

# L S C B



**Luton Safeguarding Children Board**  
Town Hall Extension  
Gordon Street Entrance  
Luton  
LU1 2BQ

Business - 01582 547590

## **Response of the Luton Safeguarding Children Board and member agencies to the Serious Case Review into events leading up to the death of Child E**

The events analysed in this Serious Case Review took place during 2013 and in early 2014. Child E died in January 2014. This report was signed off by Luton Safeguarding Children Board in September 2015. The Board has waited until June 2016 to publish the report because of criminal proceedings which resulted in Child E's mother being found guilty of three counts of cruelty to a child by failing to provide him with adequate food or drink and failing to obtain adequate medical aid and one count of causing or allowing the death of a child. Child E's grandmother was found guilty of two counts of cruelty to a child, one of causing or allowing the death of a child, and one of causing or allowing a child to suffer serious physical harm.

### **Learning and improvements to practice led by Luton Safeguarding Children Board**

Neglect - sadly, this was not an issue confined to Child E's situation. Luton Safeguarding Children Board has chosen neglect, based on the evidence we already have about our population, as one of two priority areas of work for 2016-2017. Amongst the practice improvements referred to in more detail by the two agencies involved with Child E - Cambridgeshire Community Services and Luton Borough Council - is the adoption and evaluation of a consistent assessment tool that professionals can use where they are concerned about neglect - called the Graded Care Profile. The challenge now for the Safeguarding Children Board is to follow through on its programme of action around neglect and to demonstrate in March 2017 what impact this has had.

Secondly there has been learning led by the board based on the experience of conducting a Serious Case Review at the same time as criminal proceedings. Two sessions took place once the trial of Child E's mother and grandmother had concluded. One was to agree and share what the learning had been at a strategic level, and the second, involved managers and practitioners in reflecting on what the experience had been like for them, and hearing from the range of police officers involved in the case about their views and expectations at different stages. This had the effect of greatly increasing understanding about the competing pressures for different professional groups, and the challenge now for the Safeguarding Children Board is to make sure the messages are repeated as professionals come and go.

### **Learning and improvements to practice led by Cambridgeshire Community Services**

The Trust has undertaken a series of progressive actions to strengthen the safe provision of services to children and their families since 2014 when Child E lost his life. At the time of his death the Health Visiting (HV) service in Luton was expanding as part of a three year investment strategy led nationally as part of the Government's 'a call to action' agenda. This national strategy used a standard formula to increase HV staffing numbers which meant that in Luton over a three year period April 2014 and April 2016 the qualified HV workforce has grown by an additional 6.32 whole time equivalent Health Visitors representing an increase of 14%.

At the time of Child E's death the service was therefore undergoing significant change and development and the ratio of newer and newly qualified HV staff members to more experienced staff was high. This meant that several staff were involved in the care of Child E and that in order to provide continuity of care involving numerous staff the clear assessment of need and accurate record keeping was essential.

The service has therefore undertaken a number of actions to strengthen the assessment of need by clinical staff, to audit records and to support staff development through supervision of their practice. Specifically, we:

- engaged an experienced health visitor specialist to undertake one to one supervision with all newly qualified health visitors in the first two years of their practice
- introduced a restorative model of supervision with local practitioners trained as restorative supervisors to support staff to build resilience levels and helping to reduce their own stress levels/burnout
- introduced a caseload monitoring tool to ensure that staffing levels are planned systematically in line with workload
- supported all Health Visitors and School Nurses in the use of a standard assessment tool (Graded Care Profile) as agreed by the LSCB, with further training arranged to sustain skills
- introduced an audit programme which includes audit of the quality of supervision and of training
- introduced electronic systems which enable concerns to be shared in a uniform way with a variety of appropriate professionals involved in the care of children in Luton.

### **Learning and Improvements to Practice led by Luton Borough Council - Children and Learning**

The department has followed up with the learning from both the process and the 3 recommendations contained within the Action Plan pertaining to this Serious Case Review as outlined below.

#### **Recommendation Action 1**

Provide training and supervision to enable practitioners to effectively challenge non compliance to effectively assess the impact of this on children within the family.

#### Progress:

Learning and progress has been made. A new supervision policy was agreed and launched across the C&L Department in August 2015 and the new policy has been entered onto Tri-X. A new monitoring system regarding the frequency of supervision was also introduced and performance management information was

available to the DCS covering quarter 2 and 3 which acted as a baseline for improvement.

This was made available to Ofsted during our recent inspection and they noted the progress made but nevertheless this was included as one of the 12 recommendations requiring improvement.

The monitoring spread sheet was improved in December 2015 and the new report covering quarter 4 will be available shortly.

Additionally as part of the QA process the senior manager's audit concerning the Quality of Supervision took place in February 2016 and was reported through all transparent governance arrangements.

As part of a sustained approach to embed and evidence improvement a new Practice Standard covering Supervision was agreed in May 2015. In June of this year the manager's audit will focus on the observed practice between the Team managers and practitioners in their 1-1 supervision session

Significantly an outcomes based two day supervision course x2 covering the 5 domains of supervision for all team managers, has been agreed for both children and adult staff, with the Learning and Development service. This is now with the procurement service with a planned start date of July. This will involve a 3 line whip regarding attendance.

Additionally The Board undertook an independent review of its training provision in the summer of 2015. It accepted the recommendations that the board should contract its training to the Pan beds unit (managed by Central Bedford council on behalf of Central beds and Bedford LSCB's). The aim with the new SLA is to enable a stronger provision of multi-agency training. The Pan Beds training group is currently drafting a training strategy and will be undertaking a training needs analysis to ensure the new unit focuses its provision on key areas of learning identified from audits, SCR's, research and practitioner feedback.

### **Recommendation Action 2:**

The completion of multi agency chronologies to be shared across all agencies when initial referrals or cause for concerns are made.

#### Progress:

As part of the Departments journey to deliver good services to children young people and their families there have been significant strategic and operational developments to ensure that our new vision becomes a reality.

The identified need to develop multi Agency chronologies has been overshadowed by the significant decision to establish a Multi Agency Safeguarding Hub within Luton. This will enable better information sharing between agencies at the very earliest opportunity. The MASH is due to start operations in Sept.

There are also developments led by the Pan Beds Policy and Practice guidance group to review the guidance on preparation of chronologies and this is due to be completed by Oct.

**Recommendation Action 3:**

Graded Care Profile to be completed and repeated in all cases where neglect concerns are present. GDP is to be shared with all agencies and will require training and role out for all professionals working with children who live within neglectful families.

Progress

The pilot of GCP2 is underway following a training session delivered to 20 practitioners/ managers from early years, education, health and social care testing the tool over the summer. The learning from the NCPCC pilot will help to shape the implementation of GCP2 and its use across services who support families. Plans for full rollout are being developed and have been discussed at the Board.

A handwritten signature in black ink, appearing to read 'Frances Pearson', with a long horizontal flourish extending to the right.

**Fran Pearson**

**Independent Chair - Luton Safeguarding Children Board**

**June 20<sup>th</sup> 2016**