Hampshire Safeguarding Children Partnership

Response to the Recommendations from the Partnership Review on Baby Hattie

The case was considered by the Hampshire Safeguarding Children Partnership (HSCP) at its Learning and Inquiry Group (LIG) subgroup on 5 September 2018 under Regulation 5 of the Local Safeguarding Children Board Regulations 2006. The subgroup found that this case met the criteria for a Partnership review.

The Hampshire Safeguarding Children Board (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 Partnership review on Baby Hattie.

A Designated Nurse and Senior Manager within Children's Services who were independent of the case were commissioned to lead the review as laid out in HM Government 'Working Together to Safeguard Children', 2015 (the statutory guidance at the time). A systems-based methodology was used to ensure full participation by 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 Board, and individual partner agencies on any recommendations made to them.

The report provides HSCP with the following recommendations:

Hampshire Safeguarding Children Partnership is to consider providing training and development for professionals working with parents and carers who may seek to manipulate and deceive. This should include the phenomenon first described by Reder & Duncan (1999) as 'closure', 'flight' and 'disguised compliance'.

The HSCP already provides fully funded training to its multi-agency workforce to support professionals who work with families who display disguised compliance. Learning from this case will be used to inform this course as it continues to develop. As part of the HSCP Learning Needs analysis the Workforce Development subgroup will review existing HSCP courses to ensure that information regarding the recognition and response to parental disguised compliance is included throughout its training offering where appropriate.

Post training survey's will ask how practitioners are considering disguised compliance within their role.

A 'Spotlight Briefing' on disguised compliance has been published and circulated to frontline professionals based on Reder and Duncan's research.

West Hampshire CCG in collaboration with Hampshire Safeguarding Children Board and partners are to consider the requirement for a succinct process which details how to raise an alert across health services. This should include the need for as much information as possible about the individual, such as NHS Numbers, due date and photographs (where possible) to ensure that they can be utilised by receiving organisations. Consideration will also need to be given to how widely the alert is to be distributed around the county, region and/or country.

The West Hampshire Clinical Commissioning Group Designated Nurse, with support from the safeguarding partners will develop a Standard Operating Procedure (SOP) for managing high risk alerts. Once approved this will be shared with partner agencies and uploaded onto the HSCP's web page

An audit will be conducted six months following implementation to establish if the SOP has been embedded in practice.

Hampshire Safeguarding Children Board should review the existing Concealed Pregnancy Guidelines to ensure that they reflect the learning from this case; including guidance on the management of demographic information, the importance of discharge planning meetings, the use of toxicology results and the risks of decision making without them and the escalation of professional concerns between agencies. Once reviewed and if necessary, updated, the Board should seek to explore how embedded the Guidelines are within practice.

Hampshire Safeguarding Children Partnership, in partnership with the other LSCPs in the Hampshire, Isle of Wight, Portsmouth and Southampton, will review the existing Unborn Baby Protocol (UBP) to ensure that it reflects the learning from this case; including guidance on the management of demographic information, the importance of discharge planning meetings, the use of toxicology results and the risks of decision making without them, and the escalation of professional concerns between agencies. Once reviewed and if necessary, updated, the Board will seek to explore how embedded the Guidelines are within practice.