Southampton Safeguarding Children Partnership Response – Clare

This Serious Case Review was commissioned by the Southampton Local Safeguarding Children Board in 2018. The review considers the circumstances of a child for the purposes of the review is known as Clare. Clare's family had been known to statutory agencies in Southampton for a number of years and the children in the family had been subject to child protection and child in need planning in the past.

This independent review brought together the contribution of a number of agencies and professionals that had been or were involved with Clare and her family and gained the perspectives of Clare's parents. The report captures points of learning and improvement and has made recommendations for Southampton Safeguarding Children Partnership to continue to take forward.

The Southampton Safeguarding Children Board transitioned to the new Southampton Safeguarding Children Partnership (SSCP) in September 2019 in accordance with the new statutory guidance, Working Together to Safeguard Children 2018. The SSCP, under the joint leadership of the Safeguarding Partners, have overseen the completion, publication and response to this Serious Case Review.

The Safeguarding Partners in Southampton endorse the recommendations made by the review author and will continue to work to ensure the recommendations are implemented and understood by practitioners.

This document provides the responses by the Southampton Safeguarding Children Partnership and individual partner agencies to any recommendations made to them.

Recommendation 1a.
When referrals are received into the MASH investigations are undertaken to ensure that all relevant information is gathered from agencies to make an informed decision as to the risk of harm to a child.

In February 2019 the Multi Agency Safeguarding Hub was subject to a review by two independent consultants. In March 2019 there was a detailed audit of MASH practice and decision making. The service area completed improvement activity against the recommendations and a further review in summer 2019 provided assurance.

The Ofsted ILACS standard inspection in November 2019 stated that:

Most children and families receive a prompt and proportionate response to enquiries and referrals to the MASH. The MASH benefits from the co-location of a wide range of partner agencies, promoting easy and quick information sharing that informs subsequent

recommendations and decisions. Referral thresholds are not always well understood and applied by partner agencies, and this is compounded by some inconsistent decisions by managers in the MASH. This results in a small number of children not receiving the right level of help.

The understanding and application of thresholds is an area of improvement in the Children's Services post-inspection plan and this includes work with the Southampton Safeguarding Children's Partnership.

From March 2020 to May 2020 there have been weekly dip samples of MASH decision making with a report to the Children and Families Service management team. Decision making and outcomes have been found to be appropriate in the majority of cases. A management audit of MASH is scheduled biannually, as part of the service Quality Assurance Framework.

The OFSTED inspection report (November 2019) also states that:

The quality and type of referrals made to social care are not always appropriate or well informed, particularly those from the police. Pre-referral triaging is slowly improving, but MASH staff still devote too much time screening out unnecessary contacts. Consent from families to share information is appropriately sought and overridden by managers when necessary.

Again, these areas for improvement are in focus, through the Children's Services post-inspection planning and work with the SSCP.

Hampshire Constabulary understand the need to improve the quality of their referrals via their Police Protection Safeguarding Notification (PPN1s) submissions and take an active part in multi-agency audits and inspections in order to better understand how partners work and what they require.

The constabulary has started a multi-agency PPN1 scrutiny panel to look at the issues relating to the completion of PPN1s and further work will be undertaken with officers and staff in the near future using face to face briefings and training. Policy Optimisation Drops (online training) will be used to inform officers and staff around the requirements in PPN1s. This work will be developed in conjunction the constabulary's Child at Risk Strategy

Recommendation 1b.
It is recommended that an independent audit of current MASH procedures is undertaken to reassure the Partnership that referrals are receiving appropriate priority and adequate investigation by appropriate information gathering.

As noted above, the findings of the independent review of MASH were responded to in 2019 and the Children's service has embedded the audit methodology used by the independent review into its own quality assurance framework to ensure that there is ongoing scrutiny of practice in the MASH.

The independent audit will take into account the Ofsted inspection findings (November 2019) and the Children's Services Inspection Improvement Plan (ongoing). The scope of the audit will be confirmed with strategic partners through the Safeguarding Children's Partnership and MASH Strategic Group.

Recommendation 2a.
It is recommended that an independent audit is undertaken of Public Law Outline cases to ensure that required procedures and timescales are adhered to and cases are not subject to drift.

Public Law Outline (PLO) was subject to scrutiny through an independent reviewer, commissioned by Children's Services in 2019; with PLO guidance reviewed as a result. In November 2019, the Ofsted Inspection report concluded that:

A small number of children wait too long for pre-proceedings to be started or are held in the pre-proceedings phase for too long. However, the majority are timely and appropriately concluded. The quality of letters to parents differ. All letters document concerns and expectations, but some could be improved using plain and simple English. The pre-proceedings phase ensures that most critical assessments are completed.

Children's Services now track and monitor timeliness in this area through its post-inspection improvement plan. It is recommended that this information is shared with the Safeguarding Children's Partnership as part of its biannual safeguarding improvement report, in order to provide ongoing assurance.

Recommendation 2b.
The current system whereby no designated business support is available to strengthen the legal gateway process requires urgent review.

Since this recommendation was made, review of this area of work has resulted in the following changes.

The role of designated business support to strengthen the legal gateway process has been confirmed and is in operation. There is a central tracking mechanism in place to support the monitoring of the legal gateway process. The quality assurance framework includes thematic review of the legal gateway process. The SSCP will be provided with assurance of the effective operation of the legal gateway process as part of Children's Services regular assurance reporting.

Recommendation 3a.
All agencies are to be reminded of the impact of domestic abuse on the health and emotional wellbeing of children, and support offered to professionals to adopt a trauma informed approach.

Considerable training and guidance is offered by partnership agencies and as a collective partnership. This has included training around domestic abuse and adverse childhood experiences.

The SSCP received a report in September 2020 regarding Restorative Practice, Adverse Childhood Experiences and Trauma Informed approaches from Children's Services. This identified collective actions to be taken to ensure professionals are considering and recognising the impact of domestic abuse on children and the need to be trauma informed in our response. With Children's Services as the lead, SSCP agencies are engaging with training around Restorative practice which supports trauma-informed responses in work with children.

The SCC Children and Families Service training offer 2019/2020 included training on:

- Adverse Childhood Experiences (ACEs) – 5 workshops
- Solihull Approach seminars – 4 seminars
- Attachment (1session , Brain Development (2 sessions), Understanding Trauma Workshops (1 workshop))
- Domestic Abuse and impact on children and young people – 3 sessions
- Working with families and disguised compliance – 1 session

There were 437 attendees. Plans for 2020/2021 include the continuation of these sessions when face to face training is resumed. In the meantime, resources and details of online training are being sent to the SCC workforce electronically.

The service has also recently reviewed its risk management and assessment guidance and guidance around the use of Child Safety Agreements in light of Ofsted feedback regarding Children's Services response to domestic abuse.

Moving forward, Children's Service will work to ensure consistent understanding of the impact of domestic abuse. Children's Service is tracking access to and uptake of domestic abuse training as part of its post-inspection plan. Assessment Teams have already undertaken work with the IDVA Manager. Protection and Court colleagues are working with the Principal Social Work Team to develop and embed learning with staff through learning circles.

Hampshire Constabulary are developing trauma informed approach to policing, embedding the understanding of adverse childhood experiences and resilience factors continues. Officers and staff have been trained to become Trauma informed Educators by Rockpool funded through the violence reduction units and custody staff in Basingstoke have been trained. Trauma informed training has been embedded within initial training for officers, the Neighbourhood Excellence course and Responding with excellence. However this will form part of ongoing work which will require cultural change to ensure that officers understand what they should be doing differently when attending incidents and submitting information to partners.

Governance by the Integrated Public Service Board. Emerging Strategic Plan – A life course approach.

Strategic Aim 1: To embed trauma–informed and restorative practice that promotes early intervention and prevention across all public services within Hampshire, Isle of Wight, Portsmouth and Southampton

Strategic Aim 2: To ensure that that there are a range of universal, selective and targeted interventions in place to prevent or reduce the impact of ACEs & Trauma at a population level

The Clinical Commissioning Group continue to offer regular training sessions to primary care and other private health providers, including domestic abuse and the impact of Adverse Childhood Experiences and trauma.

Education staff are committed to raising the awareness of Adverse Childhood Experiences. We have provided information through the Safeguarding updates, DSL updates and online resources to support school staff use a trauma informed approach. Health colleagues (Child and Adolescent Mental Health Services, the Clinical Commissioning Group and Public Health England) continue to provide information in relation to online training and resources to support a trauma informed approach.

Operation Encompass is in operation is Southampton Local Authority area. This recognises the need for support to be in place for children who have been impacted by domestic abuse through effective early information sharing.

Recommendation 3b.

Intimidating and aggressive behaviour by parents and carers cannot be allowed to detract from the importance of professionals focusing on the safety and protection of children. The Partnership should seek assurance that the provision of safeguarding training to raise awareness of disguised compliance, and regular, reflective supervision is being delivered and accessed by professionals. If this is not happening, then action should be taken to ensure that the situation is addressed

The SSCP are working to ensure continued delivery of training for multi-agency colleagues in relation to disguised compliance. The delivery has been impacted by COVID -19 regulations and guidance. There are now plans in place to resume delivery in 2021 (in line with COVID-19 regulations).

In addition we are developing guidance for multi-agency staff to support them in this challenging area or work. The SSCP will continue to seek assurance that the reflective supervision being accessed by multi-agency staff is maintained in terms of sufficiency and quality.

The CCG will work with safeguarding children partnership colleagues to ensure that any specific training that is available to multi-agency colleagues regarding disguised compliance is shared with and offered to primary care colleagues and safeguarding leads within other health providers. This topic can also be covered during the regular training sessions and planned webinar sessions that the CCG team will be offering to primary care and other health providers, particularly in relation to “learning from case” review sessions.

Hampshire Constabulary have developed a business case to be submitted to commission Sandstories Training (Disguised Compliance) on an annual basis to support continued awareness of repeated SCR recommendation for Child Abuse Investigation Team (CAIT) officers linked to the above.

A Sandstories Disguised Compliance event has already been held in Nov 2019 with 20 CAIT participants. Feedback supportive of wider rollout. This has been impacted by COVID-19, however a short Learning Matters bulletin in regards to disguised compliance as an interim measure

All Education staff receive regular safeguarding training/refreshing which includes recognising and raising awareness of disguised compliance. In addition, reflective supervision is currently provided by psychologists within SCC (Clinical and Educational) to social care colleagues. Education professionals have access to reflective supervision on a regular basis and school colleagues can purchase in from the EP service.

Childrens service has commissioned Sand stories disguised compliance training since November 2018. To date, the courses have been fully subscribed and 50 practitioners have attended.

Feedback about the training has included:

'I have been on many training events in my time but this is one of the best that I have ever attended'.

'Very powerful training and made me self-reflect on my work'

'I will aim to be more authoritative in my practice and have learnt not to apologise for putting the child at the centre of my work'.

'This training has refocused the children back into centre of all of the cases I am working on'.

Moving forward, the service needs to ensure that there is a strategic approach to practitioners engaging with the training, to ensure that knowledge and expertise is spread across the service

Recommendation 4.
It is recommended that an independent audit is undertaken of CAMHS to ensure that the pathway for children diagnosed with ADHD introduced by Solent NHS is adhered to, and that children are not being medicated unnecessarily to enable them to remain in education.

Solent NHS Trust has completed an internal audit (led by the new Nurse Consultant within CAMHS). Early indications (reported by the Named Nurse for Safeguarding Children) are that the audit has been positive in its findings. The audit and findings has been shared with the Serious Incident Learning Group of the SSCP for assurance.

The Clinical Lead for Children within the CCG is aware of this work.

Recommendation 5.
It is recommended that a formal procedure is developed to ensure that where siblings attend different schools, information is shared between each individual school to ensure that an overall picture of a child and their family is available to teachers and education professionals.

This recommendation will be included in the Guidance for safeguarding policies for Education settings which is reviewed annually each August.

How settings ensure they follow this recommendation will be determined by the size of the family, number of schools attended and any legal processes already in place.

Recommendation 6.

It is recommended that Southampton Children's Safeguarding Partnership gives consideration to launching a campaign to raise awareness amongst parents and carers of the need to be curious about the background of males who are invited into their homes. The toolkit used by Hampshire Safeguarding Children Partnership may assist this recommendation.

https://www.hampshirescp.org.uk/toolkits/understanding-unidentified-adults/practical-tools/

As part of the response to this review, the Southampton Safeguarding Children Partnership will work to ensure awareness is raised amongst parents and carers. This has, in part, been actioned by the publication of the review, and the communications that surround this, but also relies on increased awareness amongst professionals which will be achieved through considering the toolkit developed by colleagues from the Hampshire Safeguarding Children Partnership.

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