Children's Social Care to review its communication with front line staff following the Ofsted inspection to ensure balanced judgments in terms of risk management

SSCB should audit the completion of strategy discussion minutes in order to clarify whether the practice described in this case is common across the County.

SSCB should publicise the existence of the escalation process and audit its use and impact on practice

Children's Social Care to review information sharing at the “front door”, document and publicise the system and set out a risk management plan identifying potential risks associated with current systems and how these will be mitigated.

Children's Social Care and Sy Police to provide evidence that the central referral unit is being successful in achieving a consistent understanding across both organisations as to when a strategy discussion/meeting is required.

Children's Social Care should review and formally amend out of hours information sharing processes in order to ensure that when there is a clear need for a social work assessment this is passed directly to the assessment team for action

Surrey Police should provide a clear explanation to the SSCB of the way in which 39/24s are shared with health colleagues and ensure that children over five are not disadvantaged within the system

Surrey Police should develop a system for alerting early year’s providers and primary schools, to the fact that there has been police involvement.

Schools should be engaged in a discussion with Police and Children's Social Care in relation to the significance of the 39/24 and what action might be appropriate within a school environment.

Information should be publicised regarding existing arrangements for contacting schools during the school holidays to communicate important information about pupils.

surrey safeguarding CHILDREN BOARD

LEARNING FROM A SERIOUS CASE REVIEW

The SSCB conducted a SCR as a result of events in 2013 where a young person age 14, was found dead at home. The initial Police investigation concluded that it was likely that the young person had taken his own life and this conclusion has been confirmed by the inquest which recorded an open verdict.

For further information please contact
Angie Tregoning SSCB Case Review Officer
01372 833318
angie.tregoning@surreycc.gov.uk

www.surreycc.gov.uk/safeguarding

Synopsis

The young person came to the UK in 2010 and lived with mother in a bedsit in a shared house. Mother had arrived two years previously, leaving the young person in China with his father. The young person started school in the UK in year 7, he had limited English, but with support from school he did well.

In 2013 Mother returned to China for a month to settle family affairs. The young person (age 14) did not want to go with her, saying he needed to study for maths exams. He also refused to stay with a friend. He remained in the bedsit with arrangements for the landlord and other residents to keep an eye on him. Mother provided him with adequate money to cover food and expenses. The young person's school were unaware that he was living alone

Surrey Police were contacted by the NSPCC to say that the young person had been left at home alone. He was spoken to by police officers and professed to be happy with the arrangement and explained that it was customary in his country for children to be left alone for long periods of time. He appeared well provided for and the landlord (who did not live on the premises) confirmed that he was keeping an eye on him, as was his granddaughter who lived upstairs.

The police officers felt that there were no grounds to take the young person into police protection and that to remove him would cause him distress. They alerted Children's Services emergency duty team. A Children's Service senior manager was contacted and advised that no emergency action should be taken, but that the case should be passed to the day time team to assess further. The contact centre interpretation of the instruction was that they should review the information and decide next steps. The senior manager had meant that the area assessment team should carry out an assessment

On 23rd April Surrey Police received a call from the Ambulance Service who had been called to the address by a family friend. The young person was pronounced deceased by a member of the ambulance crew.

Practice issues that have emerged

Lack of assessment by Children's Social Care on receiving information that the young person had been left at home alone.

Contact centre staff misunderstood the instruction from a senior manager and decided there were sufficient safeguards in place.

When the police sergeant discussed the case with the assistant team manager and requested that an assessment be carried out the assistant team manager did not see any information on the computer system that raised his concerns sufficiently to pass the information to the assessment team. An assessment would have provided the opportunity to look holistically at the whole situation, including relationships with significant others and whether his emotional needs were being met.

Confusion over whether a discussion between Police and Children's Social Care was a strategy discussion and lack of appropriate record keeping in relation to this discussion within Children's Social Care.

The police sergeant from the child protection team thought that the discussion regarding the need for an assessment was a strategy discussion; the assistant team manager did not understand this to be the case. This is significant since strategy discussions are initiated where a child is thought to be at risk of harm and should prompt a thorough analysis of all known information.

Sharing information known to Surrey Police and Children's Social Care with Health professionals and Schools.

The sharing of information with the school by the youth intervention officer is an example of good practice which alerted the school to the young person's situation. This is a relatively recent County-wide process and means that 39/24s are shared with secondary schools when the youth intervention officer assesses this as appropriate (there is currently no similar process for primary schools).

Understanding potential risk across the professional network and the role of Children's Social Care when a child is left home alone.

There needs to be an understanding by all those working with children that any situation where a child is living at home alone should be assessed by Children's Social Care. The police child protection sergeant in this case was proactive in asking for an assessment but there was lack of professional agreement that this was necessary.

Key recommendations

SSCB should ensure that lessons from this review are made widely available to professionals and confirm the importance of assessing the situations of children who are at home alone