Hampshire Safeguarding Children Partnership

Response to the Recommendations from the

Local Child Safeguarding Practice Review – Baby Sally

This case was considered by the Hampshire Safeguarding Children Partnership (HSCP) at its Learning and Inquiry (LIG) subgroup on 6 November 2019 under Regulation 5 of the Local Safeguarding Children Partnership (LSCP) Regulations 2006. The subgroup found that this case met the criteria for a Local Child Safeguarding Practice Review (LCSPR) and agreed the commissioning arrangements to meet the requirements of such reviews as laid out in HM Government 'Working Together to Safeguard Children', 2018 (the statutory guidance at the time).

Working Together 2018 allowed LSCPs to use any learning model consistent with the principles in the guidance, including systems-based methodology. Senior professionals from within Hampshire agencies with no involvement in the case were identified to lead the review, using a systems-based methodology to ensure full participation by the front-line practitioners who had been involved with the family. The LIG subgroup quality assured the final draft before presentation to the Board.

This document provides the response from the Partnership Board, and individual partner agencies on the areas of learning highlighted to them (as outlined below).

Recommendations

Recommendation One:

HSCP to develop a policy that clearly articulates the key principles and rationale for discharge planning meetings where there are safeguarding concerns (as opposed to planning for broader health needs) and what roles and responsibilities there are for different agencies. This policy will clarify what safeguarding concerns would require a discharge planning meeting (being discharged to a placement being sufficient to warrant one) and define attendance, agenda setting and recording practices. This should be shared across the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) network.

A task and finish group consisting of Health (acute provider), Children's Services and Police will be established to develop a policy regarding discharge planning. Once approved this will be shared across the HIPS network and promoted through the quarterly HSCP Newsletter, 'Keeping Our Children Safe'.

Recommendation Two:

That all professionals (including foster carers) are reminded of the importance of adhering to safe sleep protocols, regardless of the attraction of taking a more pragmatic approach due to the circumstances at the time. Consistency between the messages given and role modelling provided by professionals is vital to ensuring parents receive a single clear message about the risks of co-sleeping.

HSCP have developed a programme of safe sleep promotion, 'Every Sleep Counts'. A toolkit has been developed, in addition to a HIPS Protocol, to support professionals in delivering key consistent safe sleep messages to parents. To support the toolkit and protocol, training on the 'Every Sleep Counts' programme is delivered through the HSCP Virtual Training Offer. This training is available to professionals across the Partnership agencies, including foster carers. The training emphasises the importance of consistency between the messages given and the role modelling provided by professionals.

Recommendation Three:

Where parents and their new babies are discharged to placements, the carers and/or staff must be fully informed of all the risks present in the case and ought to be integral to the discharge planning meeting. If they are unable to attend, then professionals must ensure all information is effectively shared with them and this must feature in the actions resulting from the discharge planning meeting.

Children's Services have recently reviewed their processes to ensure that foster carers, or placement providers, are invited to the discharge planning meeting and to contribute to the overall discharge/care planning process. Social work teams have been reminded of the need to share information/decisions with key partners. Communication has gone out to the social work teams to remind them of the need to include key agencies in the discharge planning meeting.

Alongside the work completed in relation to discharge planning meetings, Children's Services have also agreed that all babies will remain open for 3 months post-birth, so parents can be supported at a time when the stresses and pressures of parenting are high. Children's Services have agreed to use that 3 - month period post birth to support the family through a targeted multi-agency approach and through use of intensive workers. A menu of interventions has been produced.

Recommendation Four:

That home visiting protocols are reviewed for all professionals following the discharge of an infant from hospital, to highlight that best practice when delivering safe sleep advice is to do so whilst considering the sleeping arrangements for the child. This can be reflected within the proposed discharge planning policy.

Children's Services has a policy in place providing clear visiting guidance, which has recently been reviewed. There is a requirement, as part of the social worker visiting, to see the sleeping arrangements for the child. Safe sleep advice has been delivered through the 'Every Sleep Counts' programme (rolling programme of dates in 2021/22) with online virtual courses, which social workers are encouraged to attend.

Health visitors and other professionals working with a family where an infant has been discharged can fully support safe sleeping advice and actions. Locally there have been Case Reviews, led by the Partnership, that have identified learning relating to safe sleeping. This has been shared and embedded in practice via training, communications and learners sets. Any professional within a discharge planning process would support and respond to the acute hospitals proposed discharge planning policy.

Recommendation Five:

HSCP and partner agencies should ensure that relevant child protection training includes the understanding that Child Protection Plans are often removed from children when they become subject to Care Orders, and that this does not necessarily indicate a reduction in risk but may reflect a different mechanism for managing that risk.

HSCP has worked collaboratively with the professionals who deliver relevant child protection training to ensure that the training includes content designed to increase professionals' understanding that, while Child Protection Plans can be removed when a child becomes subject to a Care Order, this does not necessarily indicate a reduction in risk but may reflect a different mechanism for managing that risk. Through child protection training, HSCP ensures that professionals attending the training increase their awareness of the different mechanisms that can be used to manage the risk of harm to children and the thresholds for these mechanisms.

Recommendation Six:

Whilst it is recognised that some decisions about care planning are made without notice, such as during court proceedings, where it is known a decision may be made in advance, every effort should be taken to seek the views of the multi-agency team to help inform that decision making.

Children's Services have reminded team managers and social workers of the need to make sure that key partner agencies are updated regarding any changes or decisions made in relation to the care plan. Children's Services are planning some learning lessons from reviews, providing some internal workshops which will be delivered across the county.

Recommendation Seven:

Where there are concerns about the impact of medication on a mother (or parents) before or after birth, the assessments and conclusions of clinicians reviewing medication should be provided in writing and shared with all relevant professionals to support effective care planning and risk management.

A primary care template (Arden) has been created for recording medication and assessments before and after birth. Training has been provided to GP practices, with regular updates via newsletters, and all practices have a GP Safeguarding Lead. The use of the template has demonstrated increased awareness and recording of prescribing before and after birth. Information sharing has improved as Primary Care and acute hospitals are now linked with a system known as 'BadgerNet'.