

WAKEFIELD & DISTRICT
safeguarding
children board

**Wakefield and District
Safeguarding Children
Board**

Serious Case Review – Child Y

Executive Summary

31st January 2009

INTRODUCTION

1.1 Circumstances Leading to the Serious Case Review

- i) On the morning of the 13th March 2008 male Child Y, then aged 12 years and 11 months, was taken to the Accident and Emergency department of Pinderfields Hospital, Wakefield. He was unconscious and had severe burns to his upper body and left arm. These injuries had arisen as a result of the inhalation of petrol fumes, and the spillage of petrol onto his skin.
- ii) Initially, Child Y's injuries were considered life-threatening and he was admitted to intensive care. He remained in hospital until the 25th March 2008, when he was discharged to the care of his adult half sibling. He has now made a full recovery.
- iii) On the 10th April 2008 the Wakefield and District Safeguarding Children Board convened a Serious Case Review Panel to consider the circumstances around Child Y's injuries. The panel subsequently recommended to the Chair of the Wakefield and District Safeguarding Children Board that a Serious Case Review should be undertaken. The Chair of Wakefield and District Safeguarding Children Board subsequently ratified this recommendation.
- iv) Although Child Y's injury appeared to have arisen accidentally, as a result of him inhaling fumes due to having an open canister of petrol in his bedroom, it was felt by the Serious Case Review Panel that the case met the criteria for a Serious Case Review for the following reasons:
 - Neglect may have been a significant, indirect factor in Child Y's injury
 - Child Y and his family had experienced agency involvement in a number of local authority areas, and they are known to have repeatedly moved between areas
 - The case may therefore give rise to concern about multi-agency working to safeguard children, particularly across local authority boundaries.

1.2 Terms of Reference of the Serious Case Review

1.2.1 The overall purpose of the Serious Case Review was to:

- Establish whether there are lessons to be learnt from the case about the way in which the professionals and agencies have worked together to safeguard Child Y and his siblings. In particular in this case, the fact that Child Y and his family had lived in a number of different local authorities, with agency involvement in each, indicated a need to explore the effectiveness of different agencies in different authorities in working together across geographical and agency boundaries.
- Identify clearly what lessons could be drawn from the review findings and identify any actions needed by the relevant agencies to improve practice and better safeguard children in the future.

1.2.2 The Serious Case Review Panel agreed that the scope of the review should cover the period from the birth of Child Y's older sibling Child Y's older sister to the 13th March 2008 (the date of the serious childcare incident relating to

Child Y). It was known that the family was known to several agencies within Wakefield District and had also moved between Local Authorities. The Serious Case Review would include information from all Local Authority areas and agencies that held information about the family.

1.3 Membership of the Serious Case Review Overview Panel

1.3.1 Membership of the Overview Panel was as follows:

WSCB Business Manager (Chair)
Service Manager - WMDC Safeguarding and Family Support Directorate
Schools Liason Manager - WMDC Education
Service Manager - Youth Development and Support Service
Assistant Director - Barnardo's Yorkshire
Senior Probation Officer - West Yorkshire Probation Service
Designated Nurse - NHS Wakefield District
Serious Case Review Officer - West Yorkshire Police

Overview Panel meetings were also attended by Jennie Rushworth, independent author of the Overview Report, and by representatives of relevant professional agencies in Leeds and East Riding, as well as representatives of their LSCBs.

1.3.2 The Overview Report and Executive Summary have been authored by Jennifer Rushworth, the Service Manager of CAFCASS Wakefield. This agency has had no involvement with the family throughout the period under review and the author has no line-management responsibility for any of the agencies and individuals that have been referred to in the Serious Case Review.

1.3.3 Prior to being given final approval by the Wakefield and District Safeguarding Children Board, all documents were submitted to an independently commissioned expert, with no connection to the LSCBs involved in the case. This was to enable additional independent oversight and scrutiny of the Serious Case Review documents and process.

1.4 Contributors to the Serious Case Review

1.4.1 Individual Management Reviews and chronologies were submitted by the following agencies. All Individual Management Reviews were judged by the Overview Panel as being of an adequate standard.

WMDC Family Services (Safeguarding and Family Support Directorate)
Wakefield Youth Development and Support Service
Wakefield Health Community
Wakefield Family Services - Education
West Yorkshire Police
West Yorkshire Probation Service
Barnardo's Wakefield Young Carer's Service
Leeds Teaching Hospitals NHS Trust
Leeds Children and Young People's Social Care
Education Leeds
East Riding Children's Social Care
Humberside Police
East Riding Education, Inclusion and School Improvement Service

- 1.4.2 Information was also sought from the following agencies, all of whom subsequently notified the Serious Case Review Panel that no information was held on the family:

Barnsley LSCB
Calderdale LSCB
Bristol LSCB
North Yorkshire LSCB
Leeds Youth Offending Team
Leeds Partnership Foundation Trust
Bradford Safeguarding Board
Wakefield Turning Point
Wakefield District Housing
Leeds PCT
East Riding PCT

- 1.4.3 The Overview Panel also made the decision to offer the parents of Child Y the opportunity to contribute to the Serious Case Review. The Overview Panel also decided that it would be appropriate to offer Child Y's adult sister the opportunity to contribute to the Serious Case Review given her primary role in supporting the family both before and after the serious child care incident that led to the Serious Case Review.

- 1.4.4 In relation to the possibility, referred to in the Terms of Reference for the Serious Case Review, that Child Y and his siblings may wish to contribute to the Serious Case Review, this was discussed with Child Y's adult sister who is currently their full-time carer..

2 CONTRIBUTION TO THE SERIOUS CASE REVIEW FROM FAMILY MEMBERS

- 2.1 Child Y's mother and Child Y's father agreed to contribute to the Serious Case Review. They indicated that they were not aware of any significant concerns held by agencies in the past about the welfare of their children. They did not view such concerns as justified. Therefore they would not share the overall findings of the Serious Case Review that agencies should have acted more swiftly and decisively to protect the children.
- 2.2 In summary, Child Y's adult sister and her partner felt strongly that Child Y and his siblings had been failed by the professionals who should have taken action to protect them at various key times during the period under review.
- 2.3 Discussion was held with Child Y's adult sister about the possible contribution of Child Y and his two siblings to the Serious Case Review. Subsequently, the children declined this offer.

3 ANALYSIS OF AGENCY INTERVENTION WITH THE FAMILY

- 3.1 Child Y is a white, British male, and the second oldest of three siblings. Throughout the period of this Serious Case Review, he has been looked after by his birth parents.
- 3.2 It is evident that Child Y's family have lived a very unsettled life, characterised by a high level of mobility both within individual local authority areas, and

between three specific local authority areas in Yorkshire (Wakefield, Leeds and East Riding). Until their final move back to the Wakefield area in 2006, the family had rarely stayed in one place, or at one address, for any significant period of time. During the period under review, the family are known to have had at least twenty separate addresses. In addition, there are additional, very numerous occasions when the family had no specific address of their own, and were staying with a variety of friends and family members across the Yorkshire region.

- 3.3 It is known that from an early stage in his life, Child Y's parents did not engage or co-operate with universal services for children. As a result, there is a long history of failed routine medical appointments. Similarly, there is also a long history of very poor school attendance. This has been exacerbated by the instability caused by the family's frequent changes of address.
- 3.4 Concerns about the welfare of Child Y and his siblings have been present since 1996, the year of Child Y's birth. Social care agencies in Wakefield, Leeds and East Riding have received numerous referrals at different times, from both members of the public and professionals, expressing concern about various aspects of neglect and parenting capacity. This has included concerns about poor home conditions, levels of hygiene, lack of stimulation etc.
- 3.5 In addition, there have been concerns raised in relation to domestic abuse between the parents, mental health problems of the parents, parental alcohol and substance misuse and contact between the family and people thought to pose a risk of sexual harm to children.
- 3.6 As a result of these concerns, it is now evident that Child Y and his siblings have experienced prolonged neglect in relation to the meeting of their social, educational and health needs. It is also possible that Child Y has suffered physical abuse, and all the children are highly likely to have suffered additional emotional harm as a result of parental domestic abuse and other behaviours not conducive to adequate parenting. It is also known that at least for one short period of time, the children were in contact with an adult who posed a potential risk of sexual harm. It is now evident that the children of this family have suffered significant harm that warranted clear and decisive action by agencies to protect them.
- 3.7 Despite multiple and prolonged agency involvement in three separate areas, Child Y and his siblings have never been the subject of decisive agency action to protect them from harm. At no stage have they been made subject to a Child Protection Plan. The Serious Case Review has also found that on several occasions, the level of concern held by professional agencies had reached a stage where plans have been made to remove the children from the care of their parents. However these planned actions were never been implemented.
- 3.8 It is evident that the family's tendency to rapidly move between areas, often only staying for a short time, and usually not informing professionals of where they were going, has created a significant challenge for agencies in trying to keep track of the family, and to implement a plan of support or protection based on an assessment of the children's needs.

- 3.9 It is also now evident that at times, the family have deliberately moved between areas in order to avoid the attentions of professionals within agencies such as social care and the police.
- 3.10 Concerns raised by the public and professionals, and referred to social care agencies in the three local authority areas, have not always been fully investigated. Sometimes, this has been as a result of the agency's inability to locate the family. However at times, the process of assessment has been affected by delay and a difficulty in developing a clear picture of the risk to the children that could be used as a basis on which to plan intervention. At times, referrals from the public or professionals have resulted in only minimal attention, without formal assessment of the concerns raised. Some assessments have been undertaken, and decisions made, without the benefit of full consultation with all relevant professionals, and on the majority of occasions, without the children themselves actually being seen and interviewed.
- 3.11 During the period under review, a number of specific referrals related to the risk of physical or sexual harm have not been investigated thoroughly. Again, the tendency of the family to successfully evade action by moving to a different area has clearly hampered the ability of agencies to mount a thorough investigation.
- 3.12 In addition, when concerns were investigated by agencies in one area, and plans made accordingly, these plans appear to have been lost when the family eventually reappeared in a different area.
- 3.13 It is evident that agencies involved in the case have been unable to carry out actions agreed by their counterparts in a different area, and have often simply begun the process of assessment again, without giving full weight to the cumulative history. This is now referred to as "start again syndrome" and is evident in this case.
- 3.14 The family's tendency to move frequently has also impacted on the ability of professionals within health and education to build up a clear picture of the level of concern. As a result, the cumulative picture of concern growing over a long period of time has not been clearly identified.
- 3.15 As well as these concerns, the Serious Case Review has also identified areas of good practice by professionals. For example, despite the challenges, both health and educational professionals have managed to ensure that records relating to the family have been transferred when the family have moved. In addition, professionals in both settings across the three regions have been persistent in attempting to engage with the family, and diligent in expressing their concerns in a clear and appropriate way to the relevant social care department.
- 3.16 Latterly, Child Y and his siblings were provided with support in specific relation to their role as young carers for their disabled father. These services have been sensitive to the needs of the children, and have been entirely appropriate.

4 KEY THEMES ARISING FROM THIS SERIOUS CASE REVIEW

Working with Highly Mobile Families

- 4.1 This family led a highly chaotic lifestyle characterised by a high degree of instability in terms of their living arrangements. There have been in excess of twenty changes of permanent address, both within, and between local authority areas. In addition, there are numerous periods where the family had no address of their own, and were staying with friends or family across West Yorkshire. The family have rarely communicated their intentions to move, or their whereabouts, to professionals, and as a result there has been uncertainty among professionals as to where the family was living. This has evidently had a huge impact on the ability of professionals to intervene effectively.
- 4.2 On a number of occasions this family used changes of address as a deliberate means of avoiding professional intervention or action. Unfortunately they were able to achieve this because the communication of concern and coordination of action between local authorities was not sufficiently robust to ensure that plans were implemented regardless of the family's mobility and attempts to evade professional scrutiny
- 4.3 As a result of this key theme emerging, the Serious Case Review has made recommendations for agencies and LSCBs involved in the case, in an effort to ensure that the challenges created by this type of family lifestyle can be overcome more effectively in the future.

Thresholds for Intervention by Agencies

- 4.4 The issue of thresholds for intervention is a recurring theme in Serious Case Reviews. This Serious Case Review has also identified this theme, specifically in relation to the three social care departments involved in the case.
- 4.5 As a result, several recommendations have been made for agencies and LSCBs in relation to this particular issue.

“Start Again Syndrome”

- 4.6 The Serious Case Review has identified the presence of “Start Again Syndrome” in the practice of agencies undertaking assessments on the family of Child Y.
- 4.7 Specifically this relates to the number of occasions when incidents or concerns were treated as “new” and were the subject of fresh, *Initial Assessments*, without giving full weight to the historical context of past concern. Without full understanding of the past history, workers were unable to form an accurate opinion of the risk to the children in the present.
- 4.8 Start Again Syndrome in this case has evidently been promoted by the number of changes of address for the family, which resulted in frequent changes of worker, each with a tendency to *start again*.

The Challenge of Working with Long-term Neglect

- 4.9 Although at times, there were a number of critical incidents involving allegations of abuse that should have been responded to more effectively, a key feature of the case is the prolonged neglect of the children's needs, over a period of years. This neglect has in large measure arisen from the inadequacies and lifestyles of the parents.
- 4.10 Despite this, agencies did not at any stage, and despite a compelling accumulation of evidence, use multi-agency assessment or planning processes to formally identify patterns of neglect and take action needed to safeguard the children. As a consequence there was never an agreed, formal multi-agency plan within which the agencies could provide safeguards for the children and coordinated assistance to the family.
- 4.11 Within the case, there are a number of additional features that should have acted as possible indicators of neglect, and which should have triggered more co-ordinated action, including multi-agency discussion, at several key stages. These include frequent admissions to hospital, missed routine health appointments and a long record of very poor school attendance.
- 4.12 As a result, recommendations have been made for agencies and LSCBs in relation to the specific issue of neglect. This includes the need for additional staff training, the requirement to use chronologies as a means of tracking concern etc.

The Need to See and Listen to the Child

- 4.13 Although the need to see, and listen to, the child when undertaking assessments is a key principle in modern social work practice, and a key feature of several recent, high profile cases where children died as a result of abuse or neglect, it is evident that in this case, numerous decisions were made without the benefit of information arrived at through seeing, and speaking to, the children.
- 4.14 The family of Child Y were subject to a high number of assessments by social work staff. However, the children were rarely seen or interviewed during these assessments, and therefore an opportunity to gain information was lost.
- 4.15 On one occasion Child Y was interviewed during the process of assessment, however by this time, the assessment had already been completed. Additional information provided by Child Y during this interview did not lead to a review of the assessment findings, or further investigation.
- 4.16 This represents a failing in the practice of individual staff, and the managers overseeing their work. It may also represent a failure in these departments clearly communicating the need to see the child to front-line staff. As a result, specific recommendations have been made about how the social care departments involved in this case should ensure that in future, children are always seen, and their views listened to, during assessment.

Quality of Assessments

- 4.17 The quality of the assessments undertaken by all three social care departments was at times poor in terms of their providing a clear assessment of the level of risk, and a clear plan of action to address that risk. In addition, different agencies within health and education did, at varying stages, fail to use the available, cumulative information to make an assessment of the needs of the children that could have led to further action to protect.
- 4.18 It is recognised that guidance such as Working Together to Safeguard Children, The Framework for Assessment of Children in Need and the Common Assessment Framework have all had a positive impact, and as a result, the quality of assessments has already improved. However the Serious Case Review makes a number of recommendations have been made for agencies and LSCBs in relation to the need to improve the quality of assessment.

Termination of Intervention by Professionals

- 4.19 Throughout the period under review, agencies have struggled to deal effectively with the family's lack of co-operation with support offered to them on a voluntary basis. As a result, they have sometimes withdrawn support services leaving the children with less professional supervision and therefore more vulnerable. Withdrawal of service has typically been the result of unilateral decision within the agencies without recourse to multi-agency discussion.
- 4.20 Recommendations have been made in the Serious Case Review aimed at ensuring that when terminating involvement, this is done in full consultation with family members and professionals, to ensure that the decision is taken in the light of full information, and in a way that does not leave the children vulnerable to harm.

Management Oversight and Supervision

- 4.21 Within the social care agencies, there has been evident lack of oversight and leadership by managers in relation to this case. As a result, individual social workers were left without clear plans. By virtue of their responsibility for the supervision of staff, managers play a key role in monitoring the work of the social workers under their line-management. In this case a greater level of management oversight and supervision could have led to a clearer and more accurate assessment of risk, and to more decisive action being taken to intervene and protect the children.
- 4.22 The need for work at all levels to be regularly reviewed and scrutinised by more senior people, to provide a strong quality assurance role, is a key theme of this Serious Case Review and as a result, a number of recommendations have been made in this respect, in relation to how agencies should implement such systems in the future.

Case Recording and Use of Chronologies

- 4.23 The process of producing Individual Management Reviews for this Serious Case Review, and providing an analysis and explanation of certain key events, has sometimes been made more difficult by an absence of clear case records. However, as well as impacting on the process of Serious Case

Review, poor or missing case recording can also have a strong impact on safeguarding practice, enabling different workers to understand the case, and enabling concerns to be reflected and recorded. Therefore case recording itself can have a significant influence on the decision-making practice and therefore, on agencies' effectiveness in safeguarding children. There are clear lessons to be learned by all agencies in relation to this matter.

- 4.24 It is evident for all three Local Authorities that during the period under review, use of chronologies, which would have supported the assessment and decision making process, was not common or consistent. Again, there is a clear lesson here for agencies in the future, if the use of chronologies is not more widespread.
- 4.25 It is acknowledged that several agencies have provided evidence to the Serious Case Review of how their recording practices have improved in recent years, and how chronologies are now a routine practice. However, as a result of this Serious Case Review identifying the themes of case recording and chronologies, several specific recommendations have been made for agencies, to ensure that improvements continue to be made in the future.

Timeliness of Assessment

- 4.26 On a number of occasions, social care departments in all three areas responded quickly, and within timescales when acting on referrals received in relation to Child Y. However the Serious Case Review has also highlighted failings at different times in all three local authorities in relation to both the quality, and timeliness, of assessments.
- 4.27 In both Wakefield and Leeds, there is clear evidence that on occasions, assessments have not been completed within the required timescale. In some cases, the delay is considerable, and this has contributed to the lack of action identified elsewhere in this report.
- 4.28 It is acknowledged that the Framework for Assessment of Children in Need has resulted in improved performance in relation to assessment timescales since some of the events recorded in this Serious Case Review. However, despite this, recommendations have still been made aimed at ensuring that agencies and LSCBs involved in this case are able to improve their ability to undertake assessment, and hence, deliver services, in a more timely manner.

Multi-Agency Partnership Working and Communication

- 4.29 In order to protect children from harm, agencies must work together in an effective manner, and must share information as well as discuss and plan jointly. In this case, there were significant failings in partnership working. This Serious Case Review has identified occasions in which inter-agency partnership working was weak in several areas:
- This family moved between local authority areas with great frequency, and recommendations have been made as to how the challenges created by this kind of lifestyle can be managed more effectively in the future.
 - On several occasions, decisions were made by a single agency without full consultation with partner agencies who knew the family. As a result, decisions were made in isolation and without a full grasp of the information available.

Although it is recognised that the provision of statutory guidance such as Working Together to Safeguard Children and the Framework for Assessment of Children in Need has caused agencies to strengthen their practice when assessing families, in respect of the need to fully incorporate the views of all agencies, together with the views of the family and the children, a number of recommendations have been made to ensure that the agencies concerned are able to strengthen their practice in the future.

Early Intervention through the Common Assessment Framework

- 4.30 The Serious Case Review has found that during the latter period in Wakefield, leading up to the incident in which Child Y sustained his injuries, agencies involved in supporting him and his family developed concerns in relation to the support needs of the whole family e.g. in relation to the children's role as carers for their disabled father. As a result, use of the Common Assessment Framework, to undertake a multi-agency assessment or convene a multi-agency meeting, would have helped these agencies to develop a clearer understanding of the concerns, may have helped to identify additional concerns, and could have led to provision of a more co-ordinated, multi-agency plan to address these issues..

Issues of Ethnicity, Language and Cultural Diversity

- 4.31 Child Y, his parents and siblings are all of white/British background and speak English. Although the question of culture, language and ethnicity has been considered, no themes or issues have been raised during the Serious Case Review. The family's chaotic lifestyle in relation to their many changes of address is not felt to be related to any cultural issue or beliefs.

5 RECOMMENDATIONS FOR AGENCIES

The analysis of the information provided for this Serious Case Review and the analysis of key themes emerging from the review have been translated into recommendations for action by each agency involved in the case of JN and his siblings. It will be the responsibility of the LSCB in each area to closely and rigorously monitor the implementation of the recommended actions, in accordance with the timescales that are agreed.

Wakefield, Leeds and East Riding Local Safeguarding Children Boards

- 5.1 In conjunction with LSCBs across the region, to develop an effective cross-boundary protocol for case transfers in ongoing child protection investigations or cases where there are significant concerns.
- 5.2 To review multi-agency training provision training to fully reflect the learning from this Serious Case Review.
- 5.3 Wakefield and District Safeguarding Children Board should provide multi-agency training specifically in relation to the issues of long-term neglect and assessment of risk.
- 5.4 WMDC Family Services have provided evidence of their recent work on thresholds for social care intervention, informed by the findings of their Individual Management Review. The Wakefield and District Safeguarding

Children Board's Quality and Review Sub-Committee should monitor the multi-agency implementation of the outcomes of this work.

- 5.5 All three LSCBs should review multi-agency safeguarding procedures in the light of this Serious Case Review.

WMDC Family Services - Safeguarding and Family Support Directorate

- 5.6 Wakefield Safeguarding and Family Support Directorate should issue new guidance to staff on the following requirements:

- The need for chronologies on all case files
- The need to see the child and record their views
- The need to consulting other agencies before making decisions
- The need to automatically inform the new authority when a family in receipt of a service move to another district.

- 5.7 Wakefield Family Services should improve the implementation of the CAF within Local Authority education settings, by provision of additional resources in relation to co-ordination, training and awareness raising.

- 5.8 Wakefield Safeguarding and Family Support Directorate should ensure that managers are compliant with the requirement to audit all case files on a regular basis, and for this audit process to be recorded on file and with the requirement for managers to authorise (and to record this authorisation) the closure of all case files or referrals.

- 5.9 Wakefield Family Services should also undertake regular audits of case recording and staff supervision within Local Authority education settings.

- 5.10 The Safeguarding and Family Support Directorate should review its training provision for front-line staff, particularly in relation to the specific challenges faced in this case. The review should consider which courses should be made mandatory for key staff.

East Riding Children's Social Care

- 5.11 There will be further training for Children's Social Care staff, including managers with decision making responsibilities, regarding the effective implementation of the revised East Riding Safeguarding Children Board (ERSCB) threshold guidance.

- 5.12 East Riding Children's Social Care and Humberside Police decision makers will, together with the ERSCB, review the interface between section 17 and 47 investigations, including the agreement and implementation of a joint information sharing and decision making protocol in respect of child protection referrals.

- 5.13 Children's Social Care decision makers will be reminded they must be satisfied and check, that assessments have been appropriately updated and

actions taken to address identified needs before signing off referrals which raise safeguarding concerns.

- 5.14 The current joint Children's Social Care and ERSCB Quality Assurance in Assessment training for Managers and Senior Social Workers now being rolled out to all social workers will include the lessons learnt from this review.
- 5.15 A model of multi agency meetings is being introduced when cases are transferred between Family Support Services or Child Care Services after either an initial or core assessment.
- 5.16 When carrying out a child protection investigation, assessment staff must ensure that they make a joint visit with colleagues from a Family Support Service if the case has already been allocated to them. Any exception must be recorded, including the reasons why.
- 5.17 Children's Social Care records must have live chronologies and records will be regularly audited by line managers and senior managers to ensure compliance.
- 5.18 When referring or transferring family records between local authorities this must be undertaken in writing on a manager to manager basis. The timing of the referral or transfer must reflect the perceived urgency, identify any current safeguarding concerns and include the necessary information or recommendations to assist the receiving authority make its own decision e.g. a chronology and transfer summary.
- 5.19 Children's Social Care will seek clarification from the Benefits Agency regarding what information is available and how it might be accessed when children and or their families are thought to be "missing" and there are safeguarding concerns.
- 5.20 Where appropriate individual feedback on the lessons learned to staff still working within the East Riding children's social care department who were involved in this case including any actions for their professional development and training needs.

Leeds Children and Young People's Social Care

- 5.21 The Chief Officer, Children & Young People's Social Care will ensure that management oversight of cases is clearly recorded, including key decisions relating to the closure and transfer of cases.
- 5.22 The Chief Officer, Children & Young People's Social Care will ensure that case chronologies are maintained in line with guidance.
- 5.23 The Chief Officer, Children & Young People's Social Care will ensure that assessments and ongoing work include the wishes and feelings of children and young people.
- 5.24 The Chief Officer, Children & Young People's Social Care will ensure that consideration is given to establishing a system for tracking vulnerable children and young people living in families who frequently move within the city, in order to ensure child protection procedures are initiated as appropriate

- 5.25 The Chief Officer, Children & Young People's Social Care will ensure that Social Work case recording is both accurate and of high quality and that this be achieved through compliance with the Integrated Children's System.

Humberside Police

- 5.26 Humberside Police will ensure that when requests are made by Children's Social Care for their staff to check their records on grounds of child welfare and those checks identify that a person having contact is a known risk to children, immediate joint Police / Children's Social Care action should be taken to ensure they are safeguarded.
- 5.27 Senior Managers within Humberside Police need to ensure that all front line staff are aware of the risk factors associated with child protection and their statutory duty in safeguarding children.

Leeds Teaching Hospitals Trust

- 5.28 The Named Nurse for Safeguarding Children in Leeds Teaching Hospitals Trust will review assessment processes in A&E of children admitted for care.
- 5.29 The Named Nurse for Safeguarding Children in Leeds Teaching Hospitals Trust will initiate awareness sessions for staff around the need for holistic assessment of children who present with severe dental problems.
- 5.30 The Named Nurse for Safeguarding Children in Leeds Teaching Hospitals Trust will ensure that the need for holistic assessments will be written into all updates of training for the trust.

Wakefield Health Community

- 5.31 Mid Yorkshire Hospitals NHS Trust and NHS Wakefield District should review their policies in relation to families who do not engage with health services in relation to their children. Revised policy should be launched across the health sector, with emphasis on the need to identify and manage risk to children arising from disengagement.
- 5.32 All Health Trusts to review the way in which information relating to families of concern who move across boundaries is shared.
- 5.33 NHS Wakefield District should undertake review the processes by which families are removed from GP lists.
- 5.34 CAMHS in Wakefield should review how best they can support children, young people and families who do not engage with services. They should develop protocols in line with the wider policy on disengagement. Emphasis should be placed on the need to identify risk to the child arising from this disengagement.

Wakefield Barnardo's Young Carers Service

- 5.35 The service should ensure that all front-line project workers have received training in the CAF, and are therefore able to identify when a CAF Assessment should be undertaken and how, and when a CAF Meeting should be held.

- 5.36 Actions agreed in supervision should be recorded in the service users' electronic file there should be a check in the following supervision session to ensure that agreed actions have been completed and this should also be recorded on the file.
- 5.37 All case-related meetings should be minuted, and actions agreed should be recorded in the service users' electronic file by the agreed person.
- 5.38 Electronic records should be flagged by the Project Worker using the Child Protection Alert to show where there is a safeguarding children concern. This will allow easy identification of concerns and enables a referral to Family Services to be considered when a pattern becomes apparent.
- 5.39 All staff should follow the agreed procedure for referring a case to Family Services as soon as child protection concerns are identified. In the event of uncertainty about whether a referral should be made, advice will be sought from Family Services, and this should **always** be recorded on file.
- 5.40 At every supervision session, supervisors will explore and reflect upon the possible underlying causes of behaviour to identify concerns and potential safeguarding children situations. These discussions will be recorded in the supervision file and any actions will be recorded in the case-file.

Wakefield Targeted Youth Support – (Formerly YIST Service)

- 5.41 The TYS team manager should devise and implement a quality assurance tool for managing the quality of the assessments through supervision sessions with staff.
- 5.42 The YIST team should ensure that they fully record involvement with **all** family members.