Publication of serious case review report – Child Y

KSCP response

Knowsley Safeguarding Children Partnership (KSCP) accepts the findings of the review and is committed to learn the lessons, which are identified in the report.

During the period of this review, legislative changes introduced through the Children and Social Work Act 2017 saw the replacement of Local Children Safeguarding Boards (LCSB's) with local safeguarding partners.

Under the new changes the responsibility locally rests with the three safeguarding partners who have a shared and equal duty to make arrangements to work together to safeguard and promote the welfare of all children in a local area.

In July 2019, Knowsley Safeguarding Children's Partnership replaced the Knowsley Safeguarding Children Board.

The new local safeguarding arrangements will build on the strengths of the LSCB, in particular the partnership ethos and commitment for learning.

To complement this, a revised structure has been implemented, which will enable safeguarding partners to work together to identify and respond to the needs of children in the area;

There is a strong emphasis on commitment, engagement and accountability across the partnership to safeguard and promote the welfare of children in Knowsley. These principles are reflected in the strategic priorities set by the partnership and included in business plan for 2018/2020.

This includes a commitment to embed learning from reviews through the delivery of robust action plans that enable early and appropriate intervention with a particular focus on domestic abuse, neglect and child exploitation

The independent author made seven recommendations, which have been accepted by the partnership.

These are summarised as follows;

1. The Board should ensure that the local definitions and threshold criteria in relation to domestic abuse encompasses the impact of abuse from any household member which threatens the welfare of children under 18 years.
2. For thematic audit to address the response of 16-18 years olds in respect of domestic abuse and seek reassurance about the consistent application of threshold criteria.
3. Within the audit to address response to 16-18 years old, to establish the extent to which children are given a direct opportunity to express their views through the multi-agency partnership and that they are explicitly taken into account in decision making
4. For GP practices to be required to review and report how important letters about children's mental health is processed with clinician oversight assured
5. For the Hospital Trust to undertake an assurance exercise with regard to children's mental health presentations in Accident and Emergency and evidence confidence that the mental health pathway for children is being followed routinely
6. For the LSCB with local NHS commissioners to consider the particular vulnerability of children accessing private counsellors and whether further engagement with the registering body is required to consider safeguarding risks
7. The Board to engage in discussion with NWAS to achieve the following outcomes:
   - That the Safeguarding Policy provides specific guidance with regard to children and mental health/suicide risk.
   - That emergency responses to children with mental health presentations at all times explicitly consider risk of suicide when determining response

The partnership has implemented a robust action plan to ensure that learning from these recommendations can be achieved.

A review of policies and procedures is ongoing to ensure that full cognisance is taken of the impact of domestic abuse from any household member, which threatens the welfare of children under 18 years

The partnership has commissioned a series of thematic audits to quality assure the issues highlighted within the report. These include considering the consistent application of the threshold criteria for domestic abuse, establishing the engagement and response to 16 – 18 years old adolescents, the management of information by GPs concerning children's mental health, the implementation of the mental health pathway in respect of children presenting at Accident and Emergency Departments

The partnership has asked NWAS to review and amend their policies and procedures to include specific guidance with regard to children and mental health/suicide risk.

The independent chair of the partnership has written to the Department of Health to raise our concerns about the governance arrangements and consequent vulnerability of children accessing private counselling.

A multi-agency 'Practitioners Learning Event' is planned to take place in early December 2019. This will include a presentation from the independent author on the circumstances surrounding this tragic case as well as a presentation form a local support network that will highlight some of the concerns and vulnerabilities voiced by children who may experience suicidal ideations.

In conclusion, one cannot help but be moved by the sudden and unexpected death of a child who clearly had many strengths and qualities. His death has had a profound effect on those close to him. The family have indicated their hope that lessons can be learned which they hope will prevent other families suffering similar tragedy.

The partnership is determined to learn from this case and to prevent similar tragedies occurring in the future, we want to help to create an environment, which improves outcomes for children and enable them to achieve their potential.