Portsmouth Safeguarding Children Board

Response to the Recommendations from the Serious Case Review of Child E

The case was considered by the Portsmouth Safeguarding Children Board (PSCB) at its Case Review Committee on 22 January 2015 under Regulation 5 of the Local Safeguarding Children Board Regulations 2006. The committee found that this case met the criteria for a serious case review and agreed the commissioning arrangements in order to meet the requirements of such reviews as laid out in HM Government 'Working Together to Safeguard Children', 2013 (now 2015).

Working Together allows LSCBs to use any learning model consistent with the principles in the guidance, including systems based methodology. Jane Doherty, an Independent Social Work Consultant with substantial experience in Child Protection and Quality Assurance, was commissioned as the lead reviewer to complete the work using a hybrid approach. Agencies were asked to provide a narrative critiquing their own involvement with the family and their practice; and to support the process two practitioner events were held where views of those workers directly involved in the case were sought.

The PSCB arranged a panel to manage and oversee the review. An Independent Chair was appointed from a voluntary sector organisation that had no involvement with the family. The panel members were made up of senior staff from the Portsmouth Clinical Commissioning Group, Hampshire Constabulary, and Children & Families Service, all of whom had no contact with the family nor line-managed any staff who had.

The full findings of the Serious Case Review (SCR) are set out in the Overview Report that has been published in full alongside this response. The publication of this report was delayed in order to ensure that it did not prejudice the criminal investigation and other proceedings into Child E's death.

This document provides the response from the Board to the findings made in the report. It outlines the recommendations made in response to the review's findings; outlines the action which has already been taken; and comments upon what more will be done. All of this work has been monitored by the PSCB Case Review Committee and the Executive Committee has received reports on the status of the action plan developed in response to the recommendations.

Finding one: Better use of early help and intervention - Early signs of neglect were not shared between professionals because no use was made of the current mechanism for doing so e.g. an Early Help Assessment (previously referred to as a CAF Assessment). Individual agencies offered support to the parents but this was not coordinated.

Recommendation: The Board will review and report on the effectiveness of Early Intervention in enabling front-line professionals to provide early help to vulnerable families.

Action taken: The Board has re-written its Thresholds Document, and included within it a table headed 'indicators of need' which identifies what the concerns would look like under each tier of need for each of the domains on the new Early Help Assessment. The Board has delivered briefing sessions across the workforce on how to use these 'indicators of need' to describe their concerns about a child.

The early help offer in Portsmouth has been re-structured to create three locality based targeted early help and prevention services working across the age range of children 0-19.

Recommendation: The Board will ensure that partner agencies have an agreed step-up/step-down protocol concerning the use of the Early Help Assessment.

Action taken: The step-up/step-down process is described in the Early Help Protocol which is jointly produced by the PSCB and Children's Trust. The protocol is on the PSCB website and is referred to in all PSCB training and there is an Early Help Module that helps professionals understand how the process works.

Finding two: The role of supervision for all agencies - The review highlights the necessity of good reflective supervision and management scrutiny in all agencies. This is particularly prevalent in families such as this where the issues are complex. There is good evidence in this case of a shared understanding of the importance of escalation processes when there are disagreements between professionals. It was used to good effect in this case and this is to be commended.

Recommendation: PSCB via the Section 11 process should require all agencies to report on the effectiveness of their supervision and management processes in ensuring that the work of front-line professionals is scrutinised and challenged.

Action taken: There is a question in the PSCB Section 11 Safeguarding Audit that asks agencies to self-assess and provide evidence that staff in their organisation who are working with children through early help or child protection processes receive regular (at least monthly) supervision on an individual or team basis; and can access further support when required. All agencies in Portsmouth have now completed this audit and all reported that supervision is available for their relevant staff members.

As part of its multi-agency training programme, the PSCB currently offers a supervision module for anyone who provides supervision for staff working with children and families. This course is offered 5 times a year and is very well attended by professionals from a wide range of services in Portsmouth.

Finding three: Assessment of the impact of specific parental issues (DA, alcohol misuse, parental mental health) - Information was held about both adults that wasn't widely shared and as a result the information wasn't considered in terms of the impact of their issues on their parenting capacity.

Recommendation: PSCB to oversee a review of multi-agency guidance to assessing the impact of domestic abuse.

Action taken: The Board has completed a multi-agency audit of cases where children are living in households affected by domestic abuse. The audit considered how well the risk from the domestic abuse in the household had been identified, understood and prioritised, and whether the resultant decision making matched the risks, needs and strengths identified. A report summarising the findings was submitted to the Board and an action plan to strengthen safeguarding around domestic abuse is being overseen by the Monitoring, Evaluation and Scrutiny Committee.

In September 2016 the Board completed a scrutiny session on agencies' current responses to children living with domestic abuse in Portsmouth. Members were then asked to consider how they could improve partnership working and improve the skills and awareness of the staff in their agency. The Board gave an action to all members to ensure their agency's Domestic Abuse policies and practice guidance is being followed and to champion greater awareness of them amongst staff.

The multi-agency safeguarding guidance on domestic violence and abuse forms part of the pan-Hampshire 4LSCB Safeguarding Procedures. In December 2016 this guidance was

reviewed and updated by relevant staff in Children's Services and Domestic Abuse specialist services to ensure it was up to date and fit for purpose, and re-issued in the procedures manual.

In July 2017, the Care Quality Commission (CQC) undertook a review of Children Looked After and Safeguarding (CLAS) across health services in Portsmouth. This review, published in September 2017, highlighted that further work is still required to address this issue. As a result, a Safeguarding Improvement Board overseen jointly by PSCB and Portsmouth Safeguarding Adults Board has been developed to oversee action plans from this review. Portsmouth Hospital Trust has been working closely with local services to develop their assessment and support of individuals affected by domestic abuse.

Finding four: Exchange of information between agencies - In the referral and assessment process, the exchange of information between agencies is crucial. Poor exchange of information is likely to result in the wrong application of thresholds and subsequently flawed assessments. In this case the exchange of information between agencies was left wanting particularly in relation to the adults' respective histories. Some incomplete exchanges of information between the police, children's social care and the health visitor about the historical and current issues relating to domestic abuse meant that more targeted services were not offered to the family at an early stage.

Recommendation: PSCB to oversee and receive feedback from the proposed CCG audit of the use and effectiveness of the GP/Midwife Liaison Form (called the 'Maternity Booking Assessment Form').

Action taken: Portsmouth CCG undertook an audit of GP practices which found that the forms were not being regularly and consistently used. The CCG formed a Task and Finish group to review and re-develop the forms to enable GPs to use them. This Group included representatives from GP practices in Portsmouth and Hampshire, Maternity Services and a CCG rep. The review of the form included exploration of IT solutions to auto-populate parts of the form from GP IT systems to make it quicker to complete. The new form has been launched across all GP practices in Portsmouth and Hampshire.

Recommendation: PSCB to seek assurances from GP practices that they have HV/GP link meetings in place and that these are effective in identifying vulnerable families at an early stage so that the appropriate help can be offered.

Action Taken: The audit of the 19 GP practices in Portsmouth also investigated whether they were holding GP/HV link meetings and, if so, how frequently. Of the 17 practices that responded, 14 stated that they met with their Health Visitor. The three practices that did not have formal meetings reported that they have a good relationship with the Health Visitor who attends the Surgery regularly. Those practices that had meetings reported that these meetings occurred between weekly and six weekly, the most common frequency being monthly.

Since the audit was completed there have been several practice mergers. There are now 17 practices in Portsmouth. All of these practices now have regular meetings with the Health Visitor to identify vulnerable families.

All except one GP practice in Portsmouth use the same electronic record system as health visiting teams. This means - provided families have given permission to share - that Health Visitors and GPs can see each other's information. In addition all GP practices have systems

in place to identify children who are subject to Child Protection Plans, Children in Need and Looked After Children.

Portsmouth CCG has recommended to the Solent NHS Trust Health Visiting Manager that they should consider a bi-annual audit of GP/HV Liaison meetings to maintain and improve current practice and to ensure consistency of practice.

Recommendation: PSCB to undertake an audit of the quality of referrals received into Portsmouth's 'front door'.

Action taken: The mechanism for contact to the Multi-Agency Safeguarding Hub has been updated and there is now a six monthly audit of the quality of information shared between agencies, the consideration given to consent to share the information, the application of threshold and the outcome/rationale for outcome in terms of the support for the child and family - early help, targeted early help, or a statutory response by children's social care. This audit is completed by representatives of Children & Families Service, CCG and Hampshire Constabulary. Each agency is expected to have mechanisms in place to oversee the contact information into the MASH.

Finding five: Risks associated with concealed pregnancies - The risks associated with concealed pregnancies are well documented within literature. Within SCRs, families where concealed pregnancy is an issue form a small but significant number. Agencies need to have a shared understanding of these risks and their role in dealing with them. Hospital staff did have an understanding of these risks but failed to adequately convey them to CSC staff in the first instance leading to a delay in the assessment of the family. The review has highlighted the importance of agencies making detailed and thorough referrals. The circumstances surrounding any concealed pregnancy should be subject to detailed multi-agency investigation and where appropriate, support in terms of psychological or psychiatric input should be considered as part of any assessment.

Recommendation: PSCB should oversee the strengthening of multi-agency procedures in relation to the identification, referral and assessment of concealed pregnancy.

Action taken: The PSCB has monitored the revision of the pan-Hampshire 4LSCB Unborn Baby protocol. The CCG's Deputy Director for Quality and Safeguarding (who is also Chair of the PSCB Case Review Committee) has chaired a working group with colleagues from Hampshire, Southampton and Isle of Wight to ensure that how agencies should respond to a concealed pregnancy is clearly identified.

The revised Unborn Baby Protocol has been published on the PSCB website, the 4LSCB Safeguarding Procedures website and has been sent to all partner agencies to disseminate.

Recommendation: PSCB to review its learning programme to ensure it includes multi agency training on concealed pregnancy

Action taken: Concealed pregnancy is highlighted as a significant indicator of potential risk in all relevant PSCB Safeguarding Training.