CSPR – “Emily”

Response from Independent Chair and Scrutineer

As part of my role I provide scrutiny of safeguarding practice by partner agencies in Bradford District and one way in which this is done is through the exercise of some oversight of the process for determining whether significant incidents require consideration via a Child Safeguarding Practice Review (CSPR) and consideration of the outcome of such reviews.

This case involved a 6 week old child who suffered a head trauma which was deemed to be as a result of a non-accidental injury. She was the youngest of 6 children living with a single mother. The children had been offered support as children in need, and at the time of the injury were subject of a child protection plan. The child involved is referred to as “Emily”.

A CSPR was commissioned in the autumn of 2019.There was a delay in finding an independent author to carry out the review and, as a result, it was still at an early stage when Covid restrictions were imposed in March 2020. Due to the challenges facing agencies as a result of the pandemic, much of the work of the Partnership had to be suspended – the staff in partner agencies who would normally complete the work being required to shift their focus to Covid related activity.

The work on the review resumed in September 2020 and the completed report was presented to the Bradford Partnership in February 2021. As a result of these delays the timescale for completion set in government guidance was not met but agencies did not wait for the final sign off the report and developed actions to improve services as issues emerged during the course of the review. The report usefully sets out these actions in Appendices.

The Lead Reviewer suggests that Bradford Safeguarding Partnership seeks to assure itself that partner agencies have indeed completed the necessary actions to address gaps identified in this review and that agencies have focussed on practice issues such as observation, analysis, professional curiosity and information sharing; not just on process, with a view to achieving the following outcomes:

1. Processes, planning and engagement
    - All key professionals and agencies attend Child Protection Conferences.
    - Key professionals are members of Core Groups and attend Core Group meetings.
    - Child in Need plans clearly describe areas of concern, action that needs to be taken, who is responsible, when this will be achieved and the measurement of success.

- Child in Need plans are reviewed at all Child in Need meetings and Child Protection Plans are reviewed at all Core Group meetings

It is a concern that these issues continue to be in evidence as they mirror findings from a previous case reviews re “Alice” and “Kieran”. I have asked that the Case Review sub-group, which monitors completion of case review actions on behalf of the Partnership looks again at how effective the processes in place are at ensuring evidence of outcome and impact is provided not merely completion of the actions. To assist with this TBP are arranging a Multi-agency Safeguarding Operational Group that will be a group / forum in which to try and resolve some of those issues that may be causing disputes/barriers/blockages in operational practice that could be quickly resolved through dialogue and solution focused processes.

A Task and finish group has been established to enhance the audit processes currently used within the partnership to provide even greater emphasis on effective processes and positive outcomes for children and families.

- Schools seek to put arrangements in place to contribute to Child Protection Conferences and Core Groups during school holidays.

The schools involved in Emily’s case now have arrangements in place for engagement in safeguarding processes outside of terms-time. TBP has asked the Council’s safeguarding Team to establish the positions with all schools and this question will be added to the next Section 175 audit of safeguarding within schools.

2. Keeping plans up-to-date and reflecting changes in circumstances
    - Changes in the composition of a household where there is a Child in Need or Child Protection Plan in place lead to an updated social work assessment.

CSC to be asked to complete a short audit of CiN and CP cases where there has been a change to establish the extent to which this routinely prompts a review of the plan.

- Health professionals who become aware that a family has moved home ensure that relevant professionals are informed of the change of address as soon as possible.

Health colleagues have responded to this issue by discussing at the Safeguarding SystmOne group on the 11th May 2021.This group has raised a request for the functionality of SystmOne to be explored to better support the ease of updating address changes. This request will be discussed at the District Programme Board to clarify if the functionality of SystmOne can be amended. Once this is completed, governance of this request will be overseen by the Safeguarding SystmOne group with updates to the Case Review Group to understand progress.

The usual communication systems continue during and beyond this request with health colleagues sharing changes of addresses via tasks, secure emails, via phone contact etc. with relevant professionals.

.

3. Compliance with procedures
   - 'Was not brought' policies are written and implemented for all health services offering appointments and home visits to children, in line with Multi Agency Best Practice Guidance (2018) 'Management of Children not brought to medical appointments'.

Such a policy was, in fact, already in place and this was an issue of non-compliance rather than a policy gap. This was addressed during the course of the review. Assurance of compliance, as above.

Additional issues

Though not subject of a specific recommendation by the Independent Author, another issue is evident, and mirrors findings in other reviews, suggesting that there is further action required as follows:

Understanding of the long-term impact of neglect and domestic abuse, and responses to this:

Concerns about the impact of mother's use of alcohol were of long-standing, first having been raised in 2013 and the police had extensive engagement with the mother and her former partner, responding to incidents of Domestic Abuse. It was not until 2015 that formal assessment was done and support offered via Early Help services. This was in place for around nine months. In the subsequent two years there were 12 contacts with CSC expressing concern for the children's welfare, none of which resulted in a further assessment.

At the time of this incident Children's Social Care services had been judged as Inadequate by Ofsted. An improvement plan has been in progress and the quality of practice has been targeted, with new operational standards having been put in place, increased supervisory support and a framework introduced for quality audits which engage the practitioner in order to promote personal learning. In view of this I am not making any recommendation about the quality of practice.

I am however recommending that the Learning Brief which is being published alongside this review includes the importance of recognising the long-term impact of neglect and domestic abuse and that this is widely disseminated through agency partners.