REPORT ON GOOD PRACTICE
IN SSCB PARTNERSHIP REVIEWS

Introduction

As part of the on-going improvement work of the Surrey Safeguarding Children Board (SSCB) the following report describes good practice identified in three Partnership Reviews conducted between 2010 and 2015 using different methodologies. This has been undertaken in order to promote examples of good practice in addition to the learning that emerges from Serious Case Reviews and is disseminated according to SSCB's statutory duties.

Partnership Review 1

A fifteen year old looked after child died having fallen from the platform of a railway station reportedly under the influence of alcohol. The report highlighted good practice as follows:

- Agencies had shared understanding of the child's needs as well as risk factors.
- There was good communication between agencies, especially in relation to assessment, planning and decision making.
- There was an appropriate care plan in place, which was effectively implemented, monitored and renewed, as well as appropriate service provision.
- Professionals were sensitive and committed to the child's needs.
- Professionals ensured that the voice of the child was heard and the child contributed to meetings as appropriate as well as the care plan.
- Professionals supported the child to attend appointments and engage with services.
- Professionals worked well together to support the child to achieve positive outcomes.

Partnership Review 2

Bruising was noted on a five month old baby on child protection plan by the Health Visitor and the baby was referred for a child protection medical examination. The Strategic Case Review Group commissioned a review of this case in order to consider how frontline practitioners interpreted and initiated the SSCB bruising protocol. Good practice was identified as follows:

- The initial response of the health visitor on finding what she considered bruising on a non-mobile baby, as well as her explanation to parents about what would happen next and her sharing concerns with Children's Service and GP.
- Appropriate referral by the GP to Children's Service Emergency Duty Team.
- Appropriate initial response from EDT and decision making.
- Well written child protection medical, including description of baby's stage of development and gross motor skills.
- Effective multi-agency working and good decision-making through the child protection conference.
- Child seen regularly with appropriate vigilance and recording of facts.
- Good managerial oversight and supervision in Children's Service.

Partnership Review 3

A four month old baby was admitted to hospital following an incident at the family home. The baby had sustained fractures and subdural haemorrhages. A section 47 enquiry had taken place at the time of baby's birth, where concerns about mother's history of alcohol abuse and mental health as well as the fact that she had been looked after were acknowledged but it was felt that the baby was not at risk of significant harm. However, a parenting assessment commenced. The areas of good practice are as follows:

- During the antenatal period, good communication between midwifery and Health Visiting Service. Post-natally, good communication between children's centre, Health Visiting Service and Children's Service.
- Good inter-agency working and information sharing between Police, Children's Service and the Health Visiting Service.
- During the antenatal period, appropriate risk assessment and referrals as well as service provision to mother.

- Evidence of professionals' ability to challenge one another.
- Evidence that the child remained the focus despite a number of issues in relation to parents.
- Evidence of innovative practice by children's centre to engage mother.

Janice Morgans
Anastasia Drenou

26.10.2015