Serious Case Review – Baby K
Agency progress against action plan recommendations – August 2015

Alongside the publication of the Serious Case Review for Baby K, the BSBC is publishing the following statements from all of the agencies involved in review. These show the progress that has been made on the recommendations contained in the SCR action plan since the events covered in the review took place.

1 Buckinghamshire County Council

The report of the OFSTED inspection of Local Authority arrangements for the protection of children in Buckinghamshire was published in August 2014 and found the Local Authority inadequate in its ability to safeguard and protect children. The period of time that children services was intervening with this baby covered that period.

Following the Inspection a detailed improvement plan was formulated, which focussed on the critical areas that required improvement with key performance indicators to scrutinise the direction of travel. Seven key work streams were developed and an Improvement Board was established to scrutinise the performance of Children's Services. This is currently chaired by John Goldup who was appointed by the Dfe and he reports to the minister on a quarterly basis.

In addition, since December 2014 there has been external scrutiny and support offered by Dfe appointed advisors Red Quadrant, who have confirmed that the Local Authority does have the capacity to implement and drive the necessary improvements.

The changes which have occurred have included significantly increasing the work force at the front door, and returning to a more "traditional model "of contact and assessment. This has included the development and review of the Multi Agency Safeguarding Hub (MASH), to ensure that a timely multi agency decision is made to ensure the child receives the right service at the right time. The authority and its partners through the Buckinghamshire Children's Safeguarding Board have also reviewed and published the Threshold for Intervention.

To ensure continuous improvement of social work intervention, a quality assurance framework has been developed which monitors both the quality and timeliness of social work intervention against practice standards. This includes 80-100 children's files being independently audited monthly. The frequency and quality of supervision is also scrutinised and action is taken where requirements are not being met.

There has been a focus on the retaining and recruiting experienced social work staff, to ensure that newly qualified social workers are in units where there is an experience skill mix. Social work caseloads are monitored weekly and reported on a monthly basis to the senior management team to ensure that social workers have the sufficient time to undertake their role well. To support continuous learning of social workers, a partnership has been formed with Bucks New University and a Social Work academy has been developed.

2 Buckinghamshire Healthcare NHS Trust: Midwifery, Health Visitors and Neonatal Service

The focus of the learning for the Trust has centred on strengthening existing record keeping practices and in improving the means and methods of sharing information among colleagues and partners. The Trust has also focused on ensuring staff access existing training and awareness around safeguarding procedures and increased the number of safeguarding supervisors. In addition, the Trust has also identified ways in which clinical staff can access opportunities to enhance their awareness around mental health and alcohol misuse and its impact on parenting.

Specific learning includes:

- Record keeping audits have been arranged, building on previous audits from the previous two years.
- Paediatric nurses in the community and in hospitals now have access to community records in order to aid information gathering and sharing.
- Midwives are now invited to weekly neonatal ward rounds to enhance information sharing.
- All health visitors, community neonatal nurses and neonatal ward nurses have perinatal mental health training with training around alcohol misuse to be introduced in the near future.
- In line with the Trust's safeguarding and child protection supervision policy, the Trust has intensified training to create more child protection supervisors. Health visitors and neonatal staff access regular child protection supervision, and this has been increased for midwives. A new child protection supervision policy has been written and made available to all staff.
- Face to face safeguarding training includes lessons learnt from this SCR.
- To strengthen shared learning, all maternity staff have been reminded of the importance of considering information from a social perspective, and not just in terms of clinical decision-making.

3 Thames Valley Police

The specific lessons for Thames Valley Police from the SCR into Baby K focussed on the way we deal with adult vulnerability and safeguarding. Thames Valley Police have started a thorough review of their policies around the way officers risk assess vulnerable adults. We are looking at adopting a risk assessment model which can be accurately applied by frontline staff to a wide range of operational situations. We recognise the need to clarify the

level of risk at which information can be shared with adult services, where consent has not been given. The training offer from the Buckinghamshire Safeguarding Adults Board (BSAB) has been promoted to all the Local Police Areas in Buckinghamshire and there has been an increase in the amount of frontline staff undertaking this training. The BSAB is now also attended by a local Area Commander, which will strengthen the link between frontline uniform police officers and issues of adult safeguarding.

4 Buckinghamshire County Children's Centres

- Safeguarding is now a standing item on the contract monitoring agenda to which there are three elements – staff, referrals and issues in the centre.
- The early Childhood Services forum is meeting every other month with children's centres representation
- Annual reviews are being completed on a regular basis; part of this process is an audit of files and observation of services.

5 Oxford Health NHS Foundation Trust

Oxford Health NHS Foundation Trust (OHFT) has worked in partnership with Buckinghamshire County Council to review case conference invitation processes and improve case conference attendance and submission of a report by OHFT staff.
Adult services continue to support and promote the "think family "approach. Think family champions have been identified with in Psychological Services to join other think family champions across adult services.

Adult services have reviewed their internal referral processes, to ensure clear accountability of management of risk when patients are within the referral pathway.
OHFT is in the process of implementing a new patient electronic health record system. Easier recording of dependants and safeguarding concerns is now available for staff.

Identification of risks to unborn babies, children and effective management plans have been incorporated into mandatory Safeguarding Children training and risks to children are included throughout mandatory Clinical Risk and Management training.
Commissioners are currently reviewing the mother and baby perinatal mental health pathway. Psychological Services and AMHT are part of this review process.

6 General Practitioners

This review has highlighted the need for General Practitioners to be more aware of, and to be included in, the multi-agency pre-birth assessment of vulnerable families and child in need planning. Safeguarding training for GP practice leads has included education on BSCB pre-birth procedures and the recognition of safeguarding risks during pregnancy with emphasis on early sharing of information to improve continuity of care for vulnerable families.