Luton Safeguarding Children Board Response to the Serious Case Review following the death of Child F.

Myself, and all members of Luton Safeguarding Children Board were saddened by the tragic death of an eight-week baby boy, known as Child F, and would like to extend our sympathies to Child F's family and those that knew him.

The period under review, January 2010 – 17 October 2013, was now some time ago, and each organisation named in the report has made changes and reported them to the Safeguarding Board. As well asking for assurance from organisations in Luton about the changes they have made since the death of Child F, the role of the Safeguarding Board is to address multi-agency working: meaning the join-ups and cooperation between services that should keep children safe, and to tackle areas where that joint working in Luton has not been effective. This response sets out what the Board has done. More detail can be found on the Board's website and in our regular newsletter.

Why do we publish a response to a Serious Case Review?

Government guidance says that *LSCBs should publish, either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done*.

We welcome the opportunity as a Board to give an account of these actions.

Reducing child neglect in Luton

This is a priority for the Board in 2016-2017, based not just on the report about Child F's death, but on a range of data that the Board uses to measure progress. The Board is overseeing the roll-out of a tool, the Graded Care Profile, to help professionals

identify neglect in families, as a basis for doing more effective work with them. This is just one of a range of initiatives led by the Board as part of a plan of work to tackle neglect.

Providing high quality supervision and support to professionals who work with families

The Luton Safeguarding Children Board is responsible for developing multi agency policies and procedures, and Child F's case raised the question of how well agencies in Luton were complying with these. The Board leads a programme of work every year to test out not just compliance, but how professionals understand their role and what the barriers are to effective joint working, because this is the far more important question to ask. Professionals whose work is to protect children need the highest quality of supervision and support from their managers, and commitment to this from the leaders of their organisation. Each organisation named in this review has reported back regularly on the supervision they provide and how far they think their employees (for example health visitors employed by Cambridgeshire Community Services and social workers employed by Luton Borough Council), or professionals who they support with advice (in the case of the team that provides safeguarding support to schools and children's centres) understand their roles, and how supervision promotes this understanding. This is tested out in every programme of work that the Board leads - audit of cases, learning reviews, and training that brings professionals from all agencies together. The auditing of case work and testing out of what goes on in supervision suggests that organisations are giving the time and importance to supervision that it requires.

The workforce and our capacity as a partnership to respond to neglect

The Serious Case Review about Child F raised understandable questions about the children's workforce in Luton during 2010- 2013. Since then the Board has consistently followed this up by seeking assurance and trying to understand the

nature of the problem and support possible solutions. The most obvious example of this is work in the health sector to address capacity amongst health visitors. A common thread across health visiting in the NHS and social work in the local authority has been effective work to reduce the caseloads that individual workers hold, a topic that is regularly reported to the Board.

Clarity about pathways and referrals

The review raised a question about how well local agencies understand the processes and pathways by which they refer children and families to each other's services. Regular detailed information about this has been provided to the Board and the Board leads work to constantly bring professionals together and to test out their understanding of local criteria or thresholds and at the Board to ask what we can do collectively to support this. During October 2016 a planned and significant change took place - the Multi Agency Safeguarding Hub (MASH) for Luton became operational. This seats workers from different organisations together to assess new child protection referrals, with agreement about information sharing and how to make decisions on what happens next with referrals. The Board has asked for assurance about the effect of this new arrangement on identifying and responding to child neglect. The Board also has done consistent work to launch and monitor a model of thresholds for Luton, so that professionals know what the boundaries are for different services. During October 2016 these have been tested out again by the Board. Early feedback is that the thresholds are understood but there are still ways that organisations do business with each other which could be improved to the benefit of children and families in Luton.

Domestic Abuse

The Child F Serious Case Review also asked some broader questions about how well organisations working with children respond to this issue, which we know affects the lives of a considerable number of children in Luton. The strategy for domestic abuse

is led by Luton's Community Safety Partnership, but currently both the children's and adults' safeguarding boards are assessing how well current support works, because there appears to be a wide range of organisations providing it.

How well safeguarding practice responds to the number of families in Luton for whom English is not the first language

All agencies working with families in Luton frequently use interpreters. What the Child F report did not do was test out how widespread the issues were that the report author noted in relation to Child F. This is an area that the Safeguarding Board will now test out in response to the Child F Serious Case Review.

The impact of housing circumstances in relation to neglect

This was another wider question that the Serious Case Review independent author asked. Housing in Luton is now under even greater pressure than at the time when agencies were working with Child F, and the Board is testing out the implications of this for children and their families, and the professionals who work with them.

Fran Pearson
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15th October 2016