

Executive Summary of Serious Case Review

Child S

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SECTION ONE - INTRODUCTION AND BACKGROUND

This Serious Case Review looks at the circumstances surrounding the sudden unexpected death of a young woman (Child S) in Rotherham. On Tuesday 12th October 2010 as a result of a search by South Yorkshire Police, Child S's body was recovered from a canal. She had sustained multiple stab wounds. Child S was a 17-year-old single parent, having a four month old child (Infant A). Child S had been known to a number of agencies over a lengthy period. As a result of the incident, the Rotherham LSCB Serious Case Review Panel met to discuss the case and it was decided that a Serious Case Review would be conducted.

The Serious Case Review Panel was informed that following her death, charges of murder have been brought against two men aged 21 years and 17 years. The trial of the individuals arrested for the murder of Child S is due to take place later this year.

1.1 Reasons for conducting the review

Chapter 8 Regulation 5 of 'Working Together to Safeguard Children' 2010¹ requires that a Local Safeguarding Children Board considers undertaking a Serious Case Review in cases of serious sexual abuse and in cases where it is believed there has been serious impairment to the health and development of a child. The circumstances surrounding the death of Child S were considered consistent with this criteria and a Serious Case Review was commissioned.

The purpose of a Serious Case Review (as set out in Chapter 8 of Working Together to Safeguard Children 2006, and amended, as shown *in italics*, by Working Together to Safeguard Children 2010) is to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work *individually* and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are *both within and between* agencies, how *and within what timescales* they will be acted upon, and what is expected to change as a result; and
- Improve *intra- and inter-*agency working and better safeguard and promote the welfare of children.

The Executive Summary has been developed to meet the requirements identified in 8.42 of Working together to Safeguard Children 2010.

1.2 Scope and process of the review and terms of reference

A Serious Case Review was recommended by Rotherham Serious Case Review Standing Panel, a sub group of Rotherham Local Safeguarding Children Board (RLSCB), on 27th October 2010. A Serious Case Review (SCR) was then commissioned by the Independent Chair of Rotherham Local Safeguarding Children Board on 4th November 2010, in line with expectations of Working Together 2010.

A specific Serious Case Review Panel met on 18th November 2010 to consider the circumstances surrounding the sudden unexpected death of Child S.

¹ Working together to safeguard children a guide to interagency working to safeguard and promote the welfare of children DCSF 2010

The specific Serious Case Review Panel requested that the following agencies/bodies secured their records and commissioned an independent author of sufficient experience and seniority to carry out an Individual Management Review:

- Children's Social Care Services (includes Youth Offending Service)
- Education services
- RMBC Youth and Targeted Services (includes Project1 and Connexions)
- South Yorkshire Police
- GP Service
- The Rotherham NHS Foundation Trust
- Rotherham Community Health Services which includes:
 - School Nursing Services
 - Learning Disability Services
 - Community Paediatric Services
 - Safeguarding Children Health Team
 - Health Visiting Services

(Please note that from 1st April 2011, Rotherham Community Health Services became part of The Rotherham NHS Foundation Trust but for the purposes of the this review they have been assessed separately except for the development of the action plan)

The authors of the Individual Management Reviews are independent in accordance with the guidance at 8.29 in Chapter 8 of 'Working Together to Safeguard Children' 2010 which states:

"Those conducting management reviews of individual services should not have been directly concerned with the child or family, or the immediate line manager of the practitioner(s) involved"

1.3 Subjects

The subjects of the review were identified by the Serious Case Review Panel on 18th November 2010 as Child S and Infant A. The Panel felt that records of Adult B (mother of Child S) should not be reviewed as part of the Serious Case Review but that her involvement and engagement at the appropriate stage would be pertinent. The time period of the review is 1st September 2008 to 12th October 2010.

1.4 Terms of Reference

Under Chapter 8 of Working Together, 2010 this review is to:

1. establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
2. identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result;
3. ask whether specific consideration was given to ethnicity, religion, diversity or equality that were identified and required specific consideration; and as a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

In addition, specific terms of reference have been identified for this case:

- The review will cover in detail the period from 1st September 2008 until 12th October 2010.
- A summary of agency involvement for the six years prior to this period (from September 2002) should be included in order to provide some history and context.
- The review should primarily focus on the immediate family of Child S and Infant A but examine any assumption by agencies that the maternal grandmother, Adult B was the primary carer for and protector of Child S's baby, Infant A and that this became the focus of interventions, losing sight of Child S, as a mother and as a young vulnerable person in her own right.
- To consider how services support young parents where there are known issues that can impact on parenting capacity including where the parent has a learning difficulty.
- How the parenting of Child S influenced her capacity and ability to protect herself and her baby, Infant A.
- The quality and effectiveness of continued assessment of risk and interventions provided to Child S and Infant A, given the known history of sexual exploitative relationships and Child S's learning difficulty.
- The impact of the absence of information on significant adult males including the putative father of Child S.
- The effectiveness of inter and intra agency working in relation to communication, coordination and information sharing on young parents who are significantly in need, have additional vulnerabilities of their own that may impact upon their capacity to parent.
- Consider whether the decisions and actions taken by the agencies involved were in accordance with policies, procedures and relevant practice standards.
- The supervision of staff and the support provided in working with a child protection and complex children in need cases in relation to their level of knowledge and experience.
- Any similarities with previous local Serious Case Reviews or national themes, their recommendations and subsequent actions.

1.5 Process

The independent author of the overview report, Professor Pat Cantrill, is a Registered Nurse and Health Visitor and was a senior civil servant at the Department of Health. As Assistant Chief Nursing Officer, (DoH England) for Clinical Practice and Regional Director of Workforce Development and Nursing, Pat developed leadership qualities and professional credibility nationally. Her appointment is in accordance with the guidance at 8.20 in 'Working Together to Safeguard Children'.2010 which states that:

'the overview author should be independent of the local agencies, professionals involved and the LSCB. And that the person should not be the chair of the LSCB or the SCR subcommittee / panel'. *The overview report should be commissioned from a person who is independent of all the agencies/professionals involved.*"

Considerable discussion took place with Professor Cantrill to ensure that there were no elements of the review that might conflict with her being the independent author of the report whilst also the Independent Chair of Rotherham Adult Safeguarding Board but as she has not had any contact with the children's services in any of the agencies we are reassured that there is no conflict of interest. Pat has led a number of high profile serious untoward incident reviews particularly in relation to safeguarding vulnerable adults and children. She has considerable experience in cases of sexual exploitation.

To ensure clarity and independence, meetings were chaired by independent chair Peter Williams. Peter Williams is a qualified Social Worker holding a CQSW and MA in Social Work. He is currently Head of Children's Services Organisational Development for Barnsley Metropolitan Borough Council where he has responsibility for strategic organisational and workforce development including children's social care. He has significant safeguarding experience having worked in a number of Local Authorities over a twenty year period as a social worker, team manager and service manager within statutory children's social work. This includes experience of working within the context of the Serious Case Review.

1.6 Membership of the Serious Case Review Panel:

Adele Jones	Service Manager, CAF/CASS
Ailsa Barr	Service Manager, Safeguarding Children Unit
Catherine Hall	Nurse Consultant / Designated Nurse, NHS Rotherham
Deborah Wildgoose	Deputy Director of Nursing, RDASH
Eisawl Nagmeldin	Named Doctor, RFT
Sherif El-Refee	Designated Doctor, NHS Rotherham
Doreen Hollingsworth / Beckie Marjoram / Robin Williams	RMBC Solicitor
Howard Woolfenden	Interim Director of Safeguarding and Corporate Parenting, CYPS
Maryke Turvey	Head of Rotherham Delivery Unit, SY Probation Trust
Phil Morris	Business Manager, Rotherham LSCB
Sam Newton	Safeguarding Adults Manager, Neighbourhoods and Adults Services
Yvonne Weakley	Associate Director of Children and Young People's Services, RCHS
John Lambert	Consultant Headteacher, School Effectiveness Service, Children and Young People's Services

Professor Pat Cantrill attended panel meetings from 23 February 2011 as the overview author to observe but was not a formal member of the panel.

This report is based on IMRs commissioned from professionals' independent from their commissioning agency (see section 1.2). The report author has indicated whether there is confidence in the findings of an IMR.

In addition a comprehensive integrated family chronology of agency involvement and significant events from the period 1st September 2008 to 11th October 2010 has been compiled and analysed by the Serious Case Review panel.

At the time of completing this review, the court proceedings related to Child S's death have not taken place. In line with 8.26 Chapter 8 of 'Working Together to Safeguard Children' 2010 the Chair of the LSCB has negotiated with the police and crown prosecution service about progressing the SCR to ensure that the court proceedings are not compromised by the serious case review process.

Working Together to Safeguard Children 2010 recommends that serious case review panels should consider 'how family members should contribute to the review and who should be responsible for facilitating their involvement'.

Child S' Mother Adult B, Sibling 3 and Child S's father were invited to contribute to the review. Adult B agreed to participate. Sibling 3 did not wish to participate. No response was received from other members of the family.

Adult B was interviewed by the report author in the presence of the Business Manager of Rotherham LSCB.

The Executive Summary will be discussed with Adult B and other members of the family and released to the public. The recommendations will be acted upon by all agencies, in order to ensure that the lessons of the review are learned. An updated action plan will also be published as an appendix to this Executive Summary.

In parallel with the serious case review, a 'Lessons to be learned review' was commissioned by Rotherham Local Children Safeguarding Board following Operation Central. The review reported in July 2010 and identifies the learning that could be taken from the Operation regarding sexual exploitation and provision of services to young vulnerable people. The findings of this review have been incorporated into the individual management reviews and overview report for this serious case review.

SECTION TWO - SUMMARY OF EVENTS

Child S was born into a family, the youngest of four children, living in an economically deprived area of Rotherham. From the age of two she experienced the emotional and physical stress of abuse within the family. Child S's siblings had problems with their own behaviour and there were concerns associated with sexual abuse and exploitation.

In 2004, Child S was placed on the Child Protection Register as being at risk of sexual and physical abuse. The following year she was removed from the register but remained as a 'Child in Need'. Social care services' involvement with Child S ended in September 2007.

At the age of 11, Child S was assessed as having special educational needs and was then educated at a special school. She did not like being labelled as having special educational needs and did not settle well. She hated being different and was bullied in school and by children where she lived. Child S developed an ability to hide the complications in her daily life caused by her learning difficulties.

Her behaviour at school became more difficult and she was frequently absent. School1 tried to meet her educational needs by agreeing with her a timetable that consisted of time spent at a local college and at work experience in a hairdresser's shop. She enjoyed college but again there were difficulties in her attendance and there were large periods of the week when she did not have anything timetabled, so she only spent 35% of her time in education.

When Child S was ten years old one of her siblings is thought to have become involved in sexual exploitation. From then on a key issue was the ability of Adult B and agencies to support Child S and stop her becoming exploited herself. There is evidence from her behaviour that she did get involved sexual exploitation, including the facts that she was vulnerable and subsequently became pregnant at 16 years of age. There were health and youth and targeted agencies, who had specialist knowledge of working with vulnerable children, involved with Child S but they were not able to encourage her to work with them.

A referral was made to Social Care Services in 2009 but was not followed up due to confusion regarding Child S' address. There was no further involvement with Social Care until 2010. This involvement followed multi-agency work regarding a group of girls and possible sexual exploitation issues in which Child S was mentioned. By this time Child S was pregnant and an assessment took place identifying work to be carried out. This work ended in August 2010 on the basis that there had been no further concerns regarding possible sexual exploitation. Subsequently, Infant A was born, who is of dual heritage.

There has been a wide range of health service involvement with Child S over a long period of time; these services have ranged from universal services and targeted services including GP, school nursing and health visiting services and teenage pregnancy services. Some of these services were involved at an earlier stage in the context of Child S being subject to a Child Protection Plan. Child S was also known to health services due to her learning difficulty identified at a young age; and later in her life, extensive involvement of statutory agencies due to her vulnerability as a young parent with a history of potential sexual exploitation.

Following the birth of her baby, Child S returned to college. She appeared to be enjoying the experience and the college tried to address her learning needs and to support her. However, at one point Child S and Infant A left the family home, going to stay at a place which was felt to be a risk. Adult B (her mother) was given the responsibility for the safety of Infant A. The police and social care services were contacted and eventually she returned home.

At the age of 17 years in October 2010, Child S was found dead.

Child S was involved with 15 different services during the seventeen years of her life. Her needs were never fully met. The information identified above was known either singly by an agency or was available to all agencies involved in her care if multi agency communication and working had been more effective. She had a long period of involvement with agencies due to her vulnerability, unpredictable behaviour, and the risk of her involvement as a victim of sexual exploitation.

The life of Child S and her involvement with agencies reflects many of the issues raised by Ofsted in their reviews of Rotherham Children's Safeguarding Services from 2008 to 2010. It should be noted that many of the issues identified were recent - some have been addressed and others form part of the action plan.

Multi agency working

The content of the IMRs paints a picture, reflected nationally, of mixed performance in meeting the needs of Child S and Infant A. A combination of factors, including organisational, systems, workforce, cultural factors and individual deficient practice impacted on the care provided for Child S. There is evidence of good practice by some agencies.

However, there are areas of considerable concern. Of significance is that the care of Child S did not focus on her and her needs. She was almost invisible to some services. The impact of learning difficulties on her ability to make choices about her life and care was not considered by most services. The potential for poor outcomes for Child S increased significantly because of a lack of early intervention to deal with signs of concern. The cost to Child S in terms of her emotional and psychological well being appears to have been

considerable. There were missed opportunities to conduct a comprehensive assessment of her needs, including a risk assessment. There was no evidence of the use of the Common Assessment Framework. This resulted in a lack of a comprehensive plan of care developed with Child S to meet her needs. Appropriate child protection or care plans, and reviewing processes were not in place. There is a lack of effective joint working in many instances.

There were opportunities to reassess Child S, her family and the services they required. However the conclusion reached at the Child Protection Conferences in 2004 and 2005 set the style and pattern of agency involvement, individual practice, and beliefs about Child S and her family. The information available to agencies and from their own contact with the Child S and her family should have been used to address the fact that the services being provided to Child S had not achieved the required outcomes.

Child S was a difficult child for agencies to work with. She stopped working with services but some services allowed her to do this rather than supporting her to participate. Agencies did not know when to take decisive action and they did not exercise a strong enough sense of challenge as outlined in the Serious Case Review into Baby Peter:

*'The authoritative intervention is urgent, thorough, challenging, with a low threshold of concern, keeping the focus on the child, and with high expectations of parents and of what services should expect of themselves.'*²

As identified by the Beckford Inquiry³ there was unrealistic optimism about the cooperation of Child S and Adult B. Child Protection Conferences and core group meetings did not revisit the initial assessment in light of new information. Legal experts were not used appropriately at Child Protection Conferences.

On a number of occasions there was a lack of effective record keeping which has created difficulty in evaluating the work of individual practitioners and agencies.

SECTION THREE - KEY ISSUES AND THEMES

1. Legislation in the United Kingdom requires that children are consulted about any decisions that will affect their lives (DoH 2001). Child S, like many vulnerable children, had low self-esteem and self-confidence. A Child Centred Approach would have enabled her to choose, make connections and communicate. Child S was not really seen by any agency as the highly vulnerable child she was and the care provided by some agencies reflected the outcome of her vulnerability rather than addressing the cause.
2. This lack of child focussed care in the majority of the services resulted in limited or no consideration being given to Child S's special needs. She was very good at covering the problems her disabilities created, but more time spent with her would have identified that she could not grasp issues or remember more than a small fraction of what she had been told. The impact of this on her understanding of a number of contacts with services would have been considerable. It is crucial that services are able to establish the impact of a child's special needs not only on their development and understanding but to inform therapeutic work.
3. Some practitioners lacked the ability to critically analyse data and information to identify indications and patterns of safeguarding issues. This was a crucial issue in

² Serious Case Review Baby Peter. Feb 2009. Haringey LSCB

³ Beckford inquiry, London Borough of Brent 1985 A child in trust .The report of the panel of inquiry into the circumstances of the death of Jasmine Beckford

making an effective assessment of Child S. Current practice calls for the ability to use assessment tools and techniques, objective measures and a systematic approach and to constantly strive to advance practice to have; well developed observational skills, the ability to identify patterns and predict outcomes, identify escalating risk and ensure that reflexive practice is at heart of assessment.

4. There were numerous missed opportunities to work with and protect Child S and Infant A. Assessments of Child S did not lead to an effective plan of care which resulted in a lack of leadership, coordination and progress and a failure to recognise her real level of vulnerability.
5. The Framework for the Assessment of Children in Need and their Families and the Common Assessment Framework should be the basis of assessments on children and young people. Practitioners need to see every encounter with a child as an opportunity to re-evaluate their work with them in the light of any new information. All assessments must include a sound understanding of children's developmental needs. The history of the family was available to most of the agencies and individual practitioners if they had taken the time to make a fully informed assessment and therefore develop a case management plan. As the situation deteriorated, the level of vulnerability of Child S and Infant A was not systematically evaluated, and therefore the skills, knowledge and support of additional services were never effectively requested or addressed. There was a lack of a dynamic response to new and changing information.
6. There was a consistently high threshold before concern triggered action and the attitude of the professional culture overall was too tolerant in its expectations. Professionals must not lower their expectations of how a parent cares for their child based on the circumstances or community a family is in. The passive approach taken by some services is evidence that the challenges, and therefore the required systems and practice and the use of effective assessment tools, were not fully in place.
7. The agencies involved in the care of Child S needed to intervene earlier. There is sometimes confusion about what is meant by intervention in safeguarding and child protection. Procedures should place the practitioner in the right place at the right time to respond on behalf of their agency to protect a child or young person. If they are not to trap themselves into inaction, practitioners must be prepared to work only with 'reasonable inference'. Reasonable inference is when agencies follow and take full account of the facts and make a suitable response to them.
8. Working with a child who is disengaged is a challenge to most experienced professionals, so knowledge, skills and expertise need to be developed and supported by effective supervision. It makes it even more important that a coordinated plan of care is established and delivered. In the case of Child S, agencies response to her lack of engagement appears to have been to mostly end their involvement with her by closing her case. There were, however, examples of positive practice as in the case of College1 who attempted to secure and maintain her cooperation.
9. Child Protection Conferences and strategic meetings must be administered efficiently and managed authoritatively. They should produce a systematic analysis of care and abuse, to lead to decisions which are child-focussed and appropriate child protection plans.
10. The management and sharing of information within and between agencies and by individual professionals is crucial to safeguarding children and young people. The quality of record keeping was raised as an issue in many of the Individual

Management Reviews although there is evidence of improvement in information systems and processes. Auditing of records remains crucial to ensuring that required standards are achieved and maintained

11. The level of Child S and Infant A's vulnerability appears not to have been risk assessed. The Framework for the Assessment of Children in Need and their Families would have assisted in risk assessment but it was not completed. Risk assessments should identify the core features of the vulnerability of the child including:
 - Accurate identification of the risk the child is exposed to and why
 - The likely impact or consequences of the risks to the child
 - Whether the risks are externally posed or are endemic to the child and their circumstances
 - Whether the risks are acceptable.
12. What could prove to be a very significant factor in risk assessing the service provision required for Child S and Infant A is an incident when Child S was present when men broke into a house and an air rifle was fired into the room where she was. In previous reviews / enquiries of cases (Bichard 2004, London Criminal Justice Board 2009), there have been instances of violent behaviour where people have met with violent deaths, where the previous violent behaviour on the part of a perpetrator has been overlooked. This is a critical point for lessons to be learned.
13. All professionals need to recognise the responsibility and accountability that comes with the role they have. They need the ability to respectfully challenge, an enquiring mind and the tenacity to see things through. There were a number of occasions when Child S was discharged from services or her case closed when there was no follow up to ensure that her care was being met by others or that people who had originally referred her were notified of the outcome.
14. There are a number of areas where there appears to be a lack of knowledge and understanding and should form part of training in the future. They include:
 - Improved knowledge of sexual exploitation and grooming including a better understanding of perpetrators.
 - The role of fathers in the development and care of children and young people.
 - Assessment and critical analysis skills using assessment tools
 - Working with disengaged or hostile children and families.
 - Effectively monitoring the progress of families in safeguarding situations including managing risk, identifying patterns and predictive modelling.
 - Protecting children with special needs.
 - Formulating and sharing information and opinions – making yourself heard in the network
 - Challenging colleagues
 - Communicating and working with children
 - The management of information within and between agencies and by individual health professionals.
15. Whilst there is evidence of safeguarding supervision being provided in a systematic way in some agencies there is a need for agencies to strengthen the structures that underpin supervision and to ensure that professionals access supervision and as a result the right level of challenge, development and support.
16. Local Safeguarding Children Boards and Directors of Children's Services have a responsibility to ensure that the quality of care and services to safeguard children and young people are meeting required levels throughout Local Authority and partner

agencies. Whilst Section 11 audits of services provides a process to benchmark current standards, and identify both good and concerning practices the development of an assurance framework containing quantitative as well as qualitative evidence would be more effective. RLSCB needs to ensure that there is in place an assurance framework which enables the assessment of the provision of safeguarding services to children and young people and that performance is monitored and managed against this.

17. There were issues associated with the effective management of services. It is important that there are clear lines of accountability and systems in place that support professionals to undertake their role. Lack of clarity about the functioning of services, asymmetrical changes within and across services, lack of resources and effective auditing, all added to produce an environment which made it difficult for professionals to achieve quality services.
18. The complex nature of all public service organisations means that leadership is needed at different levels throughout organisations and not simply at the top. Leaders and managers of services The nature of professional practice requires individuals to be able to lead and advocate for the case management of their clients, patients and students and also to provide leadership as a member of a group or network.
19. Increasingly, social workers and other practitioners are working with clients from diverse backgrounds and cultures. Because ethnicity influences practice in many ways, it is important for a greater understanding of ethnicity and the ways in which it can influence individual's perceptions and responses to problems and care. Knowledge and understanding have therefore become critical for effective practice.
20. There was a lack of good interagency working. This is not just about sharing information (an issue raised in some IMRs) but about shared analysis, planning and interagency practice. The history of Child S and the family was available to most of the agencies and individual practitioners if they had taken the time to make a fully informed assessment and therefore develop a case management plan. As the situation deteriorated the level of vulnerability of Child S was not systematically evaluated and therefore the skills, knowledge and support of additional services were never effectively requested or addressed.
21. What is clear from the Serious Case Review is that there are considerable issues associated with safeguarding young vulnerable adults and the lack of understanding and systems in place to identify and address their needs. It is important that links are made between the planning and provision of safeguarding services for children, young people and vulnerable adults.

SECTION FOUR - GOOD PRACTICE EXAMPLES

The Children and Young People's Services in Rotherham in November 2009 were assessed by Ofsted as not meeting the requirements to safeguard children and young people. Since then the issues raised by Ofsted have been addressed rigorously. Developments in service planning, governance, addressing workforce issues and the appointment of key individuals should help to address many of the issues raised in the lessons to be learned for Child S at an organisational and operational level. However, many of the developments have still to be implemented or are in the early stages of implementation. Many of the changes made are examples of good practice including:

- The development and quality of the Children and Young People's Plan (CYPP) 2010-2013 which was informed by children, young people and families.
- As part of the CYPP the Children and Young People's Trust Board receives a quarterly performance management report with an indication of the direction of travel for each indicator. Where improvements are not being made, Performance Clinics are used to identify issues and solutions. The CYPP action plans form an integral part of the Performance Clinic process. Planning and activity is re-examined and services are developed where necessary. The findings are then reported back to the Children and Young People's Trust Board.
- Specialist support teams have been developed from January 2011 to meet the needs of children and young people with specialist needs such as Child S. They include: Learning Disability Services, Complex Health Care team, Children and Adolescent Mental Health Teams, Allied Health professionals (including Occupational therapy, speech and language therapy, Physiotherapy) and Looked After Children's Services. They will work in each locality with the police, area partnership managers, GPs, schools, voluntary and community agencies, fire and rescue services and all other providers to plan and prioritise services for children and young people. The same processes and systems will be used across multiagency teams to support coherent practice. The CAF and the role of the lead professional will be critical.
- Learning Communities have been established which provide clear routes for each and every learner, building on best practice from innovative Integrated Services Pathfinder Projects. The ambition is for each Learning Community to fully embrace the strategy for children, young people and families, life-long learning and the development of really effective Prevention and Early Intervention strategies. It is intended to transform the way in which learning happens in Rotherham. Life chances for children and young people should be transformed by work to enable early intervention, improve literacy and numeracy and create integrated approaches to helping hard to reach children and families.

SECTION FIVE - OVERALL CONCLUSIONS

The Serious Case Review Panel assessed all the available evidence and concluded that a combination of factors, including organisational issues, systems, workforce capacity and capability, cultural factors and some individuals' poor practice had a negative impact on the quality of care for Child S.

Child S was a vulnerable young woman whose needs were not fully assessed by any agency that had contact with her. Nationally, previous Serious Case Reviews have highlighted the importance of professionals and services seeing, observing and hearing the child. Few services actually saw, observed and heard Child S as the highly vulnerable child she was, and whom, society had a responsibility to protect.

Rotherham Children and Young People's Services has already put in place many initiatives that should reduce the risk of this happening again. However, the changes will require determination and commitment not only from policy makers and leaders, but also from every practitioner, if they are going to be successful.

SECTION SIX- RECOMMENDATIONS

Overview Author Recommendations

1. Rotherham Children's Trust need to ensure that the changes to services outlined in the Children and Young People Plan 2010 to 2013 are implemented and that the accompanying Assurance Framework enables the assessment of the provision of safeguarding services to children and young people and that performance is monitored and managed against this.
2. There is every reason to believe that the way in which Child Protection Conferences are conducted in Rotherham is now very different and more robust than previously but it would be appropriate for RLSCB to assure itself that the current Child Protection Conferences:
 - are administered efficiently, attended assiduously and managed authoritatively
 - produce a systematic analysis of the care and abuse
 - make decisions which are child-focussed,
 - ensure effective risk assessment
 - develop child protection plans that are purposeful and authoritative and translate into the development of a robust action plan which in turn directs interdisciplinary practice and effective performance monitoring.
3. The Strategic Director of Children and Young Peoples Service should, as a matter of urgency, review the role of Project1 as part of a whole systems review to meet the prevent, deter and treat needs of children and young people at risk of sexual exploitation and grooming.

Children's Social Care Services IMR recommendations

4. The Director of Safeguarding and Corporate Parenting Services should ensure that there is a clear line management structure so that all staff know who is responsible for providing their case supervision and there is clear accountability. This should be done with immediate effect.
5. The Director of Safeguarding and Corporate Parenting Services should ensure that work is undertaken by staff with suitable skills, qualifications and experience and with appropriate support and supervision.
6. The Director of Safeguarding and Corporate Parenting should ensure that wherever an assessment identifies the need for further action, a care plan is written that clearly describes the action to be taken.

7. The Director of Safeguarding and Corporate Parenting Services should ensure that no case is closed until a Team Manager has seen evidence that all work identified as being required has been completed.
8. The Director of Safeguarding and Corporate Parenting Services should ensure that the function and conduct of strategy meetings is reviewed, in line with recommendation 7.4.6 of the Lessons Learned Review for Operation Central. In addition to the specific areas identified in that recommendation the review should ensure that arrangements are put in place to:
 - ensure that the minutes of strategy meetings are placed on the record of the child to whom they relate. Where a strategy meeting involves more than one child, each child's record should only contain those parts of the minutes that relate to them.
 - overcome the practical difficulties of considering numerous children at a single strategy meeting.
9. The Director of Safeguarding and Corporate Parenting Services should ensure that a procedure is developed that governs how personal information about a service user can be changed on the Information System. This should address who can make such changes and how information needs to be verified before it is changed.
10. The Director of Safeguarding and Corporate Parenting Services should ensure that all social work staff within Children's Social Care have the support and skills to enable them to recognise and challenge disguised compliance.
11. The Director of Safeguarding and Corporate Parenting Services should ensure that clear guidance for the use of Contracts of Expectations and a template for such contracts are developed and disseminated to all staff that might use Contracts of Expectations. The guidance should include issues such as when and how they should be used and the need for clear arrangements for monitoring compliance.

Education IMR recommendations

12. The Senior Director for Schools and Lifelong Learning should ensure that by July 2011, guidance is issued to all Rotherham schools relating to recording practice in relation to pupil information (to include timetables, alternative curriculums, incidents and behaviour, assessments of need and risk, plans, and reviews).
13. The Senior Director of Schools and Lifelong Learning should write to all Rotherham schools to remind them and request compliance with the requirements to record actual daily attendance of any pupil undertaking any off-site curriculum activity in strict accordance with the Education (Pupil Registration) (England) Regulations 2006 and its accompanying Guidance.

14. The Senior Director for Schools and Lifelong Learning should ensure that by July 2011 revised guidance for the arrangements for the planning, implementation and review of alternative curricula are issued to all Rotherham schools and providers.
15. The Senior Director for Schools and Lifelong Learning should by September 2011 commission a review of educational opportunities and support to school age teenagers who are pregnant or are parents and those aged 16 – 19 yrs.
16. Headteachers should ensure that any pupil identified with additional needs that cannot be met within school resources, are subject to the Common Assessment Framework and the Team around the Child approach.

Youth and Targeted Services IMR recommendations

The Local Management Review of Project1 broadly confirms two of the recommendations of the “Lessons Learned Review – Operation Central”. Most notably those at 7.2 and 7.3 in relation to the need for a multi agency team to specialise in tackling sexual exploitation, and 7.4.6, the conduct of strategy meetings.

Some of these recommendations may already have been enacted but building on the above this review would recommend:

17. The Director of Community Services and the Director of Safeguarding and Corporate Parenting should ensure a shared risk assessment is agreed between agencies with agreed thresholds for intervention.
18. The Director of Community Services must review the placement of the project within Young People’s Services to ensure that adequate safeguards are placed around the work of sexual exploitation and that governance arrangements are in keeping with those in Social Care.
19. That the work of Project1 is subject to management oversight and supervision.
20. With immediate effect the Director of Community Services should issue guidance on recording standards and expectations.

South Yorkshire Police IMR recommendations

21. Headquarters Public Protection Unit is to carry out an audit to ascertain the effectiveness and use of the Gen 117 and Gen 118A system within the Rotherham District via the dip sampling of recorded incidents.
22. Headquarters PPU is to organise briefing sessions with all staff at Rotherham District with regard to the Gen 117 and Gen 118A system.
23. Referrals to Social Care with regard to a child going missing should be made within 48 hours and this referral needs to be audit trailed.

The Rotherham NHS Foundation Trust IMR recommendations

24. The Ante Natal Clinic Manager will, by August 2011 ensure that midwifery services complete a Pre-Common Assessment Framework (CAF) with all pregnant teenagers in order to assess need and maximize on appropriate services which can be offered to improve upon outcomes for young mothers and their babies. The Named Midwife and Teenage Pregnancy Midwife and the Common Assessment Framework Team will audit compliance of this in November 2011.
25. The anticipated outcome of completing a pre CAF on all pregnant teenagers is to ensure that they all have an assessment to identify their capacity to appropriately parent an infant. The CAF to include capacity recording.
26. Staff training at groups 3 and 4 to include an understanding of the challenges of working with parents with a learning disability.
27. That the Trust's safeguarding supervision policy includes a consideration of the 'Ten Pitfalls' (NCPCC 2010) as a framework with which to consider risk.

Rotherham Community Health Services IMR recommendations

This service is now integrated with The Rotherham Foundation Trust

28. By September 2011 The Associate Director of Children & Young People Services, Rotherham Community Health Services will ensure that a pathway is developed from the Midwifery Service to the Health Visiting Service for the notification of pregnancies. This will include the identification of vulnerable mothers including teenagers and potential risk factors. Antenatal contacts will be monitored centrally by the Performance Team.
29. By September 2011, the Named Nurse for Safeguarding Children Rotherham Community Health Services will ensure that training on the 'Practice Guidance on Refusal or Withdrawal from Children's Health Services' is rolled out across all community services that are accessed by children and young people. Audit of compliance with the guidance to be included in the Safeguarding Children Health Team Audit Plan 2012.
30. By September 2011, The Named Nurse for Safeguarding Children, Rotherham Community Health Services will work with the Named Midwife at the Rotherham NHS Foundation Trust, to produce guidance relating to the assessment of parenting capacity for teenage girls identified as vulnerable pre and post delivery. The guidance is to include the use of historical information, a template for recording the assessment and CAF as a planning process. Training in relation to the guidance will be included in the Safeguarding Children Training Programme 2011- 2012.
31. By September 2011 the Named Nurse for Safeguarding Children will ensure that training is available on understanding the equality and diversity issues specifically relating to vulnerable groups and the impact this may have on parenting capacity. This training is to be included in the Safeguarding Children Training Programme 2011- 2012.

32. By September 2011, the Named Nurse for Safeguarding Children, will ensure that all Clinical Team Managers and Nurse Specialists for Safeguarding Children receive training around the Safe and Well protocol and understand appropriate means for challenging other partner agencies in relation to decision making.

GP IMR recommendations

33. The Chief Executive of NHS Rotherham, by May 2011, to write to the Chief Executives of all NHS providers in Rotherham reminding them of the need to ensure that all liaisons are written in a format that readily highlights issues of concern in an accessible summary.
34. The Medical Director, by May 2011, to write to all GP Practice Managers in Rotherham reminding them of the need to have in place a protocol regarding the recording in GP records of all relevant information with an associated action comment. Use of the protocol to be assessed at the Quality and Efficiency Review 2012 with completion of a self assessment audit devised by the Clinical Audit Team.
35. The Named GP Safeguarding Children to liaise with the Named Nurse RCHS and Named Midwife TRFT, by June 2011 to set up a task and finish group to consider maternity pathways for vulnerable groups utilising the "safeguarding package" across universal health services to provide evidence of additional targeted services. The Named professionals and Clinical Audit team to audit compliance by November 2011.

Health Overview Report recommendations

36. The Director of Public Health, by May 2011, to write to all voluntary and statutory agencies re-iterating the consequences of teenage pregnancy and parenthood and the need to refer sexually active young people to contraceptive and sexual health clinics.
37. Named Professionals in Rotherham, by July 2011, to develop Group 3 safeguarding children training sessions to contain specific reference to practitioners need to maintain respectful uncertainty, professional curiosity and professional challenge.

This Executive Summary was written by Professor Pat Cantrill,
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