Serious Case Review Response Plan – FINAL December 2016

"Philip"

This is the serious case review report in respect of Philip, who was aged 3 at the time he was taken to hospital by his Mother after four days of abdominal pain and vomiting. At hospital Philip was found to be very seriously unwell, with multiple, significant bruising, several fractured ribs and a perforated intestine. All these injuries were assessed as non-accidental. Mother and her partner (Ian) were arrested on suspicion of GBH S.18. and have since been charged. Ian was charged and pleaded guilty to S20 GBH and Mother was charged and pleaded guilty to S5 of the Domestic Abuse, Crime and Victims Act 2004. Ian was been sentenced to 3 years imprisonment. Mother received a suspended sentence.

A) The Findings

The GSCB has reflected on the findings from the Serious Case Review and will use its' authority and statutory role to make sure that these findings are shared throughout all organisations working with children and young people in Gloucestershire. A series of Serious Case Review briefing sessions have taken place and the findings will also feed into all Single Agency and Inter-Agency Safeguarding training. This will include Designated Safeguarding Lead (DSL) Forums for education settings and the GSCB Annual Roadshows.

B) What the GSCB has already done

Partner organisations represented on the GSCB have not waited for the outcome of the Serious Case Review before initiating action. Together we have:

- ***Launched the revised early help graduated pathway and raised awareness through the DSL Forums for Educational Settings and the GSCB Safeguarding Roadshows.***
- ***Reinforced the importance of child focussed practice through the GSCB Safeguarding Roadshows in November 2016***
- ***Developed and launched a 'working with fathers' inter-agency safeguarding training course***

- ***Run a series of 'Master classes' including working with challenging families, working with fathers and reflective supervision***
- ***Developed and launched a Child Neglect Strategy for Gloucestershire. Further work is taking place in relation to developing a toolkit for practitioners to help identify child neglect at the earliest possible stage***
- ***Gloucestershire County Council has made significant investment to the recruitment of additional social workers***
- ***Work has started on the production of a Gloucestershire 'Children in Need' Strategy***
- ***Shared lessons arising from the review through dedicated briefing sessions, DSL forums and the GSCB safeguarding roadshow events***
- ***Developed and launched Chronology Practice Guidance for Practitioners***

C) Further Action

The revised Working Together to Safeguard Children statutory guidance (2015) is less prescriptive about responses to Serious Case Reviews and other case reviews than previous versions of the guidance. The revised guidance highlights that the LSCB should oversee the process of agreeing what action partners need to take in light of the findings; establish timescales for action to be taken, agree success criteria and assess the impact of the actions. LSCBs should publish information about actions which have already been taken in response to the review findings; the impact these actions have had on improving services and what more will be done.

The 'findings' of a systems case review are insights rather than recommendations for set action. They highlight underlying patterns of influence on performance. In contrast to the previous SCR approach, there is no assumption that the implications for the action required to achieve improvements is either known or knowable in any absolute sense. It may therefore be more appropriate for LSCBs to focus on how they respond to these insights, rather than on the specifics of how they implement a particular action plan.

By following the principles set out within Working Together to Safeguard Children 2015 about case reviews, including Serious Case Reviews, this response plan will:

- Recognise the complex circumstances in which professionals work together to safeguard children
- Support a culture of continuous learning and improvement across the organisations, identifying opportunities to draw on what works and promote good practice
- Be proportionate to the complexity of the issues being examined
- Keep professionals fully involved in further communications and learning

- Be published in order to achieve transparency; and be included in the LSCB annual report, describing the impact of the SCR on improving services to children and their families

- Make sure that improvement is sustained through regular GSCB monitoring and follow up, so that the findings make a real impact on improving outcomes for children and young people.

The table in this response plan sets out the further actions that will be taken forward. When considering the findings and the questions for consideration by the GSCB, there were three key issues for consideration:

a) **Decide to do nothing?**
Rationale – it is being addressed already; it isn't a priority; it is a risk to hold and manage

b) **Do the thinking required in order to inform our response plan?**
Rationale – some issues may need further work by the Board or Sub-Groups to inform decisions about action or non action

c) **Do something specific?**
Rationale – the finding triggers views or links to knowledge about specific strategies we need to put in place as a response

The multi-agency response plan has been informed by action plans from each agency involved in the review. Accountability for delivering actions agreed in Single Agency response plans will remain with the individual organisation. However, the GSCB Serious Case Review Sub-Group will have a role in holding organisations to account and progress against both Single Agency and Multi-Agency actions will be reported to the Executive on a quarterly basis.

The GSCB has acknowledged that a number of the findings from this review resonate with findings from other Serious Case Reviews recently undertaken. For this reason, the focus of this response plan will be on those findings which are new to the GSCB.

Finding One: The role of a formal early help response in keeping children safe
The GSCB is assured that this finding is being addressed through the multi-agency response plan for the 'Ben' (2016) Serious Case Review published in June 2016 and the development of the Early Help graduated pathway in Gloucestershire.

Finding Two: Multi-Agency Information Sharing			
How Will We Know We Are Making a Difference?	**What Are We Going to Do?**	**Who will Lead?**	**By When**
Good quality information sharing will be at the heart of effective safeguarding practice. Professionals will be confident in their responsibilities to request and share information and will challenge any discrepancies	• Raise awareness of the national information sharing guidance through all safeguarding events and training and consider ways in which this can be made more readily accessible to practitioners	Policy and Procedure Sub-Group/Workforce Development Sub-Group	January 2017
	• Work with the Early Years Team through the Education and Learning Sub-Group to provide clarity on information sharing between early years settings and schools, especially what information should be passed on, how and when	Kay Jones/GSCB Business Unit	February 2017
	• Link in with the work that is being undertaken through the graduated pathway and front door redesign in relation to a more consistent understanding of consent and what people are/aren't consenting to.	Eugene O'Kane/Julie Miles	March 2017
	• Workforce Development Sub-Group to undertake a piece of work to evidence how improving confidence in multi-agency information sharing is being promoted within organisations	Workforce Development Sub-Group	March 2017

Finding Three: The Importance of Child Focussed Practice
This finding links with findings from the 'Abigail' (2014), 'Lucy' (2016) and 'Ben' (2016) Serious Case Reviews. The GSCB will continue to use its Learning and Improvement Framework, including both single and multi-agency audits to consider where best practice exists in order to build on the strengths within the system.

Finding Four: An over-reliance on parental self-report and a lack of challenge to parents			
How Will We Know We Are Making A Difference?	**What are We Going to Do?**	**Who will Lead?**	**By When**
Healthy challenge will be evidenced as an integral part of our professional culture (linking to Finding 4, 'Lucy' Serious Case Review response plan)	• Continue the work that we are already doing to raise awareness of the importance of healthy challenge across the children's workforce in Gloucestershire	GSCB Business Unit	Ongoing
	• Continue to develop the restorative approach to ensure that professionals have the skills and confidence to build open and transparent relationships with families	Cathy Griffiths	Ongoing
	• Reinforce through all safeguarding training what is meant by parental self-report and how this should be analysed by professionals to enable 'pathways to protection' within the safeguarding system.	Izzy Dougan/Workforce Development Sub-Group	March 2017
	• Use the S11 and S175 self-assessment processes to determine how well critical thinking and opportunities for reflection are embedded within organisations working with children and families	GSCB Business Unit/Education and Learning Sub-Group	November 2017

Finding Five: A lack of recognition of the role of fathers/father figures can leave children unprotected and at risk of harm
This finding links to the findings from the 'Ben' Serious Case Review and will be monitored through actions in the multi-agency response plan. The GSCB have already taken action and have developed and implemented a new inter-agency training course in relation to working with fathers. Individual partner organisations have also taken action which will be monitored by the Serious Case Review Sub-Group

Finding Six: The important role of the Early Years Sector in Safeguarding Children			
How Will We Know We Are Making A Difference?	**What Are We Going To Do?**	**Who will Lead?**	**By When**
All professionals working with children and families will be clear on the central role that early year's settings and professionals play in safeguarding young children and they will be fully incorporated into the safeguarding network.	• Use the Early Years DSL forums to share learning from this review • Maximise the opportunities to test whether supervision arrangements are in place within early year's settings to ensure that all staff are able to discuss their concerns and have opportunities for reflection and critical thinking • Review the single-agency training that is provided for early years settings to ensure that learning from this review has been fully incorporated and practitioners are confident in ensuring their voices are heard • GSCB to ask partner organisations to provide assurance in relation to the work that is taking place with the Early Years Sector to ensure they are incorporated in to the safeguarding network.	Kay Jones Kay Jones Isobel Dougan Alison Croft	March 2017 March 2017 March 2017 February 2017

Finding Seven: Practice didn't demonstrate the role of Strategy Meetings to ensure that multi-agency information is shared
The GSCB will seek assurance from Children's Social Care that actions in the single-agency response plan are being addressed. This finding also links back to Finding 4 from this review and with Finding 5 (Ben, 2016) and Finding 4 (Lucy, 2016) and also in the establishment of a culture of high challenge, high support and restorative ways of working together.

Finding Eight: The importance of effective decision making, assessment and management of physical abuse			
How Will We Know We Are Making A Difference?	**What Are We Going To Do?**	**Who will Lead?**	**By When**
Professionals will treat unexplained injuries in the same way as non-accidental injuries.	• Raise awareness of the importance of the need to act as soon as concerns are raised, using a body map to record injuries and clearly documenting the child's explanation for the injury	Workforce Development Sub-Group/GSCB Business Unit	March 2017
	• Review the guidance for all professionals regarding the assessment of potential non-accidental injury and ensure it is compliant with existing NICE guidelines.	Policy and Procedure Sub-Group	March 2017
	• Send out guidance in relation to when a Paediatrician/GP should see a child and ensuring that Paediatricians receive a full history when a CP medical is requested, which is backed up in writing.	Policy and Procedure Sub-Group	March 2017
	• Consider through the GSCB Business Planning Day in February 2017 whether the GSCB should invest in multi-agency practice development in relation to our collective response to physical injuries in children.	GSCB Business Unit	February 2017

Finding Nine: Poor Assessment practice leaves children's needs unknown and unaddressed
The GSCB will seek assurance from Children's Social Care that actions in the single-agency response plan have been addressed.

Finding Ten: The importance of clear and effective child in need processes
The development of the Child in Need Strategy will be overseen by the GSCB Executive Committee. Once finalised, the Strategy will include key principles for working with children and families and the importance of supporting the child at the earliest possible stage.

Finding Eleven: Poor recognition of the early signs of neglect
The GSCB have developed and launched a Neglect Strategy and are currently developing a toolkit for professionals. This finding will be addressed through the Neglect Strategy delivery plan which is overseen by the GSCB Executive Committee. The Executive Committee will hold the Task and Finish Group to account for ensuring that actions are implemented and a framework is in place to be able to measure the impact of this work.

Progress against actions will be reported to the GSCB Executive Committee on a quarterly basis. The GSCB will also use its Learning and Improvement Framework, including single and multi-agency audits to test the impact of how learning from this review has been embedded into changes in practice across all organisations working with children and their families in Gloucestershire.