The Isle of Man Safeguarding Board

Board Response to Serious Case Management Review – Child O

This Serious Case Management Review (SCMR) relates to a serious incident leading to a very young baby being presented at hospital having sustained significant injuries believed to be non-accidental and needing emergency treatment. The Board note that the findings from this review provide an insight into local systems and practices when a child is born to young parents with their own significant vulnerabilities, which may indicate that a child could be at risk of significant harm.

This SCMR was commissioned in 2023 by the Isle of Man Safeguarding Board in line with the 2019 Safeguarding Together Guidance and Safeguarding Board Act 2018. The Board commissioned Nicki Pettit, an experienced independent reviewer and safeguarding expert to complete this SCMR. This is the second review in twelve months with similar concerns to those in Child N.

The review process consisted of agencies providing reports of their involvement with the family and two practitioner events. This process is supported by a Panel of independent senior managers from involved agencies who can provide necessary context on organisational policies and practice.

The agencies involved in the process were:

Isle of Man Constabulary

Manx Care- Health

Manx Care – Mental Health.

Manx Care – Children & Families.

This Board response will focus on the learning and recommendations only, as to not share any of the case details to respect the family's right to privacy and prevent any identifiable information being shared.

The report and its recommendations were agreed and accepted by the Isle of Man Safeguarding Board. The Board believe that the actions identified to address the recommendations will improve how agencies work with children and their families in similar circumstances. The learning briefing has been published by the Safeguarding Board along with this Board response.

The review identified a number of key learning points:

- The importance of knowing and sharing information pre-birth when there are known or knowable parental vulnerabilities such as mental health issues, a history of abuse or neglect, substance misuse, and concerns about anger management and violence. There must be robust consideration of the impact of these parental issues on a baby, including pre-birth, alongside offering support

- Practitioners, their managers, and agencies need to ensure that they are aware of and promote the legislation and expectations regarding information sharing where a child may be at risk. Professionals need to be clear about what is required, even if there is a lack of parental consent. Any disputes or concerns in this area need to be discussed with a manager. Isle of Man procedures clearly state that 'effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision' and that 'fears about sharing information should not stand in the way of the need to promote the welfare and protect the safety of children'.
- Professionals need to effectively consider the information available to them to fully understand a child's actual and likely future lived experience, including utilizing multi-agency meetings to share information and consider the impact on the child.
- Professionals need to challenge themselves and others if practice is parent focused. This is particularly a risk when a parent is young and has significant vulnerabilities of their own.
- Professionals involved during a pregnancy (or failing that, as soon as possible after the birth of a child) should consider the parent's history of adverse childhood experiences, especially abuse and neglect and the on-going impact of this in respect of their ability to care for a child, along with the support they are likely to need to do so safely. This should include considering the insight shown by the parents into the likely challenges they will face
- Robust consideration needs to be given to ongoing mental health issues, substance misuse, parental relationship problems, limited or potentially risky wider family support, and external stresses such as finance and housing issues
- The risk of relying on parental self-report, particularly when the parents refuse consent for information sharing and assessment.
- Avoiding professional optimism or lack of curiosity about a mother's ability to stop smoking cannabis without help, after many years of daily use, and the need to consider the impact of stopping on their mental health.
- The importance of accessing information held on the GP record about a parent's history, mental health, substance misuse etc.
- Ensuring robust information sharing (including of up-to-date information on the parents) including any gaps in information and attendance of key professionals, including those with information about adults, at multi-agency meetings, including strategy meetings
- All professionals need to challenge themselves and others to ensure recognition of; collusion or the minimising of concerns to avoid conflict or upsetting the parents; being over optimistic and overstating any positives; focusing on the parent's needs rather than the child's.
- Professionals need to ensure that they are willing to change their minds and admit that their initial view may be wrong when further information becomes available
- The need to undertake a robust assessment even when a parent is refusing consent, where safeguarding concerns are evident

Recommendations

The review recommends that:

- The Board need to be assured that where there are safeguarding concerns and consent is withdrawn or not given, an assessment must be undertaken to evaluate the impact and potential risk to the child.

- The Board to request that work is undertaken to ensure that there is improving practice in respect of strategy meetings by
  - Consistency in threshold application and decisions are evidence based
  - Meetings are held face to face unless any delay would place a child at immediate risk
  - GP information for all adults and children is sought
  - GPs and police consistently record that a strategy meeting has taken place on agency records
  - Information is sought and provided regarding adults known to mental health services, prison and probation
  - Contingency planning and the need for a further strategy meeting is considered
  - There is a transparent consideration of alternate views or professional disagreement is recorded
  - There is a review of the need for health visitors to attend strategy meetings.
- The Board asks all agencies to submit information to them, about how they are ensuring staff are skilled at engaging resistant and hard to reach families and show professional curiosity.
- The Board asks each relevant agency how they are ensuring that 'supervision' of professionals includes consideration of whether practice is child focused and safeguarding aware, which should include an audit of 'supervision'.

Immediate Actions Taken to Address the Learning and Recommendations.

There have been a number of actions already taken to improve systems and practice namely:

Manx Care Health Safeguarding team have implemented –

- the Vulnerable Adolescents pathway for maternity services
- to increase professional curiosity regarding adverse childhood experiences, there is specific prompts on the enhanced care referral form, which will also capture father's details and other hidden individuals. Should adverse childhood experience be identified in the father's background, historic health records are reviewed.
- Further, maternity services ensure a MDT is called for complex cases to ensure a robust birth and postnatal plan are in place
- An interagency pre-birth pathway has been implemented
- Maternity data base is now accessible to lead midwife, health visitor, doctors, neonatal unit, and health safeguarding team
- GP's are routinely invited to strategy meetings and outcomes are sent to GP for the records, and the records checked prior to meeting taking place
- Supervision (bespoke) policy being implemented. Supervision training completed for 0-19 service and members of the safeguarding team. This process ensure that the child voice is captured and a think family approach is adopted. Supervision files are regularly audited by the health safeguarding team

Manx Care Children & Families service have implemented

- Should consent be refused or withdrawn by parents, a group manager will provide oversight and direction on how to proceed
- An agenda template for strategy meeting to ensure consistency in discussions and decision making (including contingency planning) and all meeting are held in person unless convened

out of hours. Information is sought from GP, mental health services, prison & probation services

- Supervision is a feature in the audit schedule

The Safeguarding Board has developed a detailed action plan based on the recommendations, and the progress of actions will be monitored and assurances about progress sought from partner agencies. The impact of required changes to practice will also be tested and assessed using the Board's Quality Assurance and Scrutiny Framework.

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