6 The Board should examine the current training programmes available to professionals to ensure these provide opportunities for • The development of skills in working with hostile parents and resistant adolescents • Gaining knowledge about the impact of long-term neglect on adolescents and the associated risks	September 2015 - Lessons learned from the SCR are included within BSCB's current Resistant Families training and SCR training November 2015 & April 2016 - BSCB and Bolton's Community Safety partnership have commissioned training on understanding resistant adolescents – this has been accessed by 210 practitioners over two conference events Local training proposal developed for a 'Working with Adolescents' for delivery in 2016-2017 November 2015 – April 2016 - Neglect Strategy in development – lessons from this review are informing the strategic action plan and the supporting training	October 2016 - Independent evaluation of Resistant Families' training will be completed and findings reported to BSCB's Training sub-group August 2016 – Neglect Strategy and Action Plan to be endorsed by BSCB