STRICTLY CONFIDENTIAL

KINGSTON LOCAL SAFEGUARDING CHILDREN BOARD

Executive Summary of

The SERIOUS CASE REVIEW relating to

Tom and Vic

Published October 2013

1 INTRODUCTION

1.1 Background to the review

The serious case review was held as a result of an incident in 2012 when Tom sustained potentially life-threatening injuries and Vic was also hurt. The dispute involved a third party; all three persons involved were considered as suspects and were arrested and in 2012 both Vic and Tom pleaded guilty. It was agreed at a meeting of the Serious Case Review Sub-Committee on 8th June 2012 that the criteria for a SCR had been met on the grounds that one of the subjects was Looked After by Kingston Children's Social Care at the time of the incident, the injuries sustained by both subjects were potentially life-threatening[1], and there had been intensive involvement by a number of agencies with both young men.

1.2 The Terms of Reference

The purpose of a serious case review as set out in 8.5 of 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 worked individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons were both within and between agencies, how and within what timescales they would be acted on, 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 time frame of the review was from January 2008 up until immediately prior to the incident that took place in 2012.

1.3 Review Process

Individual Management Review (IMR) reports were received from the following sources:

- Royal Borough of Kingston, Children's Social Care,
- Your Healthcare
- General Practitioners, Kingston
- Kingston Hospital Trust
- Epsom and St Helier University Hospitals NHS Trust
- Metropolitan Police Service
- Royal Borough of Kingston, Youth Offending Service
- Kingston & Richmond Joint Substance Misuse Service
- Royal Borough of Kingston, Learning and School Effectiveness Service,
- South West London & St George's Mental Health Trust

1.4 Family Input to the Review

Consideration was given to involving the parents and the young men in the review process and the independent overview author offered to meet with both young men

[1] P235 Working Together to Safeguard Children March 2010

and separately with their parents. In the event the author met with Vic and Tom's mothers and their views are recorded in the overview report. Vic did not feel he wished to meet with the author as following discussion with his mother he felt she had provided all relevant information. An appointment was made to meet with Tom however he went missing, at the time the report was being completed.

1.5 The Review Panel

The review group membership was as follows: -

- Paul Kerswell Independent Chair
- Metropolitan Police
- Education Services, Royal Borough of Kingston
- Youth Offending Service
- NHS Kingston - Designated Nurse, Child Protection
- Children's Social Care, Royal Borough of Kingston[2]
- School – Deputy Head teacher,
- KSCB Business Manager.

2 THE FACTS

2.1 This review is complex because it concerns two young men who have different life histories but who were injured whilst together, having previously engaged, jointly, in significant levels of anti-social behaviour. In the main the services provided to the young men were separate; and, whilst some agencies were aware of the connection between them, prior to the incident, there was no significant attempt at working with them together, and no linking of the two families. The overview report therefore provides separate accounts of the services provided to the young men and then identifies any joint themes or systemic concerns that emerged.

2.2 The Family Background - Tom

2.2.1 Tom is a young man of dual heritage. All his older siblings moved away from the family home in their teens. Tom was born in England and his first language is English.

2.3 The Family Background - Vic

2.3.1 Vic is also of dual heritage. Vic is one of two children living with their mother in England. Although Vic spoke English well he may have had some comprehension issues.

2.4 Agencies' Involvement with Tom and Vic

2.4.1 The Overview report examines in detail the different agencies separate and joint involvement with both young men and their families over the period from February 2008 to 2012. In summary the two young men became involved in criminal activity, separately and together, which resulted in them receiving custodial sentences and being placed in secure accommodation. Both young men did not attend formal

[2] There was no attendance at early panel meetings by Children's Social care however after representations were made via the Chair of the LSCB there was attendance from 22nd November 2012 onwards.

education for over a year. A wide range of support services were provided to the families, however there were some delays in these starting. Tom was also accommodated and placed in foster care. The two young men also went missing on a regular basis and much of their offending behaviour occurred whilst they were absent from their home addresses. They were also both subject to 'stop and search' by the police on a regular basis.

3 KEY THEMES IDENTIFIED BY THE REVIEW PROCESS

3.1 Agency focus on procedures not outcomes

3.1.1 A significant feature of this review was that although there were high levels of input by most agencies working with these two young men there was very little evidence of any positive outcomes being achieved. This may be considered to be a facet of working with adolescents who are notoriously difficult to engage with services and often resist all interventions however the question that must be raised is the degree to which there was any review by agencies of the effectiveness of their interventions and any consideration of outcomes achieved.

3.1.2 It is clear from the IMRs that most professionals were acting in accordance with their local procedures and were providing services in an appropriate manner. The exception to this would be CSC where it is clear that there were considerable limitations in the social work interventions as described in the IMR. It is interesting then to consider why, if professionals were operating in accordance with procedures and protocols, so little was achieved with the young people. In order to understand this contradiction analysis must go beyond exploring whether procedures were followed to consider whether the procedures were right in the first place.

3.1.3 An example of an intervention that required significant resources but which achieved little in terms of outcomes were the 'missing persons' processes'. Major efforts were made by a range of professionals to ensure that these young men were reported missing to the police; which then involved the police in considerable efforts in both tracing the young men, and then undertaking follow-up interviews most of which provided minimal, useful information. As the Police IMR identifies, with the exception of reports being sent to the wrong borough, the police almost always followed procedures and the missing person investigations were completed in accordance with protocols. This however is to ignore the probable purpose of the protocols which surely must be to prevent the recurrence of the young person going missing. When judged by those standards the effectiveness of the intervention is significantly reduced. Research undertaken with young people in care who run away identified three main reasons for children running away; '…running somewhere simply to have fun… running to somebody you want to be with… and running away from your placement because you cannot cope with things there…'[3]. Young people also said that sometimes young people were reported as missing when they had simply stayed out longer than they should or had gone somewhere without permission but intended to return. Many of Tom's missing episodes either fit the last category or were simply 'to have fun' yet there was no evidence that professionals considered whether this should influence the professional responses made to his actions. Clearly when Tom and Vic were subject to curfew arrangements there was a need for more formal

[3] Running away Young people's views on running away from care Reported by the Children's Rights Director for England Ofsted 2012

intervention however it is probable that this would have been better dealt with via breach protocol rather than the missing person procedures.

3.1.4 Similarly the YOT IMR also reports that in general the YOT work was in accordance with the National Standards for Youth Justice Services' minimum requirements and thus was acceptable practice. It is clear however that in terms of reducing criminal activity committed by these two young men the YOT interventions were far from successful. The IMR does suggest that YOT could reflect on whether their interventions with '…regards to the balance of engaging him [Vic] compared with the enforcement of further external controls to monitor him…' and also suggests that with regard to Tom '…a systemic team approach may have been beneficial within the integrated offender management system in order to review the plans and directions of the young people's systemic support. It is relevant that at the time although there was appropriate management oversight neither of these things were done. There was also very little attempt to bring together agencies (including police, CSC and education) to see if alternative interventions should be considered.

3.1.5 There were also very high levels of stop and search used by the police; all of which were deemed to be appropriate and in accordance with guidance. It is clear that these young men would generally meet the criteria accorded to the police for use of stop and search as clearly they did present on occasions a threat to the community and the safety of the public. The effectiveness of this intervention to prevent these young men from committing crimes is questionable and it is unclear what positive outcomes it achieved. It probably contributed to these young men having little confidence in the criminal justice system as a positive process that could protect them as well as controlling their actions; as witnessed by Vic's unwillingness to co-operate when a victim. Research has shown that 'stop and search' may have a negative impact on some individuals. "There is no compelling 'business case' for the present level of stop and search … it has a deeply damaging effect on society; it impacts negatively on the law abiding population and is cause of a loss of public support for and de-legitimation of the police. It increases the frequency of adversarial encounters – some of which have the potential to trigger public disorder – and contributes to accelerating the flow of young black people disproportionately into the criminal justice system"[4]. There was no consideration of using a multi-agency approach to address Vic's behaviour; in particular the MST could have worked more proactively with him to enable him to manage the situation in a better way if they had been more aware of the problems.

3.1.6 There was no evidence that agencies reviewed their work with these young men in terms of its effectiveness. In fact despite there being systems in place to measure many of these interventions, the level and number of 'stop and searches' and 'missing person incidents' did not appear to be known prior to this review being undertaken. It was certainly never shared across agencies and there was no attempt to consider across all the agencies working with the young people whether there could be more effective interventions to achieve better outcomes. Despite both young people being 'looked after' for periods of time and a range of agencies being involved there was no evidence that there was ever a discussion between the

[4] Race, Crime and Justice Bowling and Philips (2007: 959-60).

professionals involved about whether there were other ways in which these young men could be helped. In fact there did not seem to be any expectation that this could or should happen.

3.1.7 The issue of greatest concern is that the absence of this was not examined within the IMRs and there was limited consideration within those reports as to whether the expected interventions were useful or effective. Instead these reports are focussed on whether professionals operated in accordance with the procedures. There was 'A concern with doing things right versus a concern for doing the right thing.'[5] The challenge for Kingston LSCB is to consider how agencies can promote and develop a multi-agency professional mind-set that enables consideration of the effectiveness of interventions and uses outcomes not outputs as measures of their success.

3.2 Insufficient direct work with young people

3.2.1 Despite these young people being of an age when they were very capable of expressing their wishes and feelings the chronology shows low levels of direct contact with the young men. Furthermore those professionals that saw them most were possibly the people who had least capacity for achieving a meaningful relationship. The professionals who had most direct contact were the police however their intervention was often in a context that could be adversarial and there was little continuity so did not provide opportunity for building relationships.

3.2.2 The other agency in regular contact with both young men was YOT and these case workers did have some opportunity for developing more meaningful contact. It must be acknowledged however that these workers are in an ambiguous position as they are also holding the young people to account for their criminal activity and are able to breach them if they fail to act in accordance with the orders to which the young people are subject. This probably places some constraints on the trust that will be accorded and for Vic was made more difficult by a lack of continuity of case worker. There was some evidence of a YOT case worker trying to build relationships when she met with both young men together to try and develop the positive side of the relationship. This was not further developed and soon after Vic was placed in secure accommodation.

3.2.3 MST also did direct work with both young men with different levels of engagement and success. The MST IMR rightly identifies that their intervention with Tom was less successful and concludes that this was because he was in foster care most of the time and did not attend appointments with the MST staff. The work with Vic was more successful but was challenged by his remands into custody. One of the significant differences between these two interventions was the level of direct contact between the MST worker and the young person; Vic attended five sessions compared with Tom attending one, but also Vic was engaged earlier in the process which probably enabled him to feel he had some control and input over the process. A significant feature of positive engagement with young people is a '…willingness to listen and show empathy, reliability, taking action, respecting confidences, and viewing the child or young person as a whole person…'[6] It is possible that Tom considered the MST intervention was unfairly biased towards his mother as the bulk

[5] 14 Peter Drucker (1909-2005), writer, management consultant, and 'social ecologist' quoted in The Munro Review of Child Protection Part One: A Systems Analysis Professor Eileen Munro DfE 2010

[6] The Munro Review of Child Protection Interim Report: The Child's Journey Professor Eileen Munro DfE 2011

of the MST worker's time was spent with her. It is clear that the worker made attempts to understand Tom's perspective and the worker did meet with him alone however it is also evident that Tom did not consider that his parents were willing to accommodate his needs, which may be why, ultimately, the MST intervention failed.

3.2.4 An agency whose professionals should have had positive relationships with the young people was CSC; however it is noteworthy that these professionals had least contact with both young men despite them both being looked after and Tom in particular having been in foster care for almost eighteen months. In reality a lack of continuity in social workers and an absence of direct work being undertaken meant that Tom and Vic had minimal relations with their social workers. This was particularly unfortunate as they should have been the professionals who could have provided the young men with advocacy and support at points of crisis. 'Elements of frontline practice that children and young people particularly valued were access to consistent help from the same social worker, to respectful treatment and to services which do not get withdrawn as soon as the crisis is passed.'[7] The other person who did develop a positive relationship with Tom is his foster carer and it is positive that this placement was maintained which did enable this relationship to continue. The lack of continuity of social worker probably made it difficult for the foster carer to intervene purposefully on Tom's behalf.

3.2.5 The absence of any truly effective relationship-based practice with these young men contributed to their increasing alienation from the system of supports supposed to assist them. Whilst it is probable that much of their offending behaviour may still have occurred the chance to positively intervene was absent whilst there was no professional who had fully engaged with them. It may have also contributed to the lack of co-ordination of service delivery which is considered later in this report.

3.3 No timely response to provide services

3.3.1 Another facet of the services provided to these young men was the slow pace of service delivery which meant that often they were no longer willing or able to engage with options that had been discussed with them. It must be noted that some services did respond rapidly most notably the SMS who provided Vic with an appointment on the same day that his mother accessed the service, but also the police who generally visited in a timely manner.

3.3.2 A stark contrast was the provision of education by the Local Authority. There were delays in the provision of educational options and a failure to engage either young man in educational provision meaning that both Vic and Tom effectively did not attend formal education for almost two school years. This was particularly apparent when reviewing the arrangements for Vic's education. He ceased attending the Specialist Academy in January and alternative educational provision was not provided for him until November. Initially his mother had some responsibility as she did not prioritise finding him a new school when he returned from abroad in March. It is unclear, however, why the Local Authority did not refer Vic to the Education Welfare Service when his mother did not identify a new school for him. Vic's mother did apply for a school place in August when he was in secure accommodation. In early September, however, a decision was made by the Local Authority that it was unsuitable for him to be placed there. When he was discharged from secure accommodation in September it was almost six weeks before alternative provision

[7] The Munro Review of Child Protection Interim Report: The Child's Journey Professor Eileen Munro DfE 2011

was provided. The lack of structured activity in the daytime was clearly a risk for re-offending yet despite this there was significant delay in provision of service. 'Poor attendance or exclusion from school, or attendance at a Pupil Referral Unit, have been cited as key risk factors in the development of offending behaviour for young people'.[8] This slow response was replicated when Vic failed to attend the PRU provision in November. Education welfare staff did not meet with Vic and his mother to discuss alternative options until 19th January and then he could not start at the NACRO project until 9th February. Vic did engage to some degree with this provision and it is possible if that had been provided immediately following his discharge from secure accommodation that different outcomes could have been achieved.

3.3.3 There were similar deficits with regard to Tom's access to education. Despite having a school placement, he rarely attended school throughout 2011 and little was done successfully to address this. An example being that a meeting in December agreed that alternative provision should be explored for him, the options being foundation learning course and Princes Trust. Funding for this was not agreed until 21st February and the application was made on 21st March but was delayed initially by the Easter holidays and then by Tom being remanded. In the event an appointment was not made until May by which time his foster carer had referred him to the education and employment programme for young people starting in September.

3.3.4 The delay in provision of education was most extreme but other agencies were also slow to provide services. After Vic left secure accommodation in September there was no contact with his mother by the social worker for ten days and that contact was only because she contacted them to say that she would no longer be responsible for him. It was only after his mother had contacted EDT on two occasions in October saying that she could no longer look after Vic that the social worker made contact.

3.3.5 Speedy and responsive service provision is essential to intervening positively with families when they are in crisis. This is particularly true of work with adolescents where there are often very limited windows of opportunity for intervention which need an immediate response.

3.4 Working with adolescents who offend in groups

3.4.1 A significant facet of this review was the extent to which Tom and Vic were offending together. It is clear that they were influenced and affected by each other's actions as well as being involved consistently with at least one other young person. The extent to which this constituted 'gang' activity is open to debate. The definition of 'gang' activity in the London Safeguarding Children Board procedures is '…a relatively durable, predominantly street-based group of children who see themselves (and are seen by others) as a discernible group for whom crime and violence is integral to the group's identity.'[9]

3.4.2 It is possible that the young men were developing a group identity and certainly they refer to other gangs and appear to be in conflict with young people who may be in gangs. Tom's mother also referred to Tom and his brother being attacked by gangs.

[8] (Farrington, 1995; Young et al, 2007) quoted in Teenagers at risk The safeguarding needs of young people in gangs and violent peer groups Kate Fitch NSPCC March 2009

[9] Safeguarding children affected by gang activity and / or serious youth violence, London Safeguarding Children Board 2009

Both young men had also been attacked and suffered significant injuries and this is often evidence of gang involvement as young people involved in gangs are more likely to be victims as well as perpetrators of violence. Whether they were directly involved in a 'gang' or not it is clear that Tom and Vic were involved in co-offending behaviour that involved 'serious youth violence'[10]. This accelerated during the period of the review and it was significant that both young men were alleged to have undertaken criminal activities using weapons and had been convicted of having offensive weapons on their person. Fear and a need for self-protection is the key motivation for carrying weapons – it affords a young person a feeling of power. Where a young person is involved with a gang or serious youth violence, the risk or potential risk of harm to the young person may be as a victim, a perpetrator or both.

3.4.3 It is clear from all the IMRs that professionals did not consider the issue of 'gang' violence prior to the review and none of them had considered using the London Safeguarding Protocol with regard to responding to the particular challenges of working with young people in gangs. They also did not identify the escalation in the levels of violence; a pattern of behaviour which is most common with serious youth violence that leads to serious injury or death. 'By far the majority of children do not become violent overnight. Their behaviour represents many years of [increasingly] anti-social and aggressive acts, with aggressive habits learned early in life often the foundation for later behaviour. Where a child succeeds at low-level anti-social acts, such as verbal abuse and bullying, violating rules and being disruptive, s/he may feel emboldened to perpetrate increased violence.'[11] This description certainly matches the profile of both young men whose activities became increasingly anti-social and involved increasing levels of violence and aggression.

3.4.4 Research into how best to respond to the needs of young people involved in serious offending behaviour identifies that it should '… be planned on a multi-agency basis and include provision from schools, youth offending teams, social care, police and youth and leisure services.'[12] This is confirmed by the London Safeguarding Procedures which advise calling a multi-agency meeting informed by advice from the local professional with specialist knowledge about gangs. This review has identified that whilst many professionals were working very hard with these young men much of their work was in isolation and without a clear perspective about how it fitted with other agencies. There was a sense that professionals found the problems presented by the young men's behaviour too challenging and looked to another agency, usually YOT to resolve the difficulties. In reality no one professional could achieve the change necessary and what was required was a well-resourced timely package of support that would divert the young people and assist them in addressing their problematic offending. The risk of failing to provide that input is that the young people continue to take increasing risks that lead to potentially more dangerous outcomes. 'The deaths or serious injury of older young people regularly make up a quarter of all serious case reviews. … The tendency for vulnerable "hard to help" adolescents to be neglected by agencies, who give up on these challenging young people because

[10] The definition of 'serious youth violence' currently in use by the Metropolitan Police Service is 'any offence of most serious violence or weapon enabled crime, where the victim is aged 1-19…'
[11] Safeguarding children affected by gang activity and / or serious youth violence, London Safeguarding Children Board
[12] Teenagers at risk The safeguarding needs of young people in gangs and violent peer groups Kate Fitch NSPCC March 2009

their needs have become too overwhelming, was first identified in the 2003-2005 study'.[13]

4 LESSONS LEARNED FROM THE REVIEW

4.1 This review identified significant limitations in the services being provided by Children's Social Care. This mirrors the findings of the Inspection of Safeguarding and Looked after Children undertaken by Ofsted between May 2012 and June 2012. This reported "significant failings in the contribution made by the council and partner agencies to child protection" and that "The quality of assessments and subsequent plans are generally of poor quality. The IMR provided by Children's Social Care acknowledges the problems and also reported on changes put in place since the Ofsted inspection. There is an Improvement Board in place which is ensuring that the changes recommended by Ofsted are implemented and this is being monitored at every LSCB meeting. For this reason the recommendations from this report focus on multi-agency learning rather than on the significant changes that are required and being implemented in Children's Social Care.

4.2 The key learning across all agencies was about the difficulties of working with adolescents who are involved in criminal behaviour and serious youth violence perpetrated by their peers in gangs, with increasing anti-social behaviour. It was clear that, although Kingston LSCB has adopted the London Safeguarding Children Board protocol 'Safeguarding children affected by gang activity and / or serious youth violence', the understanding and knowledge of these issues by all agencies was very limited.

4.3 A significant weakness identified was multi-agency working to ensure that these young men attended educational provision, during the period of this review. The assessments of need and services provided were slow to be implemented and thus there were missed opportunities to improve educational outcomes for them. In particular it was unacceptable that both young men did not attend formal education for over a year.

5 CONCLUSIONS

5.1 It is not clear whether it was possible to prevent these young men from sustaining potentially life-threatening injuries as they were both involved in risky anti-social behaviour and criminal activities and might not have ceased these activities. The review identified, however, that professionals were insufficiently aware of the implications of this behaviour and specifically did not identify that the escalation of their criminal activities could mean that they were at greater risk of significant harm. The review has also shown there could have been better co-ordination and speedier delivery of services which might have improved outcomes for these two young men.

[13] serious case reviews: A two-year analysis of child protection database notifications 2007-2009 Brandon et al DfE 2011

6 RECOMMENDATIONS

Kingston Local Safeguarding Children Board

1.1 Kingston LSCB to require all agencies to work in partnership with Learning and Children's Services to develop a system of multi-agency risk assessment and management for adolescents who are at risk of involvement in:

- Emergent criminality, serious youth violence perpetrated by their peers in gangs, or increasing anti-social behaviour; and
- Serious youth violence perpetrated by children acting on their own.

1.2 Kingston LSCB to ensure all agencies address the issues highlighted in this report around the provision of education for adolescents involved in criminal behaviour and to report on how the services have been improved. The expected outcomes to include:

- A holistic package of support to ensure;
- Immediate access to education for young people on discharge from secure accommodation;
- More rapid intervention to provide alternative provision for young people not accessing formal education;
- Improved monitoring and intervention regarding young people who are not attending education for long periods.

The Director of Children's Services to report to the LSCB on progress within one year.

1.3 Kingston LSCB to commission a workshop for middle and senior managers from across the partnership to look at the difficulties of working with hard to reach young people. The outcome of the workshop to be:

- Greater understanding by all managers of the particular needs of adolescents who may be at risk because of their own behaviour;
- Commitment by all managers to implementing changes required to implement the agreed system of multi-agency risk assessment and management;
- The development of a clear implementation plan to achieve the required changes.

RBK Children's Social Care

2.1 Children's Social Care to ensure that assessments address the risks to all children in the family. Risks to younger siblings need to be rigorously examined and be part of the assessment.

2.2 Children's Social Care in conjunction with CAIT and partner agencies to undertake a review of the current practice in RBK relating to strategy meetings and discussions, including a review of the extent to which these are inter-agency forums.

2.3 Children's Social Care to ensure that there is a clear supervision policy and protocols in place which will include 3 monthly summaries where families receive on-going work from Learning and Children's services.

2.4 Children's Social Care to ensure that training is available for social workers to develop their skills in relation to direct work with children in order to enable social workers to develop relationships with the young people and families they are involved with.

2.5 Children's Social Care to work with Adult Services to improve communication and the sharing of information, including establishing clear protocols for working with families where there is learning difficulty, physical disability or mental illness.

2.6 Children's Social Care to review the role of the virtual head teacher in RBK.

2.7 Children's Social Care to prioritise improved understanding and working about the related issues of racial harassment, gangs and postcode areas, drug use and supply, antisocial behaviour, possession of weapons, children out of secondary education as part of their on-going training plan.

2.8 Children's Social Care to ensure that there are clear transition protocols in place including manager to manager, face to face meetings to reduce the impact of the transfer process.

RBK Youth Offending Service

3.1 Youth Offending Service to implement a consistent compliance panel and protocol in regards to the breach process.

3.2 Youth Offending Service to complete a Service Level Agreement with the Police and Children's Services regarding the agreed response/interventions around safety awareness in relation to missing children.

3.3 Youth Offending Service to embed gang identification and interventions via the Pan London Safeguarding children affected by gang activity and / or serious/ youth violence and Serious Youth Crime protocol, in order to identify those vulnerable to gang/serious youth crime violence and agree the appropriate level of intervention to address the issues i.e. links with SNT wards to target areas for further surveillance.

3.4 Youth Offending Service to provide refresher training on risk management for staff with specific emphasis on external controls.

3.5 Youth Offending Service to explore the use of volunteers within Kingston and develop a volunteering strategy to embed additional resources from the third sector and volunteering opportunities. Examples of these could be compliance mentors and transitional support for LAC.

3.6 Youth Offending Service to address the lack of Education to Employment resources within the borough (this is not a direct recommendation purely for the YOS).

Metropolitan Police Service

4.1 Operation Compass to include in their current review of the Standard Operating Procedures in relation to missing children who are in care homes or foster care the need for the initial investigating officer to record which local authority has responsibility for the Looked after Child.

4.2 The Senior Leadership Team at Kingston Borough Operational Command Unit to carry out an audit of MERLIN missing person reports involving children to ensure that

the Public Protection Desk have sent the information to the Royal Borough of Kingston Children's Services.

4.3 The Senior Leadership Team at Kingston Borough Operational Command Unit to ensure that all staff are reminded that after carrying out a debrief of a missing child a MERLIN/PAC is created detailing information gleaned from that interview.

4.4 The Senior Leadership Team at Kingston Borough Operational Command Unit to ensure that all frontline staff are reminded of the requirement to comply with the completion of a MERLIN/PAC in accordance with Standard Operation Procedures (SOPs).

4.5 The Senior Leadership Team at Kingston Borough Operational Command Unit to review the frequency that checks are carried out by the Kingston Public Protection Desk for non-compliance by staff of not completing MERLIN/PAC reports and ensure that the unit is adequately staffed to carry out their duties.

Substance Misuse Service, RBK

5.1 The Substance Misuse Service should ensure that a standardised assessment form is used with all young people accessing the service. It should be adapted or developed to include an exploratory question about gang culture, with a view to exploring the potential impact of gang related activity on young people using substances further.

5.2 The Substance Misuse Service should agree a working definition of the term 'Gang' for use by the organisation. Guidance is available on the Home Office website www.homeoffice.gov.uk.

5.3 The Substance Misuse Service should identify and participate in specific training based on the guidance 'Safeguarding young people who may be affected by Gang Activity' so that a better understanding is developed of what the local problem is and the team is better able to identify and appropriately support young people at risk. This could be provided by the YOT or through Kingston LSCB.

Learning and School Effectiveness

6.1 The Director of Children's Services to ensure that there is sufficient communication about individual children and young people across the statutory bodies within the Local Authority.

South West London and St George's Mental Health Trust

7.1 When a referral is made to the Multi Systemic Therapy Team and the young person is subsequently accommodated, MST with the health service for LAC should support a multi-agency plan for the steps and milestones for the young person to return to the family home within the LAC review process. This should include a collaborative consistent approach to maximise success

7.2 Multi Systemic Therapy Service in collaboration with the Local Authority to review the referral criteria for cases where the family foster carer is involved in the care of the young person. This should include shared approaches to boundaries and limit setting and limitations of the service.

7.3 The Multi-Systemic Therapy Team to ensure that when presenting at multi agency meetings the MST plans are reviewed in conjunction with the plans of other agencies.

7.4 The Serious Case Review recommendations and their implementation as it affects MST to be considered and monitored by the MST Multi-Agency Strategic Board as part of annual review of the service.

Your Healthcare

8.1 Your Healthcare Board Lead for Universal services to discuss with NHS Kingston Commissioners, service redesign to extend the role of the school Health Team to offer health reviews of all children transferring into a Kingston school.

8.2 Your Healthcare to develop a school health transfer in policy in line with commissioning arrangements.

8.3 Your Healthcare to ensure that the LAC Specialist Nurse is aware of all LAC health reviews. Appropriate health professional to be invited to LAC reviews and receive minutes.

Epsom and St Helier University Hospitals Trust

9.1 The Hospital Trust should ensure that, as part of the information sharing audit which is currently recorded on the Safeguarding Children Audit Plan 2012/13, an information sharing audit tool should be designed to incorporate a question in relation to whether the ED record and safeguarding documents are filed in a main record when concerns are identified about the safety and welfare of children who attend the ED.

9.2 The Hospital Trust should ensure that the information sharing audit incorporates a question in relation to whether a record of the GP letter is filed electronically and whether the information recorded on the GP letter is relevant and appropriate to the safeguarding concern identified.

9.3 The Hospital Trust should ensure that a further re-audit of the Paediatric DNA Policy is added to the Safeguarding Children Audit Plan 2013/14 and the audit must include children who have not attended Outpatient Fracture Clinic appointments.

Kingston General Practitioners

10.1 GP practices to review systems in place for ensuring sharing of information with the school health team when requested.

10.2 GP practices to review their system for reading and acting on children's A+E discharge summaries.

10.3 GP practices to consider sending out a letter to the carers of looked after children to offer the child a medical review.

10.4 GP practices to consider whether in cases where risk factors for child abuse have been identified, there should be a way of cross referencing information between different family member's notes.

10.5 GP practices to review their system for identifying and documenting ethnicity of patients.

NHS Kingston/CCG – Health Overview

11.1 The Designated Nurse, NHS Kingston, to ensure that the Joint Strategic Needs Assessment for LAC includes a recommendation that health practitioners are invited to attend LAC reviews , send a full health report, and receive timely minutes of the meeting.

11.2 NHS Kingston to ensure that the commissioned RIO electronic record system is installed into Moor Lane where the LAC medical team are based. This should be the primary health record for LAC including those children with disabilities who are in respite care. The health assessments can be uploaded onto the RBK electronic system by the LAC coordinator.

11.3 The Designated Nurse, NHS Kingston, to ensure that the Joint Strategic Needs Assessment includes a clear outline of the referral process to the LAC health professionals. This is to include accurate information for all LAC, foster carers, current GP and any other health information to improve the service provision.

11.4 The Designated Doctor for Safeguarding and the Designated Doctor for LAC to ensure that all Paediatric clinicians receive and actively participate in regular supervision and support in relation to specific safeguarding child protection issues within the context of their role and specific caseload.

11.5 The named nurses for Kingston and Epsom & St Helier hospitals to ensure that A&E documentation is improved to ensure there is detailed information about the history given about the injuries sustained, any child protection concerns or any referral into safeguarding services.

Fiona Johnson