Derby and Derbyshire Safeguarding Children Partnership

Summary of progress against recommendations from the Serious Case Review report ADS18 in respect of Child A

Recommendation 1

The DSCB should seek assurance from Children's Social Care and their partners that the pre-birth protocol is operating effectively. An audit against this would be an appropriate method to provide this assurance. (The DSCB has already acted on this recommendation and completed the audit. The DSCB should now take forward the findings of the audit, and the activity required as an outcome, to continue with improvements to the operation of the pre-birth protocol)

Children's social care participated in the multi-agency audit of the pre-birth protocol undertaken in May 2019. The findings of the audit led to updates of the pre-birth protocol. The updated pre-birth protocol has been circulated across Derby and Derbyshire and learning arising from the review and the protocol has been incorporated within multi-agency training.

All referrals about unborn babies made to Starting Point (the multi-agency referral point for concerns about children living in Derbyshire) are now assessed by qualified Social Workers and decisions about actions that are needed are signed off by managers. This is now fully embedded into practice and is reflected in the decision making protocols and evidence on case workflows recorded by the local authority.

Children's services run a comprehensive audit and performance programme to provide assurance on compliance and quality of practice across the county. Following re-launch of the pre-birth protocol in 2019, the audit programme has highlighted positive compliance; this area of practice forms a key focus for audits undertaken.

The Derby and Derbyshire Safeguarding Children Partnership is committed to carrying out future audits to check that the updated pre-birth protocol is being used and that babies are being kept safe.

Recommendation 2

The DSCB should seek assurance from those services that deal predominately with adults that they take into account and fully understand, whether through a risk assessment or otherwise, the risk that the adult has to harm children.

They should then share those risk assessments and concerns with the relevant partners.

Think Family has been a key message promoted through training and briefings across agencies who provide services for children and adults. The training emphasises that all practitioners consider and fully understand risks within families and take appropriate action to alert partners of concerns. *Think Family* will continue to be an important element in all safeguarding courses.

Think Family continues to be an essential element within the assessment of the needs of children and factors impacting on parents. Children's Services in Derbyshire include *Think Family* in training and the assurance of case work with children and their families.

Think Family has been incorporated within training for Derbyshire police and the increased number of public protection notices being issued by uniformed officers provides reassurance that there is an increased awareness of risk to both adults and children.

Think Family is embedded in Derbyshire Community Health Services NHS Foundation Trust training and all clinical staff attend *Think Family* training. There is evidence through advice and supervision work streams that staff are applying the *Think Family* principles. The learning from this review is reflected in all levels of safeguarding training.

Think Family continues to be a significant feature within the Derbyshire Healthcare Foundation Trust with training in the subject mandatory for all clinical staff. *Think Family* is applied to all assessment, training and supervision activity and practice. The *Think Family* Think Tank is a group of professionals in various leadership roles across DHCFT with the responsibility to have a strategic oversight of *Think Family* implementation within the organisation in order to further take forward the T*hink Family* agenda within the trust after audit activity, Training and a Conference. There has been a considerable culture shift and there are examples of excellent practice. For example, there has been a review of relevant policies (including Core Care Standards and Care Program Approach policy) to ensure Think Family is incorporated as a "golden thread" throughout to promote family inclusive practice. The Derbyshire Healthcare Foundation Trust also commissioned a conference on *Think Family* and has reported evidence of improvement seen within supervision, training and examples of practice.

Chesterfield Royal Hospital Foundation Trust has an integrated safeguarding team and "*Think Family*" is at the core of all the work they complete. All staff attend "*Think Family*" training, which is a combination of adults and children safeguarding, ensuring that the whole family are considered during every intervention.

Think Family, the risks of harm that some adults can pose to children and the importance of sharing this information with relevant partners has been included in GP training provided by the Derbyshire Clinical Commissioning Group.

An information sharing agreement has been put in place with National Probation Service, Community Rehabilitation Service and partner agencies to ensure that concerns about adults are promptly and effectively raised and information shared to safeguard children.

The Derby Safeguarding Adult Board and the Derbyshire Safeguarding Adult Board reported on the action being taken by agencies to continue to promote *Think Family* across adult services, providing assurance that concerns about children in families are being identified and reported.

Recommendation 3

The DSCB has in place a bruising in pre-mobile babies' policy, this now includes suspicious marks. The DSCB should seek assurance that this is being used effectively.

The Derby and Derbyshire Safeguarding Children Partnership practice guidance on bruising in babies and children has been promoted by the Derbyshire Clinical Commissioning Group safeguarding children team and is included in training delivered to GPs by the Named Doctors for Safeguarding Children.

The numbers of medicals carried out where there are concerns about the safety of a baby are small. This means that making judgement about the impact of training and guidance to safeguard babies on staff practice is achieved when their work is reviewed and audited by their agency.

Children's Social Care, the Police, Health Providers and other agencies have arrangements in place to review and look at the quality of practice delivered by staff in different roles. Internal audit is providing agencies with the opportunity to make sure that appropriate action is being taken, if there are concerns about the welfare of babies. The Derby and Derbyshire Safeguarding Children Partnership has received assurance that the risk to babies is well embedded in multi-agency training and practice continues to be audited.

The Derbyshire Healthcare Foundation Trust has ensured that the policy was cascaded throughout the Trust and to relevant team meetings and the vulnerability of pre mobile babies is discussed within safeguarding children training.

The Keeping Babies Safe group includes key representatives from the multi-agency partnership across Derby and Derbyshire. The group ensures that learning from the review about the vulnerabilities of babies is the focus of briefings and written updates shared locally.

The Keeping Babies Safe group is developing a strategy to bring together important learning and improve how babies are safeguarded by their parents and practitioners from all agencies. Alongside "Shaking the Baby is Just Not the Deal" the strategy will incorporate areas such as safe sleep guidance and home safety including the dangers associated with nappy sacks.

The Chesterfield Royal Hospital NHS Foundation Trust includes the *Bruising in Pre-Mobile Babies* policy in the Trust procedures, which are reviewed regularly. The paediatric registrar on-call reviews all cases where children appear to have a mark resembling a bruise. The policy was reviewed in February 2020 and is included within safeguarding training delivered within the Trust.

The Derby and Derbyshire Safeguarding Children Partnership has started a further audit to check that there is evidence of the improved awareness of staff to bruises on non-mobile babies and that appropriate action is taken to keep babies safe and is planning to report on this early in the new year.

Recommendation 4

i) The DSCB should seek to ensure that all safeguarding learning, backed up by proactive guidance and/or policy, highlights to all mothers, fathers, and families about the vulnerability of babies.

Partner agencies have provided updates to the Derby and Derbyshire Safeguarding Children Partnership demonstrating the action that has been taken to ensure that the vulnerability of babies is a theme within a range of internal courses.

“Shaking the Baby is Just Not the Deal” is the main parent education programme for parents of newly born babies that is provided to them across Derby and Derbyshire by health staff. The practice guidance on “Shaking the Baby is Just Not the Deal” has been updated by the Designated Nurse Safeguarding Children, following an audit. The importance of this parent education programme is included in training and led by local Midwifery Services.

The Named GPs for Derby and Derbyshire CCG have included the importance of referral for bruising in non-mobile babies in the 2019-2020 training cycle and it is also included in the 2020-21 cycle. It is made very clear that the expectation is that all bruising in non-mobile babies should be referred to social care for a full assessment. The practitioners are directed to the DDSCP online procedures to review the practice guidance on bruising in babies and children.

In the 2019-2020 training cycle, there were 374 attendees at the Level 3 training across Derbyshire and Derby City. Training for 2020-21 has been run virtually due to Covid-19 restrictions. After 3 virtual sessions there have been 147 attendees.

The Named GP team have not been made aware through training or meetings with leads that any referrals made by GPs in this area of concern have not been accepted or required escalation. Learning from serious case reviews is disseminated through training and the quarterly Named GP Update. The recommendations from this review were shared in the Spring 2019 update.

ii) There is already in place locally a procedure for ensuring parents watch the DVD ‘Shaking the Baby is Just Not the Deal', which also ensures parents sign a confirmation form that they have seen it or at least a leaflet about it. The DSCB should request information on the impact that this campaign is having.

“Shaking the Baby is Just Not the Deal” educational film and leaflet has been reviewed by the Keeping Babies Safe group. The 6-8 week Health Visitor contact with new parents includes checking whether the messages in the film have been understood. The safe handling of babies has been introduced into the Early Help Assessments carried out where new parents have requested additional support from agencies.

The Chesterfield Royal Hospital NHS Foundation Trust provides the educational programmes “Shaking the Baby is Just Not the Deal” to mothers and partners. An audit carried out by the hospital demonstrated that 96.7% of mothers and their partners received the education film. The Trust completed an audit to check whether new parents received Safe Sleep advice in 2019 and this demonstrated that a safe sleep assessment was completed in full in 100% of cases families.

In 2018 the Keeping Babies Safe Group carried out an audit with a questionnaire for parents to complete with the support of health visitors about how they found the parent education programme. Health Visitors from across Derbyshire and Derby City conducted the questionnaire with parents and returned 86 completed questionnaires during April 2018. Parents were reassured that the questionnaire was confidential, and the information would only be used for the purpose of improving services for future families.

The audit topics included checking whether parents could remember receiving key messages about “Shaking the Baby is Just Not the Deal” and the different actions they should take to promote safe sleeping.

The responses of parents showed that that “Shaking the Baby is Just Not the Deal” is well embedded into practice with 84% of them describing seeing the film and 96% of parents could recall having the baby safe sleep assessment.

The Derby and Derbyshire Clinical Commissioning Group Maternity Transformation Programme continues to endorse the use of “Shaking the Baby is Just Not the Deal” and Baby Safe Programmes. Updated assurance of their impact has been delayed as a result of the impact of the pandemic leading to work with vulnerable families becoming a priority. Further audit is planned for the first quarter in 2021 to obtain updated assurance about what parents think about the education programmes.

There is a specific partnership training on vulnerable babies which is supported by members of Derby and Derbyshire Clinical Commissioning Group Safeguarding Children Team. Derbyshire Community Health Services NHS Foundation Trust, Named Nurse Team delivers training called “Shaken Babies, Non- Accidental Head Injury” three times a year. This was part of the Derbyshire Safeguarding Children’s Board multi-agency training programme and will continue as part of the Derby and Derbyshire Safeguarding Partnership training programme.

Recommendation 5

The DSCB to seek assurance from partners that they are asking pregnant woman about domestic abuse. They also need assurance that the current agreed pathway for domestic abuse notifications regarding pregnant women are being sent by all agencies to the 0-19 Children’s Service.

Assurance has been provided by partner agencies demonstrating that practitioners ask pregnant women about domestic abuse as part of the practice called “routine enquiry”. When police officers attend incidents where domestic abuse has been alleged, a specific assessment is carried out and included on a form used to identify risk to the victim.

There has been an ongoing campaign within Derbyshire police to promote the recording of “The voice of the child” by officers attending Domestic Abuse incidents. A specific “Voice of the child” document is completed recording the thoughts, feelings and demeanour of any child present at a domestic incident.

The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model is completed by police officers in relation to all Domestic abuse incidents. This form required the completion of information, specifically identifying whether the female victim is currently pregnant,

and the information contained within the assessment is shared with children's social care.

All children who reside in a household are included on the *Public Protection Notice* used by the police to record alleged crimes. For children of school age, a notification is sent by the police to alert the school that an incident has occurred at the child's address, to ensure that they receive any support they may require. Monthly reviews occur of domestic abuse incidents to ensure that the "Voice of the child" documents are recorded and have been shared where appropriate.

The Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company has delivered a safeguarding children refresher event, which equipped all operational staff with a comprehensive overview of risk assessment and referral, to relevant partnerships, should a child safeguarding concern be identified. In addition to this, all staff received refresher training which covered Domestic Abuse assessment and referral processes from both a victim and perpetrator perspective. Each month the Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company completes a robust quality assurance process, which requires all operational managers to case sample the completion of OASys risk assessment documents for their staff group.

The 0-5 Children's Service (delivered by Derbyshire Community Health Services NHS Foundation Trust) reviewed the pathway for domestic abuse notifications from the police regarding pregnant women, to ensure that they are received. The Service continues to receive domestic abuse notifications from the police; contact is made with these families to discuss the impact of witnessing/hearing domestic abuse on the health and wellbeing of children.

The 0-19 services and the enhance service (delivered by the Derbyshire Healthcare Foundation Trust) undertake routine enquiry where possible at the antenatal or primary birth visit. If this is not achieved, then further action will be undertaken to achieve this, for example a parent will be asked to attend clinic where the question can be asked in private. Further audit is planned to obtain updated assurance within children's services that routine enquiry is occurring and is effective.

The importance of routine enquiry regarding domestic abuse, particularly during pregnancy, has been included in GP training provided by the Derby and Derbyshire Clinical Commissioning Group.

Recommendation 6

The DSCB should ask DHCFT to circulate information to the safeguarding partnership, in relation to the work of the Criminal Justice and Diversion team (CJDLT). There was at the SCR panel meeting a general lack of knowledge about this team.

The Derbyshire Healthcare Foundation Trust circulated information in November 2019 about the work of the Criminal Justice and Diversion team.

When a young person is in police custody, they are offered an assessment with the Criminal Justice and Diversion Service. With the consent of the young person, the assessment is shared with their respective Youth Offending Service. The Youth Offending Service is able to use this information in discussion at the Youth Justice Panels, where decisions are made in respect about the use of an Out of Court

Disposal (which is a community based response to crime that the police can administer locally without having to take the matter to court). The same information is also valuable in respect of informing assessments and reports for the Court and if further offending behaviour occurs.

Derbyshire Children's Services report that awareness of the service is well embedded across the County and Derby City and improvements in information sharing are evident in practice.

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