Serious Case Review – Baby M
Agency progress against action plan recommendations – March 2017

Alongside the publication of the Serious Case Review for Baby M, the BSCB is publishing the following statements from the agencies involved in review. These show the progress that has been made on the recommendations contained in the SCR action plan since the events covered in the review took place.

1 Buckinghamshire Safeguarding Children Board

The Buckinghamshire Safeguarding Children Board (BSCB) accepts the findings and recommendations from this Serious Case Review. A robust action plan was produced following the completion of this review in May 2016, and the BSCB continues to monitor the implementation of this plan. The statements from partners published here outline some of the action that has taken place to date to try and ensure the lessons from this review are learned and that improvements are made to practice and outcomes for children.
The review made a number of recommendations for the BSCB. Since May 2016, we have taken the following actions to address these recommendations:

- The Overview Report identified that there was poor planning in the pre-birth period and that this led to inadequate protection for the unborn child. In response to this, the BSCB has undertaken an audit of pre-birth safeguarding to gather further learning around local practice. The findings from this audit and the Serious Case Review have been used to inform a review of the multi-agency pre-birth guidance and procedures to ensure professionals have clear and up to date information around effective pre-birth safeguarding. With our key partners we have also delivered a number of multi-agency learning sessions to share the learning from this SCR and others and to promote effective pre-birth practice.
- The Overview Report identified that there was a gap in provision for Looked after Children / Care Leavers to be given priority access to the Family Nurse Partnership in Buckinghamshire. Since the report was written, commissioned provision has been extended in Buckinghamshire and there is greater flexibility to accommodate the most vulnerable. However, the Independent Chair of the BSCB has written to the Health Minister to outline the findings from this review, since this learning is also relevant across other areas of the county where commissioning arrangements may be different.
- The Overview Report identified that threshold decisions were not understood across the partnership. The BSCB has continued to work with partners to improve knowledge and understanding of thresholds. This has been an ongoing piece of work over the last two years, and there is now consistent evidence that knowledge and understanding of thresholds has improved.
- The Overview Report identified issues with staff being able to challenge senior colleagues over decisions made. The BSCB has updated the BSCB multi-agency procedure around Escalation, Challenge and Conflict Resolution. We have also run a series of workshops for frontline practitioners and managers to further explore the

barriers to effective challenge. These sessions have helped improve knowledge, and the learning will be shared back with the Board to inform future work.
- The Overview Report identified that the BSCB Individual Case Management Procedures were out of date and there were no clear links from the BSCB website to Children's Social Care procedures relating to Children in Need. Since then the procedures have been updated to ensure up to date information is available to all professionals.

Over the coming months we will continue to embed the learning and recommendations from this review.

2 Buckinghamshire Healthcare NHS Trust

BHT has contributed fully to this case review and endorses its findings and recommendations. We have learned from this review and the Trust has already undertaken a great deal of work to deliver the actions assigned to it. Several Trust policies and procedures have been reviewed and updated, for example with regard to improving communication about a child being discharged from hospital and the requesting of images to assist early identification of possible non-accidental injuries in children.

We are committed to continuously improving the care we provide to children and their families and being responsive to their needs. We will continue to monitor all our actions to ensure that the lessons learned are embedded within the relevant services.

BHT is a committed member of the multi-agency partnership for safeguarding children and will also support the actions and learning from this review across all agencies in Buckinghamshire. An example of this is the active contribution made by the Trust to the revised BSCB pre-birth assessment procedure.

3 Buckinghamshire County Council

Since the events of this review, Children's Social Care has sought external scrutiny and support through an Improvement Board to drive forward services for children in Buckinghamshire. The recent Ofsted monitoring visits to Children's Social Care confirm that we are making progress, and that social work practice is strengthening. Children's Social Care will continue to build and sustain this improvement to further safeguard children and families.

Implementation of the actions and lessons learned from this review have already been carried out and have not waited for the publication of this review.

Multi agency risk management plans are now in place and support packages reflect the risk and needs of the individual child. Hospital discharge meetings are held with partner agencies who are party to the risk management plans.

There is now a clear pathway in place for pre-birth assessments through a new protocol and best practice guidelines for the identification of high risk pre- birth referrals. This work is assessed and case managed by suitably qualified and experienced social workers.

To ensure good quality recording and effective management decisions being made during 1:1 supervision meetings, new guidance was issued to relevant staff in September 2015.

Each child's journey is now discussed within 1:1 supervision with a clear management oversight of the plan for the child. Management oversight is regularly monitored.

The needs of all children and young people in the family are now considered when children transition from one social work team to another, prior to the transfer. This ensures that the needs and risks of all the children and young people within an individual family are jointly assessed and evaluated.

There has been a focus on recruiting and retaining experienced social work staff to ensure that newly qualified social workers are in units where there is a mix of experience and skills. Social work caseloads are monitored weekly and reported on a monthly basis to the senior management team to ensure that social workers have sufficient time to undertake their role well. To support continuous learning of social workers, a partnership has been formed with Bucks New University and Aylesbury College to launch the Buckinghamshire Social Work Academy in June 2016. The Academy is helping us to support a highly-qualified workforce which is improving social work practice.

4 Thames Valley Police

The specific recommendations for Thames Valley Police in relation to this case were centred on the way in which the Force and other partner agencies share information, as well as the understanding of some officers around the risks associated with the vulnerable child in this case.

Actions have been taken to ensure that all officers are reminded that every day policing decisions, including risk assessments and information sharing, should be made using the National Decision Model.

The Force has also provided further training to all front line staff and managers to identify and highlight risks to vulnerable children at an early stage and ensure they are able to share this information with partners in a timely and effective manner.

Work has also taken place to ensure that consultation with relevant agencies within the Multi Agency Safeguarding Hubs will take place to ascertain the general status attributed to initial discussions between police and social care following a new referral.

These measures will strengthen the Force's ability to share information relating to all vulnerable people, and will ensure that risks are identified and acted upon as quickly as possible.

5 Buckinghamshire Clinical Commissioning Groups

The specific lessons learnt for General Practitioners in Buckinghamshire following the serious case review for Baby M centred around the improvement of knowledge of multiagency thresholds for intervention and how GPs can recognise and contribute to assessments of vulnerable families in the pre-birth period. Significant work has been undertaken to improve the understanding of thresholds across the partnership and there is now increasing evidence from internal and external audit that this has improved. GP antenatal care guidelines have been updated and a multi-disciplinary audit demonstrated improved liaison between GPs, Health Visitors and Community Midwives.