Portsmouth Safeguarding Children Partnership

Response to the Recommendations from the Serious Case Review of Child I

The case was considered by the Portsmouth Safeguarding Children Board (now called the Portsmouth Safeguarding Children Partnership) at its Learning from Cases Committee in May 2018. The PSCB commissioned a concise SCR to examine issues concerning the welfare of Child I and the lessons to be learnt to improve experiences for children in similar circumstances in the future. Including the degree to which decisions were child focused and the effectiveness of working arrangements across agencies and services.

The full findings of the Serious Case Review (SCR) are set out in the Overview Report that has been published in full alongside this response.

This document provides the response from the Board to the findings made in the Child I report. It outlines the recommendations made in response to the review's findings; outlines the action which has already been taken; and comments upon what more will be done. All of this work has been monitored by the PSCP Learning from Cases Committee and the Executive Committee. Recommendations have been identified for the Partnership, or for specific partner agencies as identified below.

Recommendation 1

The PSCP to promote the learning from this review across all relevant partner agencies, and seek assurances that it has been disseminated and specific single agency recommendations have been embedded.

Action taken: A HIPS (Hampshire, Isle of Wight, Portsmouth and Southampton) wide campaign took place during the week 9 - 15 March 2020 to coincide with National Safe Sleep week. A campaign launch event was organised for 9 March at the Portsmouth Central Library with representatives attending from all 4 LSCP areas. Workshops on safe sleeping took place over the remainder of the week with attendees from a variety of organisations within the city to ensure the right messages were delivered.

The PSCP Monitoring, Evaluation and Scrutiny Committee will seek quarterly updates from all partner agencies on progress against these recommendations. Any barriers to implementation or areas of success and good practice will be shared with the Executive Committee as appropriate. There have already been examples of excellent practice in this area such as:

- The Family Nurse Partnership and Health Visitor leads have developed a template to prompt discussion about safe sleeping during out of routine events. It is anticipated this will be integrated in to the new Maternity Information System during its implementation phase. The safer sleeping campaign is also included in the Breastfeeding Friendly Initiative workstream which will support and reinforce these public health messages.
- A stock of approximately 6000 Safer Sleeping leaflets have been distributed to all clinical areas of Maternity Services, including community settings. Leaflets are given to women upon discharge with a verbal explanation of its content. Where necessary, a translator is utilised to ensure there is an understanding of the information shared.
- Copies of the safer sleeping leaflet have been enlarged into posters and laminated. These are displayed in all maternity centres, antenatal clinic, Maternity Assessment Unit and across the acute setting at QA.
- Solent NHS has shared learning across the Trust using their learning pathway. This includes sharing information in electronic bulletins, via the safeguarding champions and the Safeguarding steering group. Learning is also added to the safeguarding pages on Solent and informs updates to training packages.
- The Fertility Clinic has shared the learning from this review throughout its organisation and to the Human Fertilisation and Embryology Authority (HFEA). The

learning has been disseminated via staff meetings (operational, clinical governance and team meetings) and the staff newsletter.
- Practitioners from Children's Social Care and Early Help were encouraged to attend the March PSCP workshops on safe sleep and communication was sent out to all staff highlighting awareness.

Recommendation 2

PSCP in partnership with the Hampshire, IOW, Southampton and Portsmouth (HIPS) group to review the Child Death procedures to take into account the learning from this review and the changes in national guidance. The new procedures should include the following from this review:

- All procedures must include date ratified and date due for review
- Clear guidance on who should be invited to meetings to include fertility clinic and maternity staff where appropriate
- Ensure that the importance of joint home visits is highlighted and embedded into practice
- Support for families is considered even when there is a criminal investigation ongoing.

Action taken: The Child Death Procedures are no longer overseen by LSCPs. The Child Death Partners now hold responsibility for this piece of work. The procedures were reviewed when the new CDOP arrangements were implemented in autumn 2019. These are all on the HIPS Procedures website.

The PSCP will work closely with the Child Death Overview Panel to ensure that the procedures incorporate the bullet points listed above.

Recommendation 3

The PSCB Serious Case Review and Learning Review Procedure was last reviewed in June 2015 and was due for review in June 2017. PSCP should review and update this procedure as soon as possible. It should clearly identify expectations related to how agencies support staff involved in Case Reviews and Serious Child Care Incidents.

Action taken: The PSCP has updated it Case Review Process and Methodology, which can be found here, on the PSCP website. There is further work to ensure that that a full procedure is updated and available, detailing expectations of how agencies support staff who are involved in the process. The Learning from Cases Committee will complete the update to this document by September 2020.

Recommendation 4

Consider how PSCP supports the workforce in working with universal and high risk families to identify safe-sleep risks, with an emphasis on 'out of routine' events such as staying at a relative's house, going on holiday, attending a party where they may drink more than usual etc. and then supporting them in developing strategies to manage these and maintain safe sleeping advice for their baby.

PSCP, in partnership, to consider working with the HIPS group to develop multi-agency guidance that provides consistent, evidence based messages; and role specific guidance on what we would expect different professionals to look for and then do. PSCP to also consider how these messages are built into the range of training across agencies, so that it is relevant

and proportionate to their role and level of awareness needed around safe-sleeping messages.

Action taken: PSCP, in collaboration with the HIPS group, updated the safe sleep procedure and published in March 2020. This coincided with a County wide multiagency safe sleep event. This week long event included multiple workshops where professionals were taught about the important of safe sleep during 'out of routine' events.

Agreed key messaging and guidance has been agreed with HIPS and is available for any professional to access on the HIPS procedure page. This page also breaks down specific guidance for individual partner agencies, ensuring relevancy in the key messages shared.

The PSCP Training Team are continuously filtering key messages through the following training programmes:

- Basic Safeguarding Children
- Early Help
- Child Protection
- Restorative Practice
- DSL & Managers training
- Masterclass Webinars

There is an existing focus on the 4 C's of safeguarding: Child, Curiosity, Communication and Context. The learning from this review will fit into all 4 Cs and will be regularly integrated in to the courses listed above. The training team also plan to offer specific training sessions on professional curiosity in the autumn.

Recommendation 5

Consider how PSCP supports the workforce to be clear that when discussing alcohol consumption with parents, as well as considering their weekly average, they discuss what happens on those occasional events when they may binge/drink much more than usual. This will help conversations around safe-sleeping in high-risk situations be more grounded in the family's real-life experience. Consider a drink free parent/carer in a similar way as they would consider a duty driver to prevent drink driving situations.

Action taken: The updated safe sleep procedure, available on the HIPS Procedures website, asks professionals to strongly advise against co-sleeping if either parent has drunk alcohol or taken drugs. It also suggests that families develop a plan for the 'out of routine' events.

As reference above, the PSCP Training Team will filter key messages throughout a range of their training courses, ensuring that professionals are aware of key messaging and are demonstrating professional curiosity when working with parents.

In response to this document, PHT have ensure that the antenatal and postnatal hand held maternity notes have been updated to reflect the recommendations and include the advice of one parent / carer remaining sober. This will support conversations with families to develop strategies to manage such situations and maintain safe sleeping advice for their baby. The postnatal discharge checklist has also been updated.

A public health related social media campaign is planned for August 2020. This will focus on safer sleeping advice and include the use of drugs / alcohol and their potential impact on safe parenting. The content of PHT's Parent Education is also being updated to include this

subject.

A timeline in the antenatal period is being created to provide a prompt to staff to discuss essential PH messages. This will ensure the information is 'drip-fed' to parents throughout their pregnancy journey.

The PHT guideline specific to substance misuse in pregnancy is in the process of being updated and will promote the concept of a drink free parent / carer.

Portsmouth Hospitals NHS Trust (PHT)

Recommendation 6

Portsmouth Hospitals NHS Trust to undertake an audit of routine questioning about domestic abuse by midwives and put in place actions to ensure that this is embedded into practice. Audits should be repeated annually to ensure that practice has been embedded and progress maintained.

Action taken:

A Screening of Domestic Violence and Abuse (DVA) in Pregnancy audit was undertaken in January 2020. This demonstrated the key findings as detailed below:-

A repeat sample of 210 case files, containing the care histories of 210 recently birthed women, who had received care from Portsmouth Hospitals NHS Trust Maternity Services in 2019 were audited.

- 131 (62.5%) women were screened for DVA, this was a small decrease of 3.7%.
- Of the 131 screened no positive disclosures were made
- 79 (37.5%) cases had not been asked the question
- Of these 79 cases there was evidence documented in 70 (89%) of the records why screening was unable to take place. This is an improvement of 79% on the previous audit.
- All 70 records gave "accompanied by partner or other family member/friend" as the reason for not undertaking DVA screening during that episode of care.
- 9 (4.2%) were not screened for DVA with no recorded explanation. This is significantly decreased from being 23.5% in previous audits.

The recommendations of the audit will inform the priorities for PHT's DVA in pregnancy action plan for 2020 / 21. Completion of this has been delayed due to the COVID-19 pandemic.

Recommendation 7

Portsmouth Hospitals Trust Maternity Services to review and improve their continuity of carer arrangements, especially when there is staff sickness, to ensure that women have at least some consistency of carer.

Action taken: In September 2019, PHT piloted their first continuity model in Portsmouth city - the Athena Team. The team currently achieve 85% continuity and the aim is to replicate this across the rest of the community service. In the interim while they actively recruit staff to support this model of care, midwives are being placed into small teams of 4 to cover annual leave and sickness.

Recommendation 8

Portsmouth Hospitals to put processes in place to provide support for staff involved in

serious incidents and case reviews. They should ensure that staff are informed promptly when a child they have been involved with has died and to ensure staff are appropriately prepared to participate in any learning events including access to the records.

Action taken: The Trust has created a 'Supporting Staff Involved in an Incident, Complaint or Claim' policy. This policy guides and supports managers in the supervision of such cases and contains a staff support checklist. When used in conjunction with ongoing pastoral support from their team leader, this will ensure that all available support is offered to them following an adverse incident.

Staff involved in a serious incident are actively encouraged to participate in a rapid review of the case. This ensures that all staff, irrespective of grade have an opportunity to share their experience. This process also considers any human factors that may have impacted on the outcome. It is anticipated that this process will capture any immediate learning which can then be shared with the workforce. At the time of the rapid review, if a poor outcome is expected staff are asked as to how they would prefer to be informed.
At present, there are a number of ways in which Maternity Services are informed of a child death as this is dependent on the circumstances and the age of the child at the time of death. It is acknowledged that because of the variation of ways in which this information enters the organisation, governance processes around identification need to be more robust. Based on the findings of Child I, the process is under review.

Recommendation 9

Portsmouth Hospitals to have in place on the Children's Assessment Unit robust processes to check every child attending for unplanned care on CP-IS.

Action taken: Every child has CPIS check on admission. All staff have access to CPIS in absence of administration staff. A Global trigger tool is completed monthly with 100% compliance recorded.

Solent NHS Trust

Recommendation 10

Solent NHS Trust to review their administrative process and put in place robust process so that new birth visits are not missed in the future.

Action taken: Systm 1 is the electronic record used in Solent to allocate work to Health Visitors via tasks, the administration team monitor the tasks to ensure birth visits are completed and the Trust provide performance reporting to indicate if a new birth visit is late and the reason why this has happened, there have been no incidents relating to missing new birth visits in the last year.

Hampshire Police and Solent NHS Trust

Recommendation 11

As part of future arrangements for Joint Agency Response (JAR), where a child dies unexpectedly, the Chair of the JAR should ensure that all agencies have been identified and invited to contribute including maternity services and fertility clinics where appropriate.

Action taken: There have been discussions between Solent NHS Trust, Southern Health and Hampshire Constabulary about JAR paper work that has led to a further task and finish group looking at universal process and paperwork for the JAR process across the 3

organisations. It is agreed that the new JAR 1 meeting agenda paperwork will include a prompt to discuss if there are additional known services/ agencies that need to be included. Solent own internal paperwork now includes within the process checklist on who to invite to JAR 1 meeting; that includes consideration of other agencies such as British Pregnancy Advisory, Fertility services , Private health settings etc.

Hampshire Constabulary will encourage the identification of professionals during their initial response directly with parents prior to the JAR Immediate Meeting.

A Fertility Clinic

Recommendation 12

The fertility clinic to explore the feasibility of either informing maternity services direct, or the GP, of a pregnancy where there is a background of unusual circumstances.

Action taken: When there is a background of unusual circumstances the fertility clinic has made all staff aware that:

- If such a patient becomes pregnant, instead of asking the patient to report the pregnancy to her GP, the clinic must inform the GP of her pregnancy once confirmed.
- The consent on the HFEA Consent to Disclosure (CD) form must be checked prior to contacting the GP. If consent is not given, the patient will be asked to provide informed consent prior to GP contact.

Recommendation 13

Fertility clinic to ensure that they have in place robust process for checking information provided by patients and their partners where there are unusual circumstances or when a child has died unexpectedly.

Action taken: When there is a background of unusual circumstances or a child has died the fertility clinic has made all staff aware that:

- In addition to a Welfare of the Child (WOC) assessment being carried out by the clinic, the clinic must contact the GP for more information.
- The consent on the HFEA Consent to Disclosure (CD) form must be checked prior to contacting the GP. If consent is not given, the patient will be asked to provide informed consent prior to GP contact.

Further Considerations

In July 2020, the National Panel published their report in to Sudden Unexpected Death in Infants (SUDI). Portsmouth were visited as part of the methodology for this review. Key learning from this report includes the strong link between alcohol and substance misuse and sudden infant death. It recommends that professionals tailor their safe sleeping key messages to the needs of the family's background and history. It also highlights the importance of planning for 'out of routine' events where a child's normal sleeping arrangements may be changed, especially when this involves alcohol. Portsmouth will consider the learning and recommendations from this report when forming an action plan from this case. For further information, please see this report.