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**BOURNEMOUTH & POOLE
LOCAL SAFEGUARDING CHILDREN BOARD**

**SERIOUS CASE REVIEW
REGARDING CHILD G**

EXECUTIVE SUMMARY

**Karen Tudor
Independent Overview Author**

19 April 2011

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1. INTRODUCTION

- 1.1 This review concerns a six year old boy killed by his father in 2010. The child died as a result of an overdose of injected drugs, his father was found dead on the same day. The inquest ruled that the child was unlawfully killed and his father took his own life. To protect his identity, the child is referred to as Child G.
- 1.2 When a child dies and abuse or neglect is known or suspected to be a factor in the death, the Local Safeguarding Children Board (LSCB) should conduct a Serious Case Review (SCR) into the involvement of organisations and professionals with that child and their family. This Serious Case Review (SCR) examines the involvement of agencies with Child G between the date of his birth and his death.
- 1.3 To comply with relevant government guidance¹ the LSCB, chaired by Ron Lock, commissioned a SCR to be undertaken in respect of the circumstances of this case.
- 1.4 The purpose of this SCR reflected the relevant government guidance to
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
 - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result and
 - Improve intra and inter-agency working to better safeguard and promote the welfare of children

2. THE REVIEW PROCESS

- 2.1 The scope and terms of reference were determined by an appropriate Panel comprising senior and expert representatives from the following organisations
- Service Manager, Safeguarding, Children's Review & QA, Bournemouth
 - LSCB Business Manager
 - Service Manager, Children's Learning & Engagement, Bournemouth
 - Enhanced Service Manager, CAF/CASS
 - Head of Children's Services, Borough of Poole
 - Designated Nurse Consultant Safeguarding, B&P NHS
 - Dorset Police
 - LSCB Administrator, Normally an Ex Officio member along with the Overview Author
 - Dr J P Stephens, Consultant Psychiatrist/Lead Consultant, Dorset Healthcare Foundation University Trust
- 2.2 The Review was independently chaired by Prity Patel, a Safeguarding Consultant who had no involvement with this case and no recent involvement with safeguarding children practice in Bournemouth and Poole.
- 2.3 The Panel also commissioned an Independent Overview Author, Karen Tudor, a Safeguarding Consultant with no previous knowledge of the case or previous links with Bournemouth and Poole LSCB.

¹ A Guide to Inter-Agency Working Together to Safeguard and Promote the Welfare of Children, Chapter 8, – March 2010,

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- 2.4 In order to gather the information needed for the review, each agency which had had involvement with Child G and his family was asked to complete an Individual Management Review (IMR). The IMR's were to look openly and critically at practice and determine whether any lessons could be learnt from Child G's death. The IMR authors were independent in that they did not line manage the services provided to the family by their respective agencies.
- 2.5 IMRs were written by the following agencies
- Dorset Police (to include any involvement of MARAC)
 - Borough of Poole, Children's Services
 - Bournemouth & Poole Primary Care Trust (School Nurse, Health Visitors)
 - Poole Hospital NHS Foundation Trust
 - South Western Ambulance Trust (SWAST)
 - Royal Bournemouth & Christchurch Hospitals Trust
 - Child & Family Court Advisory Service (CAFCASS)
 - Children's Social Care, Bournemouth Borough Council
- 2.5 In addition to the IMRs a Health IMR Overview Report was written which looked at the involvement of all the health services.
- 2.6 A de-briefing meeting was held on 28 April 2010 for IMR authors who will arrange feedback to their respective agencies.
- 2.7 A publication and communication strategy will be undertaken by the LSCB Executive Board in order to ensure there is appropriate dissemination of learning to all relevant staff directly and indirectly involved as well as family members.

3. PARALLEL PROCESSES

- 3.1 A Coroner's Inquest was held on 7 December 2010 and Child G's date of death was established as 18 August 2010 when the Coroner concluded that he had been unlawfully killed. He had a mixture of drugs in his body. Mr G was said to have taken his own life. The cause of death was mixed drug intoxication.
- 3.2 The South West Strategic Health Authority was notified of the Serious Untoward Incident (SUI) and at the conclusion of this SCR will decide whether or not to undertake a review.
- 3.3 Procedures relating to CDOP (Child Death Overview Panel) were carried out appropriately.
- 3.4 The Chair of the SCR Panel also engaged in discussions and correspondence with the relevant Family Court, which provided a copy of the court file together with transcripts of the hearings which took place on the 23 and 25 June 2010.
- 3.5 The Independent Chair of the Bournemouth & Poole Safeguarding Adults Board will consider the circumstances relating to Mr G and decide whether or not they will conduct a serious case review.

4. PARENTAL AND FAMILY CONTRIBUTION TO THE SERIOUS CASE REVIEW

- 4.1 Child G's mother (Ms G) and members of his father's family were invited to contribute to the Review. Ms G was interviewed and discussed with the Overview Author her perception of events, her experience of the services provide and whether in her view, if anything had been done differently it might have prevented Child G's death. Child G's paternal uncles were interviewed and they provided useful background information and some insight into the background of Mr G. They were also invited to comment on the services provided and what, if anything, might have made a difference to the outcome. The comments from the family were fully discussed by the

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SCR Panel and contributed to the learning in this case. The report will be shared with the family prior to publication; Ms G will be visited by the Overview Author with a representative from the LSCB.

5. KEY FACTS/SUMMARY OF EVENTS

- 5.1 Child G was born in Bournemouth in 2003, the only child of Mr and Ms G who had been in a relationship for two years before he was born. Ms G also had a daughter, born in 1994, she lived with her father. Consideration was given to the involvement of Child G's Half Sister in this review, but the SCR Panel agreed that it would not contribute anything further to the learning in this case as she was not living with the G family during the relevant time period identified for this review.
- 5.2 Mr G had had numerous visits to his GP and had made attempts at suicide in 1980, 1988 and 2001. A psychiatric report written about him in 1988 indicated that there was a strong possibility that he may commit suicide in the future.
- 5.3 Child G was never an open allocated case to a Local Authority Children's Services team but the family were known to Bournemouth and Poole. Shortly after Child G's birth in 2003, Ms G was diagnosed with a chronic illness which caused a steadily worsening fatigue. Before the diagnosis, the effects of the illness on Ms G's parenting capacity prompted the Health Visitor to make a referral to social services. When Ms G's illness was diagnosed, she started taking appropriate medication and her health improved, the concerns disappeared and no action was taken.
- 5.4 In 2007, Child G was diagnosed with diabetes and regularly attended the paediatric diabetes clinic. His parents managed the treatment well and there was good communication with his school about his diet and injections. He also had some delay with his speech and was receiving a service from the local speech and language service.
- 5.5 In the spring of 2010 Child G's parents separated, Child G stayed with his father and Ms G left the family home. Child G's parents were then resident in two different local authorities. The separation was acrimonious and the couple found it difficult to agree arrangements for contact.
- 5.6 A month after his parents separated, the police were called by Ms G when she became concerned for Child G's safety; she reported that Mr G had taken Child G from school without her knowledge and without good reason. At the same time Ms G reported that Mr G had told her that he was considering ending his life. The police investigated the incident, assessed it as a form of domestic abuse and passed the information on to the relevant Children's Services areas and to the Health Safeguarding Service Unit.
- 5.7 Later the same month, Mr G made an application to the Family Court for a Residence Order (to have Child G formally living with him) and a Prohibited Steps Order. (to prevent Ms G removing Child G from his care) Within a few days of the application the case was heard at the local court. Ms G prepared a statement for the court alleging she had been subject to domestic abuse and referring again to Mr G's suicide threat. The Children and Families Court Advisory and Support Service (Cafcass) became involved with the family and interviewed Child G's parents when they were at court.
- 5.8 Because the court hearing was held with very little notice, interim arrangements were made for Child G to stay with his father and have regular contact with his mother. A report was requested which would assist the court to make permanent arrangements for Child G. In fact Child G died before this was started.
- 5.9 In the summer of 2010, six weeks after the court hearing, Ms G went to collect Child G from his father for contact and could get no answer. Earlier that day she had

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received a letter from Mr G which indicated Child G was at risk. The police were called and found Child G and his father dead at Mr G's home.

6. KEY THEMES ARISING FROM THE CASE

- 6.1 Almost up to the time he died, Child G was seen as a happy, well-adjusted child. He attended school regularly and received a high standard of medical care for his diabetes. It was only after Child G's parents separated that there were indications of serious problems and it was during this time that opportunities to intervene in family life were missed.
- 6.2 Filicide / Suicide (when a parent kills a child and then commits suicide) is very rare. It is by its nature a deliberate and thought-out act and the limited research available shows that it is almost impossible to predict. In this case the Review concluded that Child G's death could not have been predicted. Whether there was sufficient evidence to show that Child G's death could have been prevented is hard to say.
- 6.3 There was no single event where if things had been done differently it is possible to say Child G's death might have been prevented. It is evident that more questions could have been asked about Mr G, his feelings and intentions, a greater emphasis could have been placed on assessing the associated risks to Child G, but even with different decisions at key opportunities, it is unlikely Mr G could have been diverted from his intention.

7. PREVIOUS SUICIDE ATTEMPTS

- 7.1 Mr G had made several previous suicide attempts over a thirty year period. The attempts were all life threatening and occurred approximately every ten years. They all occurred before Child G was born. A psychiatrist had written in Mr G's notes that the episodes were prompted by relationship breakdowns and in his view, there was a strong possibility Mr G would kill himself at some time in the future. Because the episodes were spread out and the most recent had been nine years before his death, the information about Mr G's history was not in the forefront of his doctor's mind. Mr G changed GP practices several months before his death and his old records hadn't been read. Although Mr G attended the surgery often, this was usually for treatment for physical injuries and there was no evidence that possible links between his physical and emotional health were explored. Mr G was not seen as a suicide risk and there was therefore no consideration of the risk posed to Child G from his father.

8. DOMESTIC ABUSE

- 8.1 There was one incident shortly after Child G's parents separated, that his mother called the police because she was concerned for Child G's safety. Mr G had taken Child G out of school, allegedly for a hospital appointment. Just before this incident Mr G is alleged to have told Ms G he was considering suicide and because she didn't know where Mr G had taken Child G, she became very worried. The police responded quickly and efficiently and found Child G at his fathers' house unharmed. Although they knew from Ms G that Mr G had threatened suicide, they never asked Mr G about his suicidal intentions. This was a missed opportunity and although Mr G might not have been feeling suicidal at that point or have admitted if he was, it lead to a minimising of the threat when the information was passed on to health and children's services.
- 8.2 The incident was seen by the police as a "domestic abuse" situation because they concluded the parents were unaware of the emotional impact on Child G of their arguing over his care and where he should live. The police passed the information on but there were difficulties with the communication which resulted in lost opportunities for a proper assessment of the risk to Child G.

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- 8.3 There were two Children's Social Services to be informed of the incident, one where Child G lived and the neighbouring authority where Ms G lived. The Authority where Ms G lived were sent the form (DV1) and they concluded the circumstances did not pass the threshold for an assessment. This was an appropriate response given what they knew, but they did not consider fully consider the suicide threat, possibly because it had been downplayed by the police. The other authority was telephoned by the police but has no record of the call and made no response. The reason for the lack of recording is not known.
- 8.4 The information was also sent by the police to the Health Safeguarding Service and the police wrongly assumed that any mental health or suicidal risks would be picked up by Mr G's GP. In fact the GP never saw the information and was not aware of Mr G's history of suicide attempts or in what circumstances they had taken place. If the GP had been aware of the detail a referral could have been made to Children's Services and in addition a request made for a mental health assessment. The opportunity for these links to be made was missed.
- 8.5 There is in place a protocol which describes what actions are to be taken by each agency when an incident of domestic abuse is recorded. This case showed up the deficits in the protocol which didn't include any reference to GP's, wasn't sufficiently robust to ensure an adequate risk assessment by the health service in these circumstances or to ensure effective communication between the police and children's services.

9. THE COURT PROCESS

- 9.1 Prompted by the events described above, within a few days, Mr G lodged an application at the local court asking the Judge to settle the matter of where Child G should live and asking that his mother should not be able to take him from there. As is usual practice in these situations, the Children and Family Courts Advisory Service (Cafcass) was asked to help by providing information to the court to assist with decision making.
- 9.2 The local Cafcass office had been having problems with the standard of practice and management capacity. Some staff were struggling to understand new requirements imposed on them by a change in court procedures. The main change was a shift in emphasis to ensure a risk assessment was always carried out before a Cafcass officer made any recommendation to the court. In this case Cafcass spoke to both Mr and Ms G but did not follow the correct procedures. Cafcass did not make any assessment of risk and were seemingly unaware of the information in the statement Ms G had prepared for the court outlining some incidents of domestic abuse and her concerns about Mr G's suicidal intentions. Instead of asking for a short adjournment so that the risk assessment could be completed, they helped the court sort out contact arrangements for Child G who remained with his father while a report was to be prepared. Although reference was made to Ms G's statement during the hearing, insufficient attention was given by the Court to the need for any risk to Child G to be identified.
- 9.3 The case was adjourned for seven weeks and then adjourned again to a date after Child G had died.
- 9.4 Prior to his parent separating, Child G had been described as a happy, well adjusted little boy who coped well with his diabetes, after their separation, there was a notable change in his demeanour. By this time he was in a very difficult situation, effectively living between his parents who continued to argue over his care.
- 9.5 After the court hearing, Cafcass procedures state that the file should be kept under review, information properly documented and a case plan drawn up by the officer who will write the court report. In fact none of this happened and the officers concerned did not follow their own procedures. This meant that the lack of a risk assessment

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was never addressed and there was no plan in place about what needed to be done to provide a proper assessment for the court. There were in addition other factors which contributed to the difficulties, Cafcass had received incorrect information from Children's Services when they made enquiries to see if Child G was known and hadn't asked the police for information as was expected because of an unresolved local difficulty about the police response to requests from Cafcass. Neither of these made a substantial difference to this case but is indicative of a generally poor standard of practice.

- 9.6 Child G died in the summer of 2010, he was given a drug overdose by his father who then killed himself. Mr G had written a letter to Child G's mother, received on the day Child G's death was discovered; the letter made clear that Mr G realised his relationship with Ms G was finally over and couldn't bear to be separated from his son.

10. PRIORITIES FOR LEARNING AND CHANGE

- 10.1 All the IMR authors have considered learning from this case specific to their agencies and this is reflected in their recommendations, all of which are accepted by the Overview Author.

- 10.2 The key learning for all agencies is as follows:

10.2.1 When Mr G expressed his suicidal thoughts to Ms G and she told the various agencies involved with the family, there was a reluctance to question Mr G directly about his suicidal intentions. There was an indication in some of the IMRs that suicide threats during parental separation are common place and therefore the implication was that they were not to be taken seriously. This case demonstrates that all suicide threats should be taken seriously and insufficient thought was given to the implications and risk for Child G.

- *The threat of suicide, especially in cases where domestic abuse is a feature, should be considered as part of risk assessment. A failure to consider the seriousness of a suicide threat by a parent, particularly someone who may be a sole carer of a child may place that child at potentially serious risk*
- *Asking questions when faced with someone threatening suicide in order to ascertain the seriousness of that threat would contribute to an assessment of risk.*

10.2.2 In this case Mr G had been assessed as at significant risk of suicide in 1988 when a significant trigger factor was the break up of his relationship. Current thinking indicates that any previous suicide attempt is an indication of continued risk, this is particularly so if the same trigger factors are present. In the case of Mr G, the breakdown of relationships was a significant trigger factor. Mr G was a frequent attender at his General Practice but there was no evidence that any possible links being made by the GP between the high number of visits and his physical and emotional health was considered.

- *Whilst recognising that historic events in relation to adult mental health may be considered to have lost their significance with passing years, in respect of suicide attempts their significance needs to be retained and viewed as a continued risk factor.*
- *When trigger factors have been previously identified, this assists in the assessment of current risk.*

10.2.3 The police investigated the DV incident of 21 June and whilst they formally notified the Local Authority where Ms G was resident via the DV1 two days after the incident, they considered that Poole had been notified earlier by the telephone call at the time of the incident, and which they believed constituted a referral. The police

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procedures are aimed at the prevention of domestic abuse and are adult focused. This case highlighted the need for oversight of DV notifications to be carried out by someone with children's safeguarding training. Separate assessments of the level of risk to Child G were carried out by the police, health and children's services, each of which used their own criteria.

- *When DV1 notifications are sent out to relevant agencies, a multi-agency assessment of the potential risk to the children is likely to lead to a better outcome.*
- *When domestic abuse incidents involve two Local Authority areas, simultaneous notification of both, of the details of the incident, would support more informed communication and decision making.*

10.2.4 Mr G had an important relationship with his GP and appeared to use his visits to the surgery as a source of support. The GP had not seen the notification of the DV1 as it was not placed on Mr G's record. The local domestic abuse protocol does not recognise the role of GPs in domestic abuse situations.

- *GPs have an important role to play in the identification and management of domestic abuse and if they are not routinely considered as a source of information or additional support to the family following a DV incident, then the potential level of risk to any involved children could remain known.*

10.2.5 There was evidence in this case of the failure of staff to follow procedures and systems failures in the seeking of sharing of information and examples of lack of management oversight. The case reminds staff that the purpose of procedure is to protect children and lack of compliance can directly affect a child's safety.

- *Failure to comply with procedures undermines effective risk assessment of children*
- *Organisations have a responsibility to ensure staff are able to comply with procedures and able to access necessary training. If this is not a regular part of management support and monitoring, procedures are less likely to be followed or less stringently applied potentially leaving children at risk.*

10.2.6 A common theme in SCRs is difficulties in communication between agencies. In this case there were a number of examples where communication could have been improved. There were difficulties in information sharing between the Police and Cafcass, the Police made incorrect assumptions about how information from them would be used and Poole Children's Services procedures for noting and sharing information were inadequate.

- *Difficulties in communication between agencies hinder effective risk assessment.*

10.2.7 The Private Law Programme makes it clear that at the first hearing the Court should consider risk identification and the impact of any known risk on the child's welfare. Although the Cafcass officer didn't draw the Court's attention to the known facts, child protection is a shared responsibility.

- *A lack of clarity about the requirements of the PLP and the roles and responsibilities of court officers may lead to insufficient attention being given to the risks to children.*

10.2.8 The research is worthy of note but as yet provides few indicators helpful in assessing risk.

- *Filicide/suicide is very rare and almost impossible to predict.*

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11. IMR RECOMMENDATIONS AND ACTION PLANS

- 11.1 Recommendations and Action Plans from the full SCR are attached as an appendix to this Executive Summary.
- 11.2 It should be noted that prior to this SCR, Cafcass had a wide ranging plan in place to improve practice and had brought in new managers to oversee the improvements. Their plan includes a comprehensive training programme and changes in the way information is shared with other agencies, and implementation is well underway.

12. THE OVERVIEW REPORT RECOMMENDS

The recommendations of the IMRs and the Health Overview are adopted by the Bournemouth & Poole Local Safeguarding Children Board.

Recommendation 1: That the Pan Dorset Policy & Procedures Working Group reviews the DV protocol to include the learning from the SCR – this includes:

- Inclusion of parents threats and/or attempts at suicide as a risk factor for children
- How a consistent assessment of the level of risk to children identified in DV1s can be achieved across agencies
- The purpose of DV1s and ensuring effective sharing of information
- The role and responsibilities of GPs

Recommendation 2: That the LSCB include the lessons from this SCR in its multi-agency training programme in particular

- the implication of a parents' suicide threat and/or attempt on assessment of parenting capacity and risk to children
- enabling practitioners to be confident enough to directly question a parent making a suicide threat about their intention, in order to assist in assessing risk to children

Recommendation 3: That Cafcass liaise with the local Judiciary to ensure they have a shared understanding of the PLP requirements in the work to the first hearing, with particular reference to safeguarding practice.

Recommendation 4: The Chair of the LSCB to communicate with the Ministry of Justice or any relevant body regarding the review of safeguarding training for the Judiciary dealing with Private Law matters.

Recommendation 5: That the findings of this SCR are shared with the local Safeguarding Adults Board.

Karen Tudor
Independent Overview Author

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MULTI-AGENCY IMR RECOMMENDATIONS AND HEALTH IMR OVERVIEW RECOMMENDATIONS
ACTION PLAN**



NHS Bournemouth & Poole Health IMR Overview RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
<p>Recommendation 1.</p> <p>Each GP practice should have a system for reviewing and retrieving significant health and social information from paper records that accompany electronic records in the same way as they do for paper only GP records.</p>	<p>1. The Named Doctor for NHS B&P to send a letter to each GP safeguarding lead outlining the learning from this SCR and advising that this process should be in place.</p> <p>2. The annual contract process will randomly audit whether GPs have actioned this recommendation</p> <p>3. This recommendation will be promoted through GP safeguarding training and through SCR learning information on Primary web</p>	<p>1. Named Doctor</p> <p>2. Deputy Director Primary Care</p> <p>3. Designated Nurse Safeguarding children</p>	<p>1. June 2011</p> <p>2. March 2012</p> <p>3. June 2011</p>	<p>Each GP practice will have a robust system of reviewing transfer in information which can be audited via the contract process.</p>	<p>All relevant information which might identify risk to self or others is from paper records will be available to GPs on the patient summary card.</p>	<p>Press tab to add another line</p>
<p>Recommendation 2.</p> <p>Health Visitors and</p>	<p>1. Ensure that the social risk assessment form and promoting</p>	<p>Named Nurse, Named Midwives and managers</p>	<p>July 2011</p>	<ul style="list-style-type: none"> The social risk assessment form and health visitor 	<p>Midwives and Health Visitors will assess the needs of fathers in the</p>	

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Midwives should ensure that the antenatal assessment of parents includes an assessment of the father, including previous mental health issues and suicide attempts.	healthy child programme includes this specific aspect of assessment.			documentation will demonstrate that this information has been sought.	antenatal period, including their mental health.	
<p>Recommendation 3.</p> <p>Current midwifery discharge practice should be reviewed to ensure that whenever any concerns about a child's welfare or a parent's ability to provide care for whatever reason including mental or physical ill-health are identified, midwives ensure robust communication with the Community midwife, the health visitor and the</p>	1. Head's of midwifery at RBHT and PGHT to assess current discharge practice and procedures to ensure that if there are any concerns about a child's welfare or a parent's ability to provide care for their child these are effectively actioned and information shared with primary health care colleagues.	Head of midwifery/Named Midwives	Sept 2011	<ul style="list-style-type: none"> • All concerns will be acted on in accordance with B&P LSCB procedures & documented in the records. • HVs and GPs will be informed of concerns and actions taken when a patient is discharged & this will be documented in the notes. • The Discharge process will be 	HV's and GPs will know about any concerns identified by midwifery relating to a child or his/her parent.	

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GP. The discharge process should be audited within the next 6 months to ensure effective discharge communication between midwives and their primary health care colleagues (i.e Health visitors and GPs)				audited by midwifery & BP CHS in 6 months time.		
<p>Recommendation 4</p> <p>The Health Overview IMR recommendation is to extend the BP GP recommendation: “practices to ensure that should they receive a DV1 the information is given to the family GP who then considers risk to adult and child follows up appropriately” to: the protocol for ‘Information Sharing from Police to Health</p>	<p>Working party to be established to review protocol and to include guidance to GPs and their practices on management of DV1s.</p> <p>Once protocol agreed to be sent to GP safeguarding leads and practice managers and included on the Primary Web.</p>	Named Doctor, Named Nurse and Designated Nurse	Sept 2011	<p>GPs and their practices will have clear practice guidance on the management of DV1s.</p> <p>There will be evidence in the child’s and adult’s record of the DV! Form and action taken</p>	GPs will promptly assess information on the DV1 Form against the information they hold in the practice record and refer to the relevant agency if concerns are identified.	

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<p>Service where there is Domestic Violence and Children in the Family' should be revised in consultation with GPs, to include the roles and responsibilities of GPs and their practice staff on receipt of a DV1 form..</p> <p>The revised protocol should then be disseminated via the GP safeguarding children leads, practice managers, Poole Primary Web and through safeguarding children training provided to the GP practices by the NHS Bournemouth & Poole Designated Nurse Safeguarding Children.</p>						
<p>Recommendation 5</p> <p>This health overview</p>	<p>1. The Named Doctor for NHS B&P to send a letter to each GP</p>	<p>1.Named Doctor</p>	<p>1. June 2011</p>	<p>Each GP practice will have a robust system of</p>	<p>GPs and relevant practice staff will be aware of the risks that</p>	

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IMR recommends that a history of suicide attempts should be "flagged up" in GP records and should always be significantly to the fore in any continuing care, and especially in the transfer between practices.	safeguarding lead outlining the learning from this SCR and advising that this process should be in place. 2.The annual contract process will randomly audit whether GPs have actioned this recommendation 3. This recommendation will be promoted through GP safeguarding training and through SCR learning information on Primary web	2.Deputy Director Primary Care 3. Designated Nurse Safeguarding children	2. March 2012 3. June 2011	"flagging" previous serious suicide attempts in the records and this process will be audited via the contract process	might be present to the parent and to the child where significant previous suicide attempts have been made.	
Recommendation 6 General practitioners, midwives and practice nurses should ensure that there are processes in place to enable a full	For GPs & practice nurses: 1. The Named Doctor for NHS B&P to send a letter to each GP safeguarding lead outlining the learning from this SCR and	1.Named Doctor	1. June 2011	GPs and midwives will record in the patient's record the details of other children even when they do not	GPs and midwives will have a robust system of collecting and recording full information on a family including details of any	

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<p>holistic assessment of the whole family. This should include recording of the details of any children within the family even if they are not present in the household. The full name, address and contact details should be obtained.” (This is an extension of the BP CHS IMR recommendation)</p>	<p>advising that this process should be in place. 2.The annual contract process will randomly audit whether GPs have actioned this recommendation 3. This recommendation will be promoted through GP safeguarding training and through SCR learning information on Primary web</p> <p>For Midwives: Head's of Midwifery to ensure that the social risk assessment ensures an holistic assessment which includes the details of any children within the family even if they are not present in the household.</p>	<p>2.Deputy Director Primary Care</p> <p>3. Designated Nurse Safeguarding children</p> <p>Head of midwifery/Named Midwives</p>	<p>2. March 2012</p> <p>3. June 2011</p> <p>July 2011</p>	<p>live with the family.</p>	<p>children not living within the family.</p>	

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<p>Recommendation 7</p> <p>When parents separate and the care of a child with diabetes continues to be shared between them then the contact details for both parents should be recorded by the diabetic team.</p>	<p>The PGHT paediatric diabetic department to identify ways of ensuring that this information is collected.</p>	<p>Named professionals PGHT and Paediatric Manager.</p>	<p>July 2011</p>	<p>Information on both parents will be documented clearly in the child's notes.</p>	<p>The paediatric diabetic department will be fully aware of the contact details of both parents where there is shared care of a child following a parental divorce or separation.</p>	
<p>Recommendation 8</p> <p>The Health Safeguarding Service should forward DV1s at Level 1 when they contain any suggestion of threats to end life or self harm by a parent and the "Protocol for Information Sharing from Police to Health service where there is Domestic Violence and Children in the family" will include "any suggestion of threats to end life or self harm by a parent in the DV1 form" should automatically generate a "Level 1" response by the</p>	<p>The "Protocol for Information Sharing from Police to Health service where there is Domestic Violence and Children in the family" will include "any suggestion of threats to end life or self harm by a parent in the DV1 form" should automatically generate a "Level 1" response by the</p>	<p>Named Nurse BP CHS</p>	<p>July 2011</p>	<p>DV1's will be forwarded at level 1 when any suggestion of self harm or suicide is mentioned on the DV1 form. This will be clearly recorded by the health safeguarding children service.</p>	<p>The health visitor and GP will be able to assess the information from the DV1 against the information already held and promptly identify any potential risks to the child</p>	

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RECOMMENDATION Children in the family” should be amended to include this recommendation.	Safeguarding service in BP CHS					

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RECOMMENDATION Senior Nurses, Consultants and Associate Specialists within the medical directorate will be reminded of their responsibilities when adults present with mental health problems or chronic ill health and the implications of this for the care of children.	<p>i) E-mail and letter to be sent out with a link to the Trust’s Safeguarding Policy.</p> <p>ii) Presentation to be given to the medical directorate on safeguarding with particular reference to adults who have mental health problems or chronic ill-health.</p>	<p>Dr Kelsall, Named Doctor for Safeguarding.</p> <p>Senior Consultant Physician for Poole Hospital NHS Foundation Trust</p> <p>Dr Kelsall, Named Doctor for Safeguarding</p>	<p>March 2011</p> <p>May 2011</p>	<p>Copy of the correspondence will be reviewed by the hospital Safeguarding Interest Group.</p> <p>Presentation and attendance will be reviewed by the hospital Safeguarding Interest Group and the medical directorate. (Case study and</p>	<p>Improved awareness of the potential risks posed to children by adults with mental health problems.</p> <p>Improved awareness amongst staff of safeguarding responsibilities.</p>	

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<p>A notification to the Named Nurse for Safeguarding Children should be made when staff are aware of an acrimonious parental separation and concern is raised about either parent or the welfare of any children, particularly if the child has chronic health needs.</p> <p>The named nurse will notify Primary Care or advise referral to children's social care if there are concerns that the threshold has been met regarding significant harm.</p>	<p>Dissemination of this recommendation to all paediatric medical and senior nursing staff</p>	<p>Dr Kelsall, Named Doctor for Safeguarding</p>	<p>April 2011</p>	<p>discussion) Records kept by Named Nurse of any referrals .</p>	<p>Improved awareness of the impact on children of acrimonious parental separation.</p> <p>Increased primary care liaison</p>	

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<p>Recommendation 1</p> <p>Staff within the Trust will know how to respond when children fail to attend scheduled appointments</p>	<p>Review of DNA (Did Not Attend) policy within child health services – utilising good practice from other organisations,</p> <p>Networking with and accessing the named nurse forums. Timeframe 3 months allows for updating, circulating for agreement and ratifying</p> <ul style="list-style-type: none"> • Re-write policy • Circulate for comments • Update following comments • Ratify through Trust Policy group • Launch – publicise, educate, monitor compliance of 	<p>Named Nurse supported by Safeguarding Children team within the Trust</p>	<p>Re-write end of Feb.</p> <p>Ratified end of March.</p> <p>Launched April 2011</p>	<p>A standardised pathway which compliments our neighbouring Trusts.</p>	<p>This will ensure children who do not attend outpatients appointments so maybe at increased risk will be followed up robustly</p>	<p>Maternity has a good robust policy – it is the remainder of the Trust that needs the same</p>
<p>Recommendation 2</p>	<p>To undertake an audit</p>	<p>Head of Midwifery,</p>	<p>6 months</p>	<p>Annual 2011</p>	<p>This would have aided</p>	

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Where possible maternity case notes will be returned to RB&CH. Women will be reminded to return their maternity records to the issuer. The reasons for the retrieval and retention of records will be explained to them.	of Maternity case notes to check return rate. To include a quarter of maternity notes from 2009 and 2010, Follow up may extend the scope of the audit if problems are identified. Feedback to staff about the return rate and the importance of having notes to review.	delegated task to Governance Lead Maternity		audit report	the investigation and this IMR. It will aid future reviews of maternity notes. There will be an improvement in the return rate of hand held maternity records. Increased return of records will aid future case audits / serious case review processes	

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Recommendation 1: GP Practices to have up to date Safeguarding Children policies,	1.The commissioner to ensure that this recommendation is communicated to GP leads	1. Designated Nurse Safeguarding Children on behalf of Executive Lead for safeguarding	1. May 2011	Practice Safeguarding Children policy will be available and staff can demonstrate that	GPs and their practice staff will understand their responsibilities to safeguard and promote the welfare of children.	March 2011 Designated Nurse Safeguarding Children Bournemouth &

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Safeguarding Children training strategies, a comprehensive staff Induction programme and training in line with Working Together 2010	<p>2.The commissioner to monitor compliance through the contract review process</p> <p>3.GP safeguarding leads and their practices to ensure that a Practice safeguarding children policy is in place, including a staff appraisal process and that all practice staff attend appropriate safeguarding children training.</p> <p>4. Commissioners to audit compliance via the contract process</p>	<p>2.Designated Nurse Safeguarding Children on behalf of Executive Lead for safeguarding</p> <p>3.GP Leads for Safeguarding Children and Senior GP.</p> <p>4.Primary Care Commissioning manager</p>	<p>2. May 2011</p> <p>3.October 2011</p> <p>4. December 2011</p>	<p>they know where to find it.</p> <p>Safeguarding Children training included in all Induction programmes and staff Appraisals.</p> <p>Induction Programme available and attendance records kept. Record of agenda for discussion at appraisal</p> <p>Results of Specific audit undertaken by commissioner</p>	GPs and their practice staff will know what to do if they have concerns within their Practice.	Poole has met with the practice managers and GP safeguarding leads in each of the practices involved in this SCR and has now ensured that each has an up to date CP policy covering all relevant areas highlighted in this IMR and Wessex LMC safeguarding children policy which is compliant with Working Together to Safeguard Children.
Recommendation 2: Practices will ensure	1. The commissioner to ensure that this recommendation is	1. Designated Nurse Safeguarding Children on behalf of Executive Lead	May 2011	Each practice will have in place a robust pathway	GPs will be aware of all adult risk factors relevant to safeguarding children	

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<p>their record summary processes includes an assessment of previous adult health history for risk factors relevant to safeguarding children where it is known that the adult lives in a household where there are children.</p>	<p>communicated to GP leads 2. GP safeguarding leads to ensure that there is a process in place to review their records summary processes and to ensure that the pathway that is in place keeps GPs aware of significant information. 3. Commissioners to audit compliance via the contract process</p>	<p>for safeguarding 2. Practice managers, GP Leads for Safeguarding Children and Senior GP. 3. Primary Care Commissioning manager</p>	<p>July 2011 Dec 2011</p>	<p>/ system in place which identifies all risk factors relevant to safeguarding children taken from the adult's medical record. Results of Specific audit undertaken by commissioner</p>	<p>when ever they need to consider safeguarding children issues and will respond appropriately.</p>	
<p>Recommendation 3: GPs to be aware of the Think Family strategy and the potential risks posed by parents with a history of suicide attempts, depression and mental health</p>	<p>1. The commissioner to ensure that the Think Family Toolkit (DCSF 2009) and Information relating to the potential risks posed by parents with a history of suicide attempts,</p>	<p>Designated Nurse Safeguarding Children on behalf of Executive Lead for safeguarding</p>	<p>May 2011</p>	<p>Record of receipt of disseminated information returned by Practices.</p>	<p>GPs and their practice staff will assess adults who have mental health problems, depressions and/ or a history of suicide attempts and who also are parents or live with children, using a child centred approach to</p>	

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problems.	<p>depression and mental health will be disseminated to all GP safeguarding leads.</p> <p>2. Information relating to the potential risks posed by parents with a history of suicide attempts, depression and mental health to be disseminated to practice staff by the GP lead.</p>	Lead GP for Safeguarding Children in each of the Practices		Copies of educational programmes and attendance lists	identify any risk and protective factors relating to the protection of the child. Reassessment of needs takes place at times of transition and crisis.	

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1. The Health Visitor should ensure that the Whooley questions (or	Monthly review of performance against this outcome as part of	Public Health Clinical Service Managers	July 2011 Ongoing review and	Monthly performance against the target.	HV service will achieve at least 95% uptake of the Whooley questions.	

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<p>an equivalent mental health assessment tool) are used and outcome recorded at the 5-6 week contact. The assessment should include whether the mother has any suicidal/self harming ideation when appropriate</p> <p>(Reminder of standard practice)</p>	<p>the service specification</p> <p>Record audit to evidence in the file that this has been completed and documented</p>	<p>Head of Governance (independent audit)</p>	<p>evaluation as part of mainstream practice</p>	<p>Outcome of record audit.</p>	<p>Knowledge of any gaps in performance or why some assessments not undertaken through audit.</p>	
<p>2. Where it is known that a newborn baby leaving the maternity unit is registering with another GP practice the HV must ensure a timely transfer of the record to the new HV</p> <p>(Reminder of standard practice)</p>	<p>To review the transfer in policy to ensure time frames explicit for contact.</p> <p>Memo to staff to remind of particular issue of new born babies and need for quick handover to enable the Primary Birth Visit to take</p>	<p>Public Health Clinical Service Managers</p>	<p>Jan 11</p>	<p>Review of transfer in policy</p> <p>Evidence of memo sent out</p> <p>Key performance Indicator achievement – 100% of transfer in families to be contacted within 5</p>	<p>All babies who register with a different GP practice immediately post birth and seen by the HV in a timely manner i.e. to undertake the PBV by day 14 postnatally.</p>	

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	place.			working days of notification		
3. Following children's developmental assessments where it has been recorded that a follow-up review is required, this review must take place or be documented as to why it has not. Non attendances must be managed according to local procedures. (Reminder of standard practice)	To remind all staff to actively follow up review assessments and document accordingly. Audit of records to ensure this is being carried out	Health Visitor Practitioner and Team Leaders	Jan 2011	Audit of records. Monitoring of complaints form families	All developmental reviews are followed up and recorded with a clear recorded outcome for the child	
4. An holistic assessment, to include the needs & behaviours of both mother and father, should be undertaken in the post natal period. If these raise concerns then	To review current practice to ensure assessment standards are being met. Continue to review the antenatal assessment criteria	Health Visitor Professional Practice Development Group.	Feb 11 Ongoing assessment and review as part of mainstream practice	The rate of the KPI and whether ante natal visits are completed Results of audit	Risks factors will be identified HV service will report on the KPI for the antenatal visit which will show the number of antenatal visits	

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further exploration should be made. (Reminder of Standard Practice)	Health Visitors are equipped with an aide memoir and guidance on how to enforce the standard Audit of HV records and in review of practice in clinical supervision				undertaken by the HV service (where assessment is undertaken)	
5. Health Professionals should ensure a full holistic assessment of the whole family including details of any children within the family even if they are not present in the household. The full name address and contact details should be obtained where relevant? (Reminder of standard	Details of the family members should be recorded in full?. See comment re where relevant – I do not think this is achievable by all professionals in all circumstances When there is a child in the family living in or away from the home the following should be recorded:	Public Health Clinical services Managers. Team Leaders and Clinical Supervisors	Aug 11 – ongoing evaluation and review	Annual record keeping audit Achievement of the KPI for the antenatal visit	To ensure that a child in the family is fully included in the assessment	Including fathers males and siblings Take this out of CMs Lynn to action

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practice)	Who the child lives with The age name and date of birth of the child The contact arrangements					
6. Record keeping and professional documentation should meet the Trust and professional body standards of practice. (Reminder of standard practice)	Particular attention to be paid to including other services such as SALT within this recommendation Use of abbreviations such include an explanation of their meaning and jargon avoided. Include who brings the child to the appointment and where the appointment takes place, What is expected at	Governance team SALT Heads of Service and Safeguarding Service	Aug 11 and ongoing review and evaluation	Improvement of record keeping standards evidenced in supervision and by improvements in the record keeping audit	Jargon free records and adherence to the standards within BPCHS record keeping policy	

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	<p>what developmental age</p> <p>Consider the child's wishes and perspectives by direct questioning</p>					
<p>7. Consideration should be given to a change in how the DV1 form from the Safeguarding Service is distributed to other services within Health to ensure that the form reaches the intended destination.</p> <p>(New Recommendation)</p>	<p>Engage in the multi-agency review of the (Pan Dorset)DV protocol</p> <p>To identify a safe email route to and from the Service</p> <p>To identify a safe and central haven for receipt of email in each HV base and in the School Health Service.</p> <p>To add as an agenda item to the DV Strategic group and the B&PCHS Professional Practice</p>	<p>Safeguarding Children Service in conjunction with the Public Health Clinical Services Managers</p>	<p>April 2011</p>	<p>100% of all DV forms to reach their intended destination</p> <p>The forms from the Police and out of the Safeguarding Service to be more timely evidenced in the records</p>		

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	<p>meeting as a new medium and consequent change in HV Practice.</p> <p>To continue to triage the form in Safeguarding Service and consider how this is recorded</p> <p>To update the DV1 policy to reflect the change</p>					

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1. To ensure the case management date accurately reflecting the status of cases and file location.	CMS data to be up to date reflecting accurately open, closed, WTFH and WAFH	Office manager – /SMs and HoS.	Nov 10	CMS data accurate and used in an effective way to	Case closures to take place by the QI team on 13, 14 and 28 and	All actions arising from this action plan have been completed

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	<p>cases.</p> <p>Ensure that inputting is occurring in a timely way. Cases are inputted after court hearings especially 1st hearing in private law. There is currently a backlog of outcomes waiting to be inputted onto CMS.</p> <p>Set up further training for CMS and IT for FCA's. CMS trainers will include an assessment process to establish FCA's capabilities.</p> <p>Non compliance with IT training will be a performance issue. This will be reviewed thorough the SIM and</p>	<p>OM/Business support</p>		<p>manage demand</p> <p>CMS reflects accurately open closed cases, WTFH and WAFH.</p> <p>All FCAs using CMS regularly to manage own caseload and CMS use is used actively in supervision to review case loads.</p> <p>Increase in case closures -CMS reflect an accurate level of unallocated cases.</p> <p>Improvement in KPI 1 and 2 – percentage of allocated work in</p>	<p>29 October.</p> <p>Business support action plan in operation</p> <p>Unallocated cases have reduced from 100 to 46 on CMS.</p> <p>CMS /IT training have been set up. All FCA to demonstrate that they are IT competent and able to use the G drive.</p>	

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	<p>duty audits.</p> <p>All file location to be known. Business support to action in accordance with the business support action plan.</p> <p>Clear roles to be established within the business support team. See embedded document re Dorset Business support roles</p>			public and private law.		
2. To ensure a Duty Service operates effectively	Ongoing duty audits to be completed at 2 -3 weekly intervals by the QISM to track progress of improvements in within the duty and WTFH systems.	QISM/SM's/OM/FCA's/referral co-ordinator	Ongoing from Sept. 10	Duty audits to evidence improvements in safeguarding practice. The duty and WTFH system in	Duty audits have take place on 02.09.10, 19.10.10. Further dates for duty audits 02.11.10, 22.11.10, 06.12.10 and 20.12.10.	All actions arising from this action plan have been completed

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	<p>Duty audits to include audits of schedule 2 letters and assessing the management oversight of the backlog.</p> <p>9am and 4.30pm meeting between the referral –co-ordinator, duty FCAs and the Sm. Not turning up for duty will be a P and C issue. There will be two duty workers everyday available to complete all necessary tasks.</p> <p>Email to be issued on the above to all staff.</p> <p>Safeguarding checks need to be undertaken by Police and CYPS.</p>			<p>the Dorset team is clear, accountable and safe.</p>	<p>Enhanced Service Manager has met with the police and court users group. Police checks are now completed on all cases. Further work will be required with Dorset CYPS to ensure that there is an effective protocol for the sharing of information.</p>	

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	<p>SM to address issues on agencies compliance. This is required due to lessons learnt from the SCR and compliance with Safeguarding/Working together 2010</p> <p>Ongoing development of the WTFH to be lead by the Enhanced SM and the SM.</p> <p>Plans to be in place in the interim to ensure duty is safely managed to be overseen by the Service Manager and Enhanced Practitioner.</p>					
3. To ensure there is appropriate management oversight in respect of case work (to include case	As above –all cases on the backlog to be reviewed set in order of priority and Court.	SM/Enhanced FCA/ OM/SM/HoS	Ongoing	Backlogs reduced and a throughput of new work established.	Duty audits to continue to monitor the backlog and review mechanism.	As above

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recordings)	<p>Files should be reviewed fortnightly by a SM. There needs to be absolute clarity on the ownership and monitoring of the backlog.</p> <p>Spreadsheet currently set up to continue to be used to monitor the backlog. . When a report is ordered, business support to enter onto spreadsheet and then file to be passed to the service manager for risk assessment and prioritization for allocation.</p> <p>Use of additional bank staff to be used.</p>			<p>All new work is allocated in a timely way.</p> <p>Any remaining backlogs are risk assessed and have clear evidence of management oversight.</p> <p>Q4C assessments will evidence satisfactory and above for case recording.</p> <p>G drive will evidence increased use and compliance with case recording policy.</p>	<p>Agency worker currently being employed to review all the case, write case plan and prioritise for work/allocation.</p> <p>Agency FCA and 1 additional FCA identified to complete work of the backlog and all short term duty work.</p>	

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	<p>Review of all FCA caseloads to ensure throughput of cases and identify any capacity.</p> <p>Full implementation of proportionate working/Cafcass Operating Priorities/Presidents Guidance so that FCA are able to work proportionately according to the assessed needs of the case.</p> <p>FCA's to use new templates for reports that will promote more focused and analytical assessment.</p> <p>All work to be recorded on the Dorset G Drive to</p>					

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	<p>evidence compliance with the Cafcass case recording policy. No use of the FCA's H drive to record work.</p> <p>The use of the new templates for the G drive to be used for public and private law. G drive template to be set up Business Support upon application and then to be used throughout the life of the case.</p> <p>To be monitored through supervision and assessments to be recorded onto Q4C. Case recording to be recorded as inadequate if G drive not used.</p>					

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<p>4. To develop a strategic approach in respect of the way Cafcass delivers a safe and proportionate service to local courts in both public and private law proceedings.</p>	<p>SMs to identify those courts which order the most addenda reports and inappropriate reports where CYPs involved. To be continually addressed.</p> <p>Court duty at Bournemouth Court has identified difficulties in managing demands and expectations of the judiciary.</p> <p>Increased use of the new report templates for private and public law. A and R templates to be used in all cases.</p>	<p>HOS/SMs</p>	<p>Ongoing</p>	<p>Outcome measure -Addenda reports and inappropriate reports as percentage of total s7 orders will reduce.</p> <p>Outcome measure -Supervision notes evidence SMs have addressed with practitioners the need for proportionate working on all cases.</p> <p>Evidence of effective</p>	<p>Ongoing judicial liaison now taking place with the HoS enhanced SM, SM and Bournemouth judiciary.</p> <p>Reduction of backlogs is evident from July 2010 where it was approximately 60 cases. Current list is approximately 20, which includes that management of cases from FCA currently sick.</p>	<p>As above</p>

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	Review of all cases over 40 weeks for each FCA during supervision.			communication through court & judicial liaison meetings CMS evidences throughput of work, accurate caseloads and reduction in cases over 40 weeks and increased case closures.		
5. To carry out a review of practice in the Dorset Team.	The review of the practice in the Wimborne office and the change of HoS management has meant a review of practice has been instigated	QISM	Dec. 10	IAPs to be issued where poor practice has been identified	1 FCA currently subject to an IAP to be reviewed on 02.11.10 1 FCA to be subject to an IAP on return fro sick leave due to	As above

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	<p>Review the need to challenge current practice and develop new ways of working.</p> <p>Programme of audits of case plans, files and supervision notes against appraisal grades.</p> <p>Ongoing auditing and moderation of schedule 2 reports to evidence improvements in safeguarding practice and WTFH.</p> <p>Auditing of the duty/intake systems for</p>				<p>identified issues of poor practice.</p> <p>Further 1:1's booked where practice issues have been identified.</p>	

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	<p>private and public law</p> <p>Case plan audits</p> <p>Review of the OPC. FCA's who have not to signed by 31.10.10.</p> <p>All FCA's to have signed by 31.10.10. Performance measure to be considered where it has not been signed.</p>					
6. To ensure practice includes engagement with children	Increase use of child engagement tools. Wishes and Feelings and How it looks to me to be made available in all three offices. Office Manager to ensure copies are ordered and available.	OM/SM	Nov. 10	<p>File audits evidence increased use of child engagement tools.</p> <p>Child engagement tools accessible in</p>	<p>In progress. OM will ensure copies are available.</p> <p>Jan 11 –completed.</p>	As above

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				the Dorset offices.		
7. To ensure appropriate information sharing with service users	<p>Linked to ongoing audits. Case plans to be shared WAFH.</p> <p>Service Managers to ensure the sharing of case plans and recommendations is addressed with practitioners in supervision including routine audits of files</p> <p>Practitioners to record on contact logs, how and when case plans and recommendations are shared.</p>	SMS/QISM	Ongoing with immediate effect	<p>Outcome measure – increased sharing of case plans and recommendations documented in case files.</p> <p>Evidenced through the file audits.</p> <p>Reduction in complaints.</p>	<p>Ongoing file and case plan audits now taking place.</p> <p>Training day of 14.12.10 will incorporate this issue.</p>	As above
8. To ensure that there is appropriate safeguarding training	Further safeguarding training day to be set up	QISM to deliver safeguarding training.	Dec. 10	5 FCA's identified and a further 3	SCR /duty audit and complaints training to	As above

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in place for relevant staff	<p>for those FCA's who have yet to complete the training.</p> <p>Training on Serious case review/learning from duty audits and complaints to take place</p> <p>All training available to other teams in S7 is now available to Dorset.</p> <p>Foundation module training to be made available to new staff and agency staff.</p>	QISM and Service used engagement manager to deliver SCR/duty audits and complaints training.		agency staff and 1 new FCA to complete safeguarding training.	<p>take place on 14.12.10. Now completed.</p> <p>3 FCA's booked to complete substance misuse workshop on 19.11.10.</p> <p>DV1 training to take place on 30.11.10.</p> <p>Safeguarding training completed for those staff not yet done so completed 11.01.11</p>	
9. To ensure case planning and	QISMs and SM's promote diversity	SM/QISM	Sept. 10 onwards	File audits evidence the	QISMs working with FCAs to re-focus on	As above

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assessment includes consideration of diversity issues	<p>assessment through all 1:1s/practice observations and safeguarding training.</p> <p>Diversity to be fully considered in all levels of supervision, routine audits of files, in supervision and Practice Observations.</p> <p>Increase the use of the Assessment Framework workbook for rule 9.5 cases and reports covering more than 1 issue. Most FCA's have received training and exemplar has been shared.</p> <p>Supervision to evidence</p>			<p>integration of diversity in assessment in case planning and in reports to court.</p> <p>Outcome measure – evidence that Equality and diversity is addressed at all levels in supervision and evidence in supervision notes of scrutiny and challenge of poor practice with necessary action to address</p> <p>Case plans</p>	<p>the child's identity and use of tools etc for diversity</p> <p>1:1 completed with FCA's in the Dorset team.</p> <p>Case plans received from all active cases.</p> <p>Further 1:1's planned by the QISM where deficits in case planning and assessment have been identified.</p>	

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	<p>that Assessment framework is being used in cases where required.</p> <p>FCA's to show that they are referring to Framework for Assessment, and are using Cafcass toolkits e.g. Surge and Glaser, MARAC CAADA tool in their work.</p>			<p>address Diversity and link this to case planning, assessment and recommendations</p> <p>Files have completed Diversity Monitoring forms, the data having been entered on CMS.</p>		
<p>10. WTFH Team</p> <p>Team to be established to complete all risk screening telephone calls and 1st directions hearings.</p>	<p>Establishment of a stable WTFH team</p>	<p>Enhanced Practitioner Service Manager</p>	<p>03.01.11</p>	<p>Allocation of all Schedule 2 letters</p>	<p>All new applications to be assessed for risk prior to the first hearing with all relevant checks having been conducted. All applications to be assessed, for risk, at</p>	<p>All Schedule 2s now allocated to a named practitioner</p> <p>All telephone calls now made where possible/</p>

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<p>Schedule 2 letters to be allocated on receipt from Central Business Unit</p> <p>FCA's to be assigned courts</p>					<p>the first hearing by a named worker to enable the court to make an informed decision about the case in respect of risk</p>	<p>available on all WTFH cases</p> <p>A Cafcass officer is now available to see all parties at court for a risk interview and they are clear about the purpose of this interview.</p> <p>Regular supervision of WTFH team is now conducted</p>
<p>11. WTFH team</p> <p>Electronic Case papers returning from Central Business Unit are checked on day of receipt to ensure correct checks have been sent.</p>	<p>Establishment of a stable WTFH team</p>	<p>Enhanced Practitioner Service Manager</p>	<p>Jan 2011</p>	<p>Review of WTFH</p>		<p>All recommendations are now completed and tasks are met routinely</p> <p>Schedule 2 letters Quality</p>

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<p>Files to be made up on return</p> <p>All return police and CYPS checks to be screened within 24 hours.</p> <p>Risk screening telephone calls to be completed in all cases</p> <p>Schedule 2 letters to be sent to parties where appropriate</p>						<p>Assured to confirm consistency and quality</p> <p>All checks now screened in 24 hours</p> <p>Telephone calls now conducted on all cases where parties are available/contactable</p> <p>Consideration in all Schedule 2 letters to the appropriateness of sending to parties</p>
<p>12. Court Work</p> <p>All parties to be seen separately at court</p>	<p>Establishment of WTFH team</p>	<p>Enhanced Practitioner Service Manager</p>	<p>Jan 2011</p>			<p>All recommendations are now completed and tasks are met</p>

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Parties only to be seen together where there are no outstanding risk issues						routinely
13. Schedule 2 letters to be quality assured in line with Cafcass national standards	Regular audits of Schedule 2 letters	Enhanced Practitioner Service Manager Head of Service	Ongoing			A sample number of Schedule 2 letters are audited on a weekly basis. Prior to submission with court. Head of Service regularly audits a sample number of Schedule 2 letters across the service area. QASM continues to quality assure these letters
14. WAFH	WTFH team	Enhanced Practitioner	Jan 2011	Initial case plans		Case Plans are now routinely

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<p>All work to be clearly recorded on the contact log</p> <p>Initial case plans to be completed on cases where reports have been ordered by the court</p> <p>Case plans should evidence what the court has ordered</p> <p>Cafcass to complete any risk and diversity issues</p> <p>All cases to be reviewed by Service Manager when a report is ordered</p>		Service Manager		<p>on all WTFH cases where reports have been ordered</p> <p>Use of the electronic log to record actions at court</p>		<p>completed/updated on all cases where a report is ordered at court</p> <p>The use of the electronic contact log has now become an established method to record interventions on all cases</p> <p>All cases awaiting allocation are now continually reviewed by Service Manager. A clear review process is now established.</p>
15. Review of the		Head of Service QA Service Manager	Ongoing	Regular reviews are now conducted		Regular reviews of the team are

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process Review of the team to be set with the Head of Service						now conducted both by Service Manager, Head of Service and QA Service Manager There is a strategic audit plan for each team in the South Operation Area. Next schedule audit is May 2011, Dorset is included in this audit plan
16. Team Meetings Regular monthly team meetings						Team meetings now occur on a monthly basis. Everyone is encouraged to attend
17. Training			ongoing			Regular attendance is

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All staff to receive ongoing safeguarding training to include learning from SCR						now mandatory and tracked.

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Dorset Police should continue to evaluate the newly implemented process to streamline domestic violence and child in need referrals into a single process.	Conduct a 3 months review of the new process.	Detective Superintendent G	January 2011	A single streamlined process.	Joined up approach to domestic violence referrals involving children	Further review every three months. Three new posts – Safeguarding Domestic Violence Detective Sergeants have been established 4/4/2011 to develop police response.
Dorset Police should develop criteria for the	Provide written guidance to DVO's in	Detective Superintendent G	30/11/2010	Appropriate referrals made to	SRU receive notification of	Completed.

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identification of cases requiring referral from the DVO to the SRU.	relation to which cases are appropriate for referral.			SRU. Quarterly audits	appropriate cases and complete an assessment.	
Dorset Police make the co-location of the DVO and SRU units a priority, in order that the two units can be fully integrated, with a single line management.	Highlight to Dorset Police senior management the need to make this a key priority of the estates Strategy.	Detective Superintendent G	January 2011	DVO and SRU working together as one unit.	Collaboration and single process working.	The SRU and the DVO unit are now working under the same line management. The plan is for co-location to take place this year following Dorset Police Estates Strategy decision (expected April 2011).
All Domestic Violence referrals (DV1) and child in need referrals (C112) completed for families / children who live in two locations should be sent to Social Services offices responsible for both locations. Referrals should be made to both Social Services offices.	Issue guidance to DVO and SRU.	Detective Superintendent G	31/11/2010	No failings in referral to Social Services occur.	All Social Services where a child in need may live receive a referral from Dorset Police.	Completed

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Dorset Police consider how the training that police negotiators receive on crisis intervention can be adapted for response officers when dealing with an individual who may have suicide ideation.	Review the research leading to the current training for specialist police negotiators. Identify how best to use the research in an input for all response officers. Implement the most feasible and effective option.	Detective Superintendent G	September 2011	Risk of suicide identified, suicide ideation challenged and intervention sought where necessary.	Effective officer response to cases where a threat of suicide has been identified.	
Dorset Police and CAFACASS to ensure safeguarding checks completed.	Nominated lead manager from each organisation who can work together to ensure an effective safeguarding check process is in place and can troubleshoot issues as they arise. CAFACASS to prioritise requests in date order and forward to Dorset Police. CAFACASS to ensure requests are necessary and not duplicates.	Jacqui Farquharson, Force Disclosure Manager, Dorset Police CAFACASS Manager TBC	1/5/2011	Seamless process for checks being requested and completed. Initial trial period of data collection completed which identified issues arising. Further data collection and analysis to be completed once key tasks have been achieved.	Effective safeguarding checks process.	Dorset Police are completing checks a day for CAFACASS and complete urgent checks when requested.

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	Dorset Police to complete checks on a regular basis and complete genuine urgent checks as required.					

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Review electronic case recording (RAISE) guidance with specific reference to recording of information on foster carers/foster carer applicants children	Agree a process for recording foster carers' children on RAISE.	Team Manager, Fostering	Jan 2010	Policy review Audit planned for 2011.	Children of foster carers will have their own searchable record on RAISE.	Decision taken and communicated Dec 2010.
	Revise guidance to provide clarity on appropriate level of information to be recorded in relation to foster carer/foster carer applicants children	Team Manager, Fostering	May 2011	Revised electronic case recording (RAISE) guidance	Clarity about accessing information about foster carers' children.	

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	Ensure the decisions taken in response to this recommendation are shared with managers and practitioners in CYPSC.	Safeguarding/QA Manager	By May 2011	Email Trail IMR briefing		
Ensure a suitably investigative approach by staff in R&A services where parental separation indicates a high level of conflict and/or serious adult self harm	Specific team training to be provided in this area.	Referral and Assessment Team Manager	June 2011	Training delivered. Supervision records.	Practitioners responsible for managing information at the point of initial contact are confident and competent in managing this.	
	Individual coaching to be provided for staff identified as needing additional support.		June 2011			
	Team to consider 'lessons learnt' from this IMR at a Team Meeting and to identify any service developments needed.	Principal Manager, Referral and Assessment and Family Support Services	Feb 2011	Team meeting notes	Team understand concerns raised in this IMR and reflect on possible opportunities for service improvement.	
	Agree the way in which performance in responding to referrals is reflected in annual appraisal.	Referral and Assessment Team Manager	March 2011	Email trail. Appraisal records.	Managers are confident of employee performance and where there are development needs these are addressed through annual appraisal and	

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					development plans.	
	Service review being undertaken in 2010-11 will include messages from this review in design of future service.	Principal Manager, Referral and Assessment and Family Support Services	July 2011	Records of service review	Revised service is designed to ensure best practice in taking and responding to referrals.	
Review the way in which requests for Social Care background checks are managed and recorded to ensure accurate information is shared and that Children's Social Care retains information that will be useful to future referrals.	Identify all requests for background information received by CYPSC.	Business Support Manager, CYPSC	Feb 2011	Document identifying request types.	A consistent approach to recording the responses to requests for information is achieved within legal constraints. Approach enables full information to be available on social care record.	
	Take legal advice on retaining third party requests for information and make proposal on retention of these records.	Business Support Manager, CYPSC Legal Advisor	March 2011	Data policy updated		
	Agree how to manage casework information / data which is past its retention date, but is still held.	Business Support Manager, CYPSC Legal Advisor	March 2011	Data policy updated		

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	Agree revisions to processes where needed.	Service Unit Head, CYPSC	March 2011	Data policy updated		
	Implement changes to managing requests for background information.	Business Support Manager, CYPSC	April 2011	Practice has changed.		
Promote the new draft LSCB guidelines for schools on 'Record Keeping for Information on Individual Pupils', particularly in relation to section 2.3, which advises 'The pupil's general school file should be coordinated and either held in one file or have clearly contained links to any other school records.'	Present the learning from this IMR to schools at the Safeguarding Forum. This will include promotion of the LSCB guidelines at this meeting.	Strategy Manager - Safeguarding and Attendance	Feb 2011	Notes from meeting	Schools will understand the request for them to maintain record keeping systems which cross reference to ensure that any person accessing one record can see the links to other records if further information is needed.	
	The action will be added to the SCR self assessment grid, which goes to all schools.	Strategy Manager - Safeguarding and Attendance	March 2011			

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Children's Social Care Bournemouth RECOMMENDATION	KEY TASKS NECESSARY TO ACHIEVE RECOMMENDATIONS	RESPONSIBILITY FOR COMPLETING TASKS ALLOCATED TO	TARGET DATES	EVIDENCE	EXPECTED OUTCOME FROM RECOMMENDATIONS	PROGRESS
All information in contact/referral to be addressed when recording management decisions and actions	Team Manager to ensure this standard is met	Service Managers Fieldwork and Quality Assurance.	Immediate and Ongoing	Audit of recording of management decision reflects all referral and contact information,	This would evidence judgement and decision making and give greater clarity regarding threshold for service and improve outcomes for children and their families	
All information in contact/referral to be addressed when writing to parents/carers	Team Manager to ensure this standard is met	Team Manager. Service Managers Fieldwork and Quality Assurance.	Immediate and Ongoing	Audit of contact letters to parents/carers.	Parents/carers are encouraged to make contact with social care, and therefore improving safeguarding for children.	
Implementation of proposed Policy conversion referral to CAF when contact does not meet threshold for intervention for CCS	Team managers to ensure all referrers are informed of the CAF process if the threshold for intervention by CSC has not been met.	Team Manager. Service Managers Fieldwork and Quality Assurance.	Awaiting implementation date.	CAF referrals to show that a referral to CSC has been considered before referral for CAF	Threshold and response is appropriate and contact/referral explored at universal level for Childs needs to be identified	
Reinforce the need for serious case review outcomes to be shared	Appropriate forum for dissemination including Professional Practice	Service Manager Safeguarding and Quality Assurance	April 2011	Training programme	Improved practice and outcomes in safeguarding for	

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with staff.	Forum				children and families	
All Social Care staff should access mental health and domestic abuse training events to increase knowledge of both the connected and separate features of these issues and how they impact on children.	Domestic abuse and mental health training to be on training schedule and staff authorised to attend	BBC Training Sub group/Team Managers	April 2011	Training department information	Knowledge and skill development for a competent work force.	