Dudley Safeguarding Children Board Serious Case Review Action Plan

Action Plan regarding:	**Child M SCR - SILP**

Child M, who is the subject of this SCR, was injured in October 2014. The scoping meeting did not take place until October 2015 (refer to SCR report for rationale) and the finished report was presented to the DSCB in October 2016. During this time Children's Services and the DSCB came under the scrutiny of Ofsted and were assessed as inadequate. An agreed multi-agency Improvement Plan has been in place and is closely monitored by the multi-agency Improvement Board (IB).

The latter overlaps significantly with the recommendations of this report and therefore they recommendations are addressed more generally and in the context of the wider work to improve outcome for vulnerable children and young people in Dudley.

The DSCB has its own improvement plan which in essence aims to strengthen its assurance mechanisms in order to hold partner agencies to account for their safeguarding practice. There is a protocol in place between the IB and the DSCB

Learning or Improvement Point	Recommendation	Progress/Comment	RAG Status
1. Ensure that all available information is shared and analysed in order to build holistic picture of a family's circumstances, and of the risks and protective factors.	DSCB should seek assurance local Inter-Agency Child Protection Procedures, e.g. timescales for Strategy Meetings and assessments, are adhered to.	Adherence to CP procedures is, and will be, scrutinised by Ofsted in their three monthly monitoring visits. Timescales are monitored via performance reporting to the Improvement Board (IB),	
2. Ensure that all	Consideration should	Ofsted's monitoring visit to the MASH/SPA noted that strategy meetings were taking place	

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available information is shared and analysed in order to build holistic picture of a family's circumstances, and of the risks and protective factors.	be given to arranging Strategy Meetings, rather than telephone Strategy Discussions, whenever possible, ensuring key agencies, including health, education and Probation, are invited and full information shared.	'face to face' although in general terms they lacked input from health. A health presence in the MASH is currently under discussion between agencies. (Ofsted's focus for this visit was MASH/SPA and the Court Team). Further work is needed to ensure wider agency input into strategy discussions across the DSCB partner agencies. This should include the consideration of technology such as conference calling, and visual links (not simply phone calls between two parties).	
3. Effective supervision and management oversight is crucial in providing direction, reflect and challenge, and preventing delay in the implementation of plans.	DSCB should seek assurance that CSC have a robust Supervision Policy in place and that this is adhered to.	A Supervision Policy is in place. Ofsted's monitoring visit (as above) commented that supervision and management oversight are in place in the MASH/SPA and the Court team. Further scrutiny will take place across CSC and in future Ofsted monitoring visits. Reporting will be via the Quality Assurance and Performance Framework. The Chief Social Worker is rolling out development in reflective supervision.	
4. All Police Officers should have a working knowledge and understanding of indicators of domestic abuse, of the Force's DA procedures and the action to be taken.	DSCB should seek assurance from West Midlands Police that the Domestic Abuse procedures are being robustly followed and a process is in place to provide schools with information following Domestic	All front line officers have received DA training as part of Operation Sentinel. A revised Force Policy has since been implemented identifying specific responsibilities for officers and supervisors. The policy provides additional signposting to national guidelines. Locally, front line officers All front line officers have received DA training as part of Operation Sentinel. A revised Force Policy has since been implemented identifying specific responsibilities for officers and supervisors. The policy provides additional signposting to national guidelines. Locally, front line officers and BST (in addition to Police, Health, CSC and Women's Aid). Health or CSC can usually provide school details for a child if Education are unable to attend the meeting, and updates will be shared with Education. BST report that only one Education representative is available for MASH/BST and the appointment is not backfilled if appointed member is on leave. Finally, learning from all statutory reviews is disseminated via monthly leadership meetings	

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	Abuse Referral Team (DART) meetings.	and quarterly meetings with Learning and Development to ensure that training is dynamic and up to date with current issues.	
5. One Day One Conversation Meetings should consider risks and address	DSCB should seek assurance from West Midlands Police that the 'One Day One Conversation' meetings fully consider any continuing safeguarding concerns in relation to children and young people and take appropriate action to ensure children are safeguarded.	WMP ensure that safeguarding is one of the key principles of offender management and is included in training packages for offender management. Staff receive training in 'Safeguarding is everyone's responsibility', 'professional curiosity' and 'readiness to challenge'. They are provided with referral and signposting pathways as 'Joint Working in Partnership' identifying children at risk or where offenders have access to children. ODOC meetings ensure that safeguarding is at the forefront of everything the partners discuss. WMP ensure that any safeguarding issues highlighted before, during or after an ODOC meeting are referred through MASH and MARAC (if management is of DA offenders). **Additional Action.** WMP to provide an assurance report to the DCSB executive in Feb 2017	
6. Practitioners, notably within health agencies, should have a greater understanding of the advisory role of Safeguarding Leads and use them proactively.	Awareness of the role and responsibilities of agency Safeguarding Leads, notably within health agencies, should be increased.	All practices within the borough have a named safeguarding lead (usually a GP) who attends safeguarding workshops arranged by the Named GP and the Designated Nurses CCG. The Named GP supports the Designated Nurse to increase the profile of the safeguarding children agenda. GPs have access to the Designated Nurses for ad hoc supervision and case discussion. Contact details for the DNs and Named GP are available on the members portion of the intranet and on Safeguarding News and Practice (SNAP) Briefings sent out to surgeries.` The CCG Designated Nurse supports GPs with the escalation process when having reached level 3a or before if necessary. All provider organisations have a Named Nurse/Safeguarding Lead who offers advice and supervision to practitioners, delivers training and support staff during the escalation process.	

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		Dip sample of CCG staff demonstrated that 100% knew who the Designated Nurse was.	
7. All practitioners, working with children and adults should apply a 'Think Family' approach and always consider the impact of an adult's difficulties on children and young people with whom they have contact.	DSCB should promote a 'Think Family' approach in their communications and guidance. Safeguarding Leads should play a key role in this promotion.	By way of explanation and to approach the recommendation from a wider context - The Dudley MBC Strengthening Families Phase 2 Outcome Plan will be used in the Supporting (Troubled) Families programme as a method of identifying and holistically assessing the needs of families to enable the appropriate level of support while also facilitating an approach to measure significant and sustained progress. The outcome plan delivers a set of significant and sustainable outcome measures applicable to all families. The Early Help (EH) Strategy determines the wider context of the Supporting People agenda, outlining how partners and the range of Council wide services will contribute to supporting children and families to be more resilient and be offered support at early and pivotal points of need. This approach was promoted at the launch of the EH Strategy on 17th October 2016 which was endorsed by the chair of the DSCB. This Learning/Improvement Point and recommendation must be built into the DSCB Quality Assurance Framework. (current target date May 2016 rag-rated red) and the partnership wide outcomes framework for monitoring performance and progress and the Quality Assurance and Performance Framework	
8. GPs need to have a full understanding of their role and responsibilities.	DSCB should seek assurance that the system for GPs to 'flag' adults and children where there are safeguarding concerns is being implemented across Practices.	The internal EMIS system flags a number of risk factors including CPP, LAC, DV Substance misuse. These figures extracted on a quarterly basis and is reported in to the DSCB Business Unit in order to populate the assurance framework. Funding has been identified to implement the IRIS system in to GP Practices. This has been presented to GP's at a training session and three Practices have agreed to pilot the project. EMIS flag is being piloted to record who attends with a child. This has received positive feedback and will be deployed to all practices by 31st March 2017	
9. Health practitioners should have a full understanding of their role and	Findings of this SCR should be shared widely with GPs and the Mental Health	The SCR has been used as a case study for GP practice staff (28.02.17) and was well received. A briefing will be sent to all GP's and safeguarding leads in provider agencies regarding the case, including the recommendations and lessons learned.	

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responsibilities, notably recognising the impact that adult difficulties can have on parenting capacity and action to be taken to safeguard children.	Services, and GMC's guidance; Protecting Children and Young people promoted, to raise awareness of their safeguarding responsibilities and what action to take when there are concerns about the risk posed by adults living with children.	GMC guidance 'Protecting Children and Young People' was previously forwarded to all GP practices and Provider Safeguarding Leads. This is available on the members section of the CCG intranet. The trio of vulnerabilities and parental behaviours are included in all health single agency training	
10. Decisions by the CPS should consider and prioritise the future safeguarding of children and young people.	Review of the decision-making in 2005, which led to the charges of assault against JB being dropped and the charge of abstracting electricity continuing	The Chair of Dudley Safeguarding Children Board has written to WM Crime Prosecution Service with a request to review the decision making processes of 2005 and to provide assurance on their approach to prosecuting people in respect of offences against children, and ensuring the prioritising future safeguarding of children and young people.	
11. Should be a common understanding of the principles of information sharing between Health agencies and DSCB when SCRs and Case Reviews are being undertaken.	Discussion should be held between DSCB and the Caldecott Guardian to ensure that there is a common understanding of the principles of information sharing when there are child protection concerns,	The requirement and commitment for SCR's is collated and included in the Terms of Reference of each contributing agency. This is directed to the DSCB representative. Where SCR's are commissioned, all partners are to be reminded, by way of letter from the DSCB, of their obligations as set out in Working Together to Safeguard Children 2015. A SCR process is due for a review, this will include the implementation of a SCR toolkit, within which a template letter to be devised/added to be issued to senior officers in all agencies identified for involvement in SCR's this will further reinforce this action as it becomes embedded in the process when undertaking SCR's	

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	and when the LSCB is fulfilling its statutory responsibility to undertake a Serious Case Review or Case Review**.**		