Briefing Note

To: Education and Children's Services Scrutiny Board (2)

Date: 12 January 2017

From:
David Peplow, Independent Chair of Coventry Safeguarding Children's Board
Lizzie Edwards, Safeguarding Boards Combined Business Manager
Hardeep Walker, Serious Case Review Coordinator

Subject: Coventry Safeguarding Children's Board Serious Case Review Update

1. Purpose

The purpose of this note is to advise Education and Children's Services Scrutiny Board (2) of the progress made in relation to learning arising from five published and one unpublished Serious Case Reviews (SCR) undertaken by Coventry Safeguarding Children Board (CSCB) between March 2015 and July 2016.

2. Current position

A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. The primary aim of a SCR is to help agencies learn lessons from these events, and to use this experience to improve practice.

SCRs in Coventry are overseen by the SCR subgroup of CSCB. The SCR sub-group includes membership from social care, police, health, education and probation. The subgroup considers possible cases that may meet the criteria for an SCR and, if appropriate initiates an SCR when the Independent Chair of the Board agrees the criteria is met. The sub-group also oversees progress against action plans arising from SCRs, which are reported to the LSCB. This process enables the LSCB to fulfil its responsibility for monitoring progress, and to be assured that these recommendations have been delivered in practice.

Attached is a report highlighting how the Board have been addressing key themes arising from Serious Case Reviews

3. Recommendations

The Education and Children's Services Scrutiny Board are recommended to provide any additional comment to the Independent Chair of CSCB and Cabinet Member for Children's Services about progress made.

Appendices

Appendix 1- Serious Case Review Report

Appendix 1

1. Introduction

This report details the progress made in implementing recommendations arising from five Serious Case Reviews (SCRs) completed and published between March 2015 and July 2016, and a further review completed in June this year. The review completed in June 2016 has not been published due to an on-going police investigation; however the Board continues to work on implementing the recommendations from this review.

2. Progress to date

Significant progress has been made in the delivery of the actions and improvements required following the completion of the SCRs. Key areas of development in relation to SCRs in Coventry are as follows:

<u>Multiagency training</u>

- Coventry Safeguarding Children Board (CSCB) held three training sessions towards the end of 2015 and the start of 2016 covering recent case reviews with a particular focus on hard to engage families; this included an opportunity for practitioners to enhance their skills and approach to parents while developing a positive working relationship. Over 140 professionals from a range of agencies attend these sessions. Further training is due to take place in December 2016 through to 2017 covering very recent reviews published this year. Once again, practitioners will be given the opportunity to practice and develop their skills in holding difficult conversations with families while maintaining a positive working relationship.
- Both multiagency and relevant single agency training has been reviewed to incorporate learning from SCRs, this includes training in relation to emotional abuse and neglect, domestic abuse and themes linked to hard to engage families.

<u>Information Sharing</u>

- CSCB and Warwickshire Safeguarding Children Board have worked together to produce a short accessible guide to information sharing which has been disseminated widely across both areas given the cross boundary work undertaken by agencies.
- Work has taken place to embed a process whereby lead professionals undertaking a CAF (Common Assessment Framework) assessment will inform GPs of a CAF taking place to alert them to the family's vulnerability and allow for input and communication from GPs.
- Communication during the step up and down process between social care and children and family first service continues to be worked on, it is unclear if particularly during the step down process partner agencies are being informed of this including where partners take the role of lead professional. To assess this a dip sample of cases will be undertaken in January to determine if partner agencies are being informed.

<u>Co-sleeping</u>

The risk of co-sleeping was raised in relation to two SCRs; this prompted a review of processes and practice and the following actions were completed:

- Training regarding sleep safe information for parents was organised for multi-agency staff.
- The implementation of a risk assessment tool in 2015 which has been embedded into the personal child health book (red book), providing the basis for a comprehensive

risk assessment initially carried out by a midwife and then taken forward by the health visitor.
- Midwives and health visitors now have a robust process in place providing opportunity to reiterate the messages to new parents about safe sleeping. An audit carried out in 2016 highlighted 100% compliance where midwives had clearly recorded the receptacle the baby sleeps in and the location of the sleeping receptacle during day and night.
- A refreshed prevention campaign was launch in autumn 2016, where communication material, including a room thermometer which will be given to new parents, has been updated to include key messages and learning from recent SCRs, including advice regarding smoking, drinking and taking drugs while caring for your child. It also included advice about what to do when your child is too hot which references learning from a very recent SCR.
- There has been a reduction in sudden infant deaths in Coventry which is monitored through the Child Death Overview Panel (CDOP).

<u>Holding vulnerable families meeting at GP practices</u>
- GP Practices are being supported to implement the facilitation of formal meetings between all health professionals involved in the delivery of care for the 0-5 age group. This provides a more structured opportunity for regular and ongoing discussion about vulnerable families and enables a coordinated approach to the provision of health care and support, including signposting and referral, where appropriate. Coventry and Rugby Clinical Commissioning Group (CCG), alongside the Named GP for Coventry, have been instrumental in securing GP commitment to put this into practice. They have also made significant progress in securing funding for GP practices to implement this process. This was further emphasised at a recent GP protected learning event where learning from SCRs was shared with over 300 GPs across Coventry.

<u>Child Sexual Exploitation (CSE)</u>
- The CSE SCR identified the need for long term support for those at risk of or experiencing CSE, alongside the importance of a relationship-based support model, to build trust and confidence. It is also highlighted that CSCB should understand the impact of the CSE strategy on young people to date. The Horizon team has increased in size, with an additional 10 individual's 6 of whom are social workers and 1 dedicated CSE health professional. This has meant intensive support for young people and has provided consistency of worker for victims. In addition multi-agency responses have also improved with a dedicated local Police CSE team working alongside the specialist multiagency Horizon team.
- CSCB is currently working together with Coventry Safeguarding Adults Board to improve responses to those young people reaching 18 years of age including considering the role of the voluntary sector to support these young people.
- As a result of the CSE SCR, changes have been made to guidance for GPs regarding the approach to take when in consultation with sexually active children. The Local Medical Council has issued new guidance advising GPs to not only consider the appropriateness of prescribing contraception but also asking a number of questions to identify if a child is being exploited.

<u>Hard to engage families</u>
- Alongside the training outlined above, CSCB held a peer review on this subject matter and partners provided a test of assurance, this highlighted examples of good practice.

The learning from this review and the good practice examples are being included in the revised multiagency training package.

3. Next steps

Once the recommendations and actions from an SCR have been completed the key themes are assessed through both single and multiagency audits. These audits assess how well the learning from reviews has been embedded and the impact of this for example the work on co-sleeping has shown a clear improvement and impact on children and families. Further audits are scheduled for the coming year and are carried out once agencies have had sufficient time to embed the actions within their organisation.

In addition, the CSCB SCR coordinator will focus attention on ensuring that learning has been embedded, and tracking how this has improved the response to children and families. This work will commence in January 2017.