



Response to Serious Case Reviews - Learning and Improvement Report

29 May 2014

Preface

Every child's death is a tragedy. As a result of the deaths of Child I and Child M in 2011 and two additional very serious cases of harm to children, the Southampton Local Safeguarding Children Board commissioned three Serious Case Reviews which have now been published. The Board deeply regrets the failings across the system identified within these Serious Case Reviews.

The purpose of a Serious Case Review is to analyse the actions of each agency during the time they were supporting these children and their families, and determine if lessons could be learned from the ways in which they had worked both individually and together.

The Southampton Local Safeguarding Children Board has taken these reviews very seriously. They have given us the sad opportunity to look at the working of our local child protection systems.

The agencies involved in the review have shared information about their involvement in the cases. This has ensured an honest and transparent enquiry into the quality of work done, including gaps and missed opportunities.

These three Serious Case Reviews were written by Independent Reviewers and they cover a period dating back to 2006. Since then many working practices have changed, and many improvements have recently been implemented to ensure better safeguarding for our children.

This report summarises the learning and improvement actions agreed by the Board and its partner agencies. The Serious Case Reviews have helped us to understand what wasn't working and has shown us where we need to make changes and strengthen our procedures, knowledge and skills.



Keith Makin, Independent Chair
Southampton Local Safeguarding Children Board

Introduction

In April and May 2014 the Southampton Local Safeguarding Children Board (LSCB) received three independent Serious Case Review Reports relating to:

1. Child I and Child M – both deceased
2. Family A
3. Child L

The events which led to the three Serious Case Reviews occurred in a period of time from January 2011 in Southampton. The reviews themselves cover a period dating back to January 2006. It is important to note that the LSCB and its partners have already implemented many improvements to services prior to the publication of these reports.

This report has been produced by the LSCB as an overall response to the recommendations made within the three Serious Case Review reports. It describes how the LSCB and safeguarding services in the City are responding to the recommendations made in the Serious Case Reviews. It identifies how lessons have been learned and the improvements that have already been made since the time of these tragic events. It outlines how we will work to maintain the highest possible standards and safeguard children in the future. It should be read in conjunction with the full and detailed action plan for the LSCB.

The Children

Child I and Child M

Child M was aged two when he died in January 2011. At the time of his death, Child M and his younger sibling were subjects of a child protection plan. Child M's four year old half-brother, Child I, died three months later in April 2011. He was understood to live with the children's maternal grandmother, but at the time of his death, Child I was in the sole care of the children's Mother at the maternal grandmother's house. There have been no criminal charges in relation to either death. A finding-of-fact in subsequent care proceedings did find that both Child I and Child M had experienced neglect. The inquest into the deaths of Child I and Child M heavily relied on the finding-of-fact and resulted in an open verdict for both children.

The LSCB members wish to express deepest sympathy to the family of Child I and Child M.

The case of Child M was considered on 11th January 2011 by the Southampton LSCB serious case review sub-committee who agreed that a Serious Case Review should not be commenced at that time and that the situation should be reviewed after Child I's post-mortem. The post mortem concluded that the cause of death was unclear and no further action occurred from Police following their own investigations. Ofsted were advised that there were no indications that Child M death was linked to the reasons for his child protection plan.

The case of Child I was reviewed by the Southampton LSCB serious case review subcommittee on 19th April 2011 who agreed that the criteria for a Serious Case Review had been met but the review should not start until further results had been obtained from the Police, pathology investigations and a finding-of-fact in the care proceedings which had started in respect of Child I's younger sibling. On 14th May 2013 The Crown Prosecution Service decided not to bring criminal charges in this case and the Serious Case Review sub-committee agreed that a review should be undertaken, but at a level below a Serious Case Review. However, this decision was reviewed by the Local Authority and the LSCB and it was agreed in July 2013 that a Serious Case Review should commence in respect of both children.

Child L

Child L, who was 6 years old, arrived at A&E, University Hospital Southampton in late December 2012 accompanied by her mother. A neighbour had called the emergency services with concerns about bruising to Child L's face and her welfare. On examination, Child L was found to have 92 bruises of varying ages to the face and body, she was confused and amphetamines were found in her urine. The consultant paediatrician was not satisfied with the explanation provided by her mother as to the cause of the injuries – the explanation was inconsistent with the injuries Child L sustained. Child L and her mother were known to a number of local agencies including health, education and children's social care prior to this incident. There was particular concern about Child L's lack of school attendance and of some behaviours exhibited at school, however, there was very limited success in engaging the mother in professional interventions.

The case was referred to the Southampton LSCB Serious Case Review sub-committee in January 2013. There was insufficient information available at this meeting to decide whether the case warranted a Serious Case Review. At the next meeting in April 2013 the chair of Southampton LSCB decided to conduct a multi-agency review of the case as the criteria for commissioning a Serious Case Review were considered not to be met but that there were lessons to be learned for single and multi-agency working. This decision was reviewed by the Local Authority and the LSCB and it was agreed in July 2013 that the case met the criteria for a serious case review and that this should commence in respect of Child L.

Family A

In 2011 Family A - a father and his seven children, moved to a travellers' site in the Southampton area from Norfolk following the separation of the mother and father. The father had grown up in a traveller family, and some of his relatives lived on the Southampton site. All the children were said to be educated at home by the father, although he himself was unable to read or write. There were some continuing concerns for the general welfare and safety of the children. Evidence emerged that the children had been neglected and that they were abused by their father over many years. After this the children were initially cared for within the travelling community by relatives of the father but these arrangements were not successful. Eventually all the children were

brought into the care of the local authority through the courts. The father admitted numerous charges of neglect, physical and sexual abuse and received a long custodial sentence.

These events were considered by the Southampton Local Safeguarding Children Board (LSCB) serious case review sub committee in January 2013 and it was decided there that the case met the criteria for Serious Case Review.

Format

Southampton LSCB appointed Jane Wonnacott and Kevin Harrington as Independent Lead Reviewers for Child I and Child M and Family A Serious Case Reviews and Brian Boxall and Moira Murray for the review of the case of Child L.

The serious case reviews followed a thorough 'traditional' methodology and approach to ensure the practice and policy applied to each case was robustly analysed. This consisted of a multi-agency panel receiving individual agency management reviews from those closely working with the family in each case. The lead reviewers produced an overview report for each case highlighting lessons to be learned and recommendations for changes to policy and practice to ensure similar cases are prevented in future.

Theme – Using Child Protection Procedures Effectively

Recommendations:

1. Southampton Local Safeguarding Children Board should review the use of the 4lscb “maternity services and children’s social care joint working protocol to safeguard unborn babies 2011” and ensure that it is being implemented across Southampton. Child I and Child M

2. Southampton Local Safeguarding Children Board should evaluate the effectiveness of strategy meetings with particular reference to whether:
 - Face to face meetings (rather than telephone discussions) are taking place when required
 - All relevant staff are included
 - Meetings and/or discussions are recorded in line with procedures.Child I and Child M

3. Southampton Local Safeguarding Children Board should evaluate the current approach to child protection conferences and ensure that conferences include all those who had relevant contact with the family and the provision of reports from all key professionals. Child I and Child M

4. Southampton Local Safeguarding Children Board should review current practice in relation to Residence Order applications in order to seek assurance that:
 - Any safeguarding concerns are known to the Court
 - Social workers are aware of the importance of responding to requests for information from the Court.Child I and Child M

5. The LSCB should require the local authority to demonstrate that, where a child may be at risk of significant harm, investigations and consequent assessments are conducted without delay and meet all procedural and good practice requirements. These will include
 - being consistently directed and managed by an appropriate senior officer
 - seeing the child(ren) involved and treating them as individuals
 - consulting with those who have parental responsibility
 - making thorough agency checksFamily A

- drawing on specialist advice when necessary
 - providing formal feedback to those who have made referrals
 - ensuring compliance with the local authority's "lone working" guidance
 - ensuring that key decisions, including a decision to take no further action, are "countersigned" by an appropriate manager.
- Family A
6. The Board should require the local authority to ensure that all relevant staff are aware that the need to use formal child protection arrangements may continue, or may arise, when children are in the care of the local authority. Family A
 7. The Board to ensure that the findings of this review are used to enhance the engagement and compliance of agencies participating in the MASH to share and provide information when required to safeguard children. Child L

LSCB Response

The LSCB recognises and accepts the learning for the partnership on improvements to ensure child protection procedures are adhered to. The LSCB ensures that statutory child protection procedures are adhered to as part of its own statutory duties to quality assure and coordinate local work. This is as detailed in Working Together 2013, the Children Act and as reflected in local 4LSCB procedures. The LSCB understands the vital need for services to work closely together to respond to and prevent harm to children and young people at risk and in need of protection. The LSCB seeks assurance from Southampton City Council Children and Family Services, Police, Health, Education and other statutory partners to ensure this duty is met. The LSCB will continue to ensure that they are delivering this role and through its future actions will focus on the areas recommended above.

The LSCB will ensure that a recently updated (in 2013) local 4LSCB protocol regarding maternity services and Childrens Social Care joint working is implemented and effective and seek assurance from these services on their joint action to protect unborn children.

The LSCB accepts that the reviews highlight concerns during the timeframe of reviews regarding strategy discussions. The MASH in Southampton now coordinates this area of work. Confirmation of Police presence in the MASH will reinforce and ensure this coordination role continues to be successful. The LSCB will seek assurance from the Local Authority and Police to ensure that procedures are being followed as part of a review of MASH success in its first quarter to fully ensure the safety of children and young people at risk of harm. The LSCB recognises that the Southampton MASH will have its fullest impact only if all key agencies participate and will seek assurance that the Police and Adult services are engaged in this. The LSCB Independent Chair will seek assurance from the Local Authority and partners to evaluate the success of the MASH in its first three months and request that an analysis of current membership is included to inform discussion and future development.

The LSCB recognises the need to evaluate and seek assurance regarding child protection conferences procedures and participation. The LSCB has previously commissioned an independent audit of conferences and is currently undertaking a multi agency audit of core groups. Areas for improvement identified from these will be reviewed and actioned by the LSCB.

The Board identifies that the process of gaining a residency order in the case of Child I was not completed and that this was not satisfactory. The Panel for this SCR sought detail of the reasons for this from the Court and will seek assurance from both the Court on improvements to practice to avoid similar issues occurring in future.

Actions taken and changes made

- Southampton City Council has developed its own Multi Agency Safeguarding Hub (MASH). This offers a single point of contact for all safeguarding concerns regarding children and young people. It brings together in one place expert professionals called 'navigators' from services that have contact with children, young people and families, and makes the best possible use of their combined knowledge to keep children safe from harm. Representatives from the different agencies in the MASH and outside will collate information from their respective sources to build up a holistic picture of the circumstances of the case and the associated risk to the child or adult. As a result, better decisions will be made about what action to take and support will be targeted on the most urgent cases. MASH procedure includes specific timescales for appropriate action. The LSCB currently has oversight of the MASH and received regular updates on its progress and efficiency. As part of the MASH process, local agencies have signed up to an Information Sharing Protocol.
- 4LSCB procedures offer guidance on strategy discussions. This was updated in 2012 and is currently being updated to reflect current procedure.
- The LSCB completed an audit of Child Protection Conferences in 2012. The 4LSCB procedures also include guidance on Child Protection Conferences; this is being updated to reflect the most up to date practice.
- The 4LSCB procedures include guidance on Children Living Away from Home (including Children and Families living in Temporary Accommodation) and on "essential safeguards" that need to be observed.
- Maternity services have updated their safeguarding processes and training for staff.

Actions to be taken by the LSCB

- Raise awareness of the recently revised protocol
- Audit cases where joint working between maternity / children and families services has taken place
- Deliver an audit of cases where strategy discussions and meetings have been delivered and reported to LSCB
- Ensure awareness and clarity in the process and procedures for strategy discussions and meetings, reinforcing statutory process and procedures.

- Review MASH success including in delivery of strategy discussions following 12 weeks of delivery, to include a dip sample of cases
- Ensure Police engagement in Southampton MASH.
- Ensure greater awareness of current and future family law proceedings
- LSCB Chair to make contact with chair of FJB to be assured that procedural issues are resolved.

Theme - Neglect

Recommendations

8. The Board should develop and implement an improvement programme addressing local policy and practice in respect of child neglect. In doing so the Board should take account of the guidance recently published by Ofsted on services to children who experience neglect, and of the effectiveness of previous local initiatives aimed at improving services to neglected children.

Family A

LSCB Response

The LSCB understands the importance of recognising neglect and that this is an issue of concern for Southampton. Neglect is a serious factor in the majority of serious case reviews locally and nationally and that this is an issue for children of all age's not just younger children as this case identifies. The LSCB will develop its response to this recommendation using the guidance provided within the Ofsted report 'In the Child's Time – Professional Responses to Neglect'.

Actions taken and changes made

- The LSCB has recently agreed a Threshold Document for the partnership explaining the range of issues indicating concerns – including Neglect.
- Awareness of Neglect issues as a factor in child protection has been raised previously in the development of a Neglect toolkit in 2012. However the case review identifies further need in this area.

Actions to be taken

- The LSCB will consider the findings of the Ofsted report into neglect
- The LSCB will develop a multi agency action plan to respond to this and locally identified issues
- The LSCB will review and update the Neglect Toolkit.

Theme - Escalation of concerns

Recommendations

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| 9. Southampton Local Safeguarding Children Board should promote the use of the escalation procedures as part of the development of a culture where constructive challenge across agency boundaries is understood to be an essential and positive element of safeguarding practice. | Child I and Child M |
| 10. The Board should:
- require all agencies to remind staff, in the light of the matters arising from this review, of the established arrangements for escalating concerns to more senior managers.
- develop an audit programme across all agencies to evaluate the use and effectiveness of escalation arrangements. | Family A |
| 11. The Board should ensure that where concerns require escalation all agencies are aware and make use of the <i>Resolving Professional Disagreements Procedure</i> as agreed and implemented by Hampshire, Isle of Wight, Portsmouth and Southampton LSCBs. | Child L |
| 12. Southampton Local Safeguarding Children Board should ask Children's Services to identify a strategic lead for safeguarding for early years services and be assured that there are robust arrangements in place for supporting childminders to escalate concerns if they are dissatisfied with the response they receive from Children's Social Care. | Child I and Child M |

LSCB Response

The LSCB considers challenge throughout the partnership to be a key factor in safeguarding and promoting the welfare of children and young people and accepts that knowledge of procedures relating to this challenge are not widely known or understood in Southampton, as is reflected in these reviews. A 4LSCB procedure is in place to direct professionals on the course of action where there are concerns about the way a case is dealt with. The LSCB will ensure that this is fit for its purpose and that it is known and utilised by professionals in Southampton.

The LSCB agree that a lead role for safeguarding within early years services is needed and is assured by the Local Authority that this will be in place as part of the transformation of Southampton City Council Children and Family Services. The LSCB will ensure this role is in place and effective through its quality assurance reports from the Local Authority Children and Family Services.

Actions taken and changes made

- The 4LSCB procedure *Resolving Professional Disagreements* is available to all staff
- The LSCB is hosting Learning Workshops to disseminate learning from these reviews and will include escalation process as part of this.

Actions to be taken

- Review current procedure for escalation
- Raise awareness of *Resolving Professional Disagreements* procedure
- To seek assurance from Board Members regarding internal escalation procedures through Section 11 audits and Single Agency Reporting
- Request report from SCC Principal Social Worker to LSCB including data regarding cases where concerns are escalated by partners.

Theme – Staffing and Supervision

Recommendations

13. Southampton Local Safeguarding Children Board should establish a core standard for safeguarding children supervision and seek evidence regarding its implementation. This standard should:
Child I and Child M
 - take account of differing governance arrangements, supervision cultures and organisational structures for the delivery of supervision;
promote reflection, critical analysis and evidence informed practice
 - ensure that all staff have the psychological and emotional support required for effective decision making in safeguarding children
 - require regular evaluation of the quality of supervision being provided.
14. The Board should require the local authority to demonstrate that there are appropriate and effective arrangements for the professional supervision of staff at all levels within children's services.
Family A

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| 15. The Board should ask all agencies to review arrangements for the debriefing of staff following complex multi agency operations, to ensure that, where appropriate, debriefings are conducted on a multi-agency basis and used to contribute to forward planning. | Family A |
| 16. The Board should ask the local authority to investigate the evidence from this review that some officers or former members of staff may not have fully understood the causes for concern about aspects of the case, and to take action as necessary. | Family A |
| 17. The Board should require the local authority's housing, children's social care and education services to demonstrate that they have made arrangements to deal with any unsatisfactory relationships within and between staff groups, as identified in this review, which may affect the safeguarding of children. | Family A |

LSCB Response

The LSCB acknowledges the need to review all local supervision and de briefing arrangements for staff working in children and family services in the City to seek assurance that the issues raised in the Serious Case Reviews. The LSCB plans to develop multi-agency standards for this in the City, recognising the differing levels of supervision required depending on the service and worker role, and will incorporate this into the development of a standard as this recommendation suggests.

The LSCB has been assured through discussions following these reviews that staff involved in the case that continue to work in the local authority services understand the findings and learning coming from the review. Board members have also assured the LSCB Independent Chair where relevant that relationship issues between staff groups have been resolved. Formal assurance of these issues is to be sought.

Actions taken and changes made

- A key priority for Southampton City Council People Directorate transformation is 'a well trained, stable and effectively supported workforce'. The workforce development strategy has developed in order to maintain the permanent and stable workforce within Children's Services. The Professional Development Programme associated with this will invest in the skills and knowledge of our staff and in particular first line managers.
- Southern Health Foundation Trust staff receive regular clinical supervision which includes discussing Safeguarding children and adults. They also have a Safeguarding Children specialist who staff members can call for support 7 days a week.

- University Hospitals Trust have further developed their supervision guidance with implementation being monitored by Safeguarding Strategy Group and Divisional Governance Groups.
- The LSCB Learning and Development Sub-Group have started to pull core supervision standards together and are planning to undertake a multi-agency staff survey on this issue.

Actions to be taken

- Review of Board members supervision policies
- Establish core standards to assess policies against
- Identify action to be taken by key agencies to ensure standards are met.
- Report this to LSCB chair.
- LSCB Chair to formally seek assurance from the Director of People regarding individuals involved in review
- LSCB Chair to formally seek assurance from the Director of People that these issues have been resolved.

Theme - Thinking Family

Recommendations

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| <p>18. Southampton Local Safeguarding Children Board should review the approach across the partnership to “Think Family” and ensure:</p> <ul style="list-style-type: none"> -There is a holistic approach across adults and children’s services to assessment and service provision where a parent has a learning disability and/or mental health problem. - It promotes an approach which includes fathers. - Adequate knowledge and skills in assessing the parenting capacity of adults with a learning disability. - Adequate access to records across adults and children’s social care services. | <p>Child I and Child M</p> |
| <p>19. The Board should ensure that the dissemination of lessons learned from this review includes, as well as the “headline” issues reflected above, commentary on the need for a “Think Family” approach, so that professionals providing services to vulnerable adults remain alert to the safety and well-being of any children of the family.</p> | <p>Family A</p> |

20. The Board should require that lead professionals are made aware of the involvement of any new adults having significant contact with a family where there are children in need or in need of protection.

Child L

LSCB Response

The LSCB accepts that it is essential that agencies work holistically with families, including fathers in order to maximise the safety of children and young people. The LSCB is working closely with the Local Authority People Director, Local Safeguarding Adults Board and its members to identify areas that can align to provide effective coordination and quality assurance of services working to safeguard children and their families. The LSCB will seek assurance from partners including the Local Authority, that the transformation of the People directorate will ensure these recommendations are addressed

Actions taken and changes made

- The LSCB has hosted Learning Workshops to disseminate learning from these reviews and including reinforcing the need for a 'Think Family' approach.
- Plans drafted for aligning the management of Safeguarding Children and Adult Boards.

Actions to be taken

- LSCB Chair to seek assurance from the DASS / DCS that this approach is implemented
- Commission research to inform Local Authority People Directorate transformation plans with a focus on family experiences
- Coordinate support to both the LSCB and Local Safeguarding Adult Board (LSAB)
- Ensure Adult Services Navigator in MASH
- Implement the 4LSCB Joint Working Protocol and ensure its effectiveness through LSCB / LSAB Quality Assurance work
- The LSCB to reinforce the need for case chronology and genogram to inform awareness of new adults within SCR workshops and also in LSCB Safeguarding Training

Theme - Health Issues

Recommendations

21. Southampton Local Safeguarding Children Board should seek assurance that Southampton Hospital has adequate systems in place to review discharge plans in the light of all known information and adequately safeguard vulnerable children discharged outside working hours. Child I and Child M
22. The Board should ensure that the dissemination of lessons learned from this review includes, as well as the “headline” issues reflected above, commentary on the links between safeguarding and dental care. Family A

LSCB Response

The LSCB accepts the Health services related issues raised as recommendations above and is seeking assurance that these areas are being actioned. The links between safeguarding children and dental care are documented and it will ensure that this knowledge is disseminated across the partnership through the learning and development work of the LSCB. The review of Child I and Child M identified inappropriate discharge times for vulnerable families and the Board is seeking assurance of improvements to hospital procedures in response to this recommendation.

Actions taken and changes made

- Learning Workshops for Paediatricians are planned to disseminate learning from these reviews.
- University Hospitals are reviewing procedures for discharge in areas treating children and young people.

Actions to be taken

- The LSCB Chair will write to University Hospitals Trust to seek assurance on discharge procedures for vulnerable children.
- The LSCB will reinforce links between safeguarding issues and dental care in its multi agency training for staff

Theme – Diversity

Recommendations

23. The Board should disseminate the findings from this review in ways which re-emphasise to agencies and communities that issues of race and culture should not outweigh the responsibility which we all share for the safeguarding of children. Family A
24. The Board should highlight to the Department for Education the lack of research into the safeguarding of children from Gypsy and Traveller communities. Family A

LSCB Response

The LSCB identifies the need to ensure awareness of diversity, race and culture within work to safeguard children and young people and promote their welfare. The LSCB recognises the issues for Gypsy and Traveller communities as a particular area of development. The LSCB will take leadership on diversity and safeguarding work in the City and this will be an area for improvement and focus in the coming months. The Independent Chair will instigate a review of the inclusiveness of its approach to all sections of the City's population, particularly across all race, culture, heritage and religious backgrounds. This will be aimed at raising awareness of the particular needs of the various diverse communities and families and will lead to a thorough review of the Board's work on policies, data collection and analysis, training, membership, networking and contact with all sections of the City's population.

Actions taken and changes made

- Workshops with staff to disseminate learning from these reviews will include learning regarding Gypsy and Traveller communities and safeguarding

Actions to be taken

- Thread diversity issues through learning and development work of the LSCB.

Theme - Elective Home Education

Recommendations

25. The Board should

Family A

- ask the Department for Education to clarify the definition of “suitable education” in relation to children educated otherwise than at school.
- ask the Department for Education to re-evaluate the evidence of safeguarding concerns for children who are electively home educated, including any Serious Case Reviews where this is a feature, to satisfy themselves that national guidance in relation to the safeguarding of these children is sufficiently robust.
- ensure that local multi-agency guidance in respect of the safeguarding of children who are electively home educated is informed by the findings of this Serious Case Review.
- ask all agencies to consider ways in which they can increase the support they offer to children who are electively home educated, in the light of the issues arising from this review.

LSCB Response

The LSCB fully accepts the issues raised regarding the evidence of safeguarding concerns for children who are electively home educated and will seek assurance locally to identify richer responses. The LSCB has sought assurance from the lead for Education on the Board regarding the current arrangements for safeguarding children that are home educated and is assured that closer monitoring and support for families where this is the case is planned as part of phase two of the transformation of Children and Family Services. The LSCB chair will also raise the issues nationally given guidance on elective home education.

Actions taken and changes made

- LSCB received a single agency report from the Head of Education regarding the numbers of children that are Electively Home Educated, actions to more closely increase support and to monitor and raise concerns in this area were discussed.

Actions to be taken

- Review local procedures regarding Elective Home Education in light of these findings.
- LSCB Chair to write to Department for Education highlighting the concerns raised from this review prior to publication.

Theme – Rapid Response to Child Death

Recommendations

26. Southampton Local Safeguarding Children Board should review the effectiveness of rapid response arrangements in delivering services as set out in the 4lscb protocol particularly where these affect the safety of surviving siblings. The Board should work with the Child Death Overview Panel to develop this service. Child I and Child M

LSCB Response

The LSCB accepts that during the timeframe of this review the rapid response arrangements were insufficient. The LSCB has been since been assured that changes have been made to the arrangements. A Designated Doctor for child deaths has been identified and arrangements are in place for multiagency discussion of the process for investigating all deaths requiring a rapid response. Given the seriousness of this case the LSCB will seek further assurance that this procedure is effective by auditing recent child death cases where appropriate.

Actions taken and changes made

- Designated Doctor for rapid response in place for Southampton
- Multi agency rapid response process training taken place and continuing.

Actions to be taken

- Audit of recent cases where rapid response instigated to assure LSCB of improvements.

Theme - Liaison with Other Areas

Recommendations

27. The Board should arrange for local agencies to agree guidelines for proactively seeking, receiving and sharing information when they are made aware that children for whom there may be safeguarding concerns have moved into the area, taking account of the weaknesses which this review has brought to light.

Family A

28. The Board should ensure that the Norfolk Safeguarding Children Board is briefed about the content, process and outcomes of this review so that it can take further action as necessary.

Family A

LSCB Response

The LSCB understands the importance of effective transfer of information where children move into Southampton. This case highlights how vital this is and the LSCB will seek to improve procedures for gaining this information. The LSCB will seek good practice examples from other areas and Boards to help direct this work.

The Independent Chair of Southampton LSCB has written to the Chair of Norfolk LSCB with the final overview report for this case and to highlight areas of concern that have arisen regarding the family's time in Norfolk. The Chair of Norfolk LSCB has responded to confirm that Norfolk are undertaking their own review of this case.

Actions taken and changes made

- Norfolk Safeguarding Children Board have had sight of the report in addition to a commentary from the Serious Case Review Author.
- Norfolk are commissioning a Serious Case Review regarding the family time in that area of the UK.

Actions to be taken

- LSCB to review current procedures
- LSCB to identify good practice from elsewhere and make improvements to local arrangements
- Promote revised procedures to staff.

Theme - Involvement in the SCR process

Recommendations

29. The Board should highlight to the local authority the importance of continuing to explore ways of involving the young people at the centre of this review in:
Understanding the process and its purpose and should they wish to do so, disseminating the lessons learned so as to promote learning and good practice.

Family A

LSCB Response

The LSCB has endeavoured to involve family members and children in the review process, where appropriate and this would not impact on parallel proceedings. This has been balanced by an understanding of the impact of the trauma suffered by the surviving children in all cases. The input of family members has been positive and has influenced findings and recommendations. In the case of Family A, a full investigation into the impact of the children and young people participating was delivered by the therapeutic service that is continuing to work with them. The outcome of this led the LSCB to agree that this is a continuing piece of work.

Actions taken and changes made

- Interviews offered to all family members and delivered with those wishing to participate, included in the Overview reports
- Full analysis of involvement of the children in the review for Family A.

Actions to be taken

- Ensure the children and young people from this family are sensitively approached and briefed about findings of review and publication, and that their ongoing therapeutic needs are met.