Southampton Safeguarding Children Partnership Response

Thematic Review – Non-Accidental Injury

Three Serious Case Reviews were commissioned by the Southampton Safeguarding Children Partnership during 2018. These were combined into a thematic review due to the similarity of some of the issues that were apparent. The thematic review considers the circumstances of three infants within three families.

The independent review brought together the contribution of several agencies and professionals that had been or were involved with the infants and their families. Several areas of learning and improvement and recommendations have been made for Southampton Safeguarding Children Partnership to continue to take forward.

The Safeguarding Partners in Southampton have endorsed the recommendations and will work to ensure the recommendations continue to be implemented and the learning understood by colleagues who work to safeguard children.

This document provides the responses of the Southampton Safeguarding Children Partnership and individual partner agencies to recommendations made to them.

Recommendation 1 **(a) All agencies to ensure that professionals working with young parents are aware of the need to recognise that in the first instance parents under 18 years of age are children themselves.** **(b) This would be achieved by the provision of training concerning the research findings into the brain development of adolescents, risk taking behaviour and the impact of these factors on their parenting ability.**
Agency training programs for professionals working with young parents includes the need to recognise that parents under 18 years of age are children themselves. The training provided includes reference and information about brain development and risk-taking behaviour. Some services such as Solent NHS Trust, Family Nurse Partnership, Health Visiting Teams, received enhanced training in this area. Children and Learning Services have provided assurance that if there are specific risks to a young person who may themselves be a parent, their needs are assessed by a separate social worker. Should a parent, who is under the age of 18, and their child, require a child in need, child protection, or looked after child care plan, these plans will be created and reviewed through separate processes, but the meetings may be combined in order to reduce the number of meetings the parent is being asked to attend. The needs and wishes of the parent, will be considered during the consideration and planning of these processes.

Services have specific checks and balances in their work and contact with young parents to ensure the right level of support is provided. This includes for example from Hamshire Constabulary – their Child Centred Policing Strategy, with the first principle "Treating every child as a child first". From the Midwifery Services at the University Hospital Southampton Foundation trust, if under 18 years a young parent will be routinely referred to the Needing Extra Support Team Midwife

There is multi agency commitment to trauma informed approaches, and this is evident in several agencies, including Hampshire Constabulary.

Recommendation 2

(a) Whilst dependent on the information parents may wish to share, agencies are to be reminded that wherever possible the life history of fathers, including their own childhood experience of parenting, needs to be documented and shared with all professionals involved in working with young, vulnerable parents. Use of the information sharing agreement between the FNP and the MASH is to be encouraged.

(b) The research findings of the University of Bristol (as referenced in this report) on violence in teenage relationships and its consequences for the welfare of mothers and babies should be disseminated to all agencies working with young parents.

(c) Police to continue to recognise that domestic abuse can occur in teenage relationships and use the DASH (Domestic abuse, stalking and harassment) risk assessment, as well as the child at risk element of the safeguarding notification, to assess and share that risk with the relevant partner agencies.

Health provider colleagues, including Solent NHS Trust and University Hospital Southampton Foundation Trust currently where possible and appropriate link fathers to the child on our electronic health records and actively seek information regarding fathers. Children's Social Care Services actively seek information regarding fathers and the Information Sharing Agreement (ISA) in place between MASH and Safeguarding Partners is utilised to ensure fathers details included within the referral are researched according to the ISA. It is noted as an area for development for agencies to include father's details in referrals. Hampshire Constabulary considers it essential that officers and staff attending incidents gather information relating to other adults and children present. This enables a thorough assessment of risk and the provision of key information to partners.

The research findings from the University of Bristol are being shared with agencies working with young parents through mechanisms including a bespoke briefing document. This will be shared widely and is available on the SSCP website. Agencies also share learning through their own individual training and communication.

Hampshire Constabulary are continuing to ensure officers understand more regarding domestic abuse in adolescent relationships, this is complemented by the Child Centred Policing Strategy which sees children as children first in all encounters. For those age 16 and above who are experiencing domestic abuse a DASH risk assessment is mandatory. The DASH features as a part of the Police Safeguarding Notification (PPN1) as a combined risk assessment tool and can therefore also identify any children involved as children at risk as well as victims/perpetrators of domestic abuse. This continues to be scrutinised via the work of the constabulary's Domestic Abuse champion network and the relevant scrutiny panels for both Domestic Abuse and the PPN1 - this is further built into the constabulary's training offer.

Recommendation 3

Police Officers attending incidents of domestic abuse where children are present should be reminded of the crucial importance of professional curiosity; as embodied in careful exploration, documentation and the reporting of concerns, to ensure that children can be protected from significant harm.

Hampshire Constabulary has developed an online training POD (policy optimisation drop) which explores themes such as professional curiosity and disguised compliance – this is available to officers and staff to access in their training and briefing sessions.

As identified police officer and staff response in domestic abuse incidents continues to be scrutinised via the work of the constabulary's champion network and the relevant scrutiny panels for both Domestic Abuse and the PPN1 - this is further built into the constabulary's training offer. The Domestic Abuse champion network will review between 60 – 450 incidents per month based on a series of themes with a proposal in place to audit domestic abuse in adolescent relationships where police have attended, and domestic abuse is a feature.

Professional curiosity has also been previously addressed in face-to-face training (Sandstories) delivered to the Child Abuse Investigation team in 2019 which looks at disguised compliance and professional curiosity. Further funding was made available to deliver this more broadly to specialist teams in 2021/2022 (this was due to take place in 2020 however delayed due to Covid restrictions).

As identified in the previous recommendations the Child Centred Policing Strategy covers a wide range of themes within which professional curiosity is present. The documentation of any concerns would routinely be via the PPN1 safeguarding notification, the continuous improvement plan for the PPN1 is addressed above and in previous sections.

A HMIC child focussed inspection in June 2021, identified the need for a clear training plan for MASH staff, to ensure they were equipped with identifying and managing risk effectively in all cases referred to them. The delivery of this training programme is aimed for completion by the end of 2021.

Recommendation 4

The Safeguarding Partnership should consider reviewing as a matter of urgency the appropriateness and safety of the service currently provided to young parents and babies living in supported housing accommodation.

The **Integrated Commissioning Unit (Southampton City Council and CCG)** has undertaken an extensive review of young peoples and young parents housing/supporting lodgings provision in preparation for re-procurement in 2022. This includes the quality and safeguarding reporting requirements of all providers and the oversight measures put in place.

The review also included how the level of risk identified for a young person is appropriately matched to housing provision and the level of support required in addition to fulfilling the basic housing need- this extends to young parents.

The supported housing local authority risk assessment guidance has been updated to include reference to young parents.

Safeguarding training has also been updated and completion is being tracked by workforce development team.

The SSCP have been updated in relation to progress. It is noted two actions have been impacted in terms of timescales due to the impact of COVID-19 and work on communications and training for the multi-agency workforce remains to be completed. The SSCP are assured the remaining actions while there may be some delay in completion remain in control to be completed.

Recommendation 5

Assurance needs to be provided to the Safeguarding Partnership that the seriousness and significant risk of substance and alcohol misuse on the ability of young parents to care for and safeguard their baby/child is fully understood by all professionals by:

(a) Providing training which emphasises the risk of parental substance misuse (especially cannabis) to young babies, and the potential impact on them.
(b) Reviewing the Threshold Assessment Framework so that cannabis/substance use is included.
(c) When undertaking any assessment, cannabis/substance use by a parent is taken into account.

This recommendation has ensured agencies promote and encourage attendance at training opportunities on this subject. Some agencies also include reference to the impact of parental substance misuse within their own safeguarding training pathways**.**

The Continuum of Need (Threshold Assessment Framework) is under review through the MASH Strategic Group and is due to be considered by the SSCP in December 2021. It includes parental and adolescent substance misuse, along with adolescent parents.

Relevant agencies have provided assurance that assessments are structured to consider cannabis, substance use by parents. Advice is available to staff through line management and

named/designated safeguarding professionals. The Children and Learning Service also assure the identification of risks and concerns are part of the Quality Assurance Framework.

Recommendation 6

The FNP should be required to review standards of record keeping, ensuring inclusion of the development of babies and children and not simply a focus on concerns. This will ensure a complete picture of a child's lived experience in the care of their parent/s is captured.

The Family Nurse Partnership (FNP) are committed to ensuring high quality of record keeping. Supervisors regularly discuss in team meetings and supervision the importance of documenting formulations as well as observations, what is reported and always holding the child's perspective. Case based presentations and including additional section in supervision about the experience of the child have supported with this. A quality of records audit is planned to support this work and provide assurance that learning has been embedded.

FNP delivery includes additional Ages and Stages Questionnaire developmental assessments in addition to mandated Healthy Child Programme contacts to review development as part of the offer to every family.

Recommendation 7

Agencies to be made aware that where a baby is not registered with a GP Practice by the time of their six-week developmental check professionals need to consider this as a safeguarding concern.

Solent NHS Trust is in the process of developing guidance to support practitioners on what action is required when a baby is not registered with a GP by six-weeks.

UHSFT: The need to register your baby with a GP is discussed at defined touch points during the postnatal period such as on discharge from hospital and from maternity services

Southampton Children & Learning Services: Should a professional refer to MASH a baby that was not registered at a GP within the first 6 weeks, they would take into consideration all other elements of concerns for the child and their family members to ensure that a full risk assessment could be undertaken within the process.

The CCG will work with GP Practices to ensure that there is a robust system in place to maintain a log of births following receipt of birth notifications, which can be used to track baby registrations. Practices to aim to have all babies registered by 6 weeks of age or, at the latest, on the day of the '6-week check'. This check should ideally be carried out at 6-8 weeks of age to tie-in with the maternal postnatal check. Due to unforeseen events or reasons given by parents, occasionally the check might be postponed but this should be no later than 12 weeks. A GP should be made aware if this is the case, if there has been failed contact with the parents of an as yet unregistered baby, or if a 6-week check has been refused.

The CCG will ensure that this guidance is disseminated as part of the current process of sharing learning from reviews and reinforced in training and supervision sessions.

Recommendation 8 **Careful consideration should be given to which cases are allocated to Student Social Workers. Good quality supervision needs to be provided to the student to ensure that where concerns that a baby/child may be at significant risk of harm, the case can be reallocated when such concerns arise.**
There is now a Principal Social Worker in position within Children Services that oversees the Practice Development Team (PDT). An advanced practitioner within the PDT has the role of Practice Consultant and oversees the student programmes. Student Social Work and newly qualified social worker programmes ensuring the process includes robust supervision and support for students and newly qualified social workers so that risk is adequately assessed, and cases transferred to qualified or more experienced workers appropriately. For student social workers, they have placement review meetings, and supervision by the practice supervisor is overseen by the practice educator, who picks up if there are any issues of inappropriate work allocated.
Recommendation 9 **Chairs of Pre-discharge meetings and Initial/Review Child Protection Conferences should be reminded of their responsibility to ensure that any decision made needs to be evidence based, open to challenge and professional curiosity, and results in robust child protection planning, with advice from legal services.**
Southampton Children & Learning Services: Team Manager, Assistant Team Managers, and experienced social workers chair post-birth pre-discharge meetings, they are aware of their responsibility to ensure safe decisions are made for the child in question and welcome challenge from the network and professional curiosity. There is a clear HIPS escalation Policy for professionals who do not feel that their views or concerns have been fully weighted in decision making, or if they feel the plan does not provide sufficient safety. Managers can seek legal advice when they are considering whether legal threshold are met. Child Protection Conference Chairs are independent of the case holding team and management and are therefore able to be a critical friend to the case holding service, professional network and family when considering the balance of risks and protective factors and creating a plan to address the risks and concerns in a timely and robust manner. Senior Management oversight of child protection conference minutes and plans takes place every 2 months and reviews several cases to quality assure the standard of practice.
Recommendation 10 **The Safeguarding Partnership to ensure that all agencies recognise their responsibility to partners to share information concerning the safety and well-being of children, particularly in respect of very young, vulnerable babies if they are to be protected from harm. This can**

be achieved, by ensuring that once received by the MASH, the pathway already in place for such information to be shared with other agencies is utilised, even if the criteria for a Section 47 referral is not met at the point of initial grading.
Solent NHS Trust: FNP are in the process of updating the working protocol for information sharing with children social care to ensure that it is robust and includes/ considers the learning from this review. Southampton Children & Learning Services: There is a clear information sharing agreement in place between MASH and safeguarding agencies. Hampshire Constabulary: As previously highlighted as a part of continuous improvement to the PPN1 safeguarding notification form (which is shared with partners when risk is identified), a number of work streams have been put in place. This includes the PPN1 scrutiny panel which looks at the quality of police PPN1s and identifies any gaps in or good practice. This is to be combined with a detailed training programme which will be delivered across the constabulary via webinars and other training mechanisms. Hampshire Constabulary works closely with partner agencies within the MASH to share information regarding children at risk of harm. Existing force policy is that all child related safeguarding matters will be passed across to the attention of relevant child service departments, so that a multi-agency risk assessment can then be completed, irrespective of whether that review then leads to further formal action by those agencies. This methodology, which also includes immediate referrals to relevant schools for any child subject to a missing episode or domestic abuse incident, is currently subject to further discussion with several Local Authority areas, who are concerned on the proportionality of these automatic police referrals. The ability to meet this increased demand are matched by the equally valid concerns raised around any person making a single agency assessment of risk, when other relevant information may be readily available to them within other organisations but that they have chosen not to request. The CCG work with all agencies to ensure that Safeguarding procedures are robust and implemented. The CCG has regular meetings with MASH and other Children's Services Teams to review this and ensure that information sharing agreements are appropriate and are followed.