Independent Chair: Nicky Pace



Hertfordshire Safeguarding Children Board Response to Publication of SCR on Child 'I'

Hertfordshire Safeguarding Children Board (HSCB) has published the report of the Serious Case Review (SCR) of the services provided to a family where a child drowned in the household bath.

It is fully accepted that this was a tragic accident, and all agencies involved fully understand the family's feelings that they are trying to cope with the impact of this. As part of the learning from this case it was identified that there should be a re-emphasis to parents of young children of the dangers of leaving them unattended while bathing them. The HSCB has also publicised its Water Safety campaign again with partners and the general public.

The recommendations and responses are as follows:-

RECOMMENDATION 1: The HSCB should seek assurance from health providers and commissioners that any social and medical risk factors in pregnant woman are communicated effectively to maternity services by GPs and that the growth in self-referral does not hinder this.

<u>Board Response</u>: Health commissioners and providers in maternity services have already developed a system whereby information is shared with GP practices on those patients that self-book. An assurance report and audit findings will to be presented to the HSCB to ensure the recommendation and changes are fully embedded into practice.

RECOMMENDATION 2: The HSCB should seek assurance from the police that their procedure for responding to any incident of domestic abuse ensures in practice that all relevant information is shared with partner agencies through the current processes that exist. This includes the Domestic Abuse Investigation and Safeguarding Unit (DAISU) and where appropriate if the notification meets threshold this will also be undertaken via the Multi Agency Safeguarding Hub (MASH).

<u>Board Response</u>: There is already wide cross agency sharing of domestic abuse information and the systems in place have been reviewed since the events described in this review. The review of the effectiveness of such systems will be continuous and the Board will be informed of any issues or changes in process.

RECOMMENDATION 3: The HSCB should seek assurance from housing commissioners that their own staff and those of housing providers, in particular those who make home visits, receive suitable training in recognising and responding to concerns about vulnerable adults and children. This should take account of the needs of families with small children who fall into arrears.

<u>Board Response</u>: A training gap analysis questionnaire to be distributed to housing commissioners and providers. Findings to be analysed and feedback to Board for assurance. Any issues identified will be addressed with the individual provider/commissioner. In addition to further support colleagues working in housing, a Safeguarding Housing Conference will be run (in conjunction with HSAB). Housing staff will also be invited to learning hubs events during 2019.