Buckinghamshire BSCB Safeguarding Children Board

SERIOUS CASE REVIEW
Executive Summary

Baby E

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Contents

1 INTRODUCTION

1.1 REASON FOR REVIEW

1.1.1 In Spring 2012 a 14 week old baby (referred to as baby E) was presented at hospital with a history of poor feeding and being unsettled. The baby was diagnosed at hospital as having suffered a fractured femur. Three weeks earlier the baby had been seen at the hospital with facial bruising which a consultant paediatrician had concluded was 'less likely to be accidental injury'.

1.1.2 Donald McPhail, the independent chair of Buckinghamshire Safeguarding Children Board decided on in May 2012 that the circumstances met the criteria for a serious case review because of the severity of the injuries and the initial evidence that agencies did not work effectively together, in particular in making the assumption that mother could protect children without adequate checks and assessments.

1.1.3 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of Working Together to Safeguard Children HM Government 2010.

1.1.4 A Serious Case Review should be initiated when a child has died and abuse or neglect is known or suspected to be a factor in that death. Its purpose is to:

- 'Establish what lessons can be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result and
- As a consequence, improve intra and inter-agency working and better safeguard and promote the welfare of children'

1.2 BACKGROUND OF AGENCY INVOLVEMENT

1.2.1 Baby E was born prematurely and spent the first nine weeks of life in hospital.

1.2.2 There were concerns about baby E and child F's welfare from the point of the birth due to the discovery that their mother's new partner had previously been involved in a relationship which involved many domestic violence incidents. The children in that household were subject to child protection plans, in part due to the possibility of contact with this man.

1.2.3 Whilst baby E was in hospital it was noticed that she did not visit her baby consistently, nor take a great deal of interest in her child's development and progress. However, following the articulation of these concerns by hospital staff, she demonstrated more interest in her baby and eventually brought her new child home.

1.2.4 Over the next two weeks baby E was at home supported by several visits from health practitioners and one from social workers. Baby E continued to make good progress in terms of feeding and putting on weight, but there continued to be concerns around mother's interest in her baby and her ability to follow advice provided by health staff. Moreover, it was noted that her new partner was living in the home and observed to be caring for child F, contrary to the agreements made with mother.

1.2.5 When baby E was aged 11 weeks and had been home for just over 2 weeks, the health visitor discovered baby E to have facial bruising, which a consultant paediatrician concluded was 'less likely to be accidental injury'.

1.2.6 Baby E returned home whilst a child protection enquiry and criminal investigation were undertaken into the bruising, with an agreement with mother that her new partner would be excluded from all childcare tasks and not reside at the home. The mother and her partner provided several possible explanations for the bruising, but just before the planned meeting to consider the outcome of the investigations baby E was admitted to hospital following the health visitor being concerned that baby E was not feeding properly and cried on movement. Following admission at the hospital, baby E was diagnosed as having suffered a fractured femur, with the injury likely to be 2-3 weeks old.

1.3 SUMMARY OF FINDINGS

1.3.1 Baby E was a premature baby and the emergency services and the hospital Neo Natal Unit are to be commended for their fast responses and the support provided to the family, albeit there were some learning about communication and the need to consider all children in a family.

1.3.2 From the start there was overall good research undertaken of the history known by each agency, albeit the Out of Hours Service of the Local Authority faced problems due to the complexity of searching for information about adults on the children's electronic care record.

1.3.3 However having recognised risks to the children in the household, there was a reluctance to identify these in terms of the child protection threshold, with the view that further evidence was required to be able to explicitly consider this further.

1.3.4 The assessments undertaken in response to these concerns followed usual assessment processes, but did not sufficiently address parenting capacity issues so that judgments may be made about the cause of the problems, the potential for change and the likely outcomes for the child.

1.3.5 The health visitor is to be commended for her interventions, identifying risk, alerting social care and facilitating baby E's presentation at the hospital.

1.3.6 When the child protection threshold was identified, the subsequent multi-agency investigative process (medical, police and social care) lacked rigour, consequently weakening the chances of identifying the perpetrator of the bruising on baby E and potentially the extent of baby E's injuries.

1.3.7 Having identified the child protection threshold, assumptions were made about the identity of the perpetrator and the ability of the mother to safeguard her children, so leaving both children at risk of significant harm in the home. There was no evidence to support either of these assumptions.

1.3.8 Multi-agency processes were insufficiently collaborative; this weakened the assessments undertaken. Most strikingly the GP was totally excluded from all such processes as well as routine communications, which impacted on available information about the relationship between mother and her baby.

1.3.9 The birth father was ignored in this case. He was not informed about the concerns for his children, nor of allegations made against him. Moreover his exclusion from contact with his baby was not consistent with the welfare of baby E nor was it consistent with the law.

1.4 PUBLICATION

1.4.1 In line with publication requirements for serious case reviews, the overview report and this executive summary have both been anonymised. To protect the identity of the children concerned their gender and birth dates are not included in the report and the precise dates and location of events have not been provided. The children are referred to as 'baby E' and 'child F'.

2 REVIEW PROCESS

2.1 SERIOUS CASE REVIEW PANEL MEMBERSHIP

2.1.1 Members of the panel set up to consider the case were as follows:

- Donald McPhail (Independent Chair)
- Business Manager BSCB
- Head of Children's Quality Standards and performance – BCC
- Detective Inspector – Protecting Vulnerable People Manager – TVP
- Senior Psychologist – BCC
- Development Officer – Buckinghamshire Safeguarding Vulnerable Adults Board
- Operational Lead for Children and Young Peoples Community Services (BHT)
- Designated Doctor for Child Protection (NHS Bucks)

2.2 INVOLVEMENT OF LOCAL AGENCIES

2.2.1 The following local agencies were identified as having potential information of relevance to the serious case review and were asked to provide an individual management review:

- Local Authority Children and Families (C&F): provides the children's social care service
- Local Authority Adults and Family Wellbeing: manages the Out of Hours Service for both children and adults social care
- Thames Valley Police (TVP)
- Buckinghamshire Healthcare NHS: health visiting service, maternity services and Stoke Mandeville Hospital
- General Practitioners (GPs)

2.2.2 Additionally information was obtained from the nursery attended by child F, baby E's sibling.

2.3 TERMS OF REFERENCE

2.3.1 The SCR panel determined that learning could be maximised by asking each agency to review the period from July 2011 to April 2012 and establish:

- What assessments, including those relating to domestic abuse, were undertaken and the quality of those assessments
- What risk factors were identified in relation to the children
- If plans were implemented and to what extent the plans addressed any risk factors identified in the assessments
- If agencies shared information appropriately and involved other professionals or agencies as necessary
- If assessments took full account of the information available to the agency
- To what extend the "voice of the child" and "voice of the sibling" were heard in terms of understanding the needs of the child and taking account of their experience in the family
- To establish if there were factors which enhanced or impeded working relationships with the parents
- To what extent the parenting capacity was considered and addressed
- To what extent the father and male carer/ partner were identified and assessed in relation to their roles with the children
- If the diversity needs within the family were identified and addressed

- If there were any capacity issues within agencies that impacted on the quality of the services provided
- If staff involved had the skills, knowledge and experience to address the issues within the family
- If staff within agencies co-operated to achieve the best outcomes for the children
- To what extent strategy discussions/meetings provided a clear framework for the investigation of concerns
- To what extent individual agency and multi-agency policies were adhered to and to comment on the adequacy of those policies
- If staff directly involved had appropriate supervision and managerial guidance

2.3.2 During the course of the review it was identified that information was required about the partner's history in his previous relationship in so far as it is relevant to care of children E and F. Excluded from the scope of this review is any analysis of the agencies responses in terms of the care of the children in this second household.

2.4 INDEPENDENCE

2.4.1 Panel members had no prior involvement with baby E or the family; the panel was chaired by Donald McPhail, the independent chair of the Local Safeguarding Children Board, and the overview report was written by a suitably experienced author Edina Carmi, who has no connection with the agencies or professionals involved in this case.

2.4.2 Each agency's own individual management review was drafted by a suitably qualified individual with no line management or supervisory responsibility for the case. An independent health overview report was also provided.

2.5 INVOLVEMENT OF FAMILY

2.5.1 It was planned to involve family members in the review process, but to date this has not proved possible, due to the criminal investigation. When the police are able to agree this, interviews will be offered to mother, father and maternal grandparents and an addendum provided of their contributions.

2.6 INVOLVEMENT OF STAFF

2.6.1 The individual management reviews of each agency describe the extent to which staff have been involved through interviews. As part of the quality assurance process the panel agreed the need for any additional information from staff.

2.7 QUALITY ASSURANCE PROCESS OF IMRS

2.7.1 The serious case review panel met with the authors of the individual management reviews on several occasions to provide challenge and quality assurance, with the result that all the reports provided covered the required scope comprehensively and effectively analysed the practice within the agency, including consideration of systemic factors.

2.8 RECOMMENDATIONS & ACTION PLANS

2.8.1 Recommendations arising from the multi-agency perspective are provided at the end of this report, along with the individual management review recommendations for improving service delivery.

2.8.2 Each agency has produced its own action plans for implementation of IMR recommendations, stating how each recommendation has been or will be implemented,

identifying the responsible person, the progress made and the timescale for its achievement. These have been incorporated into an integrated action plan including the recommendations arising from the multi-agency analysis in the overview process.

3 LESSONS LEARNT

3.1 LESSONS LEARNT

Assessment

3.1.1 The identification of risks is the first part of assessment processes. This needs to be followed by consideration of the implications for the children of such a risk, how to evaluate the extent of the risk and the possibility of being able to minimise it.

3.1.2 Potential issues relating to parenting capacity such as depression, low self esteem and learning difficulties need to be identified and explicitly evaluated as early as possible. In this instance such risks were raised, but not fully explored and assessed.

3.1.3 There is a need to ensure that TVP staff undertaking domestic abuse risk assessment work understand the need:

- To ensure that any assessment takes full account of history of household members, both in relation to domestic abuse and child protection
- To raise the risk level in circumstances when the victim is not engaging
- For a new risk assessment for every incident regardless of the content of the allegations or the date of the previous incident

Joint investigation practice

3.1.4 S. 47 enquiries should be initiated in accordance with the law, when there is suspicion (as opposed to evidence) that a child is suffering or likely to suffer significant harm – the strategy discussion or meeting is held to discover if there is such suspicion. It is vital that a s.47 is initiated whenever this threshold is met, as this clarifies concerns for all agencies. There is an urgent need to discover if there are systemic problems within the multi-agency system that inhibited social workers, paediatricians and the police from recognising this threshold at various points with baby E.

3.1.5 Any suspicious injury to a non mobile baby / child must be the subject of investigation, with police involvement from the outset so that potential forensic evidence is not lost or delayed. The police have had recent training input on this, so no recommendation has been made.

3.1.6 In order for s.47 enquiries and associated criminal investigations to succeed in discovering what happened to a child, it is imperative the investigations are multi-agency co-ordinated and monitored by timely strategy discussions / meetings. Delay should not occur in the collection of forensic evidence and allegations need to be followed up before witnesses reconsider their position.

3.1.7 When non accidental injury is suspected in a young child and the identity of the perpetrator is unknown, the child should not usually be returned to the same home circumstances until investigations have been completed. In this case a return home should not have been considered until a strategy meeting was held to agree what further investigations were required.

3.1.8 When there is suspected non accidental injury of one child in the household the safety of all children in the household need to be considered, including the use of paediatric assessment (as offered in this case).

3.1.9 When children are in hospital there is no legal basis for keeping them 'safe' should parents wish to discharge them – social workers and police need to agree with hospital staff contingency plans if the expectation is that the child must not be discharged

3.1.10 Even when it is considered the child is safe in hospital, it is important that police are informed of any change of circumstances during a police investigation, such as further allegations / child admitted to hospital.

3.1.11 The weaknesses in joint practice may be associated with the lapsed use of the joint investigation protocol and this is a timely reminder of the need for such local agreements.

Health assessments

3.1.12 Pre-birth assessments to consider the need for health visiting support prior to the birth, need to be holistic and take account information from all sources, not just the midwives identification of maternal vulnerability.

Paediatric assessments

3.1.13 In order to effectively communicate to other agencies, the wording of medical reports need to make the conclusions as clear as possible, and sum up all known risks.

3.1.14 As soon as non accidental injury is suspected children's social care need to be informed so that consideration is given to the safety of the child in the hospital and any other siblings who remain at home. For these reasons as well as the clinical care of the child, it is important to avoid delays in diagnosis on the basis the child is perceived to be 'safe' in hospital.

3.1.15 Some delay was associated with both real and perceived limitations to expertise at the week-end: hospital staff need to be aware of the sources of out of hours expertise so that services are provided regardless of time of day or the day of the week.

3.1.16 This case highlights the need for consistency of review by the consultant on call, to ensure a consistent overview is available.

Working with parents and carers

3.1.17 All agencies need to develop a culture that involves working with both parents, including both in discussions and meetings about concerns and assessments and consistently following up allegations.

Multi-agency work

3.1.18 Communications between out of hours services may involve unknowns due to emergency circumstances, but when decisions are required about action to safeguard children, such discussions need to involve supervising police officers.

3.1.19 In order to maximise the quality of core assessments, all agencies should be asked to be involved in contributing up to date information and participating in the analysis process as well as the subsequent planning.

3.1.20 Practitioners in all disciplines and agencies need to understand that medical assessments do take account of social concerns and in particular any concerns about suspected abuse: these may affect the medical investigations undertaken.

3.1.21 GPs provide a universal service for all children and should have all key information about children and carers. It is vital that they are involved in the multi-agency child in need and child protection system. The fact that this is not happening either between agencies or

within health is a critical concern and there needs to be clarification about what should be shared and who is responsible for sharing information with the GP, both within the health service and with other agencies.

Focus on children

3.1.22 This case has highlighted that when staff have responded in emergencies they have not always thought about checking on the family composition and the potential implications for siblings.

Planning

3.1.23 The use of written agreements is useful in so much as it makes expectations clear to all parties, and is helpful in any subsequent legal proceedings. However, without contingency arrangements and stringent multi-agency monitoring they are of limited use, and can give a false sense of re-assurance to staff.

Social Care records

3.1.24 The national implementation of the Integrated Children's System caused considerable upheaval in Buckinghamshire and most local authorities. Whilst some of the disruption was temporary, the staff in Buckinghamshire (like elsewhere) work with a very complex record system in which it is difficult to easily identify the relevant history of a case and the current circumstances.

3.1.25 The system has additionally had unintended consequences due to its linear design, which may place obstacles in moving into child protection once a child in need approach has been followed.

3.1.26 For staff needing to obtain information in an emergency, such as the Out of Hours staff, it is challenging to obtain pertinent data in a short space of time. Moreover, because the system is designed to capture relevant information about children, it will take considerable time to put together relevant history and concerns about an adult, or indeed a family. This is a potential risk to safe practice.

Supervision

3.1.27 Social workers and their managers need to develop skills in being able to combine analytical and emotional thinking, when assessing the care of children and in particular the risks to them. Reflective supervision and/or mentoring should assist front line staff to make use of such emotions in their work.

4 RECOMMENDATIONS

4.1 INTRODUCTION

4.1.1 8.2 provides the recommendations arising from the overview report which are not already covered in the individual management review recommendations 8.3.

4.2 OVERVIEW RECOMMENDATIONS

RECOMMENDATION	INTENDED OUTCOME
All agencies	
The LSCB to develop a local Framework for Assessment to provide a sound basis for multi-agency assessment	• The child protection threshold to be identified earlier, when the risk of significant harm is suspected (in accordance with the law) as opposed to when there is evidence of significant harm • Multi-agency involvement in assessments information collection, analysis and planning
The LSCB urgently to establish if the joint investigative work in this case is indicative of current practice	• Establish via audits in whether the practice shortcomings are due to individual errors or a reflection of systemic problems • If individual problems, this can be addressed via training and supervision • If systemic problems, there will need to be strategies implemented to improve practice so that such investigations are more likely to identify what has happened to a child
The LSCB to ensure a new joint investigative protocol is agreed between all agencies	• To include the role of all agencies • To consider how to bring rigour into the investigations so that forensic evidence is followed up, that all medical investigations are completed and that the risks to all children in the household / family are considered • To ensure strategy and review is of high standard • To ensure that decisions to return children home have considered fully the risks and are not based on assumptions • To ensure that agencies are updated when there are changes of circumstances to a child subject to an open s.47 enquiry and criminal investigation
The LSCB to facilitate the development of a culture which includes working with both birth parents as well as any carers	• Fathers not excluded from meetings, without sound rationale • Fathers informed of any concerns about their children • All allegations about care of children are followed up

RECOMMENDATION	INTENDED OUTCOME
The LSCB to develop a strategy with the new clinical commissioning groups to bring GPs into the centre of child safeguarding	• Information is fully shared with GPs • GPs share information • GPs involved in s.47 enquiries and in core assessments
The LSCB to encourage a culture of critical thinking around domestic abuse, which facilitates the identification of all relevant risk factors.	• Training courses on domestic violence / abuse to emphasize the dangers of falling into 'pitfalls' by making assumptions based on simplistic stereotypes • Training courses on assessment to provide an understanding of critical thinking • Training courses on reflective practice to emphasise the use of critical thinking in challenging assumptions and potentially rigid thinking
C&F	
A review should be undertaken of the current C&F electronic care record	• ensure the records are user friendly • ensure that information is easily accessible for staff in an emergency • record includes summaries and adequate chronologies • adult records include easily accessible information of historical concerns relating to children and parenting capacity
The use of written agreements to be clarified and understood within all agencies	• Prevent false sense of re-assurance when it is not possible to ensure safety • To only be used when the risks are able to be monitored effectively • all involved practitioners to receive a copy with expectation of involvement in monitoring • contingency arrangements clarified within agreement
Health	
The system for identification of vulnerable pregnant women and foetus to be reviewed	• Ensure pertinent information from health visitors and GPs records is communicated to the midwifery service
The LSCB to be informed of progress in achieving the Healthy Child Programme in respect of antenatal contact by health visitors	• That there continues to be improvement in the percentage of families receiving this service • That families identified as vulnerable are able to be prioritised for the service

4.3 INDIVIDUAL MANAGEMENT REVIEW RECOMMENDATIONS

Children and Young People: Children and Family Services (C&F)

RECOMMENDATION	INTENDED OUTCOME
C&F should work with other agencies to ensure that it becomes standard practice for Assessments to be multi-agency.	Children will benefit from the specialist knowledge and expertise of each agency, and outcomes will improve from the Plans set up with multi-agency involvement.
Ensure all staff are using the up-to-date version of the Children in Need procedures,	Children would benefit from a clear Plan and work pathway, the expectations of which would be clear to all relevant professionals.
The use of Written Agreements should be reviewed so that they are limited to being a tool ensuring clarity of expectations for parents or young people, and the professionals in C&F interventions.	It will be generally understood that Written Agreements are not interventions: children cannot be protected by a Written Agreement especially when the outcome depends on the compliance of relevant adults.
When C&F make a written agreement with parents or young people copies should be sent to other professionals involved in the case, unless there is a specific reason why this should not happen.	This ensures that relevant professionals are aware of the expectations on the parents.
C&F with TVP should review and revise the existing Joint Investigation Protocol and ensure that SWs are updated and that the Protocol is available for reference. Once an updated protocol is agreed Training to organised as part of the revision of the Protocol about joint investigations – not just ABE training	Both agencies are committed to working within a Joint Investigation framework, are clear about roles and responsibilities. When these are not adhered to there is a clear process for professional challenge.
ICS fast-tracking facilities should be made available so that it is possible to move from Referral or Initial Assessment (or other points in a case) to CPCC without having to complete a set sequence of forms to progress the record.	The workflow will be simplified so that it is more flexible and SWs do not have to complete forms unnecessarily, so that there can be a focus on professional judgement and the analysis of risk.
When a document is stored on Livelink, an ICS record which notes where it is stored on LL must always be made.	The Child's electronic record evidences the child's journey.
As part of the planned practice changes there should be a focus on developing systemic understanding of Domestic Abuse and the dynamics of this in families. This should include pro-active work with the abuser, and if a parent who is no longer in the family is described as an abuser this should be explored with them as an extension of the dynamics,	SWs will be assisted to analyse the dynamics of the adult relationship, so that the victim is not under pressure to protect their children when the abuser is exploiting their vulnerability. There will be an assessment of the parenting abilities of the victim, including the negative affects of the relationship on their parenting. Abusers will be also be assessed and given the opportunity to change

rather than accepting the description given.	
When an adult who has been the reason for children being subject to CP plans is found to have moved in with a new family: A Child Protection Conference for the children in the new family should be considered. If there are reasons why this is not necessary, these must be discussed with a CP Chair before making a decision not to hold a CPCC. The CP Chair (and the Core group) for the previous family should immediately be made aware of the circumstances, and continue to share information	The extreme vulnerability of babies will be part of general CP understanding. There will be stronger measures taken to protect babies when suspicious injuries have been identified. Senior managers and C&F legal will support SWs in these cases, even if action has to be taken when evidence (as opposed to risk) is not definite as this can be the difference between life and death.
Guidance should be developed with the assistance of health in regard to risk to babies, and workshops to be set up to circulate the guidance	The extreme vulnerability of babies will be part of general CP understanding. There will be stronger measures taken to protect babies when suspicious injuries have been identified. Senior managers and C&F legal will support SWs in these cases, even if action has to be taken when evidence (as opposed to risk) is not definite as this can be the difference between life and death.
Risk assessment guidance tool should be developed to improve the analysis of categories and levels of risk and evidence. Risk analysis to be clearly evidenced in recording and in CPCCs	This will improve the protection of children, and work being done by C&F will be more appropriate to their needs.

Health Overview

RECOMMENDATION	INTENDED OUTCOME
Midwifery services to review discharge procedures and information sharing between hospital and community services	To ensure that there is a mechanism for information sharing regarding vulnerable families particularly when there has been a premature delivery.
NNU to review discharge policy	To ensure that the mechanism for sharing information regarding child protection concerns with GPs is strengthened.
NHS Buckinghamshire to seek assurance that the paediatric department has completed a review of its procedures in cases of suspected non-accidental injury and to report implementation of recommendations made from this SCR and the internal review.	Appropriate timely action is taken by suitably trained staff to meet the needs of children in cases of suspected non-accidental injury

GP recommendations

SURGERY SPECIFIC RECOMMENDATION	INTENDED OUTCOME
The monthly liaison meetings with the health visitor team should continue and cancellations be avoided	Improved communication to ensure the highest level of care for all.
This case should be discussed at Surgery 2's next Significant Event Review Meeting focusing on communication between agencies.	Learning points should be identified and acted upon and communication between agencies improved.
RECOMMENDATION	**INTENDED OUTCOME**
General Practitioners should put Case Conference minutes, when received, in BOTH parents notes and those of the siblings too.	To ensure parenting capacity can be assessed to safeguard children in the future, especially when parents are registered at different surgeries.
General Practitioners should be encouraged to read the GMC's new Child Protection Guidance	Improved awareness of GPs of Child Protection to ensure Bucks Children are safeguarded

Health visitor recommendations

RECOMMENDATION	INTENDED OUTCOME
The Health Trust to review the current record system RiO, on how families can be linked together so that all family members can be identified. The Health Visiting team to review processes for information sharing and communication with GP's.	Staff to revisit basic RiO training to understand how this can be done. HV to explore how monthly practice meetings can be utilised to include discussion about the dynamics in family units and ensure that any safeguarding issues are considered for every child in the family.

Midwifery

RECOMMENDATION	INTENDED OUTCOME

Access for GPs to BHT maternity guidelines.	All professionals working to an agreed standard practice.
Review of the process for complex discharges from the postnatal ward, to ensure all relevant information is relayed to the community midwife and GP. Sharing of these findings with the hospital and community midwives	Early warning to the relevant professionals that there are concerns. To use the learning from this case at the mandatory child protection updates. It highlights how a breakdown in communication with the multi–agencies can lead to far more complex scenarios.

Hospital

RECOMMENDATION	**INTENDED OUTCOME**
Clear pathways for information sharing when children present with suspected NAI between professionals within health between agencies	To ensure that a child whose safety and welfare is at risk is protected from harm.
Child Protection Supervision for the Paediatric Department	Consistency of child protection procedures to ensure all children coming through the department are equally safeguarded.
Improve Medical record keeping Documentation in the records at the time the events happen, or as soon as possible afterwards. Record concerns, including any minor concerns, and the details of any action that has been taken, information shared and decisions made relating to concerns. E-mail communication between professionals to be filed in the notes -re information that may be relevant to keeping a child safe is available to other clinicians providing care to them.	Help improve the information we have on the child, enabling improved care including safe guarding.
Consideration to be given on how staff in the hospital could contribute to the parenting assessments.	Help improve on the multi-agency working to support child and family.
Full set of medical notes should be made available to the clinician undertaking a child protection medical.	Ensure a comprehensive assessment of medical and social needs.
Consider whether a quieter setting (compared to PDU) would be better to carry out child protection medicals	Enable the clinician to work in a less stressful environment
Strengthen the hand over process between Paediatric consultants.	Ensure continuity of care
Training need analysis of the child protection training arrangements for the medical team	To indentify appropriate training to keep up to date with child protection procedures.

Paediatric consultant to review any child on the ward in whom there are social concerns /known to social care	Senior clinician input will help improve patient care.
In children under the age of 2 years where physical abuse is suspected , a full skeletal survey should be performed	Ensure consistency in child protection investigations.

Thames Valley Police

RECOMMENDATION	INTENDED OUTCOME
Recommendation 1 – That a reminder be circulated to all staff, reinforced in ongoing training, that non-engagement in the DASH risk assessment process should in fact raise the risk level not decrease it.	Improvement to TVP DASH risk assessment process
Recommendation 2 – A reminder be circulated to all TVP staff and included in ongoing training that a DASH risk assessment must be conducted at every domestic incident attended irrespective of how recently one has previously been completed.	Improvement to TVP DASH risk assessment process
Recommendation 3 – That all TVP referral sergeants be reminded of the need to conduct and review secondary investigations prior to conducting any strategy discussion. This will also reiterate the significance of bruising in babies and the need to carefully consider such injuries when deciding who will lead any subsequent s.47 investigation.	Improved information sharing by TVP to support safeguarding meetings
Recommendation 4 – All TVP staff to be reminded of the need to ensure full details of any person taking over care of a child or vulnerable person are recorded and the necessary police checks are conducted on these.	Compliance with safeguarding requirements when placing child in care of family member
Recommendation 5 – That TVP undertake work to further explore the current approach to harassment offences, particularly the use of 'first case harassment' warnings as a resolution action. This will need to include the role of current Criminal Justice procedures and supervisors in the decision making process.	Improved response to harassment offences reported to TVP ensuring effective use of enforcement options available
Recommendation 6 - That TVP circulate clarification to all TVP staff clarifying that all out of hours multi-agency safeguarding liaison must be conducted by a supervisor. This must be structured to ensure the purpose of the contact is made clear from the start and include an agreed 'out of hours safeguarding management plan' that will be in place until a follow up review is conducted by the daytime	A more robust out of hours referral process

team.	

Adults and Family Wellbeing (Adult Social Care)

RECOMMENDATION	INTENDED OUTCOME
1. Review the requirement on staff to contact the OOH team when a referral is made to determine if it should be retained and enforced to ensure compliance.	A proportionate system is agreed, in place and complied with to ensure referrals contain the key information required for effective involvement, decision making and risk management.
2. Ensure all duty staff can access livelink Clearly identify and set out any client information which cannot be accessed by members of the OOH team and on what basis.	OOH staff can access all key records required to effectively carry out their roles and duties. Where access is not required that this is also identified, explained and agreed. For example issue of sessional worker access to livelink.
3. OOH staff to raise instances where key data is missing from referrals and records with C&F staff dealing with data recording quality control aspects of practice.	Referrals to OOH clearly set out the support required from the team. Client. ICS consistently provides sufficient information to enable effective working, decision making and risk assessment
4. Summaries of key data and or recent chronologies for records kept on the ICS See recommendations in section 8 above.	Key information held in relation to adults is made more accessible to all staff that need to, or are required to access social care records.