HALTON SAFEGUARDING CHILDREN BOARD (HSCB)

Response to Serious Case Review concerning a life threatening episode to a young person due to Neglect

March 2017

1. Introduction

1.1 In January 2015 the Independent Chair of Halton Safeguarding Children Board (HSCB), Richard Strachan, decided to initiate a Serious Case Review (SCR) following a life threatening episode experienced by a young person.

1.2 The Chair's decision to undertake the SCR was made in line with Regulation 5 of the Local Safeguarding Children Board Regulations 2006 and consistent with the statutory guidance set out in *Working Together to Safeguard Children* (2013) (since revised in 2015).

1.3 The SCR was undertaken using the SCiE Learn Together Model as its theoretical methodology. The research question set as the specific focus of the SCR was: *To what extent is Early Intervention in Halton child-focused in addressing adolescent neglect?* The overall purpose of the review has been to look at what happened and why, to identify the learning for organisations and to make recommendations for either improvement or the consolidation of good practice.

1.4 The young person and family were involved in the SCR, and the HSCB would like to take this opportunity to thank them for their contribution.

1.5 The report and the findings of the SCR have been accepted by the HSCB.

2. Treatment of young people with eczema in adult satellite hospital outpatient clinics in Halton.

2.1 The SCR found that the treatment of young people with eczema in adult outpatient clinics focussed upon their physical health needs. The consequence being that any additional needs are marginalised or neglected. A failure to recognise and address these needs can result in child neglect.

2.2 Since the review a safeguarding pro-forma has been developed by the hospital to be used to identify any potential or existing safeguarding concerns amongst young people seen at the clinic. Any concerns are then raised with the hospital's Named Nurse. There has been a revision of staff training to ensure that staff working in adult outpatient clinics have more detailed safeguarding children training. In addition, a member of staff trained to Level 3 (Intercollegiate document 2015) must be available on site during clinic hours to support safeguarding / early help assessment.

3. Early Help Services in Halton

3.1 The SCR found that the effectiveness of Early Help services in Halton was measured by indicators relating to service throughput rather than child-focussed outcomes. The consequence of this approach is that children may continue to have unmet needs. For example, parents may be attending every

session of a parenting class in line with a CAF (Common Assessment Framework) Plan, but they are not putting the techniques into practice, with the child(ren) subsequently not experiencing any improvement in family life.

3.2 A system of CAF audits is now well embedded in the Local Authority which looks at how outcomes are defined and achieved. In addition CAFs are audited as part of the HSCB Multi-Agency Audit process. Both audit processes are undertaken by a multi-agency group and reported to the Board. A new electronic recording system for CAF (eCAF) is being rolled out across the partnership which will improve the performance management of the overall Early Intervention systems including quality of CAFs and reviews and attendance and engagement at reviews.

3.3 The SCR found that the pressures of work for those delivering Early Help services can lead to practitioners working in isolation rather than collaboratively, with the consequence being that staff focus on their own agency's tasks and are less likely to prioritise the need to work with other professionals.

3.4 In addition the SCR found that the role of the CAF Lead Professional across the multi-agency network is perceived as one with limited status. The consequence of this has been that staff undertaking this role have not felt confident to escalate concerns about the work of colleagues in other agencies. This has inhibited multi-agency efforts to provide the right help at the right time.

3.5 Halton's Early Intervention Strategy has been revised. A multi-agency Integrated Contact and Referral Team (iCART) has been set up including staff from early intervention teams, children's social workers, health, education, adult services and police. In addition staff from the Domestic Abuse, Missing and Child Sexual Exploitation commissioned services are in regular attendance. This single front door responds to all Early Intervention contacts and completes where needed a 360 profile of the child's needs and agency involvement to aid the professional who will lead the CAF.

3.6 The SCR questioned whether staff in universal and early help services are sufficiently confident to raise questions about family and household members who could pose a risk of harm to the child. This has been addressed via revision of the Early Intervention Strategy. The HSCB Multi-Agency training has also been revised to raise awareness.

4. Information Sharing

4.1 The SCR found that there is not a robust system for multi-agency information sharing during organisational change. The consequence of this is that although information about the risk to a child can be passed on, it does not always receive the analysis of risk to inform safeguarding decisions.

4.2 The HSCB has asked the Children's Trust to ensure that all partners formally brief and consult the Trust on any changes proposed in service delivery,

structures and responsibility and that this is disseminated across the partnership.

5. **Emergency and Urgent Care System**

5.1 The SCR found that as the emergency and urgent care system is designed to be lean and efficient, when the whole system is under extreme pressure under periods of exceptional demand, that demand cannot be met.

5.2 Cheshire & Mersey Urgent Care network is reviewing pressure on the urgent care system. The local health economy (including Halton) has set up an A& E Delivery Board which has oversight of patient flow and handover times from ambulance to hospital. Halton Clinical Commissioning Group (CCG) has improved the performance management framework for ambulance handover times. In addition an annual programme is in place to improve communication and engagement with the general public to provide information about the appropriate use of urgent care settings including ambulance call out.

5.3 The HSCB maintains oversight of actions developed from the findings of the SCR, scrutinising actions and their related impact on improving safeguarding arrangements for children in Halton.