BLACKBURN WITH DARWEN LOCAL SAFEGUARDING CHILDREN BORAD (LSCB)

Serious Case Review in respect of Child J

EXECUTIVE SUMMARY

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LSCB Independent Chair	**Mr Laurence Loft**
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Introduction

Summary of circumstances leading to the review being undertaken

Child J who is of white British origin was born in May 2009. Following J's birth J was discharged from hospital to the care of J's mother and was considered to be making good progress. Midwifery and health visiting services were involved to monitor J's progress and support and advise J's mother.

In June, J's mother called the ambulance service as she was concerned about J following an incident of domestic violence between J's parents during which J had sustained a head injury. J was aged 5 weeks. Accompanied by mother, J was taken by ambulance to accident and emergency and later transferred to a children's hospital where J's condition remained critical for several days. J was initially not expected to survive.

J has survived, but has sustained significant brain damage. J was initially subject to a child protection plan at the time of being discharged from hospital to the care of mother. J continues to receive support from local health and social care services.

The Local Safeguarding Children Board (LSCB) decided in July 2009 that the circumstances of the injury to J met the criteria for a Serious Case Review (SCR) as contained in Chapter 8 "Working Together to Safeguard Children", 2006 in that J had "sustained a potentially life threatening injury or serious impairment of health and development through neglect or abuse".

Arrangements were made in August 2009 for a SCR panel to be set up with an independent chair and an independent overview report author. Independent Management Reviews (IMR) were requested from Social Care, Health and the Lancashire Constabulary. Four SCR panel meetings were held. Final drafts of each IMR were signed off by appropriate senior managers in each agency.

Terms of Reference

It was agreed by the LSCB that the SCR Panel in reviewing the case should answer the following questions:

(i) Were appropriate risk assessments undertaken within agencies to understand the level of J's father's violence, and extent of J's mother's victimisation?

(ii) Was there evidence that agencies communicated and worked together effectively to address the issue of domestic violence in this case?

(iii) To what extent did the concerns about domestic violence inform the planning and decision making in relation to J?

(iv) Was J's mother's mental health state fully understood and assessed by health services, and was it significant in relation to her ability to safeguard J's welfare?

(v) Were single and multi-agency policies and procedures followed by all agencies in this case?

(vi) To what extent were the concerns of the extended family appreciated and taken into account by agencies involved with J's parents and J?

The period covered by the review was from January 2005 to August.2009.

Members of the SCR Panel

Mick Muir, Independent Chair
Strategic Head of Social Work Service, Blackburn with Darwen Children's Services Social Care
Head of Service Referral and Assessment Team, Blackburn with Darwen Children's Services Social Care
Designated Nurse for Child Protection, NHS Blackburn with Darwen
Specialist Safeguarding Nurse, NHS Blackburn with Darwen
Safeguarding Nurse, Lancashire Care NHS Foundation Trust
Public Health Specialist, Children and Families, Lancashire Care NHS Foundation Trust
Detective Inspector Public Protection Unit, Lancashire Constabulary
Detective Chief Inspector Public Protection Unit, Lancashire Constabulary
Strategic Head of Service, Blackburn with Darwen LSCB
Vlasta Novak, Independent SCR Report Author & Strategy Manager, Blackburn with Darwen LSCB, attended all panel meetings.

Each of the IMR authors attended the panel meetings. Furthermore, the panel consisted of the independent author and chair, LSCB officers and a number of other senior staff from the various agencies who were not directly involved in the case. The panel therefore had sufficient independence.

Family member involvement

The decision was made to comply with the Crown Prosecution Service advice and not to approach family members until after the trial was concluded when this summary was shared with them.

The Strategic Head of Service (LSCB) contacted J's father, mother and maternal grandmother after the sentencing hearing in 2011. J's father and mother met with the Strategic Head of Service (LSCB) but the maternal grandmother did not respond to the correspondence sent.

J's father met with the Strategic Head of Service (LSCB) and was provided with a copy of this Executive Summary to read. J's father read the first few pages of this document and was unable to continue reading it. J's father only commented that he is deeply upset about the injuries J had sustained and did not wish to make any further observations about the events leading up to the injuries, or the SCR.

The Strategic Head of Service (LSCB) met with J's mother on two occasions. J's mother provided some written comments on a copy of the Executive Summary. The comments provide insight into the lives of J's parents and how each was almost pursuing different objectives in life; how domestic abuse rather than violence was a feature in their lives and that the emotional and physical support to J's mother in this period was being provided by J's maternal grandmother rather than his father.

Overall, J's mother was positive about the services that she had received both prior to J's injuries and after the event, but identified a key learning point and recommendation for all agencies. J's mother identified that when services (Police, Maternity Services and Health Visiting) spoke with her about the domestic abuse incidents, J's father was either present or close by and J's mother could not comfortably disclose the *abuse* she was subjected to. In the case of Children's Services, they contacted her when she was at work and she did not feel comfortable to disclose details over the telephone. The learning for agencies is about ensuring that when disclosures are sought from victims of domestic abuse that these are sought in an environment where the victim can speak openly without fear or embarrassment. J's mother also recommended that agencies should provide advice and guidance about *how* to disclose issues of risk, rather than just provide information about where services can be accessed.

Ofsted Evaluation

The reports from this SCR were submitted to Ofsted[1] in December 2009 and they evaluated the reports in May 2010. The overall evaluation this SCR received was 'good'[2].

[1] Office for Standards in Education, Children's Services and Skills
[2] Evaluation grades range from 'outstanding', 'good', 'adequate' to 'inadequate'

Case Summary

Child J's parents are both in their twenties. J is their only child. The parents have had a volatile and sometimes violent and abusive relationship and were living together when J was born.

In early 2009, before J was born, Police were called to two separate incidents one involving J's parents and the second involving J's father and J's grandmother. Both were classified by Police as domestic abuse incidents and the risks to J's mother were assessed.

Following the second incident a health professional wrote to Children's Services to report the concerns of J's grandmother that there was violence in the relationship between J's parents and she feared for the safety of her daughter and unborn grandchild.

The duty manager within Children's Services asked for further information from the Police and was told about the two recent incidents. There was also contact with the midwifery service. A phone call was made to J's mother who felt things had calmed down and did not want any help. The case was closed.

As the pregnancy progressed a midwife discussed the incidents with J's mother and after J was born a Health Visitor also discussed the incidents with her. J's mother considered the incidents were not worrying to her and she did not want any help.

In June 2009 child J was brought to the accident and emergency department in a serious condition having received a significant head injury. Although at first it was thought that J would not survive; J has survived and made sufficient progress to be discharged from hospital to the care of mother. She and child J are being provided with services to support J's health and development though there will be long term damage to J as a result of the injury sustained. A detailed child protection plan was in place at the time of discharge from hospital; a child in need plan will remain in place to provide long term support.

In July 2009, J's father was charged with wounding J and assaulting J's mother. J's father received a custodial sentence in 2011.

Key Issues from the case

The events which had the most direct bearing on the outcomes for J are:

- the response of agencies to the two domestic abuse incidents which took place in 2009
- the response of agencies to the referral following the domestic abuse incident in March 2009 in which J's grandmother expressed her concern for J's safety

- the response of agencies to safeguarding of J following J's birth and injury in June 2009

There had been incidents of domestic violence involving J's father in 2005 and 2007 and two more which occurred in 2009, while J's mother was pregnant. Although both of the 2009 incidents involved only verbal altercations and the second was between J's father and J's grandmother, there is research which tells us that a significant proportion of domestic violence begins in pregnancy and it is likely to escalate. It is therefore of concern that when the incidents were risk assessed using a widely used checklist devised for that purpose, the second incident was graded by the Police as constituting less of a risk to J and J's mother than the earlier incident. Because other agencies involved with the family accepted this without questioning it further, there was a less robust exploration of risk to J than there should have been.

A further issue considered was the quality of those assessments. Risk assessments currently focus on the effect on the adult victim and the risk and harmful effect is then considered in relation to children who may be present during the incident. Unborn children are at great risk but are not considered as either the victim nor are they classed as a child who is present.

The concerns expressed by J's grandmother to the Police and to a health professional were not followed up sufficiently so it was not fully known why she felt her grandchild was at risk of harm.

Since the incident in which J received the injury all agencies have worked well together to ensure that J is fully protected and receives all of the services J needs to assist J's development.

Although some areas of good practice were identified there were a number of areas in which lessons needed to be learned.

Lessons to be learned

1. The SCR found was that there was no elevated risk status afforded to pregnant women and their unborn children.
2. Guidance needed to be clearer about how staff should treat the involvement of third parties in domestic violence incidents, how the concerns of third parties (including family members) should be evaluated, how risks to the unborn are assessed and how the risk assessment of the adult takes account of the risk to the child, born or unborn.
3. The Domestic Abuse Guidance and Protocol adopted in 2009 had not been sufficiently or effectively shared with some health staff.
4. The information sharing agreement was being interpreted differently leading to different expectations between agencies.
5. The historical information held by agencies can provide an indication of the strengths and vulnerabilities of families and this can and should inform risk assessments in respect of children and contextual information when considering the risk assessments provided by other agencies.
6. Both Health and Children's Services have relied too heavily on the adult focussed risk assessment in respect of adult victims and have not sufficiently undertaken their own assessments of risk to the unborn or new born child.
7. Police information about violent behaviour needs to be fully shared and not subject to artificial cut off dates.
8. There are development needs for staff in understanding the phenomenon of minimising or denying domestic violence and how to deal with this.
9. Agencies need to take account of national developments relating to engagement with perpetrators of domestic violence and incorporate these into local policies and procedures.
10. All agencies to ensure that when disclosures are sought from victims of domestic violence, that these are sought in an environment away from the perpetrator or others, where the victim can speak openly without fear or embarrassment.

Conclusions

i. The SCR Panel concluded that there were assessments of J's father's level of violence but these were compromised by both human error and by limitations to the risk assessment tool used. There were no assessments of the extent of J's mother's vulnerability to victimisation but there was much historical information available of which very little use was made. Evidence of J's mother's victimisation in the way she minimised the risk to herself and J was not identified as such.
ii. There were examples of good and speedy communication between all of the agencies involved in this SCR but there were examples of missed opportunities to communicate as fully as possible leaving key agencies, at times, with only part of the full picture. There were also examples of slow communication which were not explained sufficiently.
iii. Planning and decision making in relation to J before J was born were not fully informed by the domestic violence issues. Following the incident in which J was injured it would appear that concerns about domestic violence have fully informed the planning and decision making process.
iv. There had been no formal assessments of J's mother's mental health. However, her current ability to safeguard J is kept under review.
v. There were failures to follow policies and procedures.
vi. The concerns of the family were not fully appreciated and there was insufficient account taken of the concerns expressed.

Individual agency reports and this report recommend that the Blackburn with Darwen practice guidance is expanded to provide additional support in relation to assessing risks to children, born and unborn, where there are domestic violence concerns; that the concerns of relatives or friends are better explored; that the risk of further or escalating violence is discussed more promptly with the victim; and that all agencies are clear when they need to share information with each other.

Overview Report Recommendations

1. The Blackburn with Darwen LSCB should request the Lancashire Constabulary, Blackburn with Darwen Children's Services and Health to review and revise the Domestic Abuse Guidance and Protocol with a view to making changes which:

    - Recognise the elevated risk of domestic violence for pregnant women

    - Explicitly ensure the unborn child is treated as a child at risk and present at any incident

    - Acknowledge the phenomenon of victim minimisation and denial and the need to address this – this should also address perpetrator denial and minimisation

    - Help staff engage with perpetrators to better understand the level of risk

    - Set timescales for information sharing which emphasise dealing with the issues as near in time to the incident as possible

    - Address the significance of family member involvement in incidents

    - Clarify unequivocally the requirements for information sharing

    - Emphasise the focus of the incident risk assessment as the adult and the need, therefore, for additional risk assessment relating to the child which should take account of all information held by an individual agency.

    The review should consult with all other interested agencies who work with domestic violence victims and perpetrators in assisting the revision.

2. The Blackburn with Darwen LSCB should ensure that any changes to the Domestic Abuse Guidance and Protocol should be as a result of consultation and involvement of all interested agencies within the LSCB, should then be endorsed by the LSCB and the Guidance and Protocol should be re-launched.

3. The LSCB Chair should write to DCSF and GONW to inform them of this SCR's finding that national guidance, at present, does not sufficiently address the different risks to unborn children and pregnant mothers.

4. All LSCB agencies need to clarify to staff their expectations in relation to considering the expressions of concern by third parties (including family members) about the safety and welfare of children.

5. The themes and lessons learnt from this SCR need to be communicated to all agencies within the LSCB, Children's Trust and Community Safety Partnership.

Action Plan[3]

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
BwD Children's Services					
1. The definition of domestic abuse provided by the Lancashire Constabulary and Blackburn with Darwen Partnership is reviewed and amended to include explicit reference to the significance of incidents involving family members.	A short life multi-agency working group consisting of representatives of the existing domestic abuse forum be established to review the definition of domestic abuse currently in operational use in respect of children in households where domestic abuse is a feature and agree a definition which more accurately reflects the research as to the risks to children. The LSCB to be asked to endorse the agreed definition. Re-launch of the amended Multi-Agency Domestic Abuse Protocol.	The risks to the safety and welfare of children in domestically abusive families will be brought to the attention of children's services more quickly/often. Assessment, services and risk reduction strategies will be implemented at an earlier stage. Promotion of safety and well being of children in domestically abusive households.	Strategic Head of Service, Early Intervention, Prevention and Partnerships Service (Children's Services lead on BwD Strategic Domestic Abuse Forum)	March 2010	Implemented
2. The Lancashire Constabulary/Blackburn with Darwen partnership reviews the domestic abuse protocol to more accurately reflect the	A short life multi-agency working group consisting of representatives of the existing domestic abuse forum be established to review the definition of domestic abuse currently in operational use in	Pregnant women and their unborn children subject of domestic abuse will be categorised as high risk.	Strategic Head of Service, Early Intervention, Prevention and Partnerships	March 2010	Implemented

[3] *The action plan will be monitored quarterly by the BwD LSCB Serious Case Review Committee on behalf of the Board.*

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
research in respect of the risks of domestic abuse to unborn and newborn children.	respect of unborn children in households where domestic abuse is a feature and agree a definition which more accurately reflects the research as to the risks to unborn children. The LSCB to be asked to endorse the agreed definition. Re-launch of the amended Multi-Agency Domestic Abuse Protocol.	Children's Services will be notified at first incident and an initial assessment automatically triggered.	Service (Children's Services lead on BwD Strategic Domestic Abuse Forum)		
3. In respect of contacts/referrals from agencies or persons other than the police that express concerns about the impact of domestic abuse on unborn/children the assessment of risk and child need should be consequent on a social work assessment *informed* by but not dependent on the assessment of risk to the adult victim.	Policies and Guidance are issued to children's services social work staff emphasising their duty to undertake an holistic social work assessment of need including an assessment of risk in situations where : ▪ Domestic abuse notifications are received indicative of medium risk to the adult victims and ▪ Referrals in respect of a child's exposure to domestic abuse are received from another professional. Workshops arranged to launch revised procedures and guidance for all Referral and Assessment Social Work staff.	Children will be the focus of holistic assessments of need and services provided if appropriate to improve their safety and well being.	Head of Service Referral and Assessment team, BwD Children's Services	January 2010	Implemented

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
4. Blackburn with Darwen Council make it a procedural requirement that historical information held by them in respect of the families of children about whom there are child protection concerns is accessed and used to inform case management decisions e.g. as to the appropriateness of case closure and/or to inform risk assessments.	Procedures and guidance are written which make it an explicit requirement for social workers to record that in respect of child protection referrals or referrals which raise concerns regarding the safety of children historical information has been sought and wherever possible obtained. An explicit requirement to indicate how the historical information has informed case decisions (including the decision to close a case without undertaking an initial assessment.)	Assessment of the quality of care available to children will be better informed as to potential parental strengths and deficits and as to risks in general and in respect of domestic abuse in particular. Services and support plans likely to be more effectively targeted to improve the safety and wellbeing of children in need including those in domestically abusive households.	Head of Service Referral and Assessment team, BwD Children's Services	January 2010	Implemented
5. The role of the IDVA is further developed to include the expectation of systematic use of CAADA risk assessments with adult victims in households with children/unborn children, where referrals originate from other than the police.	Evaluation and Review of role of IDVA with the service provider (WISH). Guidance provided to social work staff as to role of IDVA. Procedures written to reflect expectation that IDVA CAADA risk assessment to be used to inform (not replace) social work assessment.	Improved assessment of quality of care and risks to children in households where domestic abuse is a feature. Support plans and services likely to be more effectively targeted to improve the safety and wellbeing of children in need including those living in domestically	Strategic Head of Social Work Service, BwD Children's Services	January 2010	Implemented

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
		abusive households			
6. Contacts/ Referrals to children's services regarding the welfare and safety of children should not be closed without evidence that every effort has been made to communicate with the referrer/source of the information, without evidence that the outcome of the referral has been communicated to the referrer and an 'outcome' letter sent.	Head of Service to issue written reminder of procedural requirements to all Referral and Assessment staff including administrative support staff. Head of Service to ensure regular random audit of contacts and referrals to the Referral and Assessment service to evidence that contact has been made with the referrer and/or the source of the contact/referral	Improved quality of information regarding concerns for safety and welfare will improve quality of assessment and decision making and contribute to the development of support plans and provision of services likely to more effectively targeted to improve the safety and well being of children in need including those living in domestically abusive households.	Head of Service Referral and Assessment team, BwD Children's Services	December 2009	Implemented
7. Existing systems of management oversight be reviewed to ensure that 'contacts' and 'referrals' from key partner agencies (Health, Police and Education professionals) are not closed without initial assessment unless authorised by a Team Manager.	Team Managers to review on a daily basis all such cases and authorise (or not) the decisions of the Duty Manager (PSW) and record the rationale for their decisions. The Head of Service (Referral and Assessment) to undertake monthly audit of a random sample of no less than 8 cases referred by key partner agencies and closed without initial assessment by children's services. The outcomes of the monthly HoS	Improved quality assurance of decision making will improve the safety and protection of children in need, including those whose needs arise from living in domestically abusive households.	Head of Service Referral and Assessment team, BwD Children's Services	December 2009	Implemented

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
	review and audit to be reported no less than quarterly to the Children and Families Management Team. A summary of the quarterly reports to the Children and Families Management Team are reported no less than bi-annually to the LSCB.				
Lancashire Constabulary					
8. Adopt the DASH risk assessment model	PVP database to be rewritten to accommodate DASH. Bespoke training prior to the implementation of DASH to consist of an E-learning package supported by Divisional training resources.	Risk assessment and subsequent risk management will shift to front line staff. This will ensure that risks are dealt with at the time they are identified thus removing the delay and lack of ownership associated with the current process	Detective Superintendent, Public Protection Unit, Lancashire Constabulary	March 2010	Implemented
9. ACPO consultation on the retention and disposal of records the issues identified within the Police IMR	Referral of issue to Impact Project Board for consideration by ACPO	Will ensure a consistent approach across agencies to the retention and disposal of child protection records	Detective Superintendent, Public Protection Unit, Lancashire Constabulary	December 2009	Implemented
10. Commission a review of force policy and procedure in respect of Domestic Abuse incidents, with particular	Identify suitably qualified practitioner to conduct review. Set terms of reference and timescale.	Will address the current gaps identified in this case in policy and procedures	Detective Superintendent, Public Protection Unit, Lancashire	February 2010	Policy and procedures updated across Lancashire - awaiting evaluation of pilot initiatives in

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emphasis on the topics of Quality Assurance and risks to the unborn child	Coordinate new policy and procedures with the launch of DASH risk assessment.		Constabulary		Lancashire to finalise
11. Bespoke training delivered by outside consultancy which will address the need to engender a wider perception of risk when dealing with safeguarding issues	Identify suitable supplier of training. In conjunction with Training School and HQ PPU develop packages for delivery to front line staff.	Promote a broader understanding of risk as it relates to the safeguarding agenda. This will lead to earlier identification of individuals at risk and allow earlier intervention when it is most effective.	Detective Superintendent, Public Protection Unit, Lancashire Constabulary	December 2009 and ongoing over a twelve month period	Implemented
12. Review information sharing policy with Children's Services in relation to screening information sharing of Domestic Abuse incidents at which children are present, or known to reside in the home	Dialogue between head of PPU and senior manager within CIS	Highlight potential risks inherent within current practice and assess if risk can be managed at an acceptable level Revised protocol to reflect outcome of discussions with Children's Services	Detective Superintendent, Public Protection Unit, Lancashire Constabulary	January 2010	Policy and procedures updated across Lancashire - awaiting evaluation of pilot initiatives in Lancashire to finalise
NHS BwD					
13. Safeguarding leads to be determined in each GP practice to take a lead on safeguarding within the practice	To be written into GP contracts including outcome measures To identify nominated leads in each practice (18/03/10, Safeguarding Children Practice Development	Improved safeguarding standards within GP practices. Compliance with LSCB and PCT Safeguarding Children policies:	GP Named Doctor for Child protection, NHS BwD	Oct 2010 July 2010	Implemented

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
	event to be held and will be raised at this event) To identify specific training needs for this role (18/03/10 Safeguarding Children Practice Development event to be held and will be raised at this event) To develop a competency framework for the role (18/03/10 Safeguarding Children Practice Development event to be held and will be raised at this event)	▪ to include record keeping ▪ follow up of referrals ▪ appropriate and timely information sharing ▪ ensure staff are trained and competent to recognise abuse and neglect in children and refer if appropriate Ensure the practice has access to the PCT and LSCB Safeguarding children policy and GP practices know how to contact Named and Designated Health staff for support as necessary		July 2010 July 2010	
14. GP's to undertake risk assessments on clients presenting with history of violent behaviour, this is particularly important if the client is also abusing drugs or alcohol or has known mental health problems. The risk assessment should consider the inter-	To be written into GP contracts Risk assessment pro-forma to be developed and rolled out to GP practices	Risk assessments will be more comprehensive and holistic Appropriate information sharing to safeguard children and vulnerable adults	GP Named Doctor for Child protection, NHS BwD	October 2010	Risk assessments to be included in GP Safeguarding Policy

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
relationship of identified health and social problems and how this was impacting on the risk to themselves or others (especially children/ pregnant women)					
15. GP practices should hold regular structured primary care meetings with health visitors and midwives /any community health professionals who are offering a service to their patients (BMA 2009)	Scoping exercise to ascertain how many practices have this information sharing system in place Build into GP Contracts Target practices where this is not operational	Where domestic abuse is a factor this information will be shared with the involved professionals in a timely manner and relevant information from practitioners/client records shared with each other as appropriate to inform risk assessments Information will be shared regarding children/ vulnerable adults in a structured timely manner Assessments will be informed by more comprehensive information Each GP practice to be	GP Named Doctor for Child protection, NHS BwD	July 2010 October 2010	Implemented in all GP practices across the borough

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
		able to evidence that they hold primary care team meetings where they share relevant information with community staff who are offering a service to their clients			
16. The NHS BwD domestic abuse guidance to be expanded to include: additional guidance	To include guidance in relation to: a. Using CAADA (DASH) risk assessment tool to risk assess all disclosures of domestic abuse with regards to pregnant women including information shared by the police and this risk assessment should be considered alongside any health information held on file b. The unborn child needs to be included as part of the risk assessment process c. Safety Planning d. information sharing with other health practitioners working with the victim of domestic abuse and their family Practitioners to be informed of changes to the guidance and relevant training provided with regards to CAADA (DASH) risk	Staff will have clarity about roles and responsibilities with regards to information sharing Staff will be clear about their role in risk assessment and safety planning Referrals will be made to helping agencies and MARAC as appropriate	Domestic Abuse Lead, NHS BwD	October 2010	Implemented

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
	assessment				
17. ELHT Domestic abuse guidance and information sharing protocol to be expanded to include additional guidance	To include guidance in relation to: a. using CAADA (DASH) risk assessment tool to risk assess all disclosures of domestic abuse with regards to pregnant women, including information shared by the police and this risk assessment should be considered alongside any health information held on file b. the unborn child needs to be included as part of the risk assessment process c. safety planning d. record keeping guidance to be expanded to include recording on a chronology of significant events; recording the 'grading risk' determined by the police assessment e. information sharing with other health practitioners working with the victim of domestic abuse and their family Practitioners to be informed of changes to the guidance and relevant training provided with regards to CAADA (DASH) risk assessment	Staff will be clear about their role in risk assessment and safety planning Referrals will be made to helping agencies and MARAC as appropriate Staff will be clear about their role in record keeping. This will aid appropriate and timely information sharing and assessments of risk	Named Nurse Child Protection, East Lancashire Hospitals Trust	October 2010	Implemented

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
18. Policy for following up referrals and non attendance at outpatient appointments to be built into safeguarding policies and procedures (NHS BwD, ELHT & LCFT)	Policy for following up referrals and non attendance at outpatient appointments to be built into safeguarding policies and procedures.	Clarity will be provided regarding the follow up of children and vulnerable adults when they fail to attend appointments / disengage form services	Designated Nurse, NHS BwD Named Nurse Child Protection, East Lancashire Hospitals Trust Lead Nurse Safeguarding, Lancashire Care NHS Foundation Trust	April 2010	Implemented
19. To risk assess the practice of the midwives having access to the full hospital record when seeing antenatal women at Children's Centres. To develop an action plan to reduce identified risks	To review and risk assess this practice as part of the whole maternity service provision To identify risks, and develop an action plan to manage these risks	The midwife will be aware of any previous incidences of domestic abuse prior to speaking with the client. This will impact positively on assessment of need and future interventions	Named Nurse Child Protection, East Lancashire Hospitals Trust Head of midwifery services and midwifery matrons, East Lancashire	October 2010	Implemented

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
			Hospitals Trust		
20. To highlight in mandatory training to midwives that safeguarding information contained in maternal records must be transferred to the neo natal hospital case notes	To give new prominence to the transfer of information from maternity case note to paediatric case notes via mandatory public health training day which all midwives attend	To ensure that paediatric staff will have documented access to issues of safeguarding concerns which have been present in the antenatal or postnatal period	Named Nurse Child Protection, East Lancashire Hospitals Trust	November 2009	Implemented
21. NHS BwD to write into provider and contracted services contracts record keeping standards	Write into provider and contracted services contracts the required recording standards for child protection cases	To ensure that the quality of record keeping is of a good standard	Children's Services Joint Commissioner, NHS BwD	Ongoing	Implemented
22. Request that BwD LSCB review the process currently in place for endorsing new policies/policy changes	Request that any resource issues for agencies to be considered by the LSCB during the endorsement and roll out/ training phase of any new policies	To ensure all agencies adapted their own internal policies to reflect new/ updated policies endorsed by BwD safeguarding Children's Board	Designated Nurse NHS BwD	January 2010	Implemented
Multi-agency Overview Recommendations					
23. The Blackburn with Darwen LSCB should request that Lancashire Constabulary, Blackburn with Darwen Children's Services and Health review and revise the Domestic Abuse Guidance and Protocol with a view to making	The Policies and Procedures Committee to convene a task and finish group to review and revise the Domestic Abuse Protocol. To agree the changes to the Protocol with Lancashire and Blackpool LCSBs.	To improve information sharing on domestic violence incidents between agencies and reduce the risk to unborn and new born children from parental domestic violence.	Chair Policies & Procedures Committee, BwD LSCB	April 2010 May 2010	Policy and procedures updated across Lancashire - awaiting evaluation of pilot initiatives in Lancashire to finalise

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
changes which: • Recognises the elevated risk of domestic violence for pregnant women • Explicitly ensures the unborn child is treated as a child at risk and present at any incident • Acknowledges the phenomenon of victim minimisation and denial and the need to address this – this should also address perpetrator denial and minimisation • How to make enquiries with perpetrators to understand the level of risk • Set timescales for information sharing which emphasise dealing with the					

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
issues as near in time to the incident as possible • Address the significance of family member involvement in incidents • Clarify unequivocally the requirements for information sharing • Emphasise the focus of the incident risk assessment as the adult and the need, therefore, for additional risk assessment relating to the child which should take account of all information held by an individual agency. The review should also consult all other interested agencies who work with domestic violence victims and					

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
perpetrators in assisting the revision.					
24. The Blackburn with Darwen LSCB should ensure that any changes to the Domestic Abuse Guidance and Protocol should consult and involve all interested agencies within the LSCB, be endorsed by the LSCB and the Guidance and Protocol is re-launched.	The Policies and Procedures Committee Chair to invite all interested partner agencies to the task and finish group. LSCB to endorse the revised Protocol Protocol and guidance launched.	The Protocol has wide partner ownership and implementation. Staff across agencies are familiar with the Protocol and are able to implement it.	Chair Policies & Procedures Committee, BwD LSCB	May 2010	Policy and procedures updated across Lancashire - awaiting evaluation of pilot initiatives in Lancashire to finalise
25. The LSCB Chair should write to DCSF and GONW to inform them of this SCR's finding that national guidance at present does not sufficiently address the different risks to unborn children and pregnant mothers.	LSCB Chair to write to the DCSF and GONW.	National guidance explicitly outlines the risks to unborn and new born children from parental domestic violence.	LSCB Independent Chair	December 2010	Implemented
26. All LSCB agencies to clarify to staff the expectations in relation to considering the expressions of concern by third parties (including	LSCB Chair to write to LSCB agencies to remind staff of internal procedures of dealing with third party child protection concerns.	Staff knowledge is refreshed on procedures to deal with child protection concerns from third parties,	LL, LSCB Chair	December 2010	Implemented

Recommendation	Agreed Action(s)	Expected Outcome(s)	Lead Officer	Timescale	Progress
family) about the safety and welfare of children.					
27. The themes and lessons learnt from this SCR are communicated to all agencies within the LSCB, Children's Trust and Community Safety Partnership (CSP)	Agencies contributing to this SCR immediately inform staff of lessons from their IMRs and the Overview Report. LSCB brief all LSCB, Children's Trust and CSP agencies of the findings from this SCR after the SCR is evaluated. LSCB training and briefings of SCR lessons reflect the lessons from this SCR.	Agencies informed of the lessons and how practice changes as a result of this SCR	LSCB Strategy Manager	December 2010 Post Ofsted Evaluation December 2010	Implemented