Sutton Local Safeguarding Children Board

Response to the Preventing Future Deaths (PFD) report

1. It is important to note at the outset that Sutton Local Safeguarding Children Board (hereafter 'LSCB') welcomes the PFD report. This response only deals with those matters which are directly relevant to the LSCB in the London Borough of Sutton. However, the LSCB has noted the entirety of the PFD report and taken on board its recommendations in full.

2. The process of implementing the learning from the Serious Case Review (SCR) has focused on much more than the recommendations set out by the Independent Author in the SCR Overview report. The single agency Individual Management Reviews (IMRs) which underpin the SCR are completed by authors who have not been directly involved with the child or the family or have had any direct line management responsibility of those involved. It involves undertaking a small scale audit of records held by the agency on the individual case to draw conclusions about learning to improve practice and systems within the organisation.

3. The implementation of the actions identified in the single agency Individual Management Reviews (IMRs) has been reviewed by the LSCB Case Review subgroup alongside the action plan to implement SCR recommendations. A total of 52 actions have been the subject of scrutiny by the LSCB to implement the learning from the Ellie Butler case review. Sutton LSCB has also held a scrutiny and challenge event to satisfy itself that every effort has been made to seek assurance that learning has been embedded into practice.

Role and Function of the Local Safeguarding Board

4. Section 14 of the Children Act 2004 states that the role and function of a LSCB is 'undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned'. The LSCB has no powers to instruct partners to implement recommendations from Serious Case Reviews, instead the role is:
    - To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the LSCB's area and;
    - To seek assurance and challenge organisations to ensure the effectiveness of what is done by each such person or body of those purposes.

Implementation of recommendations in the Ellie Butler SCR Overview report

5. On 13 February 2017, Ofsted published an Inspection report, which judged the LSCB to be 'Good'. The key findings were that:

   'The Board has undertaken an extensive range of work to ensure that the [serious case review] learning reaches practitioners, managers and leaders, and improves practice. Recurring and important themes from individual reviews, collated into a 'heat map', help to identify visually the learning points, and these form actions in a delivery plan for individual sub-groups to oversee. Findings have led to increased specific commissioned services, for example, integrated services to support young people who have emotional difficulties.'

6. The learning from the Ellie Butler case review started long before the publication of the SCR as agencies undertook to implement IMR action plans that were developed at an early stage of the SCR process.

7. The LSCB business also undertook to implement the learning from the case review through the business planning process and there is a requirement under Working Together (2015) to undertake an annual review of the effectiveness of the LSCB.

   'The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period'

8. The LSCB annual report informs the priorities for next year's business plan and Sutton LSCB identified that learning must include the safeguarding leadership. In the past three years the LSCB has hosted a number of events attended by local safeguarding leaders and Elected Members. The list below covers topics covered at leadership events that relate to the learning from the Ellie Butler case review.

   a) SCB School Leadership event 18 Nov 2015, chaired by the Independent LSCB Chair;
   b) LSCB Effectiveness seminar 14 April 2016, chaired by the Chair of the Quality Assurance group, who is the Clinical Children's Services Director for Sutton Community Health Services Royal Marsden NHS Foundation Trust;
   c) Learning from the Ellie Butler SCR event 14-15 September 2016, chaired by the Independent LSCB Chair;
   d) Neglect workshop 22 September 2017, chaired by a Sutton primary school head teacher;
   e) Listening event with voluntary and community groups, chaired by the Chief

Executive of Sutton Centre for Voluntary Services;

f) MARAC 10th Anniversary event and Learning from Domestic Homicide Reviews, led by MARAC members with an opening speech from the Mayor of London Borough of Sutton.

9. The above list include three large multi-agency events to disseminate the learning from Ellie Butler's case review. The events were hosted by the Independent LSCB Chair and the programme focused on the Independent Author sharing the details of the extensive investigation into the circumstances that led to the death of Ellie Butler. The author also explained the recommendations in more detail and responded to questions from participants alongside the Independent Chair.

10. The 14 September 2016 Learning from SCR session was held specifically for head teachers, designated safeguarding leads and governors. It provided further insights into the experience of schools and the management of responses when a child dies and allowed the school leadership to reflect on any changes they would need to undertake as a result of the recommendations in the SCR Overview report.

11. A total of 179 participants attended the three multi-agency SCR learning events and represented organisations in the LSCB network (LBS children's social care, commissioners and other Council staff, health, schools, and the voluntary sector).

12. The LSCB Learning and Development Strategy is underpinned by the Section 11 duty of the Children Act 2004, and for schools this duty comes under Sections 175/157 in the Education Act 2002. This legislation sets out employers' responsibilities for ensuring that staff are trained to fulfil child safeguarding duties. Sutton LSCB regularly seek assurance that single agencies are Section 11 compliant, and the most recent audit was undertaken in 2017 with scrutiny of the implementation of action plans continuing into 2018. The Education Safeguarding Lead undertakes an annual visit to schools to review compliance under Sections 175/157 and provides assurance to the LSCB.

13. In 2017, the LSCB training programme was re-commissioned and trainers are now required to incorporate learning from SCRs into core training modules to transfer learning into practice. The core module on "*Working with Hostile and Resistant families*" has been rolled out and continues to be included in the multi-agency training programme. In addition, there is a module on the same theme to meet the needs of social care professionals that focuses on assessment and care planning.

14. On 3 November 2015, safeguarding nurses held the first learning from SCR training course which incorporated learning from the Ellie Butler case review although the report was not yet published. There is now a core 'Learning from SCR' module in the LSCB training programme which is delivered jointly with a head of service in

Children's Social Care, safeguarding nurses, and specialist safeguarding social workers.

15. The SCR 'heat map' approach involved mapping recurring themes from the Ellie Butler SCR and other local learning reviews. It resulted in the following main eight SCR 'heat map' themes:
    a) Information sharing
    b) Record keeping
    c) Domestic violence and routine enquiry
    d) Missed appointments and follow up
    e) Supervision quality and processes
    f) Escalation of concerns
    g) The combination of parental risk factors; mental illness, domestic abuse and substance misuse
    h) The role of fathers, significant males and carers in children's lives

    The purpose of this exercise was to ensure SCR learning was transferred and fully embedded into practice. The LSCB and Children's Social Care learning and development programmes were reviewed to incorporate the SCR 'heat map' themes. It now underpins the LSCB multi-agency child protection training core modules and the Learning SCR module.

16. Children's Social Care has provided assurance to the LSCB that the Social Work Supervision has been reviewed and that there are robust systems in place to review the frequency and quality of supervision.

17. The LSCB audit tool for multi-agency case reviews/audits, practice observation template, and self-assessment template incorporates the SCR learning themes and provide the basis for assurance to the LSCB where practice has been improved as a result of multi-agency learning reviews or case audits. It also highlights areas for improvement or service development where weaknesses have been identified. The QA subgroup reports to the LSCB as a standing item to highlight key findings from learning reviews, and multi-agency audits.

18. On 7 September 2016, the LSCB held a scrutiny and challenge session with local individual agencies who had completed IMRs. A template was sent to external agencies to complete for assurance. The focus of this session was to review the recommendations set out in the action plan in the SCR Overview report, and challenge was provided where insufficient evidence was provided. The result of this exercise is set out in the Appendix.

19. The recommendation set out in the SCR Action Plan, which relate to the role of the Judiciary, was as follows:

    'The position of the Courts, and specifically the Judiciary in respect of SCRs should be clarified. In this case the request for an IMR was declined; no other form of report, other than a copy of the Judgement, was provided and there was no representation from the Courts Service (HMCTS) on the SCR Panel. Given the significance of Court judgements in this case, this lack of engagement raises questions that require serious consideration at a national level. The findings of this SCR should be brought to the attention of the President of the Family Division and the Family Justice Council. They should be asked to respond and to clarify the responsibility of the courts to LSCBs in respect of Serious Case Reviews.'

20. The completed action and outcome was reported in the Chair's foreword and other sections of the last published Sutton LSCB annual report 2016-2017. The Independent LSCB Chair first wrote to Sir James Munby, the President of the Family Division, on behalf of the LSCB, to request clarification on the role of the Family Judiciary to contribute to Serious Case Reviews under Working Together statutory guidance.

21. The Independent LSCB Chair and Independent Author met Sir James Munby, the President of the Family Division, on behalf of the LSCB, to request clarification on the role of the Family Judiciary in contributing to Serious Case Reviews under 'Working Together to Safeguard Children' (2015) guidance.

22. In May 2017, the *'President's guidance: Judicial Cooperation with Serious Case Reviews'* confirmed that Judges should provide every assistance to SCRs where it is compatible with judicial independence. Sutton LSCB takes the view that this guidance is a direct outcome of the Independent Author's recommendation and the Independent Chairs involvement to seek improvements within the Family Judiciary.

The effectiveness of local safeguarding arrangements

23. Sutton LSCB assesses the effectiveness of local safeguarding arrangements by requesting that agencies undertake Section 11 compliance audits under the Children Act 2004. It involves local agencies and commissioned services undertaking a self-assessment based on criteria set by the London Safeguarding Children Board. The key features at a strategic level are to provide assurance about the following standards:
    a) Senior management commitment to the importance of safeguarding and promoting children's welfare
    b) A clear statement of the agency's responsibilities towards children is available for all staff
    c) A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children

d) Service development takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families
e) Staff training on safeguarding and promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in contact with children and families
f) Safe recruitment and employment practices are in place
g) Effective inter-agency working to safeguard and promote the welfare of children
h) Information sharing

24. Sutton LSCB also regularly undertakes themed multi-agency case audits based on the audit tool that now incorporates the themes of learning from SCRs. In the last year, the quality assurance process has been extended to undertake a mock Joint Targeted Area Inspection (JTAI) which focused on the criteria set out in the Government's Inspection guidance on the multi-agency response to children living with domestic abuse. It entailed the following:
    a) An assessment of the application of threshold for referral and assessment by reviewing a random sample of contacts from local agencies, schools, other Boroughs, and the public which had been processed by the Multi Agency Safeguarding Hub (MASH). This involved joint scrutiny by the Detective Chief Inspector of the Borough Police, the Designated Safeguarding Nurse, a head teacher of a Sutton school, the Assistant Director of Children's Social Care and Safeguarding, and the Head of Service for MASH.
    b) Heads of Service and the Assistant Director in Children's Social Care observing practice in the multi-agency Strategy Meetings and Child Protection Conferences which are held under Section 47 under Children Act 1989.
    c) Senior management observation of a Domestic Violence Multi Agency Risk Assessment Conference (MARAC). This is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation, and other specialists from the statutory and voluntary sectors.
    d) Telephone interviews were undertaken with services users to assess their experience of the service which did not raise any issues of weaknesses in practice.
    e) Sutton LSCB requesting that local partner undertake a self-assessment of a random sample of cases that had been subject to a social work assessment under the definition of 'child in need' Children Act 1989. It involved individual agencies and schools auditing records held on the child that was subject to the review.

    The findings of the mock Domestic Violence JTAI were analysed independently and aggregated to provide assurance to the LSCB about the quality of practice and identified areas of improvement.

LSCB multi-agency Learning and Development programme

25. The function of the LSCB under Section 14 in the Children Act 2004 covers 'training of persons who work with children or in services affecting the safety and welfare of children'. Training is not limited to multi-agency training courses and includes a wide range of learning and development activities including in-service training and 'bite size' learning sessions, shared expertise, e-learning, practice observations, workshops, and conferences.

26. Sutton LSCB has a dedicated Learning and Development (L&D) subgroup to jointly review and develop course modules to strengthen multi-agency working and formally approve the annual L&D programme. Sutton LSCB annual L&D programme is published on the LSCB website and promoted widely to partners.

27. The LSCB L&D subgroup also brings together professionals to deliver training jointly in policy and practice areas that are identified as key priorities in the LSCB Annual Report. The L&D subgroup Chair is responsible for publishing the LSCB Annual L&D Report and attends Board meetings to report on the effectiveness of the L&D programme, which includes making recommendations to address any weaknesses. The Annual L&D report is published on the LSCB website and circulated to all partners.

28. Sutton LSCB partners are able to access the Council's Research in Practice (RiP) subscription which provides practice briefings based on recent research and government policy. RiP was commissioned to disseminate the learning from pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011-2014. The site includes materials to support learning in practice for LSCBs, social work and early help, police and criminal justice, health and education practitioners and has been disseminated widely within the local safeguarding network.

29. Sutton LSCB are also able to access Research in Practice for Adults (RiPfA) resources. RiPfA has been instrumental in developing learning material to disseminate learning about coercive control which is the underlying feature of domestic abuse and an offence in law. It was the main theme of the Annual Social Work conference in 2016, held jointly between adult and children's services. It covered a presentation from Women's Aid and RiPfA with material being disseminated at all levels within the service. The RiPFA coercive control webinar is offered regularly to staff in adults and children's social care teams.

30. The LSCB core training programmes continue to include "*Working with Hostile and Resistant families*" and there is a module on the same theme for social work practitioners which focuses on embedding the learning into assessment and care planning. A new course module is introduced this year to promote the 'Men and Masculinity' perpetrator programme which is targeted to social workers across adults and children's services. The LSCB L&D programme also has core domestic abuse course modules which include 'Domestic Violence and the impact on children'.

31. The LSCB also holds regular leadership events which include local Councillors, Executive Directors, senior management, and safeguarding leads. A conference is held this year to mark the 10th anniversary of MARAC and will include learning from local MARAC cases and Domestic Homicide Reviews (DHRs). The London Borough of Sutton has not had any cases that meet the threshold for undertaking a DHR but recognise the importance of embedding learning from national reviews. Sutton LSCB work jointly with the Sutton Safer Partnership (SSP) to extract learning from the DV MARAC, and assurance is provided to the LSCB through an Annual DV MARAC Report.

32. The LSCB has made Domestic Violence (DV) a standing agenda item at Board meetings to influence the Council's substantial investment in the DV transformation programme and the local DV and Violence Against Women and Girls (VAWG) strategy. The programme has already made a difference to strengthening front line practice as there is now a DV Safeguarding Social Work Specialist role. The role includes working closely with frontline practitioners in Children's Social Care, advising partners and schools on cases that include DV, preparing, chairing and contributing specialist DV knowledge to multi-agency meetings (strategy meetings, child protection conferences, and the DV MARAC). The DV co-ordinator for MARAC is also now located in Children's Services to facilitate closer working with frontline staff and the management.

33. The Chair of the DV Partnership Group is a member of all LSCB subgroups and attends the LSCB for specialist input when required. The Chair also delivers the DV training modules in the LSCB L&D programme which helps ensure that learning from local practice and case reviews is embedded into practice.

Appendix 1: Child D Action Plan

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN		
RECOMMENDATION	**ACTIONS**	**ASSURANCE TO THE LSCB**
1. Cafcass		
1.1. The Children's Guardian to seek supervision on complex cases.	A Quarterly Performance Learning Review has continued for all practitioners, as set out in Cafcass Operating Framework, including regular supervision and consultation on demand.	On 18.08.2016, an invitation was sent to the Cafcass LSCB Board representative to attend Sutton LSCB's Challenge event to scrutinise the completion of actions. The SCR action plan was attached with the template to provide assurance in writing if unable to attend. There was no response to this request. Cafcass had previously confirmed in a letter to Sutton LSCB the name of the Cafcass LSCB representative. The arrangement to send a representative to attend Board meetings had ended at this point which meant that there was no direct contact.
1.2. Liaison to take place with the IRO whilst children are accommodated.	Cafcass *Operating Framework* that the Guardian will make contact with the IRO at the start and conclusion of proceedings and, as required, during the proceedings. Standard letters have been produced to facilitate this.	See above.
1.3. Comprehensive information about relevant aspects of parents' past histories being established.	It is generally set out within the local authority application. Where it is not (either because of e.g. the urgency of the application or a lack of parental co-operation) the Guardian would be expected, in line with the Public Law Outline, to identify this within his/her 'gap	See above.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
	analysis' and to advise the Court at the Case Management Hearing. It continues to be the practice from the reading of reports by Guardians. There is continued quality assurance of Guardian reports.	
1.4. Consideration of the risks to the child's safety and welfare where the parents do not co-operate with the local authority.	The plans are better (in terms of safety for children) during proceedings. There is continued quality assurance of reports and case plans.	See above.
2. Education		
2.1. All schools maintain the levels of Safeguarding/CP training for their staff and the specific training for Designated Persons.	An annual programme of safeguarding training is being delivered. 100% of schools access the training as required through legislation and guidance. The attendance records are kept centrally in the Education Safeguarding Service.	There is an established process for the LSCB to seek assurance that schools fulfil child safeguarding arrangements through the S.175 regulation under the Education Act 2002. In Sutton this involves the Education Safeguarding Adviser visiting each schools to check their records against a template which is updated regularly to include policy changes that relate to the Department for Education (DfE) Keeping Children Safe in Education requirements. Child safeguarding is also

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
		subject to inspection under the Ofsted school inspection framework. Each school keeps a record of child safeguarding training which is checked as part of the annual visit. The Education Safeguarding Adviser provides an S.175 annual assurance report to the LSCB.
2.2. Record keeping content should be adjusted so that all information is passed from one school to another, including where there is engagement of an independent social worker supporting a family.	There is seamless transitions of records and timely liaison with all social care services. The LSCB School Leadership event addressed transfer of record keeping and sought assurance of improvements through an action plan.	Sutton LSCB has been assured that the Education Safeguarding Lead co-ordinates and holds an annual child protection file handover day. The third event is scheduled to take place in June 2018. This is a direct outcome of the learning from the Ellie Butler SCR and has been incorporated into procedures for local schools. It also provides an opportunity to discuss any pupils that are subject to child in need support with colleagues and designated safeguarding leads who attend the event.
2.3. Information sharing protocol and expectations should be drafted as a model for all schools to use and share with independent social work providers in future. These should include the process by which schools will make complaints about independent social workers and how to	Schools are capturing concerns on a pro forma and referring to Education Safeguarding Lead who in turn will escalate to line manager at Executive Director level. There is no protocol and instead schools have been advised to use LSCB escalation policy and procedure which has a flowchart covering information sharing processes. The document was circulated to schools 25.01.2016.	The LSCB hold a copy of the email circulated to schools with the attached Sutton LSCB escalation policy and procedure.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
escalation concerns to the local statutory services.		
3. Health Overview (Sutton CCG)		
3.1. Agencies involved in this review should be reminded of the theoretical frameworks to inform professional practice and these re-launched through a variety of mechanisms including: • Safeguarding training • Safeguarding supervision processes • Reflective practice opportunities • Feedback from learning reviews, including this Serious Case Review Audit processes	Providers provide assurance to the CCG that they are using the frameworks and discussing them, and by what mechanisms. This includes Section 11 audits. The CCG regularly provide assure to the LSCB through the new assurance dashboard. This is evidenced by minutes from LSCB QA meetings.	Sutton LSCB seeks assurance from the CCG and a system is in place to provide a six monthly Health Assurance report. The report is based on S.11 standards, and reports on compliance by all commissioned health providers. The report is also subject to scrutiny by the CCG Health Assurance Committee and the LSCB Business manager attends these meetings. The Designated Safeguarding nurse regularly provides child protection training to GP practices and they are all required to keep a training records as part of CQC inspection requirements. Health providers also have their own training providers alongside the training that is available in the LSCB Learning and Development programme. On 22.11.2017, a Health Leadership event which involved a Consultant Paediatrician & Professor of Child Health. The presentation focused on learning from Serious Case Reviews and safeguarding practice to explore the concept of authoritative practice in children's safeguarding. It also covered the three NHS core values which are authority, empathy and humility. Sutton LSCB has also been assured that Child Safeguarding Supervisors Training has been held for Health Economy leads to further support learning from case reviews and reflective practice.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
3.2. Sutton CCG require each agency within their health economy to increase staff competency relating to the co-existence of domestic abuse, mental ill health and substance misuse, and to provide evidence of compliance on a quarterly basis via safeguarding metrics.	The LSCB dataset has been reviewed to include domestic abuse, mental ill health and substance misuse. The training needs have been shared with the LSCB Learning and Development Group and covered by the training programme. The dataset has been agreed by the LSCB and data is now being collected through CCG and reported on to the LSCB QA subgroup.	Sutton LSCB hold copies of six monthly CCG Health Assurance report, based on S.11 standards, which includes health providers take up of child safeguarding training. The reports are scrutinised by the LSCB QA subgroup and highlights are reported to the full LSCB. Sutton LSCB programme covers domestic abuse, mental ill health and substances misuse and is available to all health providers alongside their own programme of training. The core child protection training modules include the co-existence of the above parental causes for concern in the context of responding to risk and contributing to social work assessments.
3.3. Sutton CCG Board must understand and be assured that appropriate governance arrangements are in place to code safeguarding issues in GP Independent Services.	This action was included in a letter sent to all GPs from the case review co-chairs in December 2015. All Sutton GP practices have undertaken self-assessments and have improvement plans to address gaps as necessary. The coding has been updated and an audit has been undertaken. The audit findings are used to identify any practice or	The annual audit is a requirement for commissioned GP practices as part of the Personal Medical Services Contract. GP's are required to submit an annual safeguarding assurance template at year end this includes an audit requirement for vulnerable children. A read code project has been completed and practices have access to an electronic template for agreed codes for safeguarding. These codes include statutory plans, domestic violence and codes for families causing concern.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
	training issues to address any change required linked to this recommendation.	
3.4. Sutton CCG Board require each agency within their health economy to provide evidence of direct discussions with children and young people during healthcare contacts	All healthcare economy providers, commissioned and independent, have been advised that agency audit cycles must include the elements that reflect that the voice of the child is heard and acted upon. This followed the ratification of this health overview report. The voice of the child is a section on the section 11 audit template. The CCG is seeking assurance and evidence through the health dashboard.	Sutton LSCB hold copies of six monthly CCG Health Assurance report, based on Section 11 standards, which includes health providers take up of child safeguarding training. The reports are scrutinised by the LSCB QA subgroup and highlights are reported to the full LSCB. The reports are also subject to regular scrutiny by Sutton CCG Health Assurance Committee.
4. Epsom and St. Helier University Hospitals NHS Trust		
4.1. Develop a Trust Domestic Violence and Abuse Policy in accordance with NICE guidance published in February 2014.	The Domestic Violence and Abuse Policy is in place and available on the intranet.	On 17.12.2014, the Epsom and St Helier Hospital Trust Executive Committee formally endorsed the Domestic Violence and Abuse Policy. Sutton LSCB hold a copy of the policy and have been assured that it is available to staff on the Trust Intranet. The Domestic Violence Policy was updated in January 2018 to align with new local and national changes.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
		The Trust also developed a Domestic Violence Workforce Policy in January 2018. The policies are available on the Trust Intranet and were published on the Trust e-Update prior.
4.2. Develop a rolling programme of Domestic Violence and Abuse.	Initial training has been provided for staff working in maternity and Emergency Duty Urgent Care Centre. Sutton LSCB has been assured that Domestic violence is included in all levels of CP training. IN 2015 Midwives received targeted DV training as part of the Level 3 update. Over 2015/2016 ED staff received a programme of bitesize training including DV and lessons plans have been provided for assurance. There is now a hospital based Independent Domestic Violence Advisor (IDVA) at St Helier Hospital in the London Borough of Sutton that work closely with staff to identify and support victims of Domestic Violence.	The Trust has been proactive in promoting and raising awareness of Domestic violence. A number of activities have been undertaken, including participation in the 'Blooming Strong' campaign in November 2017 which was held in the Trust. The campaign was well received, and this will now be an annual event jointly facilitated with the Sutton MARAC Lead. In February 2018, a further DV awareness event was also held. The Trust also has in place a DV Lead and DV champion in ED, and a Hospital based Independent Domestic Violence Advisor (IDVA). A rolling programme of DV training remains ongoing. A bite size training package was developed and is now being delivered by the ED Practice Educators.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
4.3. Continue dip sample audit of ED and maternity records so that staff respond appropriately when coming into contact with people who experience domestic violence and abuse.	A dip sample audit was undertaken January 2014, and a re-audit took place in April 2014. Ongoing re-audit.	Sutton LSCB has been assured that a dip sample audit was undertaken of ED and Maternity records in 2016. Last Audit has been attached. This is part of the programme of Domestic Violence routine enquiry to identify and provide support to victims. A presentation of the audit findings was provided to the LSCB QA subgroup for scrutiny, and the highlights were shared with the full LSCB. DV Dip Sample Audit was undertaken during February and September 2017 in ED; to ascertain evidence of a routine enquiry in respect of domestic abuse when patient presented to ED. A number of required improvements include continuing awareness raising and creating a pocket size aide memoir. A further audit is planned in September 2018 to determine if improvement is evident.
5. St. George's Healthcare NHS Trust		
5.1. The introduction of ward risk assessment tool.	An action plan is in progress to address ward risks, therefore a further action plan was not recommended.	On 26.09.2016 Sutton LSCB received assurance from St George's Healthcare NHS Trust, signed off by the Chief Nurse that: Age specific risk assessment tools were put in place 15/03/2014 to enable frontline staff to assess the level of risk and escalate concerns as soon as possible. The risk assessment also looks at the best way to support children and young people an example being if a young person requires 1:1 care from a registered mental health nurse. The risk assessment tool is also on the audit schedule.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
5.2. The involvement of the named doctor in complex cases.	An action plan that addresses this recommendations is in progress.	On 26.09.2016 Sutton LSCB received assurance from St George's Healthcare NHS Trust, signed off by the Chief Nurse that: There is a weekly complex cases meeting held – chaired by the consultant of the week, a weekly safeguarding teaching session led by the Named Doctor and staff can access the Named Doctor to discuss cases of concern when they arise.
5.3. Learning from this IMR is summarised and widely shared throughout the paediatric workforce, in particular the emergency department consultants, consultant paediatricians and their teams.	The IMR and its findings have been discussed by the relevant teams.	On 26.09.2016 Sutton LSCB received assurance from St George's Healthcare NHS Trust, signed off by the Chief Nurse that: This action point was completed shortly after the IMR was signed off as the implementation of the risk assessment required the sharing of learning to take place as soon as possible.
6. **Chelsea and Westminster NHS Foundation Trust**		
6.1. Develop a rolling programme of domestic abuse awareness training.	Training attendance will be reported to the Adult Safeguarding Board.	Sutton LSCB has received assured that a Domestic Abuse training course has been designed, commissioned and delivered. On 16.08.2016 a letter was sent to Chelsea & Westminster NHS Foundation Trust with the SCR action plan to request further assurance that the IMR/SCR recommendations/actions had been fully implemented and sustained over time but there was no response.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
6.2. Develop training for leads (domestic abuse leads) to be support in wards and departments in leading domestic abuse advice	The course has been designed, commissioned and delivered. Training attendance is reported to the Adult Safeguarding Board.	No further assurance received.
6.3. Define organisational response and responsibilities for supporting people at risk of domestic abuse	The policy has been approved with the Trust. There is a yearly review of policy by the domestic abuse workgroup	No further assurance received.
6.4. Appoint a Hospital based Independent domestic abuse advocate with administrative support to co-ordinate training and engagement	Letter sent to tri-borough Independent LSCB Chair to request response since no response from tri-borough safeguarding manager. The action is now closed.	No further assurance received.
6.5. Enhance documentation of disclosures of domestic abuse and how information can be shared with appropriate agencies	A unified functionality has been developed within hospital Electronic Patient Record (EPR) to keep a Social Information log. This includes a function to 'flag' or alert staff to documentation of	No further assurance received.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
	risk. It is also possible to track how information has been shared. The system is now in place to generate reports. The reports have been shared with the safeguarding committees' and work is underway to develop the learning. There is ongoing monitoring and review of functionality and user experience to enhance the log.	
6.6. To enable staff to be aware of the services and resources available to support a person's disclosure of domestic abuse and their onward access to advocacy services (see IDVA) action above. For staff to be competent to conduct the Co-ordinated Action Against Domestic Abuse (CAADA) – DASH Risk Assessment Tool. Clarify	The development of a 'library of information' accessible to all staff about local domestic violence services and risk assessment	No further assurance received.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
referral process to MARAC.		
6.7. Review escalation procedure in Child and Young People's Safeguarding Policy	An audit of the quality of referrals has been completed.	No further assurance received.
6.8. Adult DNA (Do Not Attend) follow up procedure to be put in place.	An audit of DNA escalations has been completed.	No further assurance received.
7. GP Services: Sutton and Merton		
7.1. GPs should attain Level 3 training in Safeguarding Children and this needs to be a priority.	Level 3 training in place, and available to all GPs in Sutton. CCG is seeking assurance from GP practices on training attendance and report back to the LSCB. The training data is included in the LSCB L&D report.	Sutton LSCB has been assured by the CCG that: Annual KPI requested at year end from practices for compliance for GP's at level 3 – 100% in 24 out of 26 practices as at 31st March 2016. No response from 2 – this has been followed up and training in place. Safeguarding Training Strategy and Directory for 2016/17 in place and signed off. Sutton LSCB hold a copy of the directory.
7.2. All practices should give priority to the summarisation of the medical records of	The GP validation programme has been completed, and development work took place in 2015.	Sutton LSCB has been assured by the CCG that:

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
children newly registered with the practice		GP Safeguarding Scheme completed in March 2016 – final report available on request Further briefing on learning from Child D sent out to GP Safeguarding Leads following publication. Sutton LSBC hold a copy of the briefing.
7.3. Priority should be given to recruit a Named GP for Safeguarding Children in Sutton	Completed.	Named nurse recruited in post April–July 2016 (left in July) Out to recruitment for Named GP if not successful to seek named nurse GP safeguarding lead quarterly forums in place with good engagement from practices. Practice manager update annually.
8. South West London and St. George's Mental Health Trust		
8.1. All current and historical safeguarding or welfare concerns should be included in referrals to Improving Access to Psychological Therapies (IAPT) services.	The triage document has been reviewed to record whether a service users currently are, or have, received support from local authority Children's Services.	Sutton LSCB has been assured that: At the point of triage, all referrals are asked regarding who is in their family, contact and caring responsibilities for children under 18 years and any child or adult safeguarding concerns currently or in the past. Any child safeguarding queries that may require further detail are raised with the supervisor and escalated if required to the trust Named Nurse or Doctor or Safeguarding adults lead in the case of an adult reporting historical abuse.
8.2. Historical or overturned safeguarding concerns should be reviewed and	Completed.	Sutton LSCB has been assured by that this action has been completed.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
confirmed with the referrer.		
9. Sutton and Merton Community Services (hosted by Royal Marsden NHS Foundation Trust)		
9.1. Review of the role of the link health visitor with allocated GP practices	GPs have been informed of lead HV for team. Practice managers now notifying HVs of Antenatal, New and Deregistration. . Ongoing work between health visiting teams and GP practices to maintain and improve engagement.	Sutton LSBC has been assured that: Quarterly meeting are established with the lead GP for safeguarding and the named HV for each practice. The Health Visiting Service has developed a new reporting template to support this sharing of information. Sutton LSCB hold a copy of the template. The Service Manager for Health Visiting is meeting practice managers twice per year. A protocol is currently being developed by the Health Visiting Service to reflect Health visiting teams working in partnership with GP practices.
9.2. SMCS safeguarding team to monitor the quality of record keeping and information sharing when conducting safeguarding supervision with practitioners, raising competency issues early with the support of the Universal service managers.	The supervision policy has been completed. There is robust documentation of supervision, which is audited annually	Sutton LSBC has been assured that: This is on-going in supervision and safeguarding supervisors work closely with team leaders if competency issues are identified related to record keeping. The organisations Supervision policy was updated in March 2016 and there is a current audit being undertaken of supervision looking at the quality of supervision provided by the safeguarding supervisors. The audit tool is attached.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
		RMCS Safeguarding Team completes an annual audit of record keeping and this is on the 2016/17 annual audit plan and due for submission to the RM Clinical Audit Committee in Quarter 3. Sutton LSCB hold copies of the audit records.
9.3. Transfer of records and information from the health visiting service to the school nurse service needs to be revisited and strengthened.	Completed. The safeguarding team administration now takes responsibility centrally for the transfer of vulnerable/safeguarding records.	This protocol has been ratified at SCHS Clinical Development Committee. Sutton LSCB hold a copy of the protocol for transfer of records which has the status of a Royal Marsden NHS Foundation policy.
9.4. 'Silo' working is evident throughout the SMCS IMR and needs to be addressed.	The safeguarding team is fully established and the safeguarding manager is undertaking ongoing development work.	Sutton LSBC has been assured that: The structure of safeguarding supervision now means that supervisors provide supervision across the 0-19 service (rather than specific to a professional role). Communication and liaison is monitored through supervision (both internally and externally) and there is increased staff awareness. Autumn 2016 there are a series of scheduled internal updates relating to Child D and the issue of silo working is incorporated as learning into these.
9.5. Routine enquiry to be introduced within SMCS to improve the communication and outcomes of clients	The Domestic violence policy has been completed and ratified, and staff are accessing DV training. To introduce	Sutton LSCB was assured that: All health visiting staff attended mandatory training in 2015 for Domestic Violence routine enquiry. An audit, approved by the RM Clinical Audit Committee, has been undertaken to assess how well this learning has

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
experiencing domestic abuse.	routine enquiry for domestic violence is an area of development.	been embedded into practice. The findings is available to be presented to Sutton LSCB Quality Assurance subgroup.
10. Western Sussex Hospitals NHS Trust discharged to Sussex LSCB		
10.1. Refer all women who book late in pregnancy to Children's Social Care and inform relevant agencies as outlined in the Trust safeguarding policy.	This is now reflected in the Trust Safeguarding Policy (2013).	On 18.10.2016 Sutton LSCB received assurance by the Named Midwife for Safeguarding that: In 2013 /14 Trust guideline for Safeguarding children recommended referral to social care for women who present late in pregnancy. There was also reference to follow PAN Sussex guidance. Midwives mandatory training for safeguarding children discussed this at that time.
10.2. The Maternity Division is to implement guidelines to follow if antenatal appointments are missed.	This is now reflected in the Maternity Guidance Missed Antenatal Appointments guidelines (2013).	On 18.10.2016 Sutton LSCB received assurance by the Named Midwife for Safeguarding that: The aim of the trust's guideline on missed antenatal appointments Assist's health professionals on what to do when women default appointments and provides guidance for the process to follow. The guidance is intended to establish good practice and ensure appropriate agencies are involved when women miss antenatal appointments.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
		Again following this SCR this was discussed at mandatory training for Midwives and Obstetricians.
11. Legal		
11.1. Issues of competency within a team need to be dealt with effectively and quickly before they start having an impact on team morale and upon clients' confidence within the legal team.	This has been addressed by the merger of the in house team to form the South London Legal Partnership.	Lawyers and staff within the team have regular one to one supervision meetings with their managers on a monthly basis where file reviews of work take place – quality and competency are assessed through these meetings. In addition, all concerns about lawyers from feedback meetings with clients are addressed with individuals promptly. The team receives very few complaints.
11.2. When considering choice of counsel in complex proceedings, there should also be consideration of influence in the court arena, perception of the local authority, status of other representatives and past experience of working closely with lawyers within the team as well as cost considerations.	This has been addressed by the merger of the in house team to form the South London Legal Partnership. The practice lead for Social Care and Education and Senior Lawyers are fully engaged in instruction of appropriate seniority of counsel and able to advise clients accordingly.	All decisions to instruct are signed off at a senior level by senior Lawyers or Head of Law. Whilst cost is a consideration and is always negotiated with chambers, quality of legal advice and working relationships with clients are a key consideration. There have been a number of high profile matters where a decision is reached in discussion with the Head of Law and Director of People as to choice of counsel.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
11.3. When allocating a complex and lengthy matter to a locum in the team, consideration should be given to extending their notice period to ensure there is time for an effective hand over.	This has been addressed by the merger of the in house team to form the South London Legal Partnership. There is consistency of lawyer throughout complex cases and working knowledge of such cases by supervising senior lawyer. The service uses a very limited number of locums.	Locums are supervised monthly by Senior lawyers within the team who have full knowledge of complex cases. In any event the team only has one long term locum currently and sufficient staff to take over if required. Locums rarely leave on a week's notice and usually agree dates at least 2-3 weeks in advance of departure.
11.4. Ensuring the management of the child care legal team is undertaken by an experienced child care lawyer with sufficient experienced lawyers to deal with complex cases at a senior level.	There is experienced leadership of the team with the ability to provide a service with confidence and the ability to make difficult decisions and inspire confidence in clients.	The Head of Law is an approved Children panel lawyer with 22 years' experience of this area of law. The two senior child care lawyers in the team both have in excess of 20 years' experience in this field.
11.5. To have in place a strategy to deal with difficult and aggressive telephone and email correspondence to lawyers within the team to ensure that the team	There is support for people in the team to prevent and address any form of harassment/bullying.	All lawyers are clear of the expectations in such circumstances and senior lawyers sit with them in open planned offices to provide support if required. Issues such as this are also discussed at supervision meetings where file reviews and emails can be seen.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
feel supported whilst they work.		
12. Police		
12.1. The manager of the Sexual Offences, Exploitation and Child Abuse command Croydon and Sutton Child Abuse Investigation Team ensure that a record is created of the Initial and Review conference process that took place in respect of Child D.	Completed. Record created – reference number: 4006226/14.	No further assurance required.
13. Probation		
13.1. There need to be clear probation policies on (i) the retention of records of supervision where individuals are acquitted after statutory contact has begun and (ii) on the way probation staff use this material to inform later	There is management oversight in supervision. The Local Community Rehabilitation Company (LCRC) policy with regard to retention of records is that once a case is closed on the database, the ownership of the case returns automatically to the National Probation Service (NPS).	Sutton LSCB has been assured that: The NPS has administrative processes in place for updating case records where sentences are resentenced on appeal, quashed, varied or stayed. The records of quashed sentences are rendered inactive on the case management system. Inactive records can continue to be viewed and form an event history on the case management system.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
periods of statutory contact.		
13.2. The need to respond to information received, even where it is obviously incorrect, so that there is a clear audit trail on record.	The London CRC responds to all requests in a timely and professional manner.	Sutton LSCB has been assured that: The London CRC has clear, robust recording procedures and can evidence on record a clear audit trail
14. Social Care		
14.1. Children's Services should formally meet with their legal teams after care proceedings particularly where they have been unsuccessful in achieving the desired outcome to debrief and ensure lessons are learned and entrenched in future practice.	On 3rd August 2015, the Head of Family Support and Care planning, the Head of Quality Assurance, the Court Progression Officer and a Local Authority Lawyer met to discuss this recommendation. It resulted in a review of a sample of cases and the following actions: a) Procedure outlining what needs to take place regarding any appeal process should the Court make a decision that is not in agreement with the LA's care plan. b) Contingency in care plan to be clearly outlined in all social work	When there is a decision in Court to not support the Local Authority's recommendation for a Care Order under the Children Act 1989, the Court invite the Local Authority to submit a further care plan detailing how they will support the child through an alternate order. This care plan is then agreed in court prior to a final order being made. Often in this cases a transcript is requested in order that the local authority is clear as to why an alternate care plan is requested by the court. When children's social care are asked to provide an alternate care plan there is close liaison with the legal team. The Heads of Service all have final sign off for care plans. Where there continues to be safeguarding concerns, a professionals meeting is held to discuss the outcome, and to ensure that all partners are fully engaged in delivering the care plan as agreed by the Courts. The child

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
	c) Reiterate principles of effective care planning to social workers (in appendix 1 in the procedures). d) Learning points incorporated into Court awareness training.	will be regularly seen by a social worker and the care plan is regularly reviewed with partner agencies. The staff procedure was issued in 2015: "When Court does not award the Order that the Local Authority has sought for a child". It is accessible to staff on the trix-online procedure manual Social workers are required to attend the Court Room skills training course which includes the good practice guidance from the procedure has been incorporated into the delivery. The People Directorate Learning and Development programme is available online and distributed to all staff in Children's Social Care.
14.2. Where care proceedings have been unsuccessful, Children's Services should meet with partner agencies to consider learning points and to consider how they can best safeguard the child(ren) in the future.	In all cases where the final order being sought has not been granted, to have a record on every case stating the outcome, stating whether final care plan was agreed and where final care plan not agreed a debrief takes place.	The outcome from the Courts, the care plan, and professionals meeting are held on Mosaic, the children's services case management records. The records also has details of visits undertaken by the child's social worker and review meetings with partner agencies.
15. Sutton LSCB		
15.1. All agencies should reinforce the importance throughout their work of focusing on the needs of	The standard case audit tool template now covers the voice of the child and is reported on in all completed case audits.	Sutton LSCB standard case audit tool and the Children's Social Care internal audit tool covers the voice of the child. The tool is used to systematically check case records to identify strengths and weaknesses in social work practice. The findings of multi-agency case audits are

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
the child at the centre of a case and good practice in the direct recording if the child's voice in case recording should be adopted.		reported to the LSCB QA subgroup for scrutiny to ensure that any concerns in this area is fully addressed. There is an ongoing programme of multi-agency case audits, which were subject to an Ofsted LSCB review in 2016.
15.2. When working with parents who are resistant and hostile professionals should not be deflected or distracted by parental behaviour and should focus on assessing the potential risk posed to children in these families to emotional abuse or neglect. The adequacy of multi-agency training in this topic should be assessed.	The LSCB training programme now covers working with resistant and hostile parents. The programme also covers learning from Serious Case Reviews.	The LSCB and People Directorate (social work) Learning and Development (L&D) programme is available online and can be accessed via the LSCB website. LSCB holds copies of previous years' L&D programmes and the LSCB publish an annual LSCB L&D programme on the website.
15.3. When outcomes from court cases occur which are not expected by key agencies, and may have the potential to raise concerns for children, the local authority should	This is included in the tri-x online procedures. Please see action 14.2 (Children's Social Care)	The LSCB Case review subgroup has scrutinised the evidence submitted by Children's Social Care that this recommendation have been implemented. See assurance provided above in sections 14.1 and 14.2

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
convene a multi-agency meeting to share information arising from the unexpected outcome. This should provide clarity about future actions, roles and responsibilities of various organisations and establish communication channels that can respond to any escalation of concern.		
15.4. Given that working with independent social work agencies and other independent professional is likely to continue to be a feature of children's services work, there is a need for clarity regarding respective roles and responsibilities and accountability so that it is clear who is doing what in a multi-agency context. The local authority should	An internal review of commissioning independent assessments has been completed and development work has been undertaken in the last year.	Assurance in this area has been provided in the London Borough of Sutton Preventing Further Death response to the Courts.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
take the lead in defining how commissioning, contracts and communications will be managed.		
15.5. The position of the Courts, and specifically the Judiciary in respect of SCRs should be clarified. In this case the request for an IMR was declined; no other form of report, other than a copy of the Judgement, was provided and there was no representation from the Courts Service (HMCTS) on the SCR Panel. Given the significance of Court judgements in this case, this lack of engagement raises questions that require serious consideration at a national level. The findings of this SCR should be brought to	The Independent LSCB Chair has written to the President of the Family Division.	On 6 July, the Independent LSCB Chair sent a letter to The Rt. Hon. Sir James Munby President of the Family Division to request a meeting to discuss this SCR recommendation. The Independent LSCB Chair and Independent SCR author subsequently met with the DfE (Department for Education) and MoJ (Ministry of Justice) requesting amendment of 'Working Together 2018' to better reflect the engagement of the Judiciary in SCRs. In May 2017, the *'President's guidance: Judicial Cooperation with Serious Case Reviews'* confirmed that Judges should provide every assistance to SCRs which is compatible with judicial independence. It has recently been confirmed that, the Independent LSCB Chair will be representing the AILC (Association of LSCB Chairs) on the DfE Advisory Group of the Triennial Review of Serious Case Reviews 2014-17.

SUTTON LOCAL SAFEGUARDING CHILDREN BOARD – CHILD D ACTION PLAN

RECOMMENDATION	ACTIONS	ASSURANCE TO THE LSCB
the attention of the President of the Family Division and the Family Justice Council. They should be asked to respond and to clarify the responsibility of the courts to LSCBs in respect of Serious Case Reviews.		