Haringey Safeguarding Children Board

Response to the Serious Case Review

Introduction:

The publication of the Serious Case Review of Child T has learning for all organisations involved both locally and nationally. The SCR is 59 pages in length and covers the period between mid 2010 and early 2011. The report contains single agency recommendations and specific challenges to which the LSCB should seek reassurance. These recommendations and challenges have been accepted and service improvements already in hand have been outlined in Section 10 of the report.

Agencies and LSCB response to findings

Since the period in question all agencies have demonstrated a clear commitment to learn and improve and have provided evidence to this effect to the LSCB and its sub structures.

With regard to the specific challenges of this serious case review, the LSCB has sought answers to the questions and supporting evidence from all agencies. These responses have been detailed in a composite analysis of the challenges and where changes have not yet been effected the commitment to make such necessary changes and improvement in practice is detailed.

This detailed response will be actively monitored by the board, to provide continuing evidence of impact.

From the detailed response analysis some key changes to note include:

- The use of telephone conferencing to support the involvement of key multi-agency staff where urgency precludes face to face meetings at initial strategy meetings. The practice standard requires all review strategy meetings to be face to face and inclusive of the key multi agency partnership practitioners.

- Children’s services have embedded a programme of regularly auditing assessments and where there are concurrent S.47 enquiries the Principle Social Worker is involved in reviewing the strategy meetings.

- Agencies have satisfied themselves that escalation arrangements are clear and staff are made aware as part of training and induction, who their safeguarding champion or lead safeguarding officers are and the role they have in providing safeguarding support.
Information sharing arrangements have been under specific review this year. The introduction of the Multi Agency Safeguarding Hub (MASH) has improved ownership of sharing information and the MASH information sharing guidance has recently been updated and disseminated across agencies. Agencies have assured themselves that information sharing is included in training and induction of staff.

The report stated that there were not always systems in place for supervision to take place within some services, for example; GPs recognised this and they have proposed to establish lead GP meetings where at least one GP from each practice will attend. This forum would enable communication, supervision and education. Many of the agencies have sought assurance that regular supervision is occurring through audit activity as part of quality assurance. As part of the LSCB QA framework agencies have been asked to provide updates on patterns and trends identified from their audits.

The use of resources and organisational stability was identified as a key focus for agencies; CYPS and Whittington Health have in particular developed a strategic plan to address this crucial question. The LSCB will continue to maintain focus on how agencies are managing organisational change and ensuring safeguarding remains a priority.

All GPs have been sent notification of the need to consider the possibility of non-accidental causation of injury when responding to minor injuries until proved otherwise. In particular where the child is non-mobile and there are multiple bruises in unusual areas of the body for example ears, back. This has made explicit the importance of considering child abuse as a differential diagnosis.

Domestic abuse training is firmly embedded in single and multi-agency training. All agencies apply the framework of the All London Child Protection Procedures and at the North Middlesex hospital a domestic violence policy is in place to ensure that staff are aware of the heightened risk surrounding domestic violence and pregnancy.

The LSCB training programme now includes a training course that looks at female perpetrators to support understanding around “think the unthinkable” and risks posed by females.

Many agencies acknowledge that they need to do much better when listening to children and how this is reflected in the actions they take to safeguard and protect. The board is focusing on this as a priority area for improvement.

Enfield’s children social care has reported changes outlined in the section of the report on service improvements, most notably assigning 2 members of staff to be the key point of contact between their service and the North Middlesex Hospital. The SPOE which was developed screens all their referrals and provides reassurance that if a neighbouring boroughs address is recorded appropriate action will be taken immediately.
LSCB key actions going forward:

The board will carry out its’ responsibility to co-ordinate and monitor the safeguarding arrangements in Haringey and aims to ensure agencies are transparent within their own organisation, with its partners and the public and the children and young people with whom they work, by requiring that:

- The board via its SCR sub group provide an evaluation of the progress of the responses by agencies and challenges agencies to produce evidence to determine if there has been an impact for children.

- The board checks that agencies responses have been factored in their improvement process and implemented. This should be evidenced in the agency’s annual safeguarding reports to the board and included in the LSCB annual report.

- The LSCB coordinates a multi-agency learning event available for all organisations to attend to disseminate the learning from this review.

- The board produces a presentation (PowerPoint) and briefing notes that can be cascaded to all agencies for use as part of organisational learning and included on its website. Agencies will be encouraged to make available time for their practitioners to access the report and absorb the learning.

- The board requests agencies to advise of their contact with children and young people and their families in sharing their experiences of working with that agency. Each organisation will be requested to provide details to the board of any improvement within their annual report.

- The Local Authority secures a named safeguarding lead for Education that can provide support and ensure the involvement of schools in child protection enquiries.

- The board requires that Children’s Social Care, Police and Health and other partners conduct a multi agency audit of strategy meetings in order to assure the Board of the quality and effectiveness of that process; to evidence whether decisions are made in line with policy and procedural requirement, children’s best interests and without unnecessary delay; whether the right agencies were present; whether timely action was taken and did it achieve the planned outcome?

- The agreed multi-agency escalation policy is re-sent to all agencies as a reminder to use it when required. The board will regularly review the policy to ensure it is fit for purpose and will carry out evaluation of its use and understanding.

- Enfield LSCB inform us of progress of their intention to take over the steering group of their SPOE so that the multi-agency partnership can be fully appraised of the operational efficacy of the front door of the service and assure itself of the safety of the system.
• The board to seek re-assurance from Enfield LSCB and North Middlesex Hospital that weekly child protection meetings and LINK meetings are regularly reviewed to ensure that actions identified are followed up.

• The board will seek evidence from the Children’s Trust and Health and Wellbeing board of their actions in both commissioning and review of early help and prevention.

Graham Badman

Independent Chair

10th October 2013