Hampshire Safeguarding Children Partnership

Response to the Recommendations from the

Serious Case Review of Child Z

The case was considered by the Hampshire Safeguarding Children Board (HSCB) at its Serious Case Review (SCR) subgroup on 28 June 2017 under Regulation 5 of the Local Safeguarding Children Board (LSCB) Regulations 2006. The subgroup found that this case met the criteria for a SCR 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 2015 (the statutory guidance at the time).

Working Together 2015 allowed LSCBs to use any learning model consistent with the principles in the guidance, including systems-based methodology. Edi Carmi, an independent safeguarding specialist, was commissioned as the lead reviewer to complete the work using a systems-based methodology to ensure full participation by the front line practitioners who had been involved with the family.

To support the process there was a reference group of senior staff from involved agencies which the reviewer used as a sounding board, and where necessary to provide necessary context on organisational policies and practice. The SCR subgroup quality assured the final draft before presentation to the Board.

The HSCB transitioned to the new Hampshire Safeguarding Children Partnership (HSCP) in September 2019, in accordance with the new statutory guidance Working Together to Safeguard Children 2018. The HSCP, under the joint leadership of the new Safeguarding Partners, have overseen the completion, publication and response to the SCR into Child Z.

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

Hampshire Safeguarding Children Partnership (HSCP) state:

> *"We thank all those professionals who have contributed to this complex and thorough review. The author rightly raises a number of learning points, many of which are directed at agencies that sit outside of HSCP's members. That said, the HSCP adopts a culture of continuous improvement and the Safeguarding Partners, through the Learning and Inquiry Group (LIG), have reviewed all learning points and considered where these should inform practice in Hampshire. This has included new guidance being issued on the indicators and response required when there are concerns regarding Fabricated and Induced Illness (FII). This guidance is directed at all agencies in the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) areas and is published on our shared procedures website. In addition, workshops discussing FII and specific learning from this case have been held in regional multi-agency Briefings, Learning and Themes (BLT) workshops held across the county. This has included the importance of ensuring case files and records clearly reference those people within, or part of, a family and its immediate network and how professionals*

can inquire to establish facts and information in relation to partners of parents and carers."

NHS England (NHSE) have provided the following response to the recommendations:

"NHSE have continued to support the Mother and Baby Unit to embed the recommendations from the independent review as well as undertaking quality visits throughout 2019 and early 2020. Progress continues to be overseen via contract meetings and ongoing support to ensure continuous improvements in practice and service delivery.

The chair of the NHSE Perinatal National Clinical Reference Group is aware of the recommendations from the review and is keen to ensure lessons are learnt on a wider basis across all peri-natal units."

Southern Health Foundation Trust (SHFT) have provided the following response:

"Southern Health NHS Foundation Trust (SHFT) have worked closely with NHSE and the HSCP to ensure that all recommendations from the review are captured in learning outcomes for the Mother and Baby Unit and the Trusts wider Adult and Perinatal Mental Health Services. These learning outcomes are regularly monitored via SHFT Quality improvement plans and quality visits undertaken by NHSE."

Surrey Safeguarding Children Partnership (SSCP) (previously Surrey Safeguarding Children Board (SSCB)) have provided the following response:

"The Surrey Safeguarding Children Partnership is committed to learning the lessons from this review. Since the review was initiated we have made significant improvements to practice, including the introduction of the Family Safeguarding Model, the development of the Children's Single Point of Access and the creation of a Children's Services Academy to train and equip the children's workforce to continue to work with children and families effectively. We will continue to ensure that multi-agency safeguarding practice continues to improve and all Surrey's children are safeguarded and are supported to fulfil their potential."

Recommendations

Finding One

The focus on mother's welfare, and her need to be given the chance to have her parenting assessed whilst living with Baby Z, meant that premature Baby Z's needs for emotionally secure, stable and consistent care were not given sufficient priority in the first months of her life.

Following the Surrey 2018 Ofsted inspection there has been a programme of improvement taking place within Children's Services which are designed to address some of the weak practice noted in this SCR. SSCB should consider what actions are required to assure themselves of the necessary improvements in child focused practice in relation to:

a) Plans relying heavily on family support need to specify timescales, details of who does what in relation to the child, how progress is measured, what outcome is expected and a clear contingency plan if it fails.
b) Children's social care plans, when there are parental ill health factors including physical, mental and emotional ill health, need to be child focused, not primarily based on the needs of the 'ill' parent and routinely based on child and adult services joint planning.
c) That whenever a looked after child (LAC) is admitted to hospital, the local authority ensures s/he is visited regularly in the absence of parents/carers presence in the hospital.
d) That the implementation and progress of child protection plans are monitored rigorously, with contingency plans and legal planning meetings held when insufficient progress is not made.
e) That plans to transfer a case to another local authority do not act as an obstacle in assessments and implementation of child protection plans.

Finding Two

There are systemic problems for practitioners having full access to historical and current information when working with mobile families and/or those accessing a multitude of services in different areas. The main risk in these cases is being able to undertake holistic assessments based on partial information.

SSCB to consider how to minimise risks of communication weaknesses where there are a large number of practitioners involved with a mobile family. Particular issues to focus on are:

a) That social workers are routinely notifying other local authorities when a child subject to a child protection plan or a care order stays in their area and also that the Surrey Designated Nurse for Looked After Children is notified of the moves.
b) To establish how well the child protection conference administration is working in terms of all relevant practitioners being sent and receiving conference invitations and records;

this includes both the processes of sending the information and the process of circulation within receiving agencies, when not sent to the allocated practitioner.

c) That General Practitioners (GPs) are now experiencing timely transfer of medical records.
d) That adult mental health services inform health visitors as well as social workers of parental mental health episodes and the consequent ability of a parent to care for her/his child/ren.
e) NHS England to consider how to be assured that changes implemented at the Mother and Baby Unit (MBU) have led to a staff group who now understand the significance of child protection plans and shared parental responsibility in care proceedings in terms of the need to reliably communicate with other agencies, and in particular with social workers, around any circumstances affecting the welfare of the child.

Finding Three

When a pregnant woman or parent is a high user of health services, health practitioners should always consider any impact this may have on the unborn baby and/or children in the household.

HSCB and SSCB to consider:

a) How to make practitioners more aware of the possible safeguarding risks to children when parents and/or pregnant women are high intensity users of health services, including the consideration of the potential for self-fabrication or induction of illness.
b) Does this have national systemic implications on the communication and analysis of patient health information, especially in relation to mobile families and those accessing a large number of different health providers?

HSCB and SSCB to consider:

c) How adult health practitioners are better able to analyse health information in the context of adults who are high users of health services, including the consideration of the potential for self-fabrication or induction of illness and the impact of the behaviour on the unborn baby and/or child.
d) The need for a key health practitioner with responsibility to analyse medical and health information in the context of patients over or mis-using health services.

Finding Four

Practitioners working with Emotionally Unstable Personality Disorder parents need to have an understanding of the potential impact of this on parenting, associated risks to the child, what types of treatment are effective in enabling change and the challenges in doing so.

SSCB to consider:

a) How to increase awareness of parental Emotionally Unstable Personality Disorder and the potential impact on children?
b) Whether child protection plans involving child/ren (or an unborn child) of parent/s with mental health difficulties need to specifically address the expectations of mental health practitioners to not just provide support to the parent, but to assess the potential for change of the parent, what steps will be involved and the likely timescale for these.
c) Referring this case to SSAB for review of the lessons to be learnt in terms of the co-ordination of services.

Finding Five

There is insufficient professional understanding of the different types of 'mother and baby' resource available, and their different functions, leading to the potential for unrealistic plans being made for mothers with mental health problems and their babies.

NHS England to assure themselves that:

a) The MBU (in this case) has and follows clear admission criteria and processes, which involve obtaining sufficient current information on a prospective mother and baby so as to be able to offer beds only to those that fit the criteria.
b) MBU staff have sufficient involvement in multi-agency training which includes information on child protection processes and care proceedings.
c) That management and staff of the MBU understand the need to read and review the history of patients, including any reports provided by social workers.
d) The MBU now provides adequate assessment of the mother and baby relationship and parenting, consistent with its functions – and that the level of assessment is clearly articulated in written information for professionals and includes risk assessments relating to the need, or not, for supervision of mother and baby both when in and when outside the unit.
e) That SHFT and the MBU have a clear pathway for any unwell babies on the unit, including how unwell babies on the unit are managed, how external medical help is sought after for the babies, including when a parent will need an escort from the MBU and what communications need to be made with other agencies.
f) The changes made in the MBU have been effective in changing the culture so it can work effectively, in partnership with other agencies and particularly social workers, as part of the wider safeguarding arena and also encourages and enables reflective discussions to take place which support staff in their everyday role on the unit.

g) There is continued quality oversight and improvements on this unit, to ensure there is a culture that embeds safeguarding as core business for all staff working on the unit (including medical staff).

SSCB to consider:

a) How to facilitate those making referrals to MBUs understand the different types of units available and when psychiatric mother and baby wards are suitable to use if babies are subject to child protection plans and care proceedings? Do such wards have to provide minimum services in relation to care of the babies and assessments of the mother, and if so, what are these?

Finding Six

Whenever looked after children (LAC) change placements, consideration needs to be given with the Independent Reviewing Officer (IRO) to the need to hold a LAC review or other multi-agency planning meeting, even if the move was part of the care plan. This is particularly important in parent and child residential placements or when children are returned to parental care, to promote and facilitate joint understanding, development and ownership of the care plan. It is important that this is chaired by social care and not the residential unit, so clarifying the legal position with other agencies. When such placements meetings are held without the IRO, the IRO needs to retain oversight and challenge of the implementation of the care plan.

SSCB to consider how to be assured:

a) That when a placement is changed that the local authority take responsibility for promoting and facilitating joint understanding, ownership and development of the care plan; this is best done by holding a LAC review or another form of planning meeting.
b) That the IRO retains oversight and challenge of the implementation of plans when there has been a major change in circumstances e.g. change of placement, return to parental care and in the absence of any LAC review.

Finding Seven

Staff in all agencies and settings do not always explore the household and relationships of parents when there are welfare concerns about children. Names and relationships need to be established wherever possible and records should not make assumptions (e.g. of paternity) and distinguish between known facts and what professionals have been told.

HSCB and SSCB to consider:

a) How to change the culture and behaviour of staff in terms of always clarifying and recording the names of partners, being able to distinguish in records the source of information and therefore whether this is known fact or 'as told to them'. Moreover, they need to be able to understand that service users will not always tell the truth about the paternity of children and identity of partners, and therefore this needs careful and delicate probing.