Safe Sleep Case Reviews - Learning and Improvement Report

June 2019

Preface

As a result of the deaths of 4 babies related to co – sleeping between 2016 and 2018, Southampton Local Safeguarding Children Board (LSCB) commissioned two Serious Case Reviews and a co sleeping thematic overview report which have now been published. On behalf of the Southampton Local Safeguarding Children Board, along with colleagues from the council, police and health services in the City, I would like to send our deepest condolences to the families of the children who have tragically died.

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 LSCB has taken the findings of these reviews very seriously. The agencies involved in the review have shared information about their involvement in the cases and this has ensured an honest and transparent enquiry into the quality of work done, including gaps and missed opportunities.

The reviews were written by an Independent Reviewer, they cover a period dating back to 2012. Since that time many working practices have changed, and many improvements have 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 that have either been completed or are underway. The Serious Case Reviews have helped us to understand where improvements need to be made, and strengthen our procedures, knowledge and skills.

Keith Makin - Independent Chair
Southampton Local Safeguarding Children Board

Introduction

Between 2016 and 2018 the Southampton Local Safeguarding Children Board (LSCB) received two referrals relating to the deaths of babies due to safe sleep issues. The LSCB chair agreed that both tragic cases met the statutory criteria for a serious case review as set out in national statutory guidance. In order to ensure the identity of families involved is protected the babies are known as Billy and Reece, with family members also given pseudonyms for this reason. At a similar time, the local Child Death Overview Panel (CDOP) were notified of 2 babies who had died where co-sleeping was a "modifiable factor". The LSCB decided that a thematic review should also be commissioned to identify learning related to safe sleep issues in order to identify common learning themes to inform future prevention work and awareness raising campaigns.

This report has been produced by the LSCB as an overall response to the recommendations made within the two Serious Case Review reports and a Co Sleeping Thematic Overview Report. It describes how the LSCB partnership in the City are responding to the recommendations in the review reports. It identifies by theme 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 and young people in the future. The recommendations from the review have been themed as follows:

- Child Protection
- Neglect
- Parenting Capacity and Assessment
- Thresholds and Information Sharing
- Safe Sleep and Sudden Infant Death Syndrome
- Commissioning and Safeguarding

The Children

Reece

Reece was a non mobile baby who was under the age of three months when he died. The family were living in supported accommodation. On the night Reece died he had been found unresponsive by his parents and was in cardiac arrest. He was taken to hospital where, following unsuccessful CPR, he was pronounced dead. Information from Reece's father and comments from his sibling, and evidence found in a search of the home led police to suspect that Reece may have been sharing his parents' double air mattress on the floor. Reece's mother was arrested and interviewed on suspicion of child neglect and of causing or allowing the death of a child. She maintained her account that Reece had been in his Moses basket when she found him unresponsive. She was not charged with any offences. Reece's father was not arrested and it was not within the scope of the review to enquire why.

Billy

Billy was four and half months old when he died in February 2018. Initial enquiries revealed that Billy had been sleeping on a sofa with his mother, Chloe. It appeared that Chloe had overlaid Billy whilst sleeping, pushing him down against the edge of the sofa area. There was nothing to indicate that the death was suspicious in nature.

Format

Southampton LSCB appointed Graham Bartlett as the Independent Lead Reviewer for Billy and Reece's case reviews as well as the thematic report into co sleep issues.

The serious case reviews followed a thorough methodology to ensure the practice and policy applied to each case was robustly analysed. This consisted of the reviewer receiving individual agency management reviews and chronologies from those closely working with the family in each case. A learning workshop was convened individually for Billy and for Reece which practitioners from the key agencies were invited to. The lead reviewer has produced an overview report for both Billy and Reece highlighting lessons to be learned and recommendations for changes to policy and practice to ensure similar cases are prevented in future. The lead reviewer has also written a Co Sleeping Thematic Review Report which is summary of the learning relating to safe sleep from Billy, Reece and the identified CDOP cases. The recommendations and actions from these reviews will be continually monitored by the LSCB via the relevant sub group. The LSCB will also consider the impact on practice from the actions by undertaking quality assurance activities including audits and practitioner surveys.

THEME 1 - Child Protection

Recommendations:

1. Southampton Children and Families Service should ensure that arrangements for parenting assessments, particularly additional assessments, are clear and appropriately resourced so that social workers, managers and independent chairs understand how and when to access them, whether required through child protection plans child in need plans or any other social work provision. They should also be undertaken for each Initial and Review Child Protection Conference so that sustainable and positive improvements can be shared or support given elsewhere.

2. Southampton LSCB should assure itself that present day procedures and practices around Child Sexual Exploitation reflect a more proactive and responsive culture towards those deemed at risk of, or suffering from, CSE than in the period Beth was vulnerable to that and that the provision to potential and actual victims and the pursuit of offenders is effectively robust.

3. Southampton LSCB, in conjunction with the Association of LSCB Chairs should consider whether the statutory fixed three month time period between Initial Child Protection Conference and the first Review Child Protection Conference is appropriate and whether to lobby the Department for Education for the introduction of some flexibility especially in the cases on unborn babies.

4. Southampton LSCB develops a multi-agency procedure to guide and support professionals in dealing with disguised compliance and resistant parents and carers, including when and how to share concerns with partner agencies.

5. Southampton LSCB should assure itself, on an ongoing basis, that the developments within Children and Families Services are embedded, sustained, support the multi-agency safeguarding system and deliver better outcomes for children.

6. Senior Police, Social Care and Clinical Commissioning Group officers should review how this investigation was allowed to be drawn to a close when such serious child protection concerns had been raised, documented and shared among the professionals involved. This review should include assurance that this is not a system wide failing and should ensure that measures are put in place to prevent such oversights occurring in future.

7. Southampton LSCB should develop assurance arrangements around Child Protection Conferences to enable it to provide strategic oversight, scrutiny and assurance as to the quality, attendance, involvement and outcomes of Child Protection Conferences insofar as all agencies are concerned.

8. Southampton LSCB should widen its conflict resolution and escalation policy so as to include escalation of concerns over another agency's capacity or engagement within the child protection or safeguarding systems.

LSCB Response:

The LSCB considers effective challenge throughout the partnership to be a key factor in safeguarding and promoting the welfare of children, young people and families. The LSCB will request that partners provide service assurance on the issues above and specifically to the cross county child exploitation group which meets on a quarterly basis with any key priority areas and trends reported back to individuals LSCBs. Southampton partner agencies are already aware of the safeguarding risks around disguised compliance and as a result have included this as a key learning theme in learning from reviews practitioner workshops, and we are commissioning specific training on this issue. The LSCB and LSAB Escalation processes are also promoted via these workshops to multiagency practitioners. Southampton LSCB is

aware of the continuous service improvements made within the Child Protection processes in Southampton and will be given further assurance from case audit and quality assurance work that is planned or currently underway.

Actions taken and changes made:

- Solent NHS Trust delivers 'Professional challenge' training to staff. The content of the course includes disguised compliance, resistance, how to have difficult conversations and escalation processes. Solent NHS Trust are supportive of any work that is undertaken to help practitioners identifying and respond to disguised compliance.

- Since this time period subject to review, Hampshire Constabulary have established the Missing and Exploited and Trafficked team (METT). The METT proactively manage those children who are at the highest risk of Child Sexual Exploitation (CSE) and/or missing incidents, with a renewed focus on targeting and assisting in the disruption of perpetrators. The team will provide up-to-date information on Risk Management Plans and where possible, offering practical support and expertise to both internal and external partners. The officers will work with colleagues and partners to support victims – reducing the risk to them – and to tackle perpetrators through effective disruption plans.

- Hampshire Constabulary METT will seek to identify victims and perpetrators at the earliest opportunity and to co-ordinate the initial police response, as well as raising awareness within districts of vulnerable individuals, directing any intervention and safeguarding work where it is appropriate to do so, allowing leaders to better manage and reduce the risk of harm.

- Hampshire Constabulary METT work operationally and strategically alongside other police teams and in addition alongside the Southampton City Council (SCC) CSE Hub and with the MET operational and strategic sub groups of the LSCB.

- Hampshire Constabulary METT officers will also link in with Child in Need and Child Protection processes for children at high risk of CSE.

- Hampshire Constabulary have developed an internal toolkit for Neighbourhood Policing teams who lead on managing cases of medium risk. In addition each police district has a CSE single point of contact.

- There is extensive and comprehensive material providing MET advice and guidance for police officers internally on the force intranet page.

- Since June 2018 there has been the establishment of a clear pathway for newly identified CSE cases which operates via Southampton Multiagency Safeguarding Hub (MASH). This process ensures the completion of the Hampshire Constabulary CSE risk assessment tool, assessment of push/pull factors, multi-agency assessment and where appropriate trigger Section 47 Child Protection processes. This ensures a thorough multi-agency approach and appropriate onward tasking and safeguarding of those at risk.

- CSE will also feature with the National Police Training excellence course which commenced April 2019 and will be running throughout the year.

- West Hampshire Clinical Commissioning Group have developed a form which will be completed by the consultant/relevant medical professional at the time of the Child Protection medical outlining in writing their initial findings/hypothesis. This will be given to Childrens Social Care and Police at the time of a Child Protection medical.

Action to be taken:

- SCC Children and Families Service will be completing thematic audits of cases to understand quality of assessments and impact upon children and families in 2019.

- A practice assurance stocktake will be undertaken of child protection planning to drive forward practice improvements. The actions and improvements arising from this work will be reported to the LSCB twice a year and will include information regarding repeat referrals and step down activity.

- The LSCB will be briefed on current local authority missing, trafficked and exploitation (MET) operational arrangements and provides sufficient challenge to local partners in respect of any trends / performance issues identified.
- Review of the 4LSCB Unborn Baby Safeguarding Protocol to consider revision changes within the Child Protection Plan via timely Core Group Meetings.

- Southampton LSCB need to be briefed on current MET operational arrangements and provide sufficient challenge to local partners in respect of any trends / performance issues identified.

THEME 2 – Neglect

Recommendations:

1. University Hospital Southampton NHS Foundation Trust should assure itself that the new measures improve the awareness of contextual safeguarding concerns and that when these are recognised there is appropriate communication of these concerns with Primary Care and/or Children's Services, particularly in the assessment of physical health and wellbeing of children who present with, or have a history of, neglect or emotional abuse.

2. Southampton LSCB should remind agencies of their guidance on what to do if a child is not brought or misses an appointment and, in time, audit its use to reduce the opportunity for parents to either deliberately or inadvertently neglect their children's health.

3. Southampton LSCB should embed its newly updated policy and procedures around neglect , to include multi-agency audit of its application, multi-agency work-force development and assurance of partners' internal processes so that professionals become more able to recognise, respond to and resolve neglect wherever it might be identified.

LSCB Response:

Child neglect is a key priority for us as a citywide concern and we have agreed this as an area of focus in our new partnership arrangements. . As part of this the LSCB will look in depth at the current professional response to neglect in Southampton and quality assurance of knowledge within the partnership. In May 2019 Southampton LSCB published a revised Neglect Strategy and alongside this a practitioners guide to working with Neglect to support practitioners in responding to this issue. Both are available here. In addition to support this we have developed local specialist training for practitioners on both neglect (an introduction) and using the practitioners guide.

Actions taken and changes made:

- Solent NHS Foundation Trust have promoted the 'Was Not Brought' guidance (Leaflet for Parents and carers regarding non-attendance at medical appointments). In addition, promotion of Level 2 and Level 3 Safeguarding training, supervision, case discussions has happened. Disguised compliance issues regularly feature within the recently developed Safeguarding Newsletter 'SoSafe', which comes out 6 weekly to all Solent NHS staff. Solent NHS also offer specific neglect training to staff.

- Since January 2018 the MASH Standard Operating Procedures for Hampshire Constabulary have stated that, *' Any cases if neglect where an occurrence has been classified as 'Cruelty to and neglect of children' and agreed as a S47 investigation with Children's Social Care should be graded and passed to Child Abuse Investigation Team for joint investigation.'* This process was subject to an audit in April/May 2019 and findings include that neglect cases are being appropriately identified, graded and passed to Child Abuse Investigation Team (CAIT) for specialist investigation. Hampshire Constabulary have also ensured that relevant toolkits are available on the force intranet for officers and staff. The CAIT is also currently rolling out Family Working Agreements with Children and Families Services across Hampshire, specifically targeted at identifying and addressing neglect. It will assist in putting in place clear direction and support for families helping to resolve and better monitor neglect.

Actions to be taken:

- Hampshire Constabulary's response to child abuse including neglect will be monitored and this includes a 4P plan (Prevent, Protect, Pursue and Prepare) this is in line with the force control strategy.
- Southampton LSCB to continue to deliver training regarding its revised neglect strategy and practitioner's toolkit, this is also to be embedded into all neglect training by the safeguarding partners.

- The LSCB to test awareness and take up of revised Neglect Practitioners Guide via a survey with practitioners.

- Southampton LSCB to coordinate Disguised Compliance workshops as part of their multiagency training programme. This will also include dealing with hostile parents.

THEME 3 - Parenting Capacity and Assessment

Recommendations:

1. SCC Children and Families Service should review its procedures, practices and supervision to ensure that young parents have their own needs as children recognised, assessed and supported rather than being seen as young adults who thereby fall outside of their scope, except as parents.

2. SCC Children and Families Service should enhance its Whole Family approach to social work so that, notwithstanding the differing status of various family members, at core groups and child protection conferences the collective picture can be shared and understood to aid effective multi-agency planning and delivery.

3. Solent NHS Trust should review its policy and practice around The Healthy Child Programme to determine whether its application of the various health visiting pathways is appropriate to the identified and emerging needs of families especially where any multi-agency or multi-disciplinary oversight fluctuates, and whether ECHO is making the changes necessary for those families with high need.

4. Southampton LSCB should review the Joint Working Protocol to consider whether it should be applied to a wider range of families, broader than those currently within its criteria.

5. Southampton LSCB should ensure that in multi-agency assessment, planning and delivery all agencies with significant and/ or substantial relevant involvement with the family and children concerned should become and remain actively involved so as to enhance the quality of provision across all aspects of need.

LSCB Response:

Southampton LSCB recognises that taking a family approach to working with children (including unborn babies), young people, families and adults with care and support needs, is one that secures better outcomes by co-ordinating the support they receive from Adult and Children and Family Services. In May 2019 the 4LSCB (Hampshire, Southampton, Isle of Wight and Portsmouth LSCBs) Family Approach Toolkit and protocol was launched to promote practitioners adopting a 'family approach' to practice. The protocol was commissioned in response to findings from a range of reviews across all Board's which highlight the need for professionals to work effectively together to achieve better outcomes for adults, children and their families across all areas. The information in this toolkit has been jointly developed by the 4LSCBs and 4LSABs. It is free to access and available to all practitioners from any agency / organisation working with children, adults with care and support needs, and their families across the areas. Southampton LSCB and LSAB (Local Safeguarding Adults Board) will be launching the toolkit to practitioners at their joint conference in July 2019.

Action taken and changes made:

- SCC Children and Families Service have updated the risk assessment and management framework and application will be tested through thematic audit (underway) across Children and Families service which will include focus on children subject to planning.

Actions to be taken:

- LSCB Conference to launch Practitioners Family Approach Toolkit

- SCC children and families service will be undertaking a practice assurance stocktake of child protection as part of their quality assurance work for Children and Families in 2019-20.

THEME 4 - Thresholds and Information Sharing

Recommendations:

1. Primary Care commissioners should assure that all practices follow the 2018 Local Medical Council (LMC) guidance regarding the scanning, storing and reviewing of safeguarding documents all of which should be seen by a GP. Further, commissioners should assure that practices use the correct READ codes so that GPs are able to review and take appropriate action either with the patients, their families or partner agencies and assure that all staff are up-to-date with their safeguarding training.

2. Southampton LSCB should assure itself that its continuum of need is applied by multi-agency partnerships, especially those where decisions are made to step down children or families from high multi-agency levels of support to universal services. The LSCB, in this review, should examine the management oversight of such arrangements and decisions to ensure that thresholds are applied appropriately and consistently.
3. Southampton LSCB and Southampton City Clinical Commissioning Group (CCG) should undertake a joint review of the information sharing arrangements between health providers and between the health sector and the wider safeguarding system to enable a more systemic and timely flow of information within and between agencies regarding children and families under their care.

4. Southampton LSCB should introduce standards that ensure that, across the spectrum of multi-agency safeguarding arrangements, all relevant information is shared and considered so that ongoing risks and vulnerability can be assessed and understood. Further, that the outcome of services provided are critically evaluated in the context of the children and family concerned so as to avoid risks of repeating previous interventions which may have had little or no effect at the expense of accessing more promising provision.

5. Southampton LSCB to develop operational procedures to guide professionals on when, to whom, how and for what purpose to share information within the multi-agency safeguarding and child protection system so as to avoid ambiguity or misplaced expectations while ensuring that those managing any plan are in possession of all the appropriate material.

LSCB Response:

Southampton LSCB recognises the significant challenge to practitioners regarding information sharing and threshold criteria. The changes and review of Southampton MASH contact and referral processes will be communicated with regular monitoring and quality assurance by the LSCB at its main board meeting for changes and improvements.

Actions taken and changes made:

- Awareness of the Local Medical Council record keeping guidance and Royal College of General Practitioners read coding guidance has been promoted with Southampton Primary Care practices (GP Surgeries) related to key learning from the serious case review through face to face contact and online resources. Primary Care leads within Southampton City CCG are aware of the learning and have incorporated auditing of this as part of their quality visits to practices.

Actions to be taken:

- Southampton City CCG will undertake an audit to seek assurance from provider safeguarding leads/Named Nurses re: information sharing agreements across health and social care.

- SCC Children and Families Service will complete practice assurance and monitoring activity in respect of Multi-Agency Safeguarding Hub (MASH) and Child Protection planning including thematic audit work across protection and court work to be presented to Southampton LSCB in September 2019.

- The current Southampton MASH contact and referral processes are under review by SCC Children and Families Service. There should be a co-ordinated a plan to ensure awareness raising across the partnerships of revised processes and thresholds once this is completed. Southampton LSCB should be provided with 6 monthly updates to quality assure and monitor outcomes of any changes made.

THEME 5 - Safe Sleep advice and SIDs (Sudden Infant Deaths) information

Recommendations:

1. Hospital professionals should be provided with the training and resources to deliver effective guidance to both parents, on each discharge, to reduce the risk of SIDS. This should include mattress and bedding safety, exposure to passive smoking, drugs, alcohol and management of babies with temporary or chronic respiratory illnesses. There should be graduated guidance aimed at those from standard risk through to high risk of SIDS and should be available in a range of ways so it is easily accessible. The fact, content and method of the advice given should be recorded and passed on to primary care, community midwifery and health visiting services to ensure they are equipped to emphasise it and confirm it is being put into practice.

2. Health and social care providers review and enhance their single and multi-agency workforce development around the risks of safe-sleeping and Sudden Infant Death Syndrome, their assessment of families at higher risk of SIDS and develop accessible information, advice and support to meet families' needs so they are empowered to make decisions around lifestyle and sleeping arrangements thereby reducing the inherent risk to their children.

3. Commissioners of health and housing providers, and Children's and Families Services, should develop service expectations that in working with, treating or supporting parents with a child (or children) under one year old, providers and professionals pay due regard to the risks of Sudden Infant Death Syndrome and they ensure that workforce development and supervision arrangements equip and support staff to recognise, advise upon and mitigate risks in partnership with the family.

4. Southampton LSCB, in conjunction with Public Health should commission a high profile internal and external public health campaign aimed at making safe sleeping everyone's responsibility. It should raise the wider understanding of SIDS risk factors and how parents, professionals and advertisers, can reduce those risks with the aim of supporting parents in making wise decisions around their babies' sleeping arrangements and where they can access information or support should they need it.

5. Community midwives, health visitors, community nurses and social workers should undertake home safe sleep assessments so they can support all parents, but particularly those assessed as high risk of SIDS, to make safe decisions around lifestyle and sleeping arrangements. This should include physically checking where a child is sleeping, or may sleep, and advise accordingly.

6. Parents of all babies, particularly of those who are in, or may fall into, high risk groups should receive accessible, personal and targeted advice and guidance which includes, not only the basic advice provided to all parents but also a discussion about where the baby will be sleeping and how they can reduce any evident risks. This should be provided by community services, primary care and as part of the hospital discharge process, whether that be from midwifery, NNU or the children's wards.

7. SCC Children and Families Service and Solent NHS Trust should collaborate on their safe sleep training programmes. These new provisions should be developed to empower professionals from their own agencies, and others including primary care, to provide consistent and targeted advice and support tailored to families' needs and preferred method of receiving clinical advice.

LSCB Response:

Southampton LSCB recognises the need for training and awareness raising of consistent safe sleep education for practitioners and families. The LSCB are co-ordinating multiagency workshops on safe sleep for practitioners which will be facilitated by health partners and SCC Children and Families Service. This will include learning from this review and any relevant national learning. Southampton, Portsmouth, Isle of Wight and Hampshire LSCB's are coordinating developing a multiagency safe sleep campaign and including developing resources for families and practitioners which will highlight learning from local and national case reviews. This campaign is due to be launched in Summer 2019.

Actions taken and changes made:

- Solent NHS Foundation Trust have ensured that current information on Safe Sleep and Sudden Infant Death Syndrome is available on the Wessex Healthier Together Website.

- General Practitioners (GP's) provide advice to discuss Safe Sleep with parents at the 6 week post-natal health check. GP's also have access to tutorials about safe sleep advice and have been given read coding guidance from Royal College of General Practitioners (2018).

- The SCC Children and Families Principal Social Work team are coordinating staff training on learning from serious case reviews to include lessons from Billy, Reece and safe sleep.

- Safe sleeping material is displayed within Southampton City Council public offices and public meeting spaces.

- SCC Integrated Commissioning Unit (ICU) and Southampton City CCG are currently working on improving contracts and specifications for young parent housing related support in the City.

Actions to be taken:

- SCC ICU will ensure the following requirements are set out in young parent HRS contracts and specifications:
    - Proportionate Safe Sleeping advice & information to parents
    - Staff training in providing proportionate Safe Sleeping advice & information
    - Furniture allocation is considered against risk of safe sleeping.

- Current commissioned providers of Young Parent Housing Related Support in Southampton are engaging with required training regarding safeguarding children and young people including safe sleep advice for families.

- Southampton LSCB will monitor progress of these improvements and actions including a requirements for SCC Children and Families Services and commissioned providers to review pre placement planning, referral approach and develop a more robust assessment pathway to ensure appropriate planning for accommodation and support is put in place.

THEME 6 - Commissioning and Safeguarding

Recommendations:

1. SCC Children and Families Service should ensure that, as part of child protection and child in need planning, where appropriate, a holistic housing assessment be undertaken so that the child(ren) subject of the planning are accommodated and supported to meet their needs on a long term basis.

2. Southampton housing commissioners and providers should assure themselves that the expectations within 'Provision of Accommodation for 16 and 17-Year-Old Young People Who May be Homeless and/or Require Accommodation' (2010) regarding not placing young people in bed and breakfast accommodation and the specific support required for young parents is adhered to in every case.
3. Housing commissioners and providers should work together to enhance their understanding of, application of and engagement with the safeguarding and child protection system, especially when commissioning or providing accommodation for vulnerable children and young and vulnerable parents. This should include specific assessments of accommodation allocate to such clients.

4. Housing providers and Southampton Children and Families Service should ensure that, prior to vulnerable families moving into supported accommodation, an assessment is made as to the suitability and safety of that accommodation, as well as its fixtures, fittings and furniture, for the children and family concerned.

5. Health, social care and housing providers, should develop mechanisms whereby the suitability of housing and sleeping arrangements for those families who are known to be in need or at heightened risk of SIDS is regularly assessed alongside their needs and, if necessary, safeguarding concerns raised to enable a multi-agency response to mitigate the risk.

6. Southampton Children and Families Service together with housing commissioners and providers should ensure that the provisions of 'Provision of Accommodation for 16 and 17-Year-Old Young People Who May be Homeless and/or Require Accommodation' (2010) and Section 20 Children Act 1989 are adopted to ensure that children in need are not refused accommodation on the basis of general and, otherwise, criterion based policies.

LSCB Response:

Southampton LSCB will be seeking assurance of the review and improvements made by SCC ICU to contracts of commissioned Young People Housing Related Support Providers in Southampton. SCC Housing Service has provided assurance to the LSCB that it does not place young people in bed and breakfast accommodation unless there is no alternative i.e. there is no suitable supported accommodation available. Placing a young person in bed and breakfast accommodation is very unusual and would only happened as an emergency short term measure.

Actions taken and changes made:

- Residential property in the case subject to review was assessed in April 2019 by landlord, the provider and ICU with improvements to be actioned agreed.

- SCC ICU will continue to support young people to access accommodation despite previous difficulties that they may have experienced.

Action to be taken:

- SCC Children and Families service will:

  - Use thematic audits completed throughout 2019 to understand quality of assessments and impact upon children and families. They will also undertake a practice assurance stocktake of Child Protection Planning to drive forward practice improvements. This will be reported to the LSCB on a 6 monthly basis.
  - Review relevant procedural guidance with regard to placing vulnerable families into supported accommodation and ensure that an assessment is made as to the suitability and safety of that accommodation.

- SCC Children and Families Service will also review Relevant procedural guidance with regard to 'Provision of Accommodation for 16 and 17-Year-Old Young People Who May be Homeless and/or Require Accommodation' (2010) and Section 20 of Children Act 1989.

- SCC Integrated Commissioning Unit (ICU) will review young people housing related support referral routes and this will include:

  - Access criteria
  - The complex needs of the individual beyond the housing need.
  - The option of a dedicated panel for young mothers
  - The referral form
  - Any pre placement plans required
  - To review assessment form and process and include early help assessment

- SCC ICU will continue to improve the links between the between commissioned services and existing safeguarding processes.

- SCC Housing Services to be identified and included as provider of other accommodation where young people may reside. They will also need to ensure that referrals for young people for supported accommodation have appropriate assessments in place.