Welcome to the third edition of the Local Safeguarding Children Board’s Learning Review. Serious Case and other Reviews are carried out mainly so that agencies and individuals can learn lessons to improve the way in which they work to safeguard and promote the welfare of children.

As safeguarding is everyone’s business, the purpose of this newsletter to provide a concise update of important learning points from a range of reviews of practice, both locally and nationally.

A continued aim of Tri-borough multi-agency Case Review group is to identify key learning points which should inform our practice when working with vulnerable children and their families. At the group’s February and May meetings, the following Reviews were considered:

1. A Case Management Review of a looked after child who had died aged 16, prior to becoming permanently adopted. The purpose of the review was to consider case planning and decision-making to review whether an appropriate level of support was given. Although the young person died in unpredictable circumstances, the review concluded that closer attention should have been made to the his change in behaviour, which suggested that he may have become involved with gangs. Also the adoption support plan should have been reviewed and updated at the LAC review meeting.

2. The group started a case management review of a 22 year old man who was previously in care and had been convicted of murder. The purpose of the review was to look at assessments and interventions that had taken place and to reflect on what learning could be gained. While formal early help interventions were not commonly available when the man was a young person, it was concluded that professionals should have intervened at an earlier stage and completed a comprehensive assessment which would have highlighted additional family issues. It was also noted that this case may have benefitted from a greater understanding of emotional attachment issues, how to identify them and therapies available.

3. A case management review of two brothers aged 12 and 10 who were previously known to Children’s Services and had been charged with rape. The purpose of the review was to explore whether any interventions and support provided could have been offered differently and to identify any other lessons. The review concluded that assessments could have given more priority to understanding the individual needs of each child, their wishes and feelings. A need for increased communication between professionals in different services was also noted.

4. A 15 year old boy died after taking a substance at a party. He had been subject to a managed move to another school after being found in possession of cannabis. However, prior to this, his behaviour and progress at school had been described as “exemplary” and he was from a supportive family.

5. A baby died shortly after being delivered at home without medical assistance. This was the second time the parent had given birth in this way and on the previous occasion had had a stillbirth. Both pregnancies have been concealed so no antenatal care had been provided.

There was a feeling that the first two cases reviewed included elements of “mindset” whereby the first was seen as “an adoption case” and the second as “an education case”. Compartamentalising cases in this way hindered thinking about the gangs issues in the first case and the parenting issues in the second. This illustrates the importance of effective reflective supervision and its role in encouraging a more holistic approach to meeting children’s needs.
Spotting the signs of gang related activities

Children and young people may become involved in gang related activities for a variety of reasons. It is important to be aware of possible signs and to look out for unusual behaviour (please note this list is not exhaustive):

- A new groups of friends that are not known, often older, and have sudden importance
- Unexplained money, gadgets, clothes or trainers and other amenities
- Constant phone calls and leaving the home quickly without adequate explanation
- Stopping or dropping out of hobbies or clubs they're involved in
- School or reports or relationships with parents or carers change dramatically
- Going missing for long periods, staying out later than scheduled, particularly if overnight
- Not telling you where they are going, who they are with and what they are doing
- New habits, for example smoking, drinking, dealing or taking drugs, taking an interest in illegal activities
- Adopting a change of name, or new nickname.

If you are worried that a child you may be working with is involved in gang related activities and need advice please contact your local Gangs team or service.

If you are interested in attending Gangs training please contact the Tri-borough training team or click on the following link.

Best Practice in Permanency Planning

For the same young person it was noted that the permanency plan was written 12 months prior and an ‘end of LAC’ review should have taken place immediately before any permanency arrangements commenced. These actions should have highlighted any concerns professionals may have had or any changes in circumstances. Other best practice in relation to permanency includes:

- Time is of the essence – unnecessary delays should be avoided
- Case tracking should include timetabling and the use of Permanency Planning Meetings
- Contingency plans should always be made.
- All children with Placement Orders should be referred to the National Adoption Register. This will give an indication of other possible matches, especially useful in writing Court Statements
- Keep an “open-mind” regarding the needs of each individual child, including those in sibling groups. Separation may be necessary in some cases.
- The overall aim should be to find a family who can meet the majority of the child’s needs
- Work closely across teams to share skills, expertise and knowledge. Involvement of the Recruitment & Assessment Team, Connected Persons Team and the child’s social worker helps ensure:
  - Quicker identification of potential adopters coming into the system, including those approved
  - Consideration of possible matches with children waiting
  - Sharing of information about cases where permanence may be required outside of the friends and family network
  - Development of more realistic future contact plans and support packages.
Emotional Attachment Disorders

Attachment disorders result from situations where a parent is not able to form a healthy bond with their child. The reasons behind this vary and the parent may need support to make positive changes in relation to mental health, substance misuse, domestic violence and/or parenting. A child being brought up by a parent who is not able to support him or her to safely attach may:

- Not be offered comfort when crying
- Receive little or no attention and so feel alone.
- Be abused or mis-treated.
- Experience multiple moves and changes of their main care giver.

Coping behaviours that children may develop include avoiding eye contact, not noticing when left alone, not smiling, regular and prolonged crying or tantrums and showing signs of being withdrawn. As these children grow up and become adolescents the signs of attachment difficulties in adolescence can include anger, depression or anxiety; difficulty following rules; poor relationships with family members with an inability to resolve conflict in a healthy way; lying or manipulative behaviour, stealing; keeping family and professionals at a distance or disrespecting parents and people in authority.

They may seek trusting relationships away from their families - this might be the reason for involvement in gangs. School rules can be difficult to follow leading to multiple school moves.

What to do if you suspect that a child or young person is experiencing attachment disorder

A referral to the child and adolescent mental health service (CAMHS) will help assess the child’s difficulties and the relationships in the family. CAMHS can provide support to parents, family members and the individual through family therapy, parenting services, child psychotherapy and play therapy. Parents may also need a referral of their own to mental health and/or parenting services. When working with adolescents with attachment difficulties it is important that the professional network is able to identify this. Otherwise the young person’s difficult behaviour can become the focus of the work. The painful experiences of the adolescent are then missed and they receive little help for their main attachment difficulties.

Interventions when parents conceal pregnancy

Regarding the baby who subsequently died after what was her mother’s second concealed pregnancy the sub-group asked a number of questions to better understand what happened and how interventions might best be made in such situations. This will include looking into the need for local pre-birth protocols, building on what is already in place in mental health services. The case will also be discussed at the Vulnerable Women’s Group and the response and services provided for the mother and older sibling following an earlier incident when there was a stillbirth will be reviewed.

It is likely that any learning that emerges will be reported in a future Learning Review. However all practitioners should consider the interventions that are made following incidences of concealed pregnancy, and we would be interested to hear about any examples of good multi-agency work which provides effective support.
Pathways to services for young people involved with drugs

In relation to the boy who died after taking substances at a party, the Review Sub Group queried the support that would have been offered to him and his family after being found in possession of cannabis in school. **School staff are best placed to decide on the most appropriate response to tackling drugs within their school.** This is most effective when responses are supported by the whole school community and staff have access to high quality training and support. The school’s stance should include a clear statement that illegal and other unauthorised drugs are not acceptable within the boundaries identified within the policy. Schools should outline school rules regarding authorised drugs and make links to the school policy on medicines as well as explaining that the first concern in managing drugs is the health and safety of the school’s community and meeting the pastoral needs of pupils.

**Drug education needs to be part of a well-planned programme of Personal Health and Social Education (PHSE) delivered in a supportive environment, where pupils are aware of the school rules but feel able to engage in open discussion and confident about asking for help if necessary. When schools review and refresh their PHSE programmes, account should be taken of the DfE Statutory Guidance March 2015 “Keeping Children Safe In Education” so all specific safeguarding issues are considered including drugs. Schools can have a key role in identifying pupils at risk of drug misuse and in identifying needs but should aim to distinguish between those who require general information and education, those who could benefit from targeted prevention, and pupils who require a detailed needs assessment and more intensive support.**

Locally there is a well-established **Healthy Schools Partnership** led by [David Millard](#) Healthy Schools Coordinator. The Partnership provides access to many resources which schools can draw on to include within the PHSE curriculum or commission. Pupils affected by their own or other’s drug misuse might have early access to support through the school and other local services including Early Help and School Nursing through a Team Around The School approach. Where they are at risk of exclusion because of drug use and/or dealing, this should always be a trigger to consider access to support and services.

**When pupils transfer to another school or alternative provision including through managed move process**

Regardless of the reason for transfer, the receiving school or alternative provision needs the benefit of being provided with complete information regarding any areas of vulnerability and details of any services currently being used by the child, to make sure pastoral needs continue to be met.

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More about Serious Case Reviews

The NSPCC publish a list of the executive summaries or full overview reports of all serious case reviews, significant case reviews or multi-agency child practice reviews published. It includes backgrounds of the cases, particular themes and recommendations. The full list of reviews plus a range of other information about the SCR process can be found on the NSPCC website [here](#).