

**BOURNEMOUTH AND POOLE
LOCAL SAFEGUARDING CHILDREN BOARD**

**SERIOUS CASE REVIEW
EXECUTIVE SUMMARY**

REGARDING BABY 'F'

**Overview Author
Prity Patel**

12 July 2010

Contents

1.	Introduction	Page 3
2.	The Facts	Page 5
3.	Key Themes Arising from the Case	Page 6
4.	Priorities for Learning & Change	Page 9
5.	Summary of Recommendations (Overview, IMR and Health Overview Recommendations)	Page 10

1. INTRODUCTION

Circumstances leading to a Serious Case Review (SCR) being undertaken.

- 1.1 This case concerns a baby (Baby F), aged 5 months who sustained serious non-accidental injuries whilst in the care of both his parents. At the time of the injuries, Baby F was subject to a Child Protection Plan; Baby F was taken to Hospital where he was examined and received treatment from senior medical staff. He was admitted for several days and his progress carefully monitored. Baby F was discharged into Foster Care once medical professionals considered he no longer required any further treatment.
- 1.2 As part of Bournemouth & Poole Safeguarding Children Board's (B&PSCB) commitment to learn and develop inter agency child protection practice, this serious case review was undertaken in order to establish the facts of the handling of the case and to analyse professional involvement with the family. The purpose of the review was to identify and recommend any relevant changes to professional practice and about ways in which different agencies in the Bournemouth and Poole areas work together to safeguard children and young people.
- 1.3 The Independent Chair of the B&PSCB instigated a Serious Case Review, following a recommendation by the Chair of the B&PSCB's Serious Case Review Sub-Group .It was agreed that the criteria as defined in paragraphs **8.11 and 8.12 Working Together to Safeguard Children (Dec.2009)** were satisfied, in particular;

'The child has sustained a potentially life threatening injury or serious and permanent impairment of physical and/or nor mental health and development through abuse or neglect;

The child has been seriously harmed following a violent assault perpetrated by another child or adult, and

The child was subject to a Child Protection Plan at the time of the incident.'

The SCR Process

- 1.4 Each agency that had some direct involvement with the family was required to undertake an Individual Management Review (IMR), to look openly and critically at individual and organisational practice as it related to their involvement with the family. In undertaking this, each agency was required to produce a chronology of its contact with the family. They were also asked to produce SMART (Specific, Measurable, Achievable, Realistic and Timely) action plans with suitable recommendations, if any, for their respective agencies Those conducting the Individual Management Reviews were not directly concerned with the services provided for the family, or the immediate line manager of practitioners involved.
- 1.5 Selected representatives of key agencies of the B&PSCB were brought together to form a Serious Case Review Panel to collate information provided from the IMR's and then to analyse the professional practice and inter agency working as it related to this family.

SCR Panel Members

- 1.6 The following agencies and professionals were involved in the SCR Panel:
- Mr Ron Lock, Independent Chair, Bournemouth & Poole Local Safeguarding Children Board and Chair of the Serious Case Review Panel
 - Service Manager, Safeguarding & Quality Assurance Service, Bournemouth Borough Council
 - Designated Nurse/Head of Governance for Safeguarding Children, NHS Bournemouth and Poole
 - Principal Education Social Worker, Bournemouth Borough Council
 - Head of Service, Children & Young People's Social Care, Poole
 - Designated Nurse Consultant for Safeguarding Children, NHS Dorset
 - Service Manager, CAF/CASS
 - Detective Superintendent , Public Protection, Dorset Police
 - Consultant Paediatrician, Designated Doctor for Safeguarding Children, Dorset County Hospital NHS Foundation Trust
- 1.7 An Independent Overview Author, Prity Patel, was appointed by the Chair of the SCR Panel. Ms Patel is not involved with any of the agencies and has not previously worked in the Bournemouth and Poole area.

Other Parallel Investigations/Reviews

- 1.8 Following the incident of Baby F sustaining serious injuries, the Police have carried out enquiries. This has resulted in both parents being charged for causing the injuries. The parents are now awaiting criminal prosecution.
- 1.9 There are also ongoing Care Proceedings in respect of Baby F who is represented by a Children's Guardian. Baby F remains in foster care pending conclusion of proceedings.

Involvement of Family Members

- 1.10 The Independent Chair of the SCR Panel wrote to the parents informing them of the SCR taking place and offering them an opportunity to meet with the Independent Overview Author. Both parents agreed to this. The Overview Author met with both parents separately to ascertain their views and experiences of professional intervention and services provided. The Overview Author is grateful to both parents for their valuable and positive contribution to the Review process.
- 1.11 It is agreed that the lessons learned from this Review will also be shared with the parents by a representative from the Serious Case Review Panel and family Social Worker. The Executive Summary will also be shared with the parents prior to publication.

2. THE FACTS – SUMMARY OF EVENTS

- 2.1 Baby F was born in the summer of 2009, following an uncomplicated pregnancy. He lived with his mother, in rented independent accommodation. He was having contact with his father, who was still living with his mother at home. The parents were teenagers and not married. Baby F also had contact with his maternal and paternal grandmothers. Baby F had no siblings.
- 2.2 The mother had had no significant involvement with any agencies previously. The father had a history of being involved with several agencies due to his violent offending behaviour, substance misuse, possible concerns about his mental welfare, and volatility. Although the father attended some meetings, he did not engage well with professionals.
- 2.3 The relationship between the young couple was volatile, the mother experiencing domestic violence from the father during the pregnancy and after the birth of Baby F. The first reported incident of domestic violence took place in August 2009. Baby F, aged 5 weeks, was present during the incident and he was being held in his mother's arms when she was assaulted by the father. Baby F was seen by a medic, he had a small superficial scratch to his arm and no other injuries. Whilst being examined, medical staff found that Baby F had an unrelated physical condition which was monitored. The father was arrested and charged with common assault against the mother. The father was released on bail conditions; he was to have no contact with the mother.
- 2.4 Following the reported incident Children's Social Care commenced a Child Protection enquiry. No decision was taken regarding a referral to a Child Protection Case Conference at this stage. This was not challenged by any of the professionals involved with the family. However, this may have been as professionals considered the bail conditions to be protective measures for Baby F, together with the fact that the mother consistently told professionals that the couple were responsive to the bail conditions, and their relationship was working well. Following this incident, the Police appropriately referred the matter to MARAC (Multi-Agency Risk Assessment Conference.) a multi-agency forum which considers and provides a co-ordinated response for those at the highest risk of domestic abuse. Some actions were agreed in respect of this case; however they focussed on protection for the mother.
- 2.5 An incident occurred in autumn 2009 when it became apparent to professionals that Mr A had breached his bail conditions and he had been having contact with the mother and Baby F. A Child Protection Case Conference was held, when Baby F was made subject to a Child Protection Plan and his name registered under the category of emotional abuse. Although a plan was in place, it was not as robust as it could have been.
- 2.6 Whilst Baby F was subject to a Child Protection Plan, professionals became aware that he had sustained a bruise to his face. This was explored with the mother who indicated that Baby F had hit his head on the side of his cot. This explanation was accepted by professionals.
- 2.7 The father was convicted of the earlier assault upon the mother and received a 48 month Community Supervision Order and a referral to an Integrated Domestic Abuse Programme. There remained an expectation that the father would not have contact with the mother and Baby F.

- 2.8 At the beginning of January 2010 whilst in the care of both his parents, Baby F sustained serious injuries which included haemorrhages, scratches, bruises, and fractures. Baby F was admitted to hospital where he was given immediate treatment. The father subsequently admitted to dropping Baby F onto a hard floor. The father confirmed that the mother was not aware that he had done this at the time.
- 2.9 Following the serious injuries, a Review Child Protection Conference took place when it was unanimously agreed that Baby F should remain subject to a Child Protection Plan, however the category was changed to physical abuse. Following further Police enquiries, both parents have been charged, and at the time of writing, are on bail pending criminal prosecution.
- 2.10 Baby was discharged from Hospital after making good progress. He was placed with Foster Carers pending an application for a Care Order by the Local Authority.

3. KEY THEMES ARISING FROM THE CASE

- 3.1 There were times when appropriate services were provided for the family and these interventions were helpful. These included good support from the Police for the mother when she reported the domestic violence, as immediate action was taken to safeguard the welfare of Baby F and herself as well as a referral to MARAC (Multi-Agency Risk assessment Conference). The Police also demonstrated good practice, when they decided to pursue the prosecution of the father despite the mother withdrawing her statement against him. Appropriate medical ante-natal care was also provided to the mother. The fact that a Child Protection Conference was held resulting in Baby F being subject to a Child Protection Plan, demonstrated that professionals recognised the need to afford Baby F some protection, albeit it was not as robust as it could have been. Within the Plan, provision was made for both parents to discuss the nature of the relationship, to assist the father with his anger management and the impact of it upon parenting, which was not taken up.
- 3.2 Whether the manner in which professionals dealt with this case could have predicted or prevented the serious injuries to Baby F from occurring is debateable. A contributory factor which provides some context was each of the parent's lack of willingness to actually engage with whatever professional advice and support was provided. Although not excusable, professionals were not assisted by the mother, who throughout her involvement with professionals, presented as a competent, confident and articulate young lady. The mother's ability to express herself in a co-operative and rational manner certainly had an influence on how professionals perceived her ability to protect Baby F and believe her when she indicated that the relationship was working well. It is therefore perhaps easier to understand how professionals were possibly 'taken in' by the mother when dealing with her, which led to professionals minimising the actual level of risk Baby F was exposed to whilst in his mother's care. In the mother's own words ".....although I appeared to be listening, I wasn't really listening as I was not ready to do so. I couldn't see anyone including him (the father) wanting to hurt the baby.....'
- 3.3 There was sufficient historical information available about the father, which if considered collectively would have highlighted the risk factors much sooner.

- 3.4 Agencies should have seen that in fact the father needed support in a way that he would engage with professionals. The father's history, if it had been looked at in a collective forum, would have highlighted that any previous attempts to engage him had primarily failed, although engagement by services such as the Youth Offending Team (YOT) because of the father's offending behaviour and Child and Adolescent Mental Health Services (CAMHS) because of his behavioural difficulties was often not with the father direct, but via his parents/carers.
- 3.5 It seems as though any preventative work that YOT and CAMHS could have carried out with the father when he was younger was done without any conviction or impetus which effectively meant that he drifted in the system. The father continued to be 'the ghost in the equation' or absent father when professionals intervened with his own child. This may have influenced his perception of all other professionals and his lack of willingness to engage, as he felt failed by unmanaged and inconsistent intervention from agencies involved earlier on in his life. This is supported by research from the Fatherhood Institute Research-Young Fathers, which makes it clear that fathers are not normally involved in the child protection process as they tend to perceive social workers as being a negative influence within the family, and that social work relationships tend to force fathers to distance themselves. The father expressed this view to the Overview Author '.....that they didn't want to ask Children's Services for help as they thought they would be involved for ever.....'
- 3.6 Had consideration been given to the history, the professionals would have come to the likely conclusion that the father may have found it challenging to be a parent and this in turn may have highlighted the significant risk factors. The fact remains, however, that he was not even on the professionals' radar. This is supported by research of serious case reviews and is a key theme. '.....There appears to be a minimalist need-to-know attitude to sharing information about the appearance of men in a household, so that unless specific questions are pursued, the presence of a male will not be passed on and the men become invisible to practitioners working with families.....'. – Biennial Analysis of SCR (2005-2007). Had this 'bigger picture' of the father been formed, there would have possibly been other options of how this family were dealt with.
- 3.7 This case also highlights the need for all professionals to understand domestic violence, which may be coupled with substance misuse and its impact on parenting capacity. Professionals need to have a common understanding of identifying risk factors. It is only if a risk is identified by a professional, can the appropriate safeguards for a child who may be exposed

- 3.8 What this case demonstrates is that there needs to be a greater vigilance amongst professionals about the 'disguised co-operation or apparent compliance' of parents or extended family. Professionals need to recognise and look beyond the 'smoke screen' of information that is being self-reported by a parent. Professionals need to develop an investigative or probing style of approach to any assessment in order to elicit all relevant information. A balance needs to be achieved between what may seem apparent confidence and competence of a parent, with actual ability to protect a child from harm. This also applies to extended family members and any over reliance on them as part of a supportive package.
- 3.9 This case highlights the need for professionals to recognise and have a multi-agency service approach to try and engage with young parents who may be a Child in Need themselves. This became even more pertinent in this case with the parents having an unplanned pregnancy and the pressure this would have brought with it. Professionals need to recognise that additional support needs to be provided during antenatal and postnatal care which should include aspects of social and medical care for both parents. Research suggests that '.....younger men have more children who are the subject of Child Protection Plans, perhaps because of their lack of parenting skills.....' Egan Sage & Carpenter, Characteristics of Children in Alleged Abuse and Neglect Fatherhood Institute, as in this case.
- 3.10 This case clearly demonstrates how robust the multi-agency child protection process around Child Protection Conferences needs to be and what occurs if it is not. All appropriate professionals who hold key information not only need to be invited but also be present at Conferences as endorsed by Lord Laming. - The Protection of Children in England: A Progress Report, March 2009. The father's GP was not invited in this case, which meant crucial information was not shared between agencies. An exchange of up to date information needs to take place resulting in effective and Specific, Measurable, Achievable, Realistic and Timely (SMART) Child Protection Plans being agreed and implemented by professionals. Only then will a child be safeguarded as far as is possible, from harm. Although a Child Protection Plan was in place for Baby F, it was not as purposeful as it could have been in ensuring that appropriate protective measures were in place for him.
- 3.11 This case also illustrates that there is a need for professionals to be challenging of one another, to have 'respectful uncertainty' as Lord Laming states. Where this does not happen as in this case, this only adds to the missed opportunities. There should have been professional challenge about the possibility of the Child Protection Conference being held sooner and ensuring that the correct category of abuse was identified, albeit this did not impact on the actual outcome and plan itself.
- 3.12 It is evident from this case that there was a lack of understanding and over reliance by professionals on the bail conditions imposed on the father. They

- 3.13 What this case also clearly shows is that there needs to be a co-ordinated response from multi-agency partners where there is a need for safety planning not only for an adult victim or perpetrator but this should also include focus on a child where the adult concerned is a parent/carer. The partners should ensure that the benefits of an existing multi-agency forum such as MARAC should extend and include, within its remit, or at least make some cross-reference to, agencies who have responsibility for the safeguarding of children.
- 3.14 During the period of time that it has taken to complete this serious case review, a number of the lessons which have been learned have already begun to be implemented. The YOT service already had an Improvement Plan in place in respect of its overall safeguarding service which is monitored by the Youth Justice Board for England and Wales and will be reviewed on an annual basis. Similarly relevant Health professionals have already introduced revised documentation regarding the Social Risk Assessment tool which will make it expected practice for practitioners to complete and will provide suitable prompts to elicit details about fathers/significant males and domestic abuse. A new Convenor's Checklist has been drafted and implemented which will ensure that all appropriate professionals are invited to Case Conferences so that all relevant information historical and current is obtained to assist informed decision making and planning to safeguard a child from harm.

4. PRIORITIES FOR LEARNING AND CHANGE

The following are the key lessons to be learned from this case.

- 4.1 It is vital that professionals understand and apply thresholds appropriately when evidencing risk, particularly in relation to identifying risk factors in relation to domestic abuse and its impact upon parenting. The failure to do so leads to "missed opportunities".
- 4.2 It is crucial that professionals engage with fathers/significant males in the household as part of any assessment of the family. Fathers/ significant males must not be excluded from assessments and all efforts need to be made by professionals to ensure that they are engaged and very much part of any professional intervention and inform what support services are needed.
- 4.3 There needs to be effective child protection processes in place, with professionals' understanding the criteria and purpose of having such processes in place. Professionals also need to have the confidence and competence to challenge and scrutinise other professionals to ensure the best and realistic outcomes are achieved for the child from any child protection process.
- 4.4 Professionals to recognise that there needs to be a multi-agency service approach to working with teenage or very young parents who require a much more supportive environment, particularly where there are issues of domestic violence.

- 4.5 A much more 'investigative style' of assessment/approach needs to be developed by professionals, particularly where there may be disguised or apparent compliance by the family.
- 4.6 Professionals need to have an understanding of the impact of bail conditions in parallel to the child protection process or any other relevant parallel investigation.
- 4.7 There could be the potential for professionals to have an over-reliance on the impact and effectiveness of MARAC. It is important for professionals not to make assumptions that this forum can provide some form of protection for children as well as the vulnerable adult (parent/carer) victim of domestic violence. However, the consideration of both is vital at MARAC resulting in making the appropriate referral/link to the relevant agency in order to safeguard the welfare of a child.

5. SUMMARY OF RECOMMENDATIONS

(NB All action plans are available as an appendix to this document)

Overview Recommendations

- 5.1 Bournemouth & Poole LSCB to ensure that **all** social, risks and needs assessments of families by the Bournemouth & Poole LSCB constituent agencies, must always include fathers and other significant males in the household, who need to be engaged as fully as possible in the assessment process.
- 5.2 Bournemouth & Poole LSCB to review whether or not there is sufficient and relevant multi-agency training provision in respect of how domestic violence and substance misuse can impact upon parenting. Such training should enable professionals to take on an approach of sensitive enquiry in order to elicit information that could be pertinent to identifying risk factors.
- 5.3 For the Bournemouth & Poole LSCB to seek confirmation from Children's Social Care and the Police that strategy meetings/discussions, as pivotal parts of the child protection process, are consistently taking place in cases of domestic violence, and if not, to address the shortfalls.
- 5.4 For the Bournemouth & Poole LSCB to develop a comprehensive multi-agency Teenage Pregnancy Strategy for teenage parents which will include an agreed multi-agency package of intervention, addressing concerns or difficulties identified. Current protocols and arrangements must be reviewed and updated accordingly to meet these requirements.
- 5.5 For the Bournemouth & Poole LSCB to be assured that the focus at MARAC will not only be on the adult victim but will also take recognition of any safeguarding needs of a child and make referrals to the relevant agency as appropriate.
- 5.6 For the Bournemouth & Poole LSCB to be assured that all child protection plans are Specific, Measurable, Achievable, Realistic and Timely (SMART).

- 5.7 For the Bournemouth & Poole LSCB to be assured that the purpose and nature of bail conditions is clarified, understood and appropriately scrutinised by conference members/conference chair as part of the risk management of a case.

Individual Management Review Recommendations

Below is a list of the different agencies who were asked to provide Individual Management Reviews to the Serious Case Review. Based on their analysis of their organisation's professional practice with this family, these are the recommendations which they made for their own organisations. Timescales for completion of these recommendations have been submitted as part of their Action Plans, and will be monitored both within the respective organisation and also by the B&PSCB.

5.8 DORSET POLICE

NB. As the Dorset Police IMR was asked to consider the work of MARAC, the first two recommendations below relate to the role of MARAC. It is acknowledged that the implementation of these recommendations is not the responsibility of Dorset Police and will be incorporated into those in the Overview Report recommendation (25.5).

1. A review of the Bournemouth and Poole MARAC should be undertaken.
2. The responsibilities of MARAC in relation to identifying issues relative to the safeguarding of children in violent families should be part of all cases discussed and relevant agencies that can impact on the welfare of children should attend the meeting.
3. All Domestic Violence forms which show that children live within the family should be forwarded to the relevant other agencies, but also the Dorset Police Safeguarding Referral Unit in order that the police can consider the need for a more specific referral under S.17 or S.47.

5.9 POOLE SOCIAL CARE

1. By July 2010 all Social Workers will make unplanned visits to children and their families on a frequency agreed with their line manager, appropriate to the assessed risk.
2. By August 2010 all Social Care Staff will be aware / reminded about the need to use an investigative approach to properly account for any injury to a child or significant change in their circumstances.
3. By July 2010 completion and outcome of s47 must include the frequency of visiting expected prior to CPC.
4. By December 2010 Social Care Practitioners to be provided with training and briefings about evidence based social work practice with families where Domestic Violence is a risk factor and the perpetrator remains in the household.
5. By May 2010 agency colleagues attending CP Conferences will have available guidance about how to select a category of abuse for the CP Plan which is more specific about risks to children related to Domestic Violence.
6. By July 2010 Team Managers will have an agreed standard for the way in which documents on the electronic recording system, RAISE, are authorised.

7. By Dec 2010 Social Workers to understand the requirement for greater investigative practice and to have developed greater skills to achieve this.
8. By July 2010 Social Care Staff to be clear about their specific responsibilities in relation to the MARAC process and attendance with particular reference to vulnerable children.

Reminder of Existing Practice

9. By May 2010 any decision to convene an ICPC will be made between a Team Manager and Conference and Review Co-ordinator and will be recorded appropriately.
10. By July 2010 all s47 enquiries to be completed within agreed timescales and with sufficient information to inform the outcome.
11. By May 2010 Social Care practitioners to be reminded of the need to record observations about children they visit and to record timings to assist in understanding the sequence of events.

5.10 YOUTH OFFENDING TEAM

1. To ensure that the Improvement Plan addresses organisational shortfalls in terms of safeguarding practice in this case. (An improvement plan is already in place).
2. To develop a bespoke training programme to support the Improvement Plan and to meet service priorities across the service.
3. To ensure that the recent review of the YOT risk management and safeguarding procedures are in place and effective.

5.11 BOURNEMOUTH & POOLE PCT (School Nurse, Health Visitor and GP)

General Practitioner

1. Midwives and General Practitioners have clear protocols on their respective roles and responsibilities for antenatal assessment. This will include assessment of the father, the support available to new parents and consideration and assessment of areas of vulnerability such as domestic abuse, substance misuse or mental ill-health.
2. Information sharing practice between Emergency Departments and General Practice is clear and can be easily understood by General Practitioners.

Community Health Services

1. To ensure the antenatal assessment includes an assessment of the father and a consideration and assessment of any domestic violence within the relationship past or current. (Reminder of appropriate/effective practice)
2. Where it has been identified that there welfare concerns about a baby or a child the health visitor must assess and record how babies and children present and the quality of the interactions between all children and their care givers. (Reminder of appropriate/effective practice)

3. The health visitor should ensure that when the Whooley questions (or an equivalent mental health assessment tool) is used the outcome and tool used is fully recorded at the 5-6 week contact (Reminder of appropriate/effective practice)
4. If a bruise is sustained to a baby who is pre-mobile the health visitor must gain a full history of how the bruise occurred and to record the reaction of the care giver noted. The HV must refer ALL bruises on a pre mobile baby to a consultant paediatrician for opinion. (Reminder of appropriate/effective practice)
5. Where an injury is observed to a parent where there is known domestic violence within the household it must be noted and recorded in the record and the health visitor should inform CYPS at the time of occurrence. (Reminder of appropriate/effective practice)
6. Record keeping and professional documentation should meet the Trust and professional body standards of practice. All significant information should be accurately recorded in the main body of the records. (Reminder of appropriate/effective practice).
7. Where children are subject to a Child Protection Plan and they do not attend a planned appointment, all efforts must be made to follow up the non attendance at the earliest opportunity – preferably on the same day. (Reminder of appropriate/effective practice).
8. To develop Practice guidelines for Health in the MARAC process in Primary Care – expectations of staff, information sharing etc. (New recommendation).

5.12 POOLE HOSPITAL NHS FOUNDATION TRUST

1. When a pregnant woman attends the Emergency Department or any other department as a result of domestic violence there will be liaison with Maternity Services.
2. As part of the 'rolling' safeguarding induction programme to medical staff in emergency department, the needs of the unborn child will be addressed.
3. Nursing staff must check who they are speaking to both on the telephone and face to face contacts. (This is a reminder of good practice)
4. Referrals to Social Care by the Consultant Community Paediatricians will be followed up in writing within 48hrs. (This is a reminder of effective/appropriate practice)
5. The Consultant Community Paediatricians will include an evaluation of risk in their reports to Child Protection Case conferences.
6. A Trust Safeguarding Children Supervision Policy is to be developed.

5.13 POOLE MATERNITY UNIT

1. When a pregnant woman attends the Emergency Department there will be liaison with Maternity Services.
2. The social risk assessment form will assess maternal and paternal risks and will be completed for all antenatal parents.

3. Midwives will be provided with effective training so that they feel confident and competent to carry out the new social risk assessment as part of their new documentation.
4. Midwives will record who has accompanied the woman to all midwifery contacts.
5. All antenatal training and safeguarding children training will include the importance of the role of the father and making an assessment of the involvement of the father in the child's life.
6. Links between GP practices and the midwifery service to be strengthened.

5.14 **DORSET HEALTHCARE NHS FOUNDATION TRUST**

1. CAMHS staff must consider which engagement strategies would best enable a young adult (aged over 16) to attend appointments following a referral to the service and ensure that these are clearly recorded within the young person's records.

5.15 **SOUTH WEST AMBULANCE TRUST (INCLUDING OUT OF HOURS)**

1. Awareness of the referral process to be reinforced with GPs working in the Urgent Care Service.

5.16 **CONNEXIONS**

1. Review training of staff in relation to domestic violence awareness
2. Review links with the Midwifery Service in terms of sharing of key information by 31.08.10
3. Training & Area teams should ensure that all staff are aware of level of detail that will be required should a young person be subject to a SCR

5.17 **STONHAM HOUSING ASSOCIATION**

1. Have a Safeguarding Lead person at Tatnam Lodge service and all Stonham services.
2. Provide further guidance for Stonham staff on their role around use of Common Assessment Framework, MARAC and working with statutory authorities.
3. Launch new Safeguarding policy in all Stonham Services.
4. Stonham Safety Planning tool, 'Safety, Me and Others' to include prompt to share with other agencies as applicable.
5. Recommendations of this review to be shared at senior level within Stonham.

5.18 **DORSET PROBATION TRUST**

1. Offender managers to routinely undertake, as a priority, a genogram exercise with offenders convicted of Domestic Violence (to include violence against family members, but not standalone Unpaid work requirements).

2. Strengthen the links between the Probation Service and the Youth Offending Team.
3. Re-consider the practice of self referral to drug agencies, when drug use had been linked to risk of re-offending or harm.
4. Review information sharing procedures between Probation and Police Officers.

5.19 **NACRO**

1. To change the induction paperwork to include questions with regard to Domestic Violence.

5.20 **FAMILY MATTERS – RELATE**

None

5.21 **DAYBREAK FAMILY GROUP CONFERENCES**

None

5.22 **HEALTH OVERVIEW RECOMMENDATIONS**

1. Midwives will ensure that the father's GP is identified and informed that their patient is to become a father.
2. Midwifery management will ensure that antenatal teenage pathway is complied with.
3. The Midwifery Department will develop regular planned safeguarding supervision for community midwives.
4. The possibility of developing a secure, receipted system of electronic distribution of conference minutes will be agreed between GPs and the Local Authority Children & Families Safeguarding Services.
5. Health professionals will be reminded of their responsibilities to question and challenge other agencies, as well as health professionals, if they have reason to believe that the child protection process is not robustly safeguarding a child.
6. Child Protection Plans should be adhered to and if there is a reason for the change, this should be agreed or discussed at the Core Group or Child Protection Conference. Adherence to a specific plan is vital post a Child Protection Conference.
7. GPs will be informed about the MARAC process via the weekly NHS Bournemouth & Poole briefing to GPs and on the Primary Web.
8. The Midwifery Department will audit practice against the Midwifery Domestic Violence Procedures.
9. IMR authors should only undertake IMRs if they have received appropriate training or undertaken an agreed development plan of shadowing and mentoring.

**BOURNEMOUTH & POOLE LOCAL SAFEGUARDING CHILDREN'S BOARD
SERIOUS CASE REVIEW REGARDING BABY F
IMR RECOMMENDATIONS ACTION PLANS**

DORSET PROBATION TRUST RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
Offender managers to routinely undertake, as a priority, a genogram exercise with offenders convicted of Domestic Violence (to include violence against family members, but not standalone Unpaid work requirements)	a) Discuss desired learning outcomes with TB. b) Relevant training to be provided, possibly by SSD so that OMs can feel confident in this task. Link in with the Training sub-group. c) HQ memo produced to ensure this is seen as good practice/risk management in terms of priority over other routine interventions d) Production of an electronic genogram so information can be shared quickly between agencies.	a) SPO2 and report author b) ACO2 and SPO2 c) ACO2 d) IT services	a) 1 st July 2010 b) 1 st Oct 2010 c) 1 st Oct 2010 d) 1st Oct 2010	a) Confirmation of discussions b) Training Plan includes Genogram training c) HQ Memo d) Report to LSCB that software solution provided	For the use of genograms to become embedded in practice when working with Domestically violent offenders	Part a) complete. Remainder in progress
Strengthen the links between the Probation Service and the Youth Offending Team	To review the current practice of sharing information between YOT and Probation.	ACO1 and ACO2	End of Sep 2010	Protocol shows that review has taken place.	Reduce the risk of key pieces of information being lost when an offender reaches 18 years old. More robust risk management	Not yet started.

DORSET PROBATION TRUST RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
					plans based on all available information rather than the most recent only.	
Re-consider the practice of self referral to drug agencies, when drug use had been linked to risk of re-offending or harm.	a) Review of the practice of officers when considering substance related problems if they are related to offending behaviour.	a) AM1 & Performance Group	1 st Oct 2010	Minutes of PPQ show that managers to discuss in supervision with staff and at team meetings.	a) Ensure that offenders who have drug related problems attend community drug services as part of their sentence plan.	Not yet started
Review information sharing procedures between Probation and Police Officers.	a) Review existing procedures under the authority of MAPPA to ensure that when a child is injured/killed, the information is passed onto the suspect's offender manager	ACO1; ACO2 and SPO3	1 st Oct 2010	a) Discuss solutions at MAPPA SMB b) Procedures established to ensure single point of contact for police and probation liaison	Improved communications so that the offender's circumstances are better understood by the offender manager.	a) complete

CONNEXIONS RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
Review training of staff in relation to domestic violence awareness	Ensure that there is a process in place should domestic violence be raised as an issue	Training Manager and Quality & Compliance Manager	From 01.07.10	Training is sourced and included on Ciphtr Training database to enable staff to access it	Training for key staff in each area Process in place for referral of concerns When factors are identified, staff should seek the advice of their Line Manager	Discussion at Senior Management Team to ratify this instruction
Review links with the Midwifery Service in terms of sharing of key information by 31.08.10	Ensure that there is a Link Worker to monitor relationship; Discussions to agree a data sharing protocol	Area Managers	01.09.10	Discussions take place; named Link worker identified; Data sharing protocol in place; information is shared	Link worker identified Data sharing discussions take place resulting in an agreement Information was shared with the Midwifery Service on a monthly basis	Discussion at Senior Management Team to ratify this instruction
Training & Area teams should ensure that all staff are aware of level of detail that will be required should a young person be subject to a SCR	Ensure that training about SCR processes and recording and reporting requirements is included in Induction Training and Safeguarding Training	Training Manager	From 01.06.10	Input to staff Area and Team Meetings	All staff will be aware of SCR requirements and be able to provide the necessary information	Discussion at Senior Management Team to ratify this instruction

DORSET POLICE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
A review of the Bournemouth and Poole MARAC should be undertaken.	The review should consider the threshold for referral, levels of demand, assessment of outcomes arising from the MARAC (to truly assess its value) and consider the most appropriate process to agree administrative support to the function.	Detective Superintendent Public Protection	3 months from completion of SCR		A more effective MARAC process, with proper administrative functioning.	The SCR has not finished yet
The responsibilities of MARAC in relation to identifying issues relative to the safeguarding of children in violent families should be part of all cases discussed and relevant agencies that can impact on the welfare of children should attend the meeting.	The MARAC process should be amended to include 'children within the family' as a consideration in all MARAC cases.	As Above	As Above		A more effective MARAC process, which is inclusive of safeguarding children issues.	As Above
All Domestic Violence forms which show that children live within the family should be forwarded to the relevant other	Introduce the process and update policy within Public Protection Unit. Ensure that relevant staff are made aware of the change.	As Above	Immediately		Dorset Police Safeguarding Referral unit will consider S.17 and S.47 in terms of all DV involving children.	Currently being implemented

DORSET POLICE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
agencies, but also the Dorset Police Safeguarding Referral Unit in order that the police can consider the need for a more specific referral under S.17 or S.47.						

NACRO RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
To change the induction paperwork to include questions with regards to Domestic Violence	Suggestions to be forwarded to National Child Safeguarding Conference	Child Safeguarding Committee	September 2010	Copy of e-mail in CPO file	That the recommendation be accepted and put into practice.	Ongoing

NHS BOURNEMOUTH & POOLE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
<p>Midwives and General Practitioners have clear protocols on their respective roles and responsibilities for antenatal assessment. This will include assessment of the father, the support available to new parents and consideration and assessment of areas of vulnerability such as domestic abuse, substance misuse or mental ill-health.</p>	<p>Review the current antenatal and post natal protocols and guidelines for multi-disciplinary working between midwives and GPs.</p> <p>Agree good practice antenatal and postnatal protocols and guidance to ensure that the following are considered, assessed, and appropriate care pathways documented and enacted:</p> <ul style="list-style-type: none"> • Name, date of birth and address of father • His role/contact with the baby • Any relationship difficulties <p>Any significant background information for either parent that would inform future care of a baby/child, including domestic abuse, use of drugs or alcohol or mental ill-health</p>	<p>Deputy Director Public Health / Deputy chair PEC / Designated Nurse Safeguarding Children</p>	<p>October 2010</p>	<p>Antenatal/postnatal Protocol agreed and in place</p> <p>The protocol will be published</p> <p>It will be advertised and distributed via the Primary Web site for GPs and for midwives via the Trust dissemination of procedures mechanism and promoted for both through training. Its will be audited via the annual audit undertaken by the supervisors of midwives</p>	<p>GPs and midwives will be clear about their respective roles and responsibilities for antenatal assessment and have agreed communication pathways to ensure that any identified risk factors are shared and acted upon with other agencies.</p>	

NHS BOURNEMOUTH & POOLE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
Information sharing practice between Emergency Departments and General Practice is clear and can be easily understood by General Practitioners.	Information sharing practice between Emergency Departments and General Practice will be reviewed to ensure that the information clearly states the reason for attendance, diagnosis, treatment that a patient received and management of child protection issues where appropriate	Designated Nurse/Richard Hatton	October 2010	Information sharing forms will clearly state the reason for attendance, diagnosis treatment that a patient received and management of child protection issues where appropriate	GPs and their practice staff will receive clear information which can be assessed with information already known to the practice.	

POOLE HOSPITAL NHS FOUNDATION TRUST RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
1. When a pregnant woman attends the Emergency Department or any other department as a result of domestic violence there will be liaison with Maternity Services	Working party between Poole Hospital and Maternity Services will be convened to develop a care pathway between Emergency Department and Maternity Services.	Named Nurse,, Specialist Midwife for Safeguarding Children, Emergency Dept Nurse Practitioner and Emergency Department Consultant.	Sept. 2010	Evidence of liaison between Emergency Department and Maternity will be audited by maternity services in September	Maternity Services will be informed of all pregnant women who attend Poole Emergency Department and other departments within the hospital. This will give midwives the opportunity to fully assess the pregnant women,	

POOLE HOSPITAL NHS FOUNDATION TRUST RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
	A policy 'Care of the pregnant woman seen in emergency department or anywhere in the hospital' is currently being developed.	midwifery Matron Named Nurse Safeguarding Children	June 2010	2010 'Care of the pregnant woman' policy will be included in the Safeguarding Policy.	discuss domestic violence and potentially reduce the risk to the child.	
2. As part of the 'rolling' safeguarding induction programme to medical staff in emergency department, the needs of the unborn child will be addressed	The training presentation will include domestic abuse during pregnancy.	Named Doctor Safeguarding Children.		Slides regarding domestic abuse in pregnancy included in the presentation	Medical staff will be aware of the risk of domestic violence in pregnancy and possible harm to the child.	Completed April 2010
3. Nursing staff must check who they are speaking to both on the telephone and face to face contacts. (This is a reminder of good practice).	Heads of paediatric nursing departments will be informed at staff meetings to disseminate to their staff. This will be followed by a letter from the Director of Nursing Services to all staff groups.	Named Nurse Safeguarding Children Director of Nursing Services.	May 2010	Nursing records will be audited in October 2010 to ensure compliance.	Confidential information will only be disclosed to, identified, appropriate people.	
4. Referrals to Social Care by the Consultant Community	Consultants and Community Paediatricians will be informed at their Community Paediatric	Named Doctor for Safeguarding Children	June 2010	Safeguarding Records will be audited in September 2010 to ensure	Social Care will have details of safeguarding concerns in writing to enable them to carry out	

POOLE HOSPITAL NHS FOUNDATION TRUST RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
Paediatricians will be followed up in writing within 48hrs. (This is a reminder of good practice)	Clinical Governance meeting.	Named Nurse Safeguarding Children	Sept 2010	compliance	their initial investigations	
5. The Consultant Community Paediatricians will include an evaluation of risk in their reports to Child Protection Case conferences.	Consultants will be informed at their Community Paediatric Clinical Governance meeting.	Named Doctor for Safeguarding Children. Named Nurse Safeguarding Children	June 2010 Sept 2010	Reports from the Consultant Community Paediatricians to Child Protection Case Conferences will be audited to ensure compliance.	Child Protection Case conference members will be better informed regarding medical implications of injuries sustained. They will be better able to evaluate the risks to the child and so help to protect them.	.
6. A Trust Safeguarding Children Supervision Policy is to be developed.	Discussions with paediatric staff to ascertain the most appropriate staff groups to receive supervision.	Named doctor for Safeguarding Children, Named nurse Safeguarding Children and Service Manager	Sept 2010	The supervision policy will be included in Poole Hospital Safeguarding Policy.	To ensure safe, child centred delivery of safeguarding care to children who attend Poole Hospital and to ensure staff are properly supported.	Producing a more robust policy was discussed at the Safeguarding Steering Group. Paediatric staff groups have already been

POOLE HOSPITAL NHS FOUNDATION TRUST RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
						identified. Some groups are already receiving planned supervision.

SOUTH WESTERN AMBULANCE TRUST RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
Awareness of the referral process to be reinforced with GPs working in the Urgent Care Service	A reminder of the SWAST safeguarding referral route, is being shared with all clinicians working in the Urgent Care Service by means of a Bulletin.	Safeguarding Manager South Western Ambulance Service NHS Trust.	March 2010		Awareness and tracking of identified concerns	Email April 2010 to all clinicians.

BOURNEMOUTH & POOLE PCT – HEALTH VISITORS RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
<p>To ensure the antenatal assessment includes an assessment of the father and a consideration and assessment of any domestic violence within the relationship past or current. (Reminder of appropriate/effective practice)</p>	<p>Review the antenatal assessment criteria and include the following:</p> <p>Record whether father has been seen directly by the HV and recording the following:</p> <ul style="list-style-type: none"> • Name, date of birth and address of father • His role/contact with the baby • Any relationship difficulties • Any significant background information that would inform the future care of a baby/child, including use of drugs or alcohol • In young parents identifying any potential additional needs <p>The assessment should consider the following:</p>	<p>Health Visitor Professional Practice Development Group</p>	<p>Sept 2010</p>		<p>Health Visitors will be equipped with an 'aide memoir' and guidance on how to enforce the Standard</p> <p>Risk factors will be identified and shared with other agencies as appropriate</p>	

BOURNEMOUTH & POOLE PCT – HEALTH VISITORS RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
	<p>The '3 direct questions' about DV:</p> <ul style="list-style-type: none"> • Has your partner ever hit you? • Are you afraid at home? • Have you been forced to do anything sexually that you did not want to do? <p>Any other known information or previous relevant background of either parent including extended family support.</p>					
<p>Where it has been identified that there welfare concerns about a baby or a child the health visitor must assess and record how babies and children present and the quality of the interactions between all children and their care givers.</p>	<p>Clarity in the assessment process of the appropriate recording of the baby's/child's interactions and patterns of behaviour during assessment visits</p> <p>To ensure that 3 sets of records (from 2 HV's per locality) are audited at a supervision session in this coming financial year and repeated 4 months later to</p>	<p>Safeguarding Supervisors at supervision sessions</p> <p>Service Managers to be assured that Staff are working within the code of conduct for record keeping via the annual Community Health Services</p>	<p>March 2011</p>		<p>To ensure that a baby's and child's needs are included in the assessment, irrespective of age</p> <p>To ensure that there is an increase in the recording of interactions between all children and the care giver.</p>	

BOURNEMOUTH & POOLE PCT – HEALTH VISITORS RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
(Reminder of appropriate/effective practice)	<p>ensure appropriate recording of the infants presentation</p> <p>Audit to include:</p> <p>Children of any age</p> <p>Measure of whether the interactions are fully recorded</p> <p>To ensure in the annual update to Priority staff that this recommendation is included in the training.</p> <p>To share all the recommendations in the HV team meetings once the SCR is completed.</p>	record keeping audit	<p>Dec 10</p> <p>As soon as SCR complete</p>			
The health visitor should ensure that when the Whooley questions (or an equivalent mental health assessment tool) is used the outcome and tool used is fully	<p>To ensure all HV's have assess to the 'Whooley questions'</p> <ul style="list-style-type: none"> • During the past month or so have you often been bothered by feeling down depressed of 	Public Health Clinical Services Manager	March 2011		<p>To see an increase in the HV Service KPI percentage that measures mental health assessments at 5-7 weeks.</p> <p>To see better recordings of mental health assessments by HV staff.</p>	

BOURNEMOUTH & POOLE PCT – HEALTH VISITORS RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
<p>recorded at the 5-6 week contact (Reminder of appropriate/effective practice)</p>	<p>hopeless?</p> <ul style="list-style-type: none"> During the past month or so have you often been bothered by little interest or pleasure in things? <p>To ensure that HV's have completed a mental health assessment at 5-7 weeks and that this is audited in the HV Service as it is one of the KPI's.</p> <p>To include the review of this assessment documented in the records through the annual record audit</p>				<p>To provide a more effective preventative screening for women post natally</p>	
<p>If a bruise is sustained to a baby who is pre-mobile the health visitor must gain a full history of how the bruise occurred and to record the reaction of the care giver noted. The HV must refer ALL bruises on a pre</p>	<p>To ensure that the safeguarding Service monitors any recordings of bruising in advice calls or in referrals and the action taken by the frontline staff.</p> <p>Examples of appropriate/effective practice and poor practice to be kept as case</p>	<p>Safeguarding Service</p>	<p>May 2010</p>		<p>Staff to feel more confident in reporting injury.</p> <p>Advice calls and referrals to indicate the above.</p> <p>Babies to be seen by the appropriate medical practitioner as per policy.</p> <p>The Paediatrician on call</p>	

BOURNEMOUTH & POOLE PCT – HEALTH VISITORS RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
<p>mobile baby to a consultant paediatrician for opinion. (Reminder of appropriate/effective practice)</p>	<p>examples. A Memo from the Safeguarding Service to be sent to all frontline staff who work predominantly with babies. The memo should include:</p> <p>Link to LSCB website Link to other training tools or references i.e. NICE 2009 Link to NSPCC Core- Info website</p> <p>Specific section from Working Together 2009 as what do if abuse is suspected?</p>				<p>should be contacted if the Named paediatrician for Safeguarding Children is not available.</p>	
<p>Where an injury is observed to a parent where there is known domestic violence within the household it must be noted and recorded in the record and the health visitor should inform CYPS at the time of occurrence. (Reminder of appropriate/effective</p>	<p>To ensure the DV Direct questions are considered as above in all assessments, particularly where DV is known and/or suspected</p> <p>To incorporate this and recommendation 1 in the DV awareness training.</p>	<p>DV Co-ordinator</p>	<p>October 2010</p>		<p>To increase the referral rate from HV's to MARAC</p> <p>To see an increase in referrals to CYPS by HV's for bruising in care givers</p>	

BOURNEMOUTH & POOLE PCT – HEALTH VISITORS RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
practice)						
<p>Record keeping and professional documentation should meet the Trust and professional body standards of practice. All significant information should be accurately recorded in the main body of the records. (Reminder of appropriate/effective practice)</p>	<p>To ensure that the safeguarding advisors include this recommendation in their supervision sessions as a reminder of appropriate/effective practice and put it on the supervision session agenda as evidence.</p> <p>To ensure a question relating to the specifics of this case is reflected in the annual record keeping audit,</p> <p>Any information gathered or remembered as a result of completing a child protection report should be transferred to the HV main records. A list of acronyms should be included in the new HV records. (reminder of appropriate/effective practice)</p>	<p>The Safeguarding Advisors at supervision.</p> <p>Service Managers to be assured that Staff are working within the code of conduct for record keeping via the annual Community Health Services record keeping audit</p>	<p>June 2010</p>		<p>Improvement of record keeping practice evidenced in Supervision and by improvements in the record keeping audit.</p>	
<p>Where children are subject to a Protection Plan and they do not attend a</p>	<p>Ensure all HV teams are aware of the Children who miss appointments policy.</p>	<p>Public Health Clinical Managers</p>	<p>May 2010</p>		<p>All children who miss appointments will be followed up directly and outcome recorded in the</p>	

BOURNEMOUTH & POOLE PCT – HEALTH VISITORS RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
<p>planned appointment all efforts must be made to follow up the non attendance at the earliest opportunity – preferably on the same day. (Reminder of appropriate/effective practice)</p>	<p>Send note out to all HV teams to ensure children subject to a plan / child in need status who miss appointments are followed up at the earliest opportunity and all outcomes recorded</p>				<p>record as to any further actions required.</p> <p>Issues in the family can be identified quickly and addressed as appropriate</p>	
<p>To develop Practice guidelines for Health in the MARAC process in Primary Care – expectations of staff, information sharing etc. (New recommendation)</p>	<p>A Task and Finish group to be set up to develop the guidance.</p> <p>Once guidance in Draft form HV Managers to be consulted as to their agreement to the Process involving Health Visitors.</p> <p>Agreement from:</p> <ul style="list-style-type: none"> Commissioners as to their responsibility to the Process. <p>The Guidance will be approved by the Policy Review Group and the Clinical governance and Risk Management Committee.</p>	<p>Task and Finish Group to be lead by the DV Co-ordinator Health.</p> <p>Input from Locality leads (Health Visiting) and representation from Police preferably the MARAC chair and GP representation</p>	<p>October 2010</p>		<p>Practitioners will be aware of the role and responsibility of others and of themselves in the MARAC Process.</p> <p>Duplication of role will be avoided</p> <p>Information sharing will be more effective</p>	

POOLE HOSPITAL MIDWIFERY SERVICE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
When a pregnant woman attends the Emergency Department there will be liaison with Maternity Services	<p>Working party between Maternity Services and Emergency Department will be convened to develop a care pathway</p> <p>Ratify new policy "Guideline for the admission of pregnant or postnatal women to the Emergency Department or any hospital ward.</p>	Specialist Midwife Safeguarding Children, Named Nurse, Emergency Department Nurse Practitioner and Department Consultant.	<p>Sept 2010</p> <p>April 2010</p>		<p>Maternity Services will assess all notifications of pregnant women who attend any hospital department. This will give midwives the opportunity to fully assess the pregnant woman, discuss domestic violence and potentially reduce the risk to the child.</p> <p>Emergency Department will inform Specialist Midwife Safeguarding Children that a pregnant woman has attended with any injuries. She will inform the woman's named midwife.</p>	
The social risk assessment form will assess maternal and paternal risks and will be completed for all antenatal parents.	<p>The social risk assessment form will be amended to include assessment questions about the father.</p> <p>Include in new antenatal</p>	Named Midwife	<p>May 2010</p> <p>August 2010</p>		<p>Risk assessment form to be secured in notes to ensure that midwives are always reminded to complete the assessment.</p> <p>Midwives will clearly</p>	

POOLE HOSPITAL MIDWIFERY SERVICE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
	<p>documentation guidance for completing the revised social risk assessment form</p> <p>Electronic memo to all community midwives. Attend next community midwives meeting scheduled for 3 June 2010.</p> <p>Ratification of 'Improving Patient Safety – A Guide to Documentation' Implementation of the above into practice</p> <p>Completion of social risk assessment form to be audited in the Annual Supervisor of Midwives Audit of Record Keeping.</p>	<p>Named Midwife</p> <p>Specialist Midwife Safeguarding Children</p> <p>CNST Lead/Matron</p> <p>Supervisors of Midwives</p>	<p>May 2010</p> <p>April 2010</p> <p>Oct. 2010</p>		<p>understand how to complete the social risk assessment form.</p> <p>Midwives will understand the need for accurate records in order to recognise when concerns arise.</p> <p>Increased awareness of professional responsibilities with regard to record keeping.</p> <p>To ensure that safeguarding issues are correctly documented.</p>	
<p>Midwives will be provided with effective training so</p>	<p>Training sessions will be provided on implementation of the new social risk</p>	<p>CNST Lead/Matron and Specialist Midwife</p>	<p>Dec 2010</p>		<p>Midwives will be up to date with documentation which will improve their</p>	

POOLE HOSPITAL MIDWIFERY SERVICE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
that they feel confident and competent to carry out the new social risk assessment as part of their new documentation	assessment form.	Safeguarding Children			recognition of safeguarding concerns therefore reducing the risk of potential harm to the child.	
Midwives will record who has accompanied the woman to all midwifery contacts	Antenatal documentation will be amended to include a section on who has attended with the woman.	Named Midwife	August 2010		Midwives will have a greater understanding of the support that is available to the woman and who may be involved in the child's life.	
All antenatal training and safeguarding children training will include the importance of the role of the father and making an assessment of the involvement of the father in the child's life	All antenatal and safeguarding children training programmes will be revised.	Specialist Midwife Safeguarding Children	Sept 2010		Midwives will understand the importance of assessment of the father and his involvement in the child's life.	
Links between GP practices and the midwifery service to be strengthened.	a. Review of liaison between midwives and GPs to be undertaken to establish good practice guidelines b. Practice guidelines to be	Named Midwife / specialist Midwife Safeguarding Children	a. Oct 2010 b. Dec 2010			

POOLE HOSPITAL MIDWIFERY SERVICE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
	disseminated to midwives and GPs and audited.					

POOLE CHILDREN & YOUNG PEOPLE SOCIAL CARE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO:	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
1. By July 2010 all Social Workers will make unplanned visits to children and their families on a frequency agreed with their line manager, appropriate to the assessed risk.	SUH Memo to Team Managers setting out expectation of unplanned visits to families.	Service Unit Head	May 2010	Memo	Team Managers are clear about expectations of them in relation to unplanned visits.	
	Conference and Review Co-ordinators to write the requirement for unplanned visits into the Child Protection Plans.	Conference and Review Co-ordinator	May 2010	Sample of CP Plans	All plans detail the need for unplanned visiting.	
	Team Meetings to be used to discuss the need for unplanned visiting. Record of Team Meeting to be made.	Team Managers	July 2010	Record of Team meetings	Team members have discussed the need for unplanned visits and have a better understanding of the value of this.	
	Supervision record to prompt frequency of unplanned visits.	Policy and Planning Officer	July 2010	Revised Template for supervision	Supervision records give clear detail of expectation of unplanned visits.	

POOLE CHILDREN & YOUNG PEOPLE SOCIAL CARE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO:	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
	Social Care visiting policy to be amended to give greater emphasis to unplanned visiting.	Policy and Planning Officer	July 2010	Revised Visiting Policy	Clear Policy guidance about unplanned visits available to all social care staff.	
2. By August 2010 all Social Care Staff will be aware / reminded about the need to use an investigative approach to properly account for any injury to a child or significant change in their circumstances.	CYPSC Child Protection Policy to be updated to include specific section on social work response to injuries noted on children or significant change in their circumstances.	Policy and Planning Officer	June 2010	Revised CP Policy	CYPSC are clear through procedures of expectations of investigative social work.	
	Social care practitioners to receive team / individual briefings about the need to report and record any injury to a child or significant change in their circumstances Records of briefings to be maintained.	Principal Managers / Team Managers	Aug 2010	Records of briefings	Social care practitioners have a clear understanding of the need to investigate thoroughly any injury to a child or significant change in their circumstances.	
3. By July 2010 completion and outcome of s47 must include the frequency of visiting expected prior to CPC.	CYPSC Child Protection Policy to be updated with requirement for Team Manager to record an expected visiting pattern for the period before ICPC when completing the Record of s47 Enquiries with an	Policy and Planning Officer	July 2010	Revised CP Policy	An expectation of visiting frequency is stated in every Record of s47enquiries which has an outcome of ICPC.	

POOLE CHILDREN & YOUNG PEOPLE SOCIAL CARE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO:	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
	outcome of ICPC.					
	Team Managers and social workers to be made aware of this practice requirement through SUH memo.			SUH Memo		
4. By December 2010 Social Care Practitioners to be provided with training and briefings about evidence based social work practice with families where Domestic Violence is a risk factor and the perpetrator remains in the household.	Explore research for ways in which risks posed by violent men are effectively managed.	Principal Manager R&A / Workforce Development Officer	Sept 2010	Research summary.	Research will be available to Social Care about effective domestic violence practice.	
	Briefing sessions to be undertaken with social care practitioners to develop practice based on the messages from research. Records of briefings maintained	Workforce Development Officer	March 2011	Records of briefings	Social Care Practitioners will have received briefings on research around effective practice in domestic violence.	

POOLE CHILDREN & YOUNG PEOPLE SOCIAL CARE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO:	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
<p>5. By May 2010 agency colleagues attending CP Conferences will have available guidance about how to select a category of abuse for the CP Plan which is more specific about risks to children related to Domestic Violence.</p>	<p>Laminated agenda card to be updated with guidance on how to choose between abuse categories for CP Plans where DV is the risk factor.</p>	<p>Safeguarding Manager</p>	<p>May 2010</p>	<p>Agenda card.</p>	<p>Guidance is available to all those attending CP Conferences about the abuse category to select in DV cases.</p>	
<p>6. By July 2010 Team Managers will have an agreed standard for the way in which documents on the electronic recording system, RAISE, are authorised.</p>	<p>Principal and Team Managers to agree principles and practice for authorising documents, including the practice of back-dating the end date of documents.</p>	<p>Principal Managers R&A and S&P and Team Managers</p>	<p>July 2010</p>	<p>Revised recording policy.</p>	<p>Clear guidance available to Managers and to those who undertake Quality Assurance Audits about expectations of practice in authorising documents.</p>	

POOLE CHILDREN & YOUNG PEOPLE SOCIAL CARE RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO:	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
7. By Dec 2010 Social Workers to understand the requirement for greater investigative practice and to have developed greater skills to achieve this.	During 2010 Social workers to undertake Evidence-Based Assessment Training. Detail of those attending to be collated.	Workforce Development Officer	Sept 2010	Training content and attendance records	A number of social workers have undertaken Evidence-based Assessment Training and are better equipped to practice in a more investigative style.	
	2011-2012 Training Needs Analysis to identify further training needs for effective ways of developing practice in this area.	Workforce Development Officer	Dec 2010	2011-2012 TNA	Further training needs identified to inform training plan for 2011-2012.	
8. By July 2010 Social Care Staff to be clear about their specific responsibilities in relation to the MARAC process and attendance with particular reference to vulnerable children.	Clear policy to be written setting out responsibilities of social care practitioners in the MARAC process.	Policy and Planning Officer / Principal Manager R&A	June 2010	CYPSC - MARAC Policy	Practitioners understand their role in the MARAC process.	
	Social care responsibilities to be shared and formally agreed by MARAC.	Policy and Planning Officer / Principal Manager R&A	July 2010	CYPSC - MARAC Policy		
	Briefing sessions to be held with practitioners to share new policy. Records of briefings maintained.	Policy and Planning Officer / Principal Manager R&A	July 2010	Briefing record		

STONHAM RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
<p><u>Recommendation 1</u></p> <p>Have a Safeguarding Lead person at Tatnam Lodge service and all Stonham services.</p>	<p>Project Worker to perform role as per draft job description currently in (Stonham) national consultation. Agenda item at every team meeting. Remit of role clarified with policy team where required and used in setting Service improvement plan (SIP) for Tatnum Lodge and 'Lead's' personal work objectives. Email contact group previously established to review new safeguarding policy will become ongoing forum for support.</p>	<p>Service Manager will monitor performance of Lead person. Policy Officer will run email contact group.</p>	<p>Beginning of March 2010 lead identified.</p> <p>SIP and personal objectives set by May 2010</p>	<p>Minutes of meetings. SIP.</p>	<p>This will ensure all Stonham staff can respond quickly and appropriately to safeguarding issues following Stonham national policy and local safeguarding procedures. A named lead will be responsible for acting as liaison person working with local agencies. There will be Stonham national support via the lead Stonham Policy Officer who will facilitate an email contact group to ensure all staff are learning from best practice and discuss specific cases.</p>	<p>This has already been implemented at Tatnam Lodge and will be reviewed in six months time (October 2010).</p>
<p><u>Recommendation 2</u></p> <p>Provide further guidance for Stonham staff on their role around use of Common Assessment Framework, MARAC</p>	<p>The guidance is currently being developed and consulted on by Stonham Policy Team. Stonham Safeguarding Leads to find out about MARAC in their area and make the appropriate contacts in case there is a need for future joint working.</p>	<p>Operational Policy Advisor</p> <p>All Stonham Safeguarding Leads overseen by Service Manager</p>	<p>May 2010</p> <p>June 2010</p>	<p>Guidance circular.</p> <p>Minutes of meetings.</p>	<p>This will include when to initiate CAF and when to share safety plans and risk assessments.</p> <p>Safeguarding Lead and Service Manager will have good links with all appropriate agencies with</p>	<p>A tool has already been developed following this review to enhance Stonham support planning</p>

STONHAM RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
and working with statutory authorities.					established local protocols for use and sharing of both CAF and MARAC. This will enable a joined up approach of delivering one service to the individual child or adult. This guidance will now also include recommendations on what to record about children in contact sheets and linkwork notes.	tools to encourage staff to talk about welfare of children our clients are caring for.
<p><u>Recommendation 3</u></p> <p>Launch new Safeguarding policy in all Stonham Services</p>	Policy to be agreed by executive team April. Develop and agree implementation plan with Project Sponsor. Launch policy in line with implementation plan.	Policy sponsor, Area Business Manager. Operational policy leads. Implementation responsibility, Area Business Manager	Policy launch Sept 2010	Policy will be available.	The new policy brings together best practice and government recommendations. All project staff are inducted into the use of policies and specific training will be tailored to ensure staff have the necessary skills to understand their role in safeguarding issues.	Policy due to go to executive team for sign off. Training Department is aware of training need and will be working with policy team to design training product. Section on Stonham intranet

STONHAM RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
						already includes examples of good practice, links to government reports, websites and there is a feedback opportunity.
<p><u>Recommendation 4</u></p> <p>Stonham Safety Planning tool, ‘Safety, Me and Others’ to include prompt to share with other agencies as applicable.</p>	<p>Policy team fully briefed as part of this review so are aware of need for change. Lead policy advisor to make changes to forms.</p>	<p>Operational Policy Team</p>	<p>May 2010</p>	<p>Forms available</p>	<p>The guidance for this tool will include a section to remind staff to discuss with the client when the information should be shared. This will also cross reference to the Confidentiality and Information Sharing Policy.</p>	<p>There are plans to issue guidance on Intranet as a reminder of better ways to use the support plan tool.</p>
<p><u>Recommendation 5</u></p> <p>Recommendations of this review to be shared at senior level within Stonham.</p>	<p>This will be an agenda item at the Directors Management Team.</p>	<p>Report Author</p>	<p>June 2010</p>	<p>Minutes of meeting.</p>	<p>This will ensure areas for improvement in our practices are embraced by organisation.</p>	<p>Report prepared.</p>

YOUTH OFFENDING TEAM RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
<p>1. To ensure that the Improvement Plan addresses organisational shortfalls in terms of safeguarding practice in this case (An improvement plan is already in place)</p>	<p>To identify that the content of the Improvement Plan reflects the findings of this IMR.</p> <p>The progress of the Improvement Plan to be regularly monitored through the Chair of the YOT management board and its members and the Youth Justice Board for England and Wales.</p> <p>An HMI re-inspection will occur within the next twelve months.</p>	<p>YOT manager.</p>	<p>Monthly improvement board meetings .</p> <p>October 2010, dates TBC.</p> <p>YJB pre-inspection run focusing on assessment, planning, interventions, and supervision with clear emphasis on YOT's ability to manage risk and</p>	<p>Thorough assessment, planning and reviewing processes will exist in order to respond appropriately and smarter to identified needs and risks.</p>	<p>The embedding of a new performance and quality assurance culture allied to more open communication channels.</p> <p>Thorough assessment, planning and reviewing processes will exist in order to respond appropriately and smarter to identified needs and risks.</p>	<p>Ongoing but HMI re-inspection in next twelve months.</p>

YOUTH OFFENDING TEAM RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
			safeguard.			
<p>2. To develop a bespoke training programme to support the Improvement Plan and to meet service priorities across the service</p>	<p>To ensure that arrangements are in place for training to be provided on management information systems, - assessment, planning, - interventions and – supervision.</p> <p>To ensure that the training has a particular focus on quality assurance, safeguarding (VMP) and risk of serious harm (ROSH), and solution focused approaches to improve engagement and retention skill sets</p>	YOT Manager	<p>May 2010 x 3 days Solution Focused.</p> <p>June 2010 X 2 Assessment, planning, intervention, and supervision 27th/28th</p> <p>July 2010 Assessment, planning, intervention and supervision, risk of harm and safeguarding.</p>	<p>Training and development programmes will have been delivered.</p> <p>Work with young offenders will demonstrate that relevant safeguarding issues have been addressed.</p>	<p>The training provision will ensure that staff have the relevant skills, knowledge and confidence to work with young people in not only addressing their offending behaviour but also to address safeguarding issues whenever they arise in the work with a service user and his/her family.</p>	

YOUTH OFFENDING TEAM RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
			<p>24th August 2010. Assessment, planning, intervention and supervision, risk of harm and safeguarding.</p> <p>September 2010 2 days, dates TBC. Information system/quality assurance.</p>			
<p>3. To ensure that the recent review of the YOT risk management and</p>	<p>A robust quality assurance system will be created to ensure good assessments, planning, and sequencing of</p>	<p>YOT manager.</p>	<p>Under the auspices of quality</p>	<p>Quarterly and other reviews will have taken</p>	<p>The new processes will encompass all identified need, and where specific issues are identified e.g.</p>	<p>Ongoing with YJB and management board</p>

YOUTH OFFENDING TEAM RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
safeguarding procedures are in place and effective.	<p>delivery according to identified needs/priorities.</p> <p>To identify that the YOT improvement plan includes safeguarding and risk management and that workshops for all staff and ongoing audits to embed learning.</p>		<p>assurance arrangements <u>quarterly reviews</u> should occur in all cases save when risks are identified as concerning e.g. high/very high. On these occasions reviews should occur <u>at least monthly</u> and be multi agency focused.</p>	<p>place as planned, supported by relevant records of decisions and actions from such reviews.</p>	<p>substance misuse or CAMHS, identified pieces of work are allocated to in house representatives who link into wider services such as health and report back progress.</p> <p>Where issues arise concerning poor response or lack of acceptance this is followed through existing channels for resolution. If concerns continue to persist the YOT manager has recourse to report to the YOT Management Board</p>	<p>oversight and 2011 re-inspection.</p>

OVERVIEW RECOMMENDATIONS

HEALTH RECOMMENDATIONS	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
<p>The Midwifery Department will develop regular planned safeguarding supervision for the community midwives</p>	<p>Specialist Midwife for safeguarding children to develop supervision procedures and establish planned supervision sessions</p>	<p>HW / Specialist Midwife Safeguarding</p>	<p>October 2010</p>	<ul style="list-style-type: none"> • Procedures written disseminated and included in midwifery safeguarding training • Supervision dates established 	<p>Midwives have support in assessing antenatal parents and understand their responsibilities in making referrals to social care in safeguarding children situations.</p>	
<p>The possibility of developing a secure, receipted system of electronic distribution of conference minutes will be agreed between GPs and the Local Authority Children & Families Safeguarding Services.</p>	<p>LA Poole to establish secure email communication for conference minutes</p>	<p>Poole LA/ Designated Nurse</p>	<p>December 2010</p>	<ul style="list-style-type: none"> • Secure email process in operation between LA Safeguarding service and GP practices 	<p>Child Protection Conference minutes will be shared promptly with GPs (& other health professionals).</p> <p>LA safeguarding children service & GPs will have evidence of whether minutes were sent and received.</p>	<p>Safeguarding children Manager, Poole LA liaised with business support about secure email communication. Some work is in progress. To advise Des. Nurse when at a stage to introduce to GPs.</p>

HEALTH RECOMMENDATIONS	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
Health professionals will be reminded of their responsibilities to question and challenge other agencies, as well as health professionals, if they have reason to believe that the child protection process is not robustly safeguarding a child	Ensure that this is clearly included in Multi-agency & in Health provider Units Local Agency CP procedures. Letter to provider units asking them to confirm that this is included in their CP procedures.	Director of Patient Safety & Quality /Designated Nurse/ Named Nurses Provider Units	Sept 2010 July 2010	Letter to provider units. Inclusion in Multi-agency procedures. Inclusion in Health provider Units Local Agency CP procedures. Included in CP training.	Health professionals will challenge or question single-agency or multi-agency practice if they have reason to believe that the child protection process is not protecting a child.	
Child Protection Plans should be adhered to and if there is a reason for the change this should be agreed or discussed at the Core group or Conference.. Adherence to a specific plan is vital post a CP conference.	Ensure that this is Included in Health provider Units Local Agency CP procedures Letter to provider units asking them to confirm that this is included in their CP procedures	As above	Sept 2010 July 2010	Letter to provider units. Inclusion in Multi-agency procedures. Inclusion in Health provider Units Local Agency CP procedures. Included in CP training.	Health Professionals will adhere to the child protection plan. In cases where there is a reason for change this will be agreed or discussed at the Core group or Conference.	
GPs will be informed about the MARAC process via the weekly NHS B&P briefing to GPs and	Information briefing on the MARAC process and GP's role and responsibilities will be placed on the primary web and highlighted in the weekly	Designated Nurse	July 2010	Briefing on MARAC available on the Primary Web.	GPs and their practice staff will understand the MARAC process and their role in it.	

HEALTH RECOMMENDATIONS	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
on the Primary Web.	briefing. Information on MARAC will be incorporated into safeguarding training.			MARAC information found in safeguarding children training presentations.		
Midwifery Unit will audit practice against the Midwifery Domestic Violence Procedures.	Audit tool to be developed and audit undertaken.	Designated Nurse / HW / PK	October 2010	Audit completed with appropriate practice changes identified if required	Midwives will follow the midwifery domestic violence procedures.	
IMR authors should only undertake IMRs if they have received appropriate training or undertaken an agreed development plan of shadowing and mentoring.	Identify those IMR writers who have not received IMR training Identify Training courses Obtain management agreement and support for staff to be released.	Designated Nurse / Named Nurses / Executive Leads Health Provider Units	Sept. 2010	IMR writers will have received training IMR writers will receive support & mentoring when completing an IMR	IMR writers will feel confident when writing an IMR IMR writers will understand the standards expected of them when writing an IMR	

OVERVIEW RECOMMENDATIONS	KEY TASKS NECESSARY TO ACHIEVE RECS.	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECS.	PROGRESS
<p>1. Bournemouth & Poole LSCB to ensure that all social, risks and needs assessments of families by the Bournemouth & Poole LSCB constituent agencies, must always include fathers and other significant males in the household, who need to be engaged as fully as possible in the assessment process.</p>	<p>Letter from LSCB to constituent agencies requesting confirmation that a process is in place to ensure compliance with this rec.</p> <p>Responses to be reviewed and further evidence sought if necessary.</p> <p>Process is "signed off" as completed and that all agencies are compliant.</p>	<p>LSCB Chair</p> <p>LSCB SCR sub group</p> <p>Performance and Effective Sub Group of LSCB</p>	<p>July '10</p> <p>Dec '10</p> <p>Feb '11</p>	<p>Letter written and sent</p> <p>Responses received from all agencies with evidence of compliance</p>	<p>Fathers and male partners will be effectively involved in professional interventions when there are parenting concerns regarding their children.</p> <p>- There will be more informative assessments and detailed analysis of parenting strengths and weaknesses.</p> <p>- Improved father/male partner's participation has led to more effective safeguarding practice</p>	
<p>2. Bournemouth & Poole LSCB to review whether or not there is sufficient and relevant multi-agency training provision in respect of how domestic violence and substance misuse can impact upon parenting. Such training should enable professionals</p>	<p>To review the sufficiency and content of Domestic Violence and Substance Misuse training, to ascertain if they meet this requirement.</p> <p>To make implement any changes to this aspect of multi agency training, based on the findings of the review.</p> <p>To include this as part of the ongoing broad review of</p>	<p>Pan Dorset Training and Workforce Development sub group</p>	<p>Dec '10</p>	<p>Initial Report from the Sub Group with evidence to support that rec. has been met</p>	<p>So that the Bournemouth & Poole LSCB can be assured that all professionals are appropriately trained on how domestic violence/substance misuse can impact upon parenting, which in turn will enable professionals to take a more investigative and probing style of approach to conducting assessments.</p>	

OVERVIEW RECOMMENDATIONS	KEY TASKS NECESSARY TO ACHIEVE RECS.	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECS.	PROGRESS
to take on an approach of sensitive enquiry in order to elicit information that could be pertinent to identifying risk factors.	training recently commissioned by Dorset and B&P LSCB		March '11	To be included in final report to LSCB Boards.	Improvements in professional practice in respect of understanding and taking relevant action to safeguard children when domestic violence and substance misuse is feature of parenting.	
3. For the Bournemouth & Poole LSCB to seek confirmation from Children's Social Care and the Police that strategy meetings/discussion, as pivotal parts of the child protection process, are consistently taking place in cases of domestic violence, and if not, to address the shortfalls.	LSCB to initiate a self audit tool which will identify practice experience for the period April '09 – March '10. As part of a planned LSCB review of domestic violence incidence and services, to include the link with strategy meetings in this review.	LSCB Chair LSCB Business Manager	July '10 Dec '10	Audit response and DV review identifies any shortfalls, as well as the actions to address them.	Incidents of domestic violence are fully investigated as safeguarding concerns, with the consistent arrangements for Strategy Meetings a key part of that investigation.	
4. For the Bournemouth & Poole LSCB to develop a comprehensive multi-	To identify the value and use of any current teenage pregnancy protocols in place, and whether they meet the requirements of this recommendation.	Performance and Effective Practice sub group	Oct'10	A relevant strategy or protocol is in existence	Bournemouth & Poole LSCB to be assured that a cohesive multi-agency approach is taken when teenage parents present	

OVERVIEW RECOMMENDATIONS	KEY TASKS NECESSARY TO ACHIEVE RECS.	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECS.	PROGRESS
<p>agency Teenage Pregnancy Strategy for teenage parents which will include an agreed multi-agency package of intervention, addressing concerns or difficulties identified. Current protocols and arrangements must be reviewed and updated accordingly to meet these requirements.</p>	<p>Dependant on the findings above, establish a task group to either : - 1) Revise and re-disseminate the current protocol/strategy 2) Develop a strategy to meet the requirements of this recommendation.</p>	<p>Task Group to be established with the support of the LSCB</p>	<p>Dec '10</p>		<p>themselves to agencies in the Bournemouth & Poole LSCB area.</p>	
<p>5. For the Bournemouth & Poole LSCB to be assured that the focus at MARAC will not only be on the adult victim but will also take recognition of any safeguarding needs of a child and make referrals to the relevant agency as appropriate.</p>	<p>To place this item on the agenda of the MARAC Boards for Poole and Bournemouth. From the above, to identify relevant actions and timeframes which will address this issue</p>	<p>Lead Safeguarding Advisors for Children's Services, Bournemouth and for Poole.</p>	<p>Oct '10</p>	<p>MARAC has been able to identify the safeguarding needs of children, which has led to referrals appropriately made to Children's Services</p>	<p>Bournemouth & Poole LSCB can be assured that MARAC does not operate in isolation and a cross-reference is made between MARAC and the relevant agency dealing with the safeguarding needs of a child who may be part of the adult victim's household.</p>	

OVERVIEW RECOMMENDATIONS	KEY TASKS NECESSARY TO ACHIEVE RECS.	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO: -	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECS.	PROGRESS
<p>6. For the Bournemouth & Poole LSCB to be assured that all child protection plans are Specific, Measurable, Achievable, Realistic and Timely (SMART).</p>	<p>An audit is undertaken of a specific number of CPC Plans for both Bournemouth and Poole.</p> <p>Report of outcome of audits to be presented to SCR Sub Group</p>	<p>Lead Safeguarding Advisors for Children's Services, Bournemouth and for Poole and/or LSCB Business Manager</p>	<p>Oct '10</p>	<p>Findings from audits are produced for consideration by the SCR sub group</p>	<p>Bournemouth & Poole LSCB can be assured that any child protection plan for a child is robust and effective in meeting the child's needs, including the correct category of registration.</p>	
<p>7. For the Bournemouth & Poole LSCB to be assured that the purpose and nature of bail conditions is clarified, understood and appropriately scrutinised by conference members/conference Chair as part of the risk management of a case.</p>	<p>A letter is sent to the managers of the CPC Chairs informing them of this recommendation, asking for reassurance that this practice is adhered to, and how this will be achieved</p>	<p>LSCB Chair</p> <p>Managers of CPC Chairs</p>	<p>Aug '10</p> <p>Oct '10</p>	<p>Response to letter confirms that this rec. is being adhered to</p>	<p>This will ensure that proper consideration has been given at conference regarding the status of bail conditions and the impact of them on any child protection plan</p>	