



GS Serious Case Review

What happened?

This Review involves a British young person in public care to Sandwell Children Services. Their early childhood history is characterised by an attachment disorder with mother, few boundaries, neglect and a witness of domestic violence between parents.

During their time in care they experienced 19 moves of placement and five changes of social worker. Their emotional immaturity and vulnerability led them to run away from home, care and school during which they were sexually exploited by a number of men. Emotional distress led to several suicide attempts and to regular self-harm. Several suicide attempts were made, the last of which resulted in attempted strangulation whilst in a care facility.

What can we do now?

Listening to the voice of the child and embedding culture and relationship

What is your understanding of a 'healthy relationship' and how do you support young people in achieving this?

How do you ensure cultural competence is implemented in your practice?

How do you evidence the voice of the child?

Multi-agency approach and response to CSE

Are you confident in recognising CSE and how to refer cases appropriately?

How do you share information with other agencies and Authorities around CSE?

How do you know your approach is working?

Do you challenge inappropriate views to CSE?

The Effectiveness of Health Interventions

How are your contributions to health assessments effective?

When working with other Authorities, how do you ensure that information is shared appropriately?

Do you feel you are equipped sufficiently to deal with situations that may arise in your practice such as suicide prevention?

Care Planning, placements and transition

Are you aware of the Corporate Parenting Board and their responsibilities?

How do you know that the available services and resources are effectively being used?

How confident are you that your information sharing is as robust as it should be?

When do you risk assess during placement moves?

What did it tell us?

- The Review finds that the multi-agency response to sexual exploitation was patchy and inconsistent. There is evidence that although the young person's views were sought, they were not acted upon. Supervision of the social workers was also poor with little evidence of good transfers .
- Statutory Reviews were held in timescale, but were not based on a Core Assessment of need and did not always consider attempts at self-harming which meant that placements were not always suitable.
- Whilst many health professionals were involved, information sharing between primary care, specialist services and Children Services was poor with little consideration of the impact of sexual exploitation.
- Missing from care and school episodes were not reported to the Virtual school leading to a fragmented approach.

If in doubt ask for advice from your manager, safeguarding lead or Sandwell Safeguarding Business Unit on 0121 569 4800