Babergh DHR Multi-Agency Action Plan

RECOMMENDATION	Scope of recommendation	Action to be taken	Lead Agency	Key milestones to enact recommendation	Target date	Progress indicator	Agency response to recommendations	Date of completion and outcome
What is the over-arching recommendation?	Local, regional, or national level?	How relevant agency will make this recommendation happen? What actions need to occur?			From date of publication of report – 13 October 2016.	Red Amber Green		
Recommendation 1: **Any existing protocol that exists between GPs and The Trust for emergency referrals be reviewed and clarity communicated about expectations.**	Local	Review existing current protocols for GP referral to mental health services Develop and agree language used for level of immediacy of referral and assessment Ensure clear and effective processes are in place for communicating referrals, level of concern and outcomes	Michael Lozano, Patient Safety & Complaints Lead Norfolk and Suffolk NHS Foundation Trust Dr Ed Garratt, Chief Accountable Officer Clinical Commissioning Group (CCG)	Review existing protocols Amendments as required Communication to all parties of new protocols Review effectiveness of new protocols	By 31/12/2016 By 31/01/2017 By 31/01/2017 By 31/03/2017		Email dated 15/11/2016 from Michael Lozano – Patient Safety and Complaints Lead, Norfolk and Suffolk NHS Foundation Trust. ***Response:*** The Trust discussed this recommendation with the Clinical Commissioning Group as part of its monthly quality meetings, held on 11	Response from the Board. Form has been amended and updated. Evaluation of the effectiveness of the revised form ***diarised for June 2017.***

							November. Taking account of the time this event occurred and the ongoing monitoring of the Trust's performance it was acknowledged that the current referral process has been embedded into practice now for an additional two years. In this context it was considered whether a change of any language may increase the potential risk of confusion. Where there are four hour assessments being requested GPs have the option of ringing this through to the Trust's Access and Assessment team. This offers opportunity to	

							discuss the elements of the referral and whether emergency (four hours) is the appropriate course of action. GPs also retain the option of sending through by fax, whereupon assessment and telephone contact may also occur. Taking account of this the action examined was about further communication of the current process. Regular communication updates serve to assist the individual in maintaining the desired practice. To this end the meeting identified a newsletter that is shared with CCGs and GPs to which an entry will be	

							made. The Trust will work with the CCG to complete this over the next two months. Ongoing monitoring of the process- There are a number of ways the system is continually monitored and which awareness of the DHR findings are considered. These include a quality reporting system whereby GPs can register concerns regarding aspects of the Trust's performance and a monthly quality meeting held with the CCG. Both the CCG and Trust are informed of the report's findings. Letter dated 18/11/2016 from	

							Dr Ed Garratt, NHS West Suffolk Clinical Commissioning Group (CCG). ***Response:*** To advise that the team have produced a draft report today which needs to be ratified at a meeting with the mental health provider on 09 December 2016, but it appears that key changes were made to the protocol and pathway in 2014 as a direct result of this tragedy. The protocol and pathway have been reviewed by our safeguarding lead and deemed fit for purpose. As part of the investigation we discovered that the existing forms, although they	

							follow the protocol and pathway, are not as clear as they could be, so we have adjusted the form and will be negotiating these changes with Norfolk and Suffolk Foundation Trust (NSFT). The report will be made available to WSCSP as soon as possible after 9 December, when we will be able to circulate the GP communications, and the revised form. The effectiveness of the revised form will be evaluated in six months' time, and reported back to the Board.	
Recommendation 2: **That the Local Safeguarding Children's Board**	Local	Review current support services for families experiencing domestic violence Ensure all staff are aware of services	Sue Hadley, Independent Chair Local Safeguarding	List of support services available	By 01/12/2016		Letter response from LSCB Chair, Sue Hadley dated 17/11/2016. ***Response:*** There is	February 2017 – Further letter sent to LSCB Chair, Sue Hadley.

take steps to ensure that the range of support available is clear to all professionals who engage in work with children and families.		available and have knowledge and understanding of how to access these services for families and offer these services Identify gaps in current provision and develop plan of how to address these gaps to maximise support to families and minimise risk to children and families	Children's Board	Publication / dissemination of above list to all relevant organisations Gaps in service identified Plan developed to address gaps	By 31/12/2016 By 31/12/2016 By 28/02/2017		a new Domestic Abuse Strategy in Suffolk and the LSCB is supporting and monitoring this. The Suffolk Safer and Stronger Communities Group are overseeing this work and the Action Plan includes mapping commissioning of services to develop quality and consistency of service. The Action Plan also includes raising awareness of Domestic Abuse via a dedicated campaign and associated training across the multi-agency partnership. The Local Safeguarding Children's Board website provides a range of policies, procedures and guidance and the	The WSCSP members have requested details of the individual/organisation leading on the Strategy and Action Plan in order to ensure that this work is being taken forward.

							Multi-Agency Safeguarding Hub provides a dedicated Professional's helpline to provide guidance and signposting to services.	
Recommendation 3: **That the Local Safeguarding Children's Board work in partnership with the County's Education Department, C&YPS, the Courts and CAFCASS to review current processes in relation to Court Orders so that it properly supports the children and closes any potential safeguarding gaps.**	Local and Regional	Review current protocols for information sharing for court orders Ensure protocols enable information to be shared when required to minimise risk to children Develop a partnership agreement as to how information is to be shared and how a lead professional in each organisation could be identified to work with the courts and child/young person to ensure effective and relevant information flow and provide support to the child/young person.	Sue Hadley, Independent Chair, Local Safeguarding Children's Board	Current protocols reviewed Clear processes for information sharing in place Partnership agreement in place	By 31/12/2016 By 31/01/2017 By 28/02/2017		Email sent 12 August 2016 by Rebecca Dale, Safeguarding Administrator on behalf of Richard Green, Cafcass National Child Care Policy Manager. ***Response:*** The recommendation is to the LSCB and it is for them to decide whether and how to action it. However, as we previously explained, Cafcass is bound to comply with the Family Procedure Rules regarding the sharing of information, other	February 2017 – Letter regarding recommendation sent to Adrian Orr, Assistant Director for Education. ***Response:*** I do not believe that it is within the sphere of influence of SCC Education and Learning to ensure that Court orders issued in the course of private law proceedings are

							than where this is in the furtherance of child protection. Schools do not fall within that definition, so the permission of the court would be required. Letter response from LSCB Chair dated 17/11/2016. ***Response:*** It was discussed that in this case, the schools knew there were private court proceedings but did not have a copy of the court order. ***Response:*** This is not the role of LSCB but a role for education and CYPS. Education will consider any further guidance or support where there are acrimonious private	routinely shared with schools. Currently, the responsibility sits with the child's parent(s) to share a copy of any such Court order with the school where appropriate. As set out in the response from Cafcass, and included in the DHR overview report, it would require the permission of the Court to enable Cafcass to share such information with schools. As such, I believe that this recommendation reflects a

							law proceedings. This is an Action for Adrian Orr, Assistant Director for Education.	wider issue in relation to Court orders issued through private law proceedings in relation to the exercise of parental responsibility or a child's care or upbringing, and is not necessarily one that can be resolved through a local area partnership agreement, as such information can only be shared within the law. However, we recognise the importance of schools being in

								receipt of all pertinent information in relation to pupils on their roll in order that they may fulfil their duties to safeguard and promote their welfare. I understand that in circumstances where CYPS is asked to complete a s7 (Children Act 1989) report in respect of a child subject to private law proceedings and where the child/family is already known to CYPS

								services, the school would be made aware that CYPS was being asked to complete that report and would, therefore, be aware that private law proceedings were in train. The Department for Education (DfE) issued guidance to schools in January 2016 'Understanding and dealing with issues relation to parental responsibility' which makes it clear that parents should

								‘ensure that schools are provided with a copy of the most recent Court order in place, so that the school’s duties in respect of child safeguarding are supported.’ Education and Learning issues a weekly electronic communication to schools and settings in Suffolk, Suffolk Headlines, containing important news and updates, including safeguarding matters. We will ensure that

								the DfE guidance relating to parental responsibility and Court orders is signposted to schools through this communication channel and remind schools of the need to question parents as to whether any court orders are in place when a child or young person is placed on their school roll and as appropriate thereafter. Additionally, officers within our Resolution team and

								Suffolk Legal are available to provide advice and guidance to schools on matters relating to parental responsibility. An information sharing agreement has been drawn up between SCC and schools with the purpose of facilitating the exchange of information between CYPS and the Designated Safeguarding Leads (DSL) for schools within Suffolk in relation to incidents of

								domestic violence or abuse reported to Suffolk Constabulary where there are school aged children within the family. The objective is to alert professionals within schools to incidents which can be detrimental to a child's overall welfare which may in turn contribute to greater safeguarding concerns. Schools are strongly recommended to sign up to this agreement.

Recommendation 4: That the Local Safeguarding Children's Board work with the local Education Authority to review the policy about recording of incidents such as this within its schools with a view to ensuring all unexplained injuries are recorded and what steps are taken to seek explanation.	Local	Review current protocols for recording all unexplained injuries as noted by schools. Amend and update the above aforementioned protocols as required Ensure all schools are made aware of any changes and their role in recording and reporting any unexplained injuries and that this is disseminated to all staff Ensure all staff have suitable level of safeguarding training and awareness of when and how to report any safeguarding concerns	Sue Hadley, Independent Chair Local Safeguarding Children's Board	Current protocols reviewed Protocols updated Information communicated to all Suffolk schools with clear guidance on informing staff All staff have up to date safeguarding training	By 31/12/2016		Letter response from LSCB Chair dated 17/11/2016. ***Response:*** The current protocol has been reviewed and the current guidance is clear and adequate. It is felt that the school acted appropriately. ***Response:*** Clear and appropriate guidance is given to schools detailing how to record all unexplained injuries. Schools are well informed of the process to refer on concerns and where to access additional advice. Schools are monitored through S175/S157 audits by the Designated Safeguarding leads. There is a robust overview system to ensure staff have safeguarding	February 2017 – Letter regarding recommendation sent to Adrian Orr, Assistant Director for Education. ***Response:*** The DfE has issued statutory guidance to all schools, 'Keeping Children Safe in Education' which makes it clear that all staff members within school should be aware of systems within their school or college which support safeguarding and that these should be explained to them as part of staff induction. The guidance

							training and are aware of safeguarding concerns.	makes it clear that all staff should receive appropriate safeguarding and child protection training which is regularly updated. The guidance further sets out an expectation in the section headed 'Record keeping' that 'All concerns, discussions and decisions made and the reasons for those decisions should be recorded in writing. If in doubt about recording requirements staff should discuss this with the designated safeguarding lead.'

								This statutory guidance is shared with school staff through safeguarding training and regular safeguarding updates communicated through Suffolk Headlines. As referenced by Sue Hadley in her response, schools' compliance with safeguarding arrangements is monitored by SCC annually through S175/S157 audits. Whilst current protocols do not specifically reference the recording of 'any unexplained

								injuries' this is implicit in the clear requirement to record **all** concerns, discussions and decisions. In line with recommendation 4, I will ensure that a specific communication about the need to record any unexplained injuries is disseminated to schools with immediate effect.
Recommendation 5: That CAFCASS reviews its working practice to ensure that all staff completing assessments have adequate levels of quality assurance.		Review current quality assurance process within CAFCASS Amend processes if necessary to ensure that there is sufficient senior level quality assurance of the work undertaken Ensure all staff have up to date safeguarding training and awareness of when to report any concerns	Richard Green, Cafcass' National Child Care Policy Manager				Email sent 12 August 2016 by Rebecca Dale, Safeguarding Administrator on behalf of Richard Green, Cafcass National Child Care Policy Manager. ***Response:*** This seems an odd recommendation in	

							light of one of the findings of the report (page 62) is that Cafcass has a fit-for-purpose system of quality assurance. However, (and more pertinently) the mechanisms by which Cafcass quality assures have been reviewed several times since these deaths occurred nearly two years ago. In February this year we produced an updated Quality Assurance and Impact Framework. Establishing that work is of the required standard is undertaken by a range of different mechanisms including: performance and	

							learning reviews; situational supervision; national audits of safeguarding practice (which have found sustained improvement); thematic audits; Area Quality Reviews; dip sampling by senior managers etc. We are not persuaded currently that a further formal review is required. Can we suggest therefore that the recommendation is removed?	
Recommendation 6: That the Home Office consider adding CAFCASS as a statutory body within the meaning of the Act.	National	For the Home Office to review role of statutory bodies within the Act and whether CAFCASS should be an addition	Christian Papalleontiou, Chair of the DHR Quality Assurance Panel Home Office				30/11/2016 Letter sent to Mr Christian Papalleontiou, Chair of the DHR Quality Assurance Panel at the Home Office. Although the Lead	13/01/2017 – Response received from Chair of the Home Office DHR Quality Assurance Panel – Christian Papaleontiou. The Home

							Agency for Recommendation 6 is the Home Office, a letter from LSCB Chair dated 17/11/2016 has included a response to this Recommendation. ***Response:*** Section 13 of the Children Act 2004 sets out those organisations who must be included on LSCB membership as a statutory partner. Cafcass are included on this Statutory list. Although this is a Cafcass recommendation, on reading the DHR and considering the current Serious Case Review undertaken by the LSCB, a question has arisen to be put to Cafcass. 'When an immediate	Office have discussed CAFCASS involvement and in relation to DHRs, CAFCASS seeks the court's permission for disclosure on a case by case basis. The Home Office are keen to ensure that the resources CAFCAS have available are primarily invested in Serious Case Reviews. ***CAFCASS will not to be included as a statutory body within the meaning of the Act for DHRs, although the Home Office will keep this under review.***

							disclosure is made and/or immediate Child Protection concerns are identified, is it clear to all Cafcass staff that in addition to completing their assessment as agreed in the LSCB should be made to the Local Authority, CYPS?'	
Recommendation 7: That a clear County-wide partnership governance structure be established for the strategic leadership of domestic abuse within Suffolk	Regional	Identify and gain agreement of key organisation required to develop a county wide strategic leadership approach Develop a governance arrangement for strategic leadership for domestic abuse across Suffolk Identify leads for domestic abuse within each organisation Develop clear terms of reference for strategic roles to enable each organisation to understand their role and function within the county in preventing and reducing harm caused by domestic abuse.	**Chair of Community Safety Partnership to co-ordinate with Police and Crime Commissioner ** Following the WSCSP meeting on 15 November 2016, WSCSP members agreed that the Lead Agency for this Recommendation is incorrect and should be amended to the Health and		By 31/01/2017		Letter sent 14/12/2016 to Chair of Suffolk Health and Wellbeing Board, Tony Goldson. ***Response:*** 28/01/2017 Letter received from Cllr Tony Goldson, Chair Health and Wellbeing Board providing an update on progress in relation to each of the actions listed	06/06/2017 Contacted DHR Author GG for clarification on Action 4 regarding clear terms of reference for strategic roles. GG advised that since the action plan was produced at the time of writing there was no clear governance for multi-agency strategic development of

			Wellbeing Board being the Lead Agency. Ian Gallin, Chair of Suffolk Health and Wellbeing Board				in the DHR action plan and, where we feel more clarity is needed in order for us to accurately respond. Identify and gain agreement of key organisations (Action 1) **Response**: Agreement made by all HWB members in September 2016 for them to take the strategic responsibility for DA in Suffolk and for the SSCG to be responsible for the implementation following the Suffolk Domestic Abuse Interim Review. SDAP will be the consultative/co-	DA across the county. Part rested with the police, part with the police and crime commissioner, part with the local authority. When GG asked what was the governance for DA across the county no-one could say. However, since then this work is being progressed County Wide and a Domestic Abuse Interim Report has been produced

							design partnership. Develop a governance arrangement (Action 2). **Response:** As above. Identify leads for DA within each organisation (Action 3) **Response:** The organisations/services which form the statutory membership of the HWB all have specific DA leads or lead officers with responsibility for safeguarding, which includes DA. Develop clear terms of reference for strategic roles (Action 4). **Response:** I am not	

							clear which strategic roles you are relating to, however, the HWB and the SSCG all have terms of reference which can be made available to you.	