# Isle of Wight Safeguarding Children Board

# Response to the recommendations from the Serious Case Review of Child G

# Introduction

The case was considered by the Isle of Wight Safeguarding Children Board (IOWSCB) at its Serious Case Review Subgroup on 21 July 2016 under Regulation 5 of the Local Safeguarding Children Board Regulations 2006.

The subgroup 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' 2015.

Sian Griffiths, an independent safeguarding specialist, was commissioned as the lead reviewer to complete the work using a systems-based methodology to ensure full participation by front line practitioners and the family.

An initial meeting, which took place in July 2016, identified that due to the particular circumstances of this case, other statutory reviews were likely to be required. This was confirmed at a subsequent meeting and it was established that the following reports would be required:

- Serious Case Review
- Serious Incident Requiring Investigation Report (SIRI) regarding NHS Primary Care Services (Level 2)
- Serious Incident Requiring Investigation Report (SIRI) regarding NHS Mental Health Services (Level 2)

It was agreed by relevant agencies that these Reviews should work closely together to minimise repetition and ensure the best learning for all. This SCR therefore, as far as possible, acted as a joint agency review.

However, the threshold was also met under the NHS Serious Incident Framework for a separate 'Level 3' Independent Investigation which would be completed within 6 months of the completion of the Level 2 SIRI.

It was also agreed that although the criteria for a Safeguarding Adult Review had not been met, there was likely to be learning for the Safeguarding Adults Board, who would also contribute to the process.

The purpose of this one Review was therefore as far as possible to:

- Meet the statutory requirements for a Serious Case Review
- Identify appropriate learning for the Safeguarding Adults Board
- Incorporate the learning identified within the two NHS Serious Incident Requiring Investigation Reports (SIRI)

To support the process, a review group of senior staff from involved agencies was formed, chaired by the Independent Chair of the IOWSB, as a sounding board for the reviewer, and where necessary to provide context on organisational policies and practice. The SCR subgroup quality assured the final draft before presentation to the Board. This document provides the response from the Isle of Wight Safeguarding Children Board and individual partner agencies on recommendations made.

## Recommendation 1:

**That the systems for sharing information amongst all agencies involved in the assessment of risk to both adults and children are reviewed and effectively aligned.**

**Responses to the recommendation:**

- Isle of Wight NHS Trust will review current processes of communication between internal teams and statutory agencies including: Information governance agreements in place that cover families and mechanisms for sharing information from different electronic record systems
  **Expected Outcome:** Information pathways will be agreed for sharing information including methods to be used e.g. telephone, email, and fax. This will be monitored in the Mental Health & Learning Disability Quality and Risk Safety meeting.
- Police will review and align systems for sharing information with other agencies, including risk assessments in relation to both children and adults.
  **Expected Outcome:** The current (CA12) adult referral form has been subject to a multi-agency review. A new form has been designed and agreed to be implemented in 2017 once tested. A line will be added regarding parental responsibility for a child which would trigger a CYP notification form.
  A single risk form to use for adults and children is planned to go live in April 2017, with staff training in March 2017
- The Isle of Wight Safeguarding Children Board (IOWSCB) will seek assurances that appropriate information sharing in relation to assessment of risk to both children and adults is in place across partner agencies by: carrying out a review of the IOWSCB Information Sharing Policy annually and including Information sharing questions in all Multi Agency Case Audits.
  **Expected outcomes:** The Information Sharing Policy will reflect the effective alignment of systems for sharing assessments of risk to both adults and children. Multi-agency Case Audits will show that appropriate information sharing takes place and that risks to both children and adults are assessed in all cases .

## Recommendation 2:

**That the Isle of Wight Safeguarding Adults Board and the Isle of Wight Safeguarding Children Board develop a shared strategic approach to 'Think Family' for the Isle of Wight and agree priority areas for development within their annual planning.**

- The IOWSCB will form a joint Task and Finish group with the Safeguarding Adults Board (SAB) to produce a 'Think Family' written protocol. They will implement the approach across all service members of the LSCB/SAB. Information for practitioners will be provided through learning workshops across the IOW and the approach will be promoted on the Adult and Children's Board web sites and in newsletters.
  **Expected outcomes:** There will be a clear and succinct protocol in place outlining the 'Think Family' approach and how to put it into practice. The LSCB will test implementation of the approach via Multi Agency audits. Learning workshops will be delivered across the IOW for practitioners and the protocol will be on the web sites and available for all staff and volunteers to access.

## Recommendation 3:

**The Isle of Wight Safeguarding Children Board to work with its partner SCBs to**
**a) review the current *4LSCB Joint Working Protocol for safeguarding children and young people whose parents/carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress* with a view to developing a more accessible document with practitioner friendly information for the wider multi-agency partnership.**

**b) Seek assurance from partner agencies that effective means have been put in place for developing staff knowledge and practice as identified within the Joint Working Protocol.**

- The 4LSCB (Hampshire, Isle of Wight, Portsmouth and Southampton Safeguarding Children Boards) joint working protocol was revised in 2016 in the light of new legislation but remained too lengthy. A working group has been set up to create a short and clear protocol for front line staff to use as well as a full policy document to underpin the Protocol. The new documents will be launched across the 4LSCB via the web site. The IOWSCB will seek assurance from each agency detailing how they have developed their staff knowledge, practice and compliance in implementing the joint working protocol.
  **Expected Outcomes:** The protocol will be succinct and clear and will include a simple flowchart for practitioners to use in their daily work. The policy will link directly to the protocol providing more strategic information and agreed ways of working and the theory behind them. The documents will be launched via 4LSCB meetings, Board meetings and the LSCB web site. The IOWSCB will be assured that all staff have been given opportunities to develop their knowledge of and skills in using the protocol in their daily work.

## Recommendation 4:

**That action is taken to ensure that professionals know when undertaking risk assessments with adults, that it is the parental response to any caring responsibilities for children, not the children themselves that may be considered a protective factor.**

- NHS Trust Clinical Staff will complete a minimum of Level 3 children safeguarding training and managers (Band 7 and above) to complete Level 5 by July 2017. The Joint Working Protocol will be discussed in team meetings to emphasise the child's needs are paramount.
  **Outcomes:** NHS Trust staff will 'Think Family' in all assessments. Staff awareness will be raised and peer challenge will ensure all possible safeguarding measures are taken. This will be monitored in the Mental Health and Learning Disability Quality and Risk Safety meeting.
- IOWSCB will seek written assurance from GPs and Adult Mental Health Services that all staff understand that children can **never** be seen as a protective factor and that any assessment of adult responses to caring for children being seen as a protective factor can very quickly change over time and should be reviewed regularly.
  **Expected outcomes:** The IOWSCB will be assured that partner agencies have taken active steps to ensure that their staff understand protective factors and that it is inappropriate for a child to be seen as a protective factor for a parent and that protective factors are not static.

## Recommendation 5 (for Health partners):

**A plan to be put in place between the IOW CCG and the IOW NHS Trust to develop the professional understanding between primary health care and mental health services of their roles and operating procedures.**

**NHS Trust Action:**

- IOW NHS Trust and IoW CCG will ensure that the Island's health and care system partners are consulted on plans for information system sharing e.g. System One and PARIS. The Mental Health and learning Disability Clinical Business Unit (CBU) at IoW NHS Trust will present at GP training on Mental Health services April 2017. A stakeholder event will be held regarding Mental Health and Learning Disabilities CBU changes Sept 2017.
  **Expected Outcomes:** Primary Care and Mental Health services will understand each other's roles and responsibilities and how to access information.
- The IOWSCB will require assurances from CCG and NHS Trust outlining agreed roles and operating procedures between Primary Mental Health Care and Mental Health Services.
  **Expected outcomes:**
  The IOWSCB will be provided with assurance that the CCG and NHS Trust have developed clear and agreed operating procedures and that staff understand their roles and those of others within Primary mental health care and Mental Health Services across the NHS Trust and CCG.