NYSCP Learning Review:

Following the arrest and conviction of two young people for serious offences within North Yorkshire

Briefing paper - August 2020

Overview from the North Yorkshire Safeguarding Children Partnership (NYSCP) Independent Chair and Scrutineer

Maggie Atkinson

Chair of NYSCP Executive and Independent Scrutineer

"It is vital that we seek feedback from, reflect and learn from those most closely affected by serious events involving children, young people and their families. This review is a crucial illustration of that need. The impact of the circumstances surrounding this case were serious and long lasting, in particular for a number of young people and their families. The impact of this case was also felt by professionals involved from many services in North Yorkshire and those services have been closely involved and worked and continue to work together to ensure lessons are both learned, and applied.

In my role as former North Yorkshire Safeguarding Children Board Chair and now the North Yorkshire Safeguarding Children Partnership Executive Chair and Independent Scrutineer I have had detailed oversight of the findings of the review and recommendations and have regularly received information about the work being undertaken by services and agencies concerned with this tragic and complex case.

By law, I must seek concrete and detailed assurance that such work is completed appropriately, professionally and sensitively. In relation to this case, I can confirm that I am assured of this I am also clear that the findings and recommendations in relation to the review of this case have been and continue to be acted upon in order to strengthen existing professional practice."

Background:

This learning review briefing relates to an NYSCP Learning Review undertaken in relation to information reported to services and incidents leading up to the arrest, charge and subsequent conviction, of two young people for serious offences in the Hambleton and Richmondshire District of North Yorkshire during 2017/18. The circumstances surrounding this case are, thankfully, rare, not only for North Yorkshire, but nationally. The management of the case was complex in nature and involved multiple services and organisations.

Since the arrests of the two young people in October 2017, the circumstances of the case have been subject of regular oversight by the NYSCP Executive Chair and Independent Scrutineer and the NYSCP Executive Members Group. Whilst the case did not fit the criteria for a Serious Case Review, the NYSCP Executive determined that an NYSCP Learning Review should be undertaken.

The subsequent Learning Review focused on the identification of any partnership learning relating to multi-agency information sharing and responses to the reported incidents, on the lead up to and prior to the arrest of the young people involved. A number of strategic and operational leads who were involved in the case management have been involved in the review process and have contributed to the learning. This included representatives from the North East Counter Terrorism Unit (NECTU) who facilitated one of the events. The Learning Review process additionally supported practitioners to reflect on the case, with a focus on learning and practice improvement and also considered how services and organisations worked together. Information provided by some of those closely affected by the case contributed to the learning review process.

The Learning Review findings identified and acknowledged that much has changed since 2017 in relation to strategic and operational working practice. The below recommendations stem from the learning from the specific case, and as such, may have been surpassed with changes that were already on-going and/or have been subsequently implemented.

The full NYSCP Learning Review Report contains highly sensitive and personal information, including relating to the young people involved. Due to the particular circumstances of the case, some of those involved would be identifiable and the ongoing welfare of children, young people and families is a key consideration in any decisions around publication. As such, the full report will not be published. However, the key recommendations, overview of action taken to date and next steps, are outlined below.

Recommendations and Overview of Action Taken to Date:

As outlined above, the NYSCP Executive Group have overseen the review process and have received regular updates from the Author in relation to the progress of the review and recommendations. As a result, a number of changes have already been made to partnership and single agency procedures and practice. Further, changes in practice have taken place as a result of work that was already underway prior to the Learning Review or subsequently through the work of the NYSCP arrangements.

Outlined below are the 11 recommendations the review identified, together with an update in terms of action taken.

No	Recommendation	Action
1	Front line professionals working with or engaging with children and families need to deliver early help and support families to access appropriate services in line with the NYSCP Early Help Strategy.	Prior to this case, work had already commenced in relation to reviewing the early help offer across North Yorkshire. Subsequently, the new NYSCP Early Help Strategy (October 2019) and Ladder of Intervention (September 2019) has been launched across the partnership. This has significantly strengthened early help arrangements and clearly outlines the roles and responsibilities of professionals to support families and ensure that they can access the appropriate services, at the right time. The new Early Help Strategy is subject of regular review through the work of the NYSCP arrangements, in particular through the NYSCP Learning and Improvement and Practice Development Sub Groups.
2	NYSCP is undertaking work to reinforce understanding of thresholds and this includes on-going work relating to introducing new guidance This work should include the risks young people may pose to third parties (named or un-named), criminal acts either committed or threatened to be committed and should be concluded with the new guidance published as a priority. The new guidance needs to be subject of launch to ensure understanding amongst professionals is maximised.	NYSCP are in the process of writing a new threshold document which will be launched during 2020. The work in relation to this was temporarily put on hold due to the requirement to respond to Covid 19, however, work has re-commenced. A draft threshold document has been prepared and will be subject of consultation across partners. The new document includes contemporary guidance on contextual safeguarding (experiences of harm outside of the home, for example with peers, in schools and in communities) and the arrangements in place to manage contextual safeguarding concerns. Prior to the learning review, work was already underway within the Multi Agency Screening Team (MAST) to enhance existing referral screening procedures in relation to the identification of threats children and young people may pose to others. Where appropriate, such contextual safeguarding cases would now be progressed into relevant multi-agency screening arrangements. A review of a number of subsequent cases has

		identified that robust arrangements are now in place to identify threat, harm and risk where information indicates similar reported concerns.
3	The NYSCP Child Protection procedures should be updated to include a section regarding front line practitioner's responsibilities to identify and appropriately act on receipt of safeguarding concerns as outlined at Recommendation 2 above. This includes the need for heightened awareness, by professionals, to any additional vulnerabilities that may make a child or young person susceptible to/or at increased risk of harmful situations or associations. Further, practitioners should then be reminded of their responsibility to follow cases up with the MAST where there are repeat referrals and/or cases that require an urgent response.	NYSCP Child Protection Procedures have been updated (2019) and additional information has been included in relation to contextual safeguarding and the detail required when making a referral. The new procedures highlight the need for professionals to make contact by phone with the MAST in urgent cases. Further work has been undertaken through the work of the NYSCP Practice Development and Learning and Improvement Sub Groups to ensure that all organisations are also aware of the escalation procedure. As per recommendation 2 above, the MAST referral screening procedures have been refreshed and updated.
4	All schools across North Yorkshire should be reminded of their responsibility to ensure that they must have robust procedures and operational practice in place to tackle bullying and support victims effectively. Professionals have a responsibility to challenge and share concerns with the school, and if necessary the Local Authority, where they have evidence of lack of appropriate action being taken	As per Recommendation 1 above, work has been undertaken with educational settings across North Yorkshire, through the launch of the NYSCP Early Help Strategy and Ladder of Intervention. NYSCP and NYCC have overseen the development, implementation, launch and progress of this through the NYSCP Executive, Sub Groups and the Education Reference Groups. As per Recommendation 3 above, through the work of the NYSCP Sub Groups all organisations have been reminded of the escalation procedure. The 2020 Growing Up in North Yorkshire Survey has been postponed until the Autumn 2020 term (due to Covid 19) however it will enable ongoing tracking of the extent to which children and young people think their school takes bullying seriously, nature and scale of incidents to inform training and targeted work with schools. Hate incident reporting has been included in the NYSCP sample child protection policy template to ensure that all schools follow the guidance and procedures should incidents arise.

5	The NYSCP Complex Case Procedures to be revised to include a section in relation to the inclusion of the management of cases involving complex and/or organised threat, harm and risk posed by children and young people to third parties. The revised procedures need to be subject of communication to all NYSCP organisations. The NYP and NYCC MAST leads to revise guidance to MAST staff to ensure that all staff are aware of the need to consider the criteria for Complex Case Procedures and the escalation of cases for consideration.	NYSCP Complex Case Procedures have been re-written and will be re-published by October 2020. The new updated version includes a specific section in relation to the threat, harm and risk children and young people may pose to others. As per Recommendation 2 above, the MAST ensure early identification of complex contextual issues and, where relevant, these are escalated following the NYSCP Complex Case Procedures to the appropriate senior management level for consideration of instigation of Complex Case oversight. Subsequent to the reporting of this case, there have been several examples of cases being identified, escalated appropriately and the instigation of Complex Case Procedures. This way of working has now been recognised and established as good working practice, across the partnership.
6	NYSCP together with North Yorkshire and City of York JCG to devise additional guidance to professionals regarding the identification and management of abusive, coercive and controlling relationships/associations between children and young people under 16 years. This should include appropriate use of terminology.	The work in relation to this action needs to be progressed through to the North Yorkshire and City of York Joint Co-ordinating Group (JCG) for Domestic Abuse. However, within North Yorkshire, NYSCP have significantly strengthened the Multi-Agency Child Exploitation (MACE) arrangements and this includes our partnership response to contextual safeguarding. We have launched these changes across the North Yorkshire area by holding masterclasses and locality events and this is now embedded practice. As per recommendation 2 above, the MAST referral screening procedures have been refreshed and updated.
7	All schools in North Yorkshire must abide by the partnerships agreed policies outlined within the NYSCP Early Help Strategy and its companion Policy, The Ladder of Intervention. This is to ensure as far as possible that vulnerable pupils who are at risk of exclusion, either fixed term or permanently, have their needs identified and have an appropriate support plan in place. NYSCP should seek assurance through data, performance and audit that these new strategies are being implemented and achieved.	As per updates in Recommendation 1 and 4 above, this is monitored through the work of the NYSCP Executive and Sub Groups. To support the aims of the Early Help Strategy and Ladder of Intervention, the Inclusion (Pupil Support) Pathway has been designed and implemented to enable a joined-up approach from Early Help and Locality Hubs to intervene earlier with all pupils (including the most vulnerable) to reduce fixed-term and permanent exclusions. Two separate (but connected) pathways support children and young people who are known and open to the Early Help, Social Care or Youth Justice teams and those who are not. A robust reporting system quickly identifies all pupils who have received a fixed term exclusion in the past week so that either Early Help or the Locality Hub workers can take appropriate action. Workers from all teams encourage and support

		schools to use the Early Help Strategy and Ladder of Intervention assessment and intervention processes. In addition to providing regular updates to the NYSCP and other stakeholder groups, NYCC have created a communications strategy (including a regular bulletin) to support schools to be more inclusive (and to answer frequently asked questions around inclusion and exclusion) and have also created a transparent process to identify the least inclusive schools (e.g. those with high fixed-term exclusion rates, etc.) in order to challenge improved inclusion and reduce exclusion rates. The Escalation Pathway and accompanying documentation will support Locality Hubs to work proactively with schools by offering a series of visits across an academic year to support school leaders to identify ways to improve inclusion and reduce exclusion rates. This process will be advertised to schools from September 2020.
8	All schools in North Yorkshire should be reminded of the need to have robust mechanisms in place to manage, monitor and report on inappropriate access to and use of the internet.	The NYSCP Section 11 Audit template for schools to complete will have a section included in relation to assessing their own arrangements in relation to this. The NYSCP sample child protection policy template issued for schools, NYCC Online Safety Guidance for Schools (updated annually) and within online safety training for schools also includes the requirement. This is also highlighted as a requirement in safeguarding training for Governors. Headteacher/Designated Safeguarding Leader networks have been introduced in 2019/20 which have provided an important opportunity for sharing new NYSCP procedures, guidance and sharing good practice.
9	NYSCP with the support of NYP and NYCC Head of Safer Communities to organise/facilitate development sessions with NECTU to strengthen and improve understanding of roles and responsibilities and operational practice within respective disciplines.	This action will be progressed through the NYSCP Learning and Improvement Sub Group.

10	NYSCP should consider utilising live-time, simulation and table top exercises to test critical incident response to safeguarding incidents (both office and out-of-hour capability).	This action will be progressed through the NYSCP Learning and Improvement Sub Group
11	The NYSCP MAST Procedures should provide clarity and guidance for the management of which cases are screened on a multi-agency basis (including management of linked cases). This is to then be approved by NYSCP and an audit of reassurance undertaken on an annual basis. This should include a review of capacity and ratio of resource within the MAST, in particular to strengthen information sharing and accessibility to databases across the health economy.	As per Recommendation 2 and 5 above, the MAST Procedures were updated and refreshed to include the specific learning from this review. As outlined earlier a review of subsequent cases involving similar threat and risk has identified that they were appropriately identified and managed. A review of capacity and ratio of MAST resource has been undertaken. The recommendation relating to the strengthening of information sharing and accessibility to databases across the health economy remains subject of on-going discussions relating to the potential addition of a mental health practitioner involvement within the MAST. In the interim, a pilot of Tees, Esk and Wear Valley (TEWV) Clinical Commissioning Group (CCG) resource supporting MAST decision making is on-going.

Next Steps:

Whilst much work has already taken place to strengthen arrangements across North Yorkshire, the outstanding and on-going recommendations and further action required in relation to this learning will now be managed through the NYSCP Learning and Improvement Group. The NYSCP Executive Chair and Independent Scrutineer and NYSCP Executive Group will continue to have oversight of the action plan until completion.