

HSCP Chair: Jenny Coles

### Hertfordshire Safeguarding Children Partnership Response to Publication of SCR on Child J

Hertfordshire Safeguarding Children Partnership (HSCP) has published the Serious Case Review (SCR) into the death of Child J, who died aged three months whilst in the care of his mother. The death was initially regarded as a sudden unexplained death in infancy, however, the initial post mortem found fractures and healing fractures. Expert opinion is that the fractures would have required significant force and a pulling and twisting action on the leg. The mother did not seek any medical attention for these recently inflicted injuries. The cause of Child J's death is undetermined however it would not have been caused by these injuries.

This review has demonstrated that the child protection procedures that HSCB and its member agencies have put in place under Working Together 2015<sup>1</sup> were implemented: early recognition of risk, early referral, assessment and planning. Child J was being seen regularly as part of the child protection plan and the plan was being implemented. On the whole the systems worked and there was multi-agency discussion and challenge at the Child Protection Conferences.

The case has also highlighted some areas for improvement. These are outlined in the recommendations below and work on the learning highlighted has already commenced.

The recommendations and responses are as follows;

**Recommendation 1 - The Clinical Commissioning Groups (CCGs) have introduced systems for children in receipt of a Child Protection Plan but must provide assurance to the HSCP that the system is robust and able to identify practices that require improvement.**

***Partnership Response*** – *The Clinical Commissioning Groups in Hertfordshire are conducting a review in order to provide the Hertfordshire Safeguarding Children Partnership with assurance of the strength of systems place in General Practice to receive and store Child Protection and Children In Need information safely within the practice. The review will ensure that any issues identified are resolved and further monitoring will continue to ensure that the receipt and storage guidance is adhered to.*

**Recommendation 2 - The CCG through the Named GPs must challenge GP safeguarding practice where necessary, and monitor practices through audit and the use of Key Performance Indicators.**

***Partnership Response*** – *As part of the review being undertaken by the Clinical Commissioning Groups in Hertfordshire, the Named Safeguarding GPs for the County will include assurance on any GP Practices where there is an identified need to improve their systems for receipt and storage of information relating to Child Protection or Children In Need. The report will evidence how these were identified and what is being done to support improvements.*

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<sup>1</sup> New guidance Working Together 2018 has been published since this review was undertaken

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**Recommendation 3 - Children's Services must provide assurance to HSCP that the modular parenting assessment undertaken by the Family Safeguarding Team is being carried out in a timely and systematic way; information is provided by the multi-agency network and is highlighted and explored as part of the overall assessment. Assessments should offer an effective understanding of parenting strengths and weaknesses.**

**Partnership Response** – *In order to provide assurance to the Hertfordshire Safeguarding Partnership Children's Services are commissioning an in depth audit of practice in relation to the completion of the 'modular parenting assessments'. In response to the recommendations of this Serious Case Review the audit will ensure that partners receive the assurance that these assessments are timely and systematic. It will also explore the use of multi-agency information to inform the assessment process and that there is evidence of the evaluation of parenting strengths and weaknesses. On completion the recommendations from the audit will be shared with the Hertfordshire Safeguarding Children Partnership for challenge and assurance.*

**Recommendation 4 - HSCP should take an active role in monitoring the understanding that the safeguarding partners (police, health and local authority services) and other member agencies have of agreed approaches to identifying and meeting need at all levels (targeted support, child in need services and child protection plan) and that services provided are proportionate to risk and presenting need. There should be evidence that the understanding is manifest in practice as well as at the level of policy and procedure.**

**Partnership Response** - *The Hertfordshire Safeguarding Children Partnership conducts regular audits into different areas of safeguarding practice. In response to the findings from this Serious Case Review the partnership will ensure that future audits include an opportunity for evaluation of the multi-agency partner's application of the 'Continuum of Need'. This will enable the partnership to identify any areas of misunderstanding or misinterpretation of the agreed approaches to presenting need and that services delivered are proportionate to the assessed risk.*

*In addition the Hertfordshire Safeguarding Children Partnership will ensure that all partners are cited on the 'Continuum of Need' and have clear evidence of how this is embedded within their individual organisations.*

**Recommendation 5 - HSCP needs to ensure that key professionals are aware of the significance of a diagnosis of Emotionally Unstable Personality Disorder and the impact that this may have on the parents' ability to parent.**

**Partnership Response** – *The Hertfordshire Safeguarding Children Partnership has a plan in place to deliver face to face learning events over the next twelve months on 'Emotionally Unstable Personality Disorder' and the ability to parent. Key staff from across the partnership will be targeted to attend these sessions, which will be evaluated on completion.*

*In addition to support the understanding of this diagnosis the partnership will provide a practitioner guide which will be easily accessible by all staff*

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