THINGS YOU SHOULD KNOW

SSCP Learning Bulletin "Things You Should Know"
February 2020, edition 22

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An outline of **case review** findings is on page 2-3, looking at the serious issue of child malnutrition with some suggestions of good practice in this area. The findings of an audit of **strategy discussions** is on pages 4-5. An invitation to the forthcoming Multi-agency Practitioner Interest Groups (**MAPIGs)** is on page 6. Below is a letter from Somerset's new Independent Scrutineer, **Dr Mark Peel**.

Dear Somerset Safeguarding Children Colleagues,

I have recently taken up the role of **Independent Scrutineer** for the Somerset Safeguarding Children Partnership (SSCP).

This role in Somerset originated from the new **safeguarding arrangements** that came into effect last year, with statutory responsibilities now shared between Avon & Somerset Constabulary, Somerset Clinical Commissioning Group, and Somerset County Council in accordance with the Children and Social Work Act (2017) and the revisions to Working Together to Safeguard Children (2018).

I will principally relate to the new Somerset Safeguarding Children Partnership Executive, comprised of the three key safeguarding partners. I look forward to working with them as an independent 'critical friend' to provide an evidence-based, strategic view as to how well the SSCP is functioning, and the progress made against the priorities and the impact on children's lives.

I have a professional background working with children and in safeguarding that stretches back more than thirty years, for example as an academic at University of Leicester, and more recently as Independent Chair of the Leeds Safeguarding Children Partnership.

One of the great attractions of taking up this new role in Somerset is the greater emphasis the new legislation places upon making sure that learning, identified from **reviews and other activity**, is acted upon more swiftly to improve practice - an agenda I will push very hard indeed. I will also be seeking to improve our understanding of the safeguarding work already being done by reviewing available data sets. This is with the aim of drawing together and better evidencing the effectiveness of our partnership.

Time permitting, I would also like to add to the mechanisms already in place that bring the voice and experience of local children and young people to inform partnership safeguarding activity in a constructive manner and to guide future priorities.

I am delighted by the prospect of meeting as many of you as possible in the course of my work over the next year, and especially to hearing your thoughts as to how the partnership can best safeguard all our children and young people.

Dr Mark Peel, Independent Scrutineer,

Somerset Safeguarding Children Partnership

Contact through the SSCP
SSCP@somerset.gov.uk

Somerset Safeguarding Children Partnership

SSCP CASE REVIEW
MALNUTRITION IN THE UNDER-FIVES

1. The Background

A recent case, together with other very similar cases, has highlighted a particular **neglect issue** which needs awareness and action in the wider community.

2. Safeguarding concerns prior to the incident

The child, aged 14 months had a viral illness and stopped eating solids and reverted to **just drinking cow's milk**. This is not uncommon as a temporary feature, but usually toddlers should be back to a sensible mixed diet suitable for their age after a few days. However, this family had multiple other issues, so either through lack of awareness or domestic chaos the toddler remained just drinking up to nine bottles per day and **little else**.

3. The Incidents

This resulted in **profound iron-deficiency anaemia** – so severe that the child nearly died of heart failure. There was also delayed development, both motor and cognitive, which may not be entirely rectified with age.
In another **very similar case** a child suffered such severe iron-deficiency anaemia that they suffered a stroke, leaving life-changing consequences.

4. Complicating factors

If there have been no health needs identified and no notification of new risks, then an infant may not have a planned contact with the Health Visiting service after 12 months until 27 months, neither are these children usually in nursery. They can therefore be **completely hidden** from many professionals' view.

5. What we learned from reviewing this case

It is vital that all agencies, who may be involved with the family or other children are aware that they should 'Think Family' and if they see **pale, limp toddlers just being fed bottles of milk** that they may be being seriously neglected and could **die from the consequences**. As more and more families take their weaning advice from Facebook and other social media there may well be more toddlers receiving **dangerously restricted** diets.

Case reviews completed by the SSCP
Learning and Improvement Subgroup, 2020.

Things you should know

Feeding infants

- Cow's milk is not nutritionally complete for children over 6 months old, and in the cases reviewed this led to severe iron deficiency with life-long repercussions.
- Signs of malnutrition include
  - Faltering growth
  - Tiredness
  - Pallor
  - Irritability
  - Slow behavioural and intellectual development, possibly resulting in learning difficulties
  - Recurrent illnesses and slower recovery.
- Malnutrition can also result from medical conditions.

If you are worried consider ***early help***, and share concerns with other professionals.

Useful resource: malnutrition case review

A short presentation summarising this case review, prepared by Somerset Public Health Nursing.

Malnutrition Presentation PDF

Useful resources—weaning and nutrition

- **Weaning (NHS start4life)**
- **First solid foods (NHS pregnancy and baby)**
- **Infant and young child feeding (WHO factsheet)**
- **Maternal and Child Nutrition (NICE)**

AUDIT SUBGROUPS

The SSCP has two **Audit Subgroups** (ASG) which meet on a regular basis to look at the quality of multi-agency working and adherence to child protection policy and procedures.

The audits

The ASGs looked at the cases of 8 children, in which a **strategy discussion** had been held following a disclosure of sexual abuse.

The findings

- These strategies were all held in response to a **disclosure of sexual abuse**. Three disclosures were made to school, one to a carer, and in three cases an adult spoke to a service (111, therapist, police).
- It is positive that each of the disclosures was **managed in line with agency guidelines**, and there is no evidence that agencies had received previous disclosures and failed to act on them.
- It is also positive that the **timescale was appropriate** in all cases, and the name and role of the practitioners taking part was clearly recorded.
- The **voice of the child** was heard in each strategy discussion.
- Six of the eight strategy discussions were **quorate**. Notably, key professionals missing were partners in health agencies:
    - **GPs** were invited to contribute in only three of the cases. The need to invite GPs has been raised in previous audits and in the **SSCP guidance published last year**.
    - **Hospitals** were not always consulted / invited. As they have a separate computer system key information could be missed by not consulting them. As these cases were in response to concerns of sexual abuse, health records and information were particularly important.
    - There were two strategies where there was **no consultation with any health agencies**.
    - If a medical examination is going to be sought, a **paediatrician** needs to be involved in the decision to do this and should be invited to the strategy.
- Sending **notes of a strategy discussion** to the relevant agencies continues to be a problem. This includes the family GP and should happen regardless of whether they have been invited, and /or whether they attend. Police did not receive the notes on two occasions.
- There was one case where the **parents'/carers' ability to protect the child** was not considered.
- One case was complicated because of the **family's move into the area** and the lack of a chronology. Chronologies should be created if they are not supplied.
- Where **further enquiries** were needed to establish risk, clear plans for progressing this were recorded in every case.
- **Interim safety plans** to protect the child were recorded in five of the eight cases. The safety of all children in the household should be considered and a brief rationale given if a plan is not needed.

The Quality and Performance Subgroup oversees the audit work and is responding to the findings. Please see the reminder box at the top of page 5 for how you can help improve strategy discussions.

Good practice in strategy discussions—learning from the audit

- If any practitioner has not received minutes from a meeting, with the result that they are unsure of the safety plan or their role then they should be proactive in chasing it up or escalating to the manager if they are not getting the information needed.
- All practitioners attending the strategy have a responsibility for making sure that they are satisfied with the interim safety plan and that the needs of each child in the family are considered.

See page 4 for details of the audit.

Early Help Assessment E-learning course

The Early Help Assessment (EHA) has been updated. The EHA is a shared tool for all practitioners working with children, young people and families in Somerset.
There is a new, free training tool available to all practitioners to ensure you make the best use of the improved EHA to get children, young people and their families the right support in the right place at the right time.

The Early Help Assessment E-learning course on the Learning Centre is a comprehensive course designed to raise awareness of early help and increase your knowledge and confidence to use the EHA. We expect this course to take 30 minutes to complete and includes a certificate on completion.

Early Help Assessment (EHA) eLearning for SCC Practitioners

Early Help Assessment (EHA) eLearning for non SCC Practitioners

A quick guide to strategy discussions

A SSCP one page reminder document on strategy discussions is available. This was developed by a multi-agency group following a previous audit, and is published on the **SSCP website**.

The guidance gives information about the purpose of a strategy discussion, attendance, agenda, and an outline of who should receive a copy of the minutes and action plan.

Contact the SSCP!

Please note our **new** email address: SSCP@somerset.gov.uk.
The SSCP has a circulation list to send alerts when new newsletters or learning bulletins are published. If you do not currently receive these alerts and would like to sign up to the list, visit our website sscb.safeguardingsomerset.org.uk

Multi-Agency Practitioner Forum (MAPIG)

Local Child Safeguarding Practice Review (CSPR): Improving Practice with Reflective Learning.

The new review process as set out in *Working Together to Safeguard Children 2018* (formerly Serious Case Reviews) will enable practitioners to reflect on how our multi-agency safeguarding practice can be continuously improved to offer effective safeguarding services for all children and families in Somerset.

These MAPIG events will provide an opportunity for all practitioners, within a multi-agency environment, to consider the learning from the SSCP most recent reviews and how all partners can work together to continue to build on existing strengths, discuss solutions to barriers to effective working and avoid recurrent themes to improve safeguarding practice for children in Somerset.

The sessions will look at key components of multi-agency working – Early Help Assessments, Team Around the Child (TAC) activity and the role of the Lead Practitioner - and how to ensure families receive the right level of support. We will reflect on what families have said about how to improve the services we offer.

They will also consider features of neglect, particularly for unborn and very young babies, and how best to act on these at the earliest point

Guest Speaker
Adrienne Plunkett
Independent Review Author

Thursday 26th March 2020	Friday 27th March 2020
10am – 12pm **Edgar Hall** **8 Cary Court, Somerton Business Park, Somerton TA11 6SB**	**10am – 12pm** **Taunton Rugby Club,** **Commsplus Stadium Hyde Lane, Bathpool, Taunton TA2 8BU**
2pm – 4pm **Yeovil University Campus** **Mudford Road | Yeovil | BA21 4DR**	**2pm – 4pm** **Sedgemoor Auction Centre, North Petherton, Bridgwater TA6 6DF**

Please contact SSCPtraining@somerset.gov.uk

For further venue details and to register attendance