Executive Summary

Serious Case Review

Undertaken for North Tyneside LSCB

RE: Child F

August 2010

Introduction

1.1 Working Together to Safeguard Children 2006 (updated 2010) sets out in Chapter 8 the circumstances in which Local safeguarding Boards should consider conducting a Serious Case Review (SCR) where:

> "*a child has died and abuse and neglect is known or suspected to be a factor in the death".*

1.2 North Tyneside's Serious Case Review sub-group, none of whom had any involvement with the family, met on 10th January 2010 and considered the criteria for a SCR were met with respect to the circumstances of Child F; this view was endorsed by the Independent Chair of North Tyneside's Safeguarding Children Board (NTSCB) on 13th January 2010.

1.3 The purpose of the overview report is to bring together information from individual management reviews to identify any lessons to be learnt about the way in which local professionals and organisations work together to safeguard and promote the welfare of children: to identify how any lessons will be acted upon and as a consequence, to improve inter-agency working and safeguard and promote the welfare of children.

1.4 This report is a summary of the events and findings of the overview report.

1.5 The terms of reference for the review are as follows:

- What were the key relevant opportunities for assessment and decision-making in relation to Child F and the family?
- How far was the issue of age, ethnicity, cultural or religious needs taken into consideration in the assessment process?
- Did the cultural and ethnicity issues impact on agency responses to this family?
- To what extent were father's views taken into consideration?
- How was the vulnerability of this family addressed by universal agencies?
- How did Adult Services and Health Services effectively assess parenting issues in the light of mother's mental health condition?
- Did actions accord with assessments and decisions made and were appropriate services offered or relevant enquiries made in the light of assessments?
- What was the level of mental health involvement and was this sufficient, based on relevant assessments, to meet need?

1.6 Barbara Williams is the Independent Chair of North Tyneside's Safeguarding Children Board.

1.7 Sue Barker is the Independent Chair of the Serious Case Review Panel.

1.8 Ann Spencer, CQSW, MA, is the Independent Author of the Overview Report, she has substantial experience of child protection and child care work across a range of social care services in both the statutory and voluntary sectors. Her experience includes lecturing in social work, supervision training and mentoring, undertaking SCR's and management reviews and investigating serious child care complaints. She has had no previous involvement with this case.

2. Process of the Review

2.1 It was initially agreed that the time frame for the review was the 24th April 2008 when the family first registered with the GP to Child F's death. The review period was later amended to 1st April 2008 when information about an earlier contact with a GP practice was discovered which was relevant to the matter under review.

2.2 The panel was made up of:

- Independent Chair
- Head of Safeguarding, North Tyneside Children's Services
- Safeguarding Operations Manager, North Tyneside Children's Services
- Safeguarding Manager (Designated Nurse), North Tyneside PCT
- Consultant Paediatrician, Designated Doctor
- Assistant Director, Clinical Governance NHS, North of Tyne
- LSCB Business Manager
- Detective Inspector, Police Protection Unit, Northumbria Police
- Director of Nursing, Northumbria Healthcare NHS Trust

2.3 Individual Management Reports (IMR's) and chronologies were provided by the following agencies:

- Newcastle and North Tyneside Community Health (this report included Northumbria Healthcare NHS Foundation Trust and Newcastle Tyne and Wear NHS Mental Health Foundation Trust)
- North Tyneside Children's Services
- Northumbria Police
- Children's Centre Nursery
- Voluntary agency providing services for women experiencing domestic abuse
- NHS North of Tyne (Primary Care)
- North Tyneside Adult Services

2.4 In addition reports were received from the following agencies:

- A private nursing home provider
- A report from a North East University

An Overview Report from Health

The following documents were also received:

- A reflective account of his earlier arrest written by Child F's father
- A letter from a private provider of mediation
- Note from the Pastor of the Pentecostal Church

2.5 In order to ensure independence and objectivity, none of the people who produced IMR's had direct line management responsibility for any of the staff involved with Child F's family.

2.6 In accordance with guidance, Child F's parents were invited to contribute to the review. Father took this opportunity but mother, who was undergoing a psychiatric assessment, failed to respond. Unsuccessful attempts were also made to contact maternal grandmother.

3. Background

3.1 Child F was born after an uneventful, planned pregnancy; the ethnic origin of both parents is Black African. It is thought that the couple had been together for approximately two years prior to Child F's death. It is believed, but not confirmed that mother had been in the country for less than five years and father slightly longer. Both mother and father are committed Christians and attended church. At the time of Child F's death, father was studying for a professional qualification and mother was working in health care.

3.2 Child F was father's only child. Mother has a seven year old child who has remained in mother's country of origin. There is conflicting information about who the main carer is, maternal grandmother or the child's father. It is believed that mother has had only intermittent contact with her older child and has not cared for the child since the child was a baby; she is believed to send regular payments to her mother.

4. Brief Summary of Events

4.1 Both parents were living together at the time of Child F's death. Father had returned home after an evening out and found his child dead and his partner unconscious. Child F had been given a morphine derivative; mother had also taken the same drug. Mother was sentenced to an Indefinite Hospital Order for Child F's manslaughter.

4.2 Mother had been receiving treatment from GP services for low mood and suicidal ideation from April 2008; shortly before becoming pregnant she had attempted suicide and had a short hospital admission; she attributed this to the racist abuse she was experiencing at work. Following her discharge from hospital mother received counselling between June and August 2008; she was also put in touch with her professional body to help her deal with the racism she was experiencing. Initially she was prescribed anti-depressants but these were discontinued when she was found to be pregnant with Child F.

4.3 Both mother and father contacted the police prior to Child F's birth. Mother alleged she had been assaulted by father and also that she had been the victim of domestic violence in the past. At a later date, father informed both the police and Children's Services that he was concerned about the effect mother's mental health was having on their unborn child.

4.4 Child F was born after an uneventful labour. Child F was seen by a number of health professionals throughout the child's short life and also attended a nursery for a short time; all of those involved noted that Child F was thriving and had no concerns about the child's care.

4.5 Mother complained to the police about a further incident of domestic violence when Child F was 3 months old. On this occasion mother made serious allegations about a threat father had made although mother said she did not take the threat seriously and ascribed it to father's temper.

4.6 An Initial Assessment (IA) was undertaken by Children's Services. Father denied mother's allegation. No concerns were raised about Child F's care by any of the agencies contacted by Children's Services and after putting mother in touch with a specialist Domestic Violence Service the case was closed as father was no longer living in the household. Father disagreed with this decision.

4.7 After the couple reconciled, mother made a number of complaints about Child F's response to father and believed he had unrealistic expectations of Child F. Child F was noted to be thriving.

4.8 Child F attended a nursery intermittently from late August 2009 until November 2009 when mother withdrew her child. Child F was noted to be happy and well cared for and both parents were seen to be loving and caring towards their child. The HV also noted father's interaction with Child F was excellent.

4.9 In September father visited mother's GP without her knowledge, to ask for an appointment for mother because of his concerns about her mental health. The GP

complied with this request and after assessment, prescribed anti-depressants. Mother told the GP that she had good support from both father and her work place.

4.10 Child F was seen by several health professionals during the autumn; the child's development was good and Child F continued to thrive.

4.11 Mother responded well to medication and returned to work in October. She described herself as feeling "much happier, more relaxed and calm" and in December 2009 told the GP that she was no longer arguing with father and felt cheerful. Later in December there was an incident at her workplace when mother was alleged to have been abusive to members of her team who made a formal complaint against her.

4.12 In the week prior to Child F's death mother sent two letters to her work place, one relating to taking on more management tasks and the second alleging that the care team had made racial comments the previous week. Following this, mother telephoned work and was described as "upbeat" during the call.

5. Analysis

This section summarises each of the areas identified in the Terms of Reference. The author found evidence of good practice as well as deficiencies in practice under each of the sections.

What were the key relevant opportunities for assessment and decision making in relation to Child F and his family?

5.1 There is evidence that some agencies missed opportunities for assessing Child F in the context of the child's family. The GP practices were responsive to mother's low mood but failed to question her plan to become pregnant and the potential effect on her mental health of stopping her medication. The mental health practitioner discharged mother after her mental health improved without putting a plan in place to help her when she returned to work. The midwife failed to undertake a Level 2 assessment when mother provided her with her history.

5.2 The police took appropriate action when mother first contacted them but failed to question the circumstances when father contacted them shortly before Child F's birth and so missed an opportunity to refer mother for further support. There was also a failure on the part of Children's Services to respond adequately when father raised concerns shortly before Child F's birth. Later, when an Initial Assessment was undertaken, questions were asked and responses provided based solely on information about Child F. The decision to close the case was based on the fact that Child F was thriving and there were no concerns; no information was made available about mother's mental health. There was no re-assessment when father disputed this decision. Children's Services saw father primarily as the perpetrator of violence against mother but no contingency plan was put in place should father return home as he had done in the past. The specialist domestic violence service also failed to share the assessments they had undertaken or to inform Children's Services when mother opted out of their service.

5.3 The HV service was aware that father had returned to the family home as mother told her about concerns she had about father's behaviour and attitude towards Child F. These concerns warranted an assessment under the Common Assessment Framework (CAF). The HV shared the information with Children's Services who made an initial attempt to see mother but took no further action when their first attempt failed. In view of the concerns which were raised it would have been appropriate to hold a strategy meeting; this would have allowed agencies to share information and identify discrepancies between mother's accounts of father's behaviour and direct observation of his behaviour and attitude towards Child F. Had this occurred, mother may have been provided with additional help.

How far were the issues of age, ethnicity, cultural or religious needs taken into account?

5.4 There is evidence of a lack of importance being given to the parents' ethnicity, culture or religion. There was little evidence that these factors were considered adequately when assessments were made or when services were being provided.

Did the cultural and ethnicity issue impact on agency responses to this family?

5.5 Many of those who provided services adopted a "colour blind" approach and ignored cultural differences. The couple were frequently described as "westernised" and assumptions were made about their ability to access specialist help without further input.

5.6 There was no evidence that those dealing with Child F and the parents were overtly racist or that services were deliberately restricted because of cultural differences.

To what extent were the father's views taken into consideration?

5.7 Father's role in Child F's life was largely ignored by the HV service who took mother's allegations about father's attitude to Child F at face value. When father was observed to be interacting with Child F appropriately, no attempt was made to re-assess the situation.

5.8 Children's Services focussed on the allegations of domestic violence. Father's concerns about the effect on Child F of mother's mental ill health were not taken seriously.

5.9 The GP responded immediately to father's concerns, however, the GP was unable to share this information with Father for reasons of confidentiality. Father was unaware that his concerns had been taken seriously and as a result, when his concerns grew, decided to look outside the professional network for advice.

How was the vulnerability of this family addressed by universal services?

5.10 Aspects of the family's vulnerability such as the impact of ethnicity, isolation and their incomplete understanding of British culture were overlooked by universal services. No one service looked at this family as a whole; each service focussed solely on a single factor. Had there been better communication, a fuller picture of the family's vulnerability would have become apparent.

How did Adult Services and Health Services effectively assess parenting skills in light of mother's mental health condition?

5.11 The midwifery service failed to take into account information about mother's previous mental health issues and her failure to bond with her first child when assessing parenting skills; this information was not passed to the HV service.

5.12 Father's attitude and parenting skills were not assessed by any agency. Had an assessment been undertaken, this may have challenged some of mother's allegations about him.

5.13 Mother's parenting ability was not questioned by any agency since she was seen to have bonded well with Child F who was thriving.

Did actions accord with assessments and decisions made and were appropriate services offered or relevant enquiries made in the light of assessments?

5.14 Some of the shortfalls in practice which relate to this heading have been dealt with in section 5.1-5.3. Although many of the decisions were made based on positive reports of Child F's care and development the focus of enquiries was often too narrow. Good practice relies on constant reassessment of initial judgements.

What was the level of mental health involvement and was this sufficient, based on relevant assessments, to meet need?

5.15 Mental health involvement by the self-harm team was limited and mother was seen once after being discharged from hospital, this was based on an assessment that she was a low risk. During Child F's short life GP's regularly re-assessed mother's mood using recognised assessment tools and noted improvements. It is not known if these were designed to allow for diverse cultural and ethnic differences. The National Institute of Clinical Excellence (NICE) guidelines recognise that the current diagnostic systems for depression do not capture a number of factors including biological, psychological and social factors; these factors have a significant impact on the course of depression and the response to treatment.

6. Conclusion

6.1 Services were not adjusted to take into account the impact of race and culture and the family's difficulties were viewed as if they were a white British family. Assumptions were made about their ability to pursue the help they required without additional assistance; there were few attempts to explore how to help them further their aims. When significant issues were raised by both mother and father that identified very different cultural beliefs, no attempt was made to explore these differences and any impact these beliefs may have had on parenting.

6.2 Previous SCR's have identified the failure of agencies to pay sufficient attention to the child. In this case, Child F was the central focus throughout but scant attention was given to the family context and the issues raised by parents were seen in isolation. No single agency attempted to view the family holistically and there were

limited attempts to share information. Had a CAF been undertaken this may have prompted Children's Services to undertake a fuller assessment or at least hold a multi-agency meeting. However, it is not likely that this would have prevented Child F's death; there are limits to what would have been achieved by conducting a fuller assessment.

6.3 Research into mothers who kill their children show that many of them have suicidal tendencies prior to the event and have identified a variety of psychosocial factors which play a major part. Although with hindsight, mother demonstrated many of the characteristics identified in the research, this research is based on information available only after a tragedy has occurred; there appears to have been no research on mothers who have a similar background to Child F's mother.

6.4 There was nothing in mother's behaviour to warrant a referral for full psychiatric assessment. She presented a rational account of her problems, sought help from health professionals and the police, held down a responsible post and showed no signs of mental disturbance to the many professionals who were in contact with her. She was noted to provide a high standard of care for Child F with whom she had a close bond.

6.5 Many women suffer from depression and experience a variety of stresses and do not harm their children. The dispute at work in December where once again mother believed she was the victim of racial abuse and where members of staff took out a grievance against her may have been the precipitating stress factor. If this hypothesis is correct, then it is unlikely that any of the agencies involved could have prevented this tragedy.

7. The areas identified for improvement are as follows:

- Staff from all agencies failed to take sufficient account of race, culture and religion when undertaking risk assessments.

- Insufficient attention was paid by GP practice 2 to the potential dangers of leaving a patient with suicidal ideation without any support when leaving the practice.

- Staff did not look beyond the superficial presentation of this family, consider their difference and how these might impact upon the way they saw and responded to the world; this limited the scope of assessments.

- A serious allegation of racial abuse from staff at a provider agency was not followed up effectively by Adult Services.

- Children's Services failed to take a full history before closing the case in spite of obvious cultural differences.

- Police failed to include important information in a Child Concern Notification (CCN).

- No attention was paid to key statements about beliefs which had a direct bearing on potential risk to the child.

- Primary Health Care staff were reluctant to provide information about mother's mental health.

- Mental Health professionals did not consider past history and social factors when undertaking a diagnostic assessment.

- GP's failed to look at adult records when enquiries were being made about the well being of a child.

- Children's Services failed to ask the GP questions about the mental health of the parents.

- The effect on depression of cumulative factors were not considered by either mental health professionals or GP's when devising treatment plans.

- Domestic violence was recognised as a key element of risk in this family but other factors were not considered during assessments.

- Father was not included in either the HV or midwives assessments which limited their effectiveness.

- No CAF was undertaken despite the recognition of the vulnerability of mother and child.

- No multi-agency meeting was held to share information despite the number of concerns identified.

- Concerns expressed by father about the care of Child F were not followed up.

- Mother's interest in a service provided by the Children's centre was not followed up.

8. Recommendations

The recommendations from the single agency reports have been taken into account when making these recommendations and where matters have already been addressed, no additional recommendations have been made. The subsequent action plan is attached.

8.1 North Tyneside LSCB must take appropriate action to ensure its constituent members are aware of the need for staff, when undertaking risk assessments, to fully take account of issues of belief, culture and other distinguishing features. The LSCB to consider a local performance indicator that ensures the LSCB monitors the impact of the action taken.
Reference: the Child F SCR highlights ethnicity was not always recorded and/or recorded incorrectly. Agencies 'saw' the family as 'westernised' and failed to take into account appropriate matters linked to their heritage. Focused attention to this matter via the LSCB will make agencies and their staff more aware of its importance when doing risk assessments.

8.2 North Tyneside LSCB must take appropriate action to ensure that single and multi-agency child protection training effectively addresses equality and diversity issues. The training must include an emphasis upon how child rearing is impacted upon by the cultural and related beliefs of parents. The LSCB to put in place a monitoring system to measure the impact of the training.
Reference: the Child F SCR illustrates how professionals did not seek to understand how the parents' background influenced their parenting. On occasions a homogenous view of African heritage failed to distinguish differences between cultures. On other occasions the family were seen as adopting western attitudes. This is a weakness in the current impact of the training offered. The LSCB will take this opportunity to strengthen the impact of the training.

8.3 North Tyneside LSCB should explore the feasibility of setting up a web-based information system where staff from any agency can obtain information about specialised services for non-British service users from ethnic minorities.
Reference: the Child F SCR shows how the lack of a readily available information resource has meant staff do not routinely avail themselves of necessary knowledge and are not sensitised to issues of culture. A web-based resource will help address this issue.

8.4 North Tyneside LSCB, with North Tyneside Safeguarding Adults Board, should seek assurances that mechanisms and checks are in place by local Health and Social Care Commissioners to effectively manage and quality assure, systems that prevent the misuse of patients' drugs.
Reference: the Child F SCR notes the drugs used by the parent were improperly removed from a care setting. This recommendation will bring joint action and assurance that all necessary steps to prevent such misuse are in place.

8.5 North Tyneside LSCB should ensure, through a joint enquiry with local commissioning and contract units, that there is in place robust monitoring by managers of compliance to equal opportunity and diversity policy and practice by commissioned services.
Reference: the Child F SCR acknowledges a response to an allegation of racial harassment in the workplace. This recommendation will bring about joint action to strengthen the necessary awareness and actions required by staff.

8.6 The LSCB should take appropriate action to strengthen multi-agency assessment practice. Agencies should submit a report to the LSCB on the steps they will take to ensure training for those who supervise front-line staff, is in place and effective:

- ensuring a broad view of the family's circumstances is taken into account
- all those whose view needs to be sought are contacted when doing an assessment

Reference: the Child F SCR highlights that assessment practice was not always thorough and robust. For example, and in addition the points noted 9.1-9.2 it is also highlighted that direct questions were not asked of the GP by the social worker when concerns were highlighted about the care givers mental health. The role of first line managers is crucial in ensuring practitioners follow up all lines of necessary enquiry.

8.7 Northumbria Police and North Tyneside Children's Services should provide a reviewed (and subsequently implemented) protocol to the LSCB relating to the calling of strategy discussions via the Child Concern Notification,
Reference: the Child F SCR points to the Police Child Concern Notification as submitted in this case requesting a strategy discussion. This request was not followed up and illustrates ambiguity in the system that requires attention. The new protocol will ensure that requests for strategy discussions are highlighted.

8.8 Newcastle and North Tyneside Community Health and Northumbria Healthcare Foundation Trust should provide a report to the LSCB on the progress made on the recommendation, arising from the Serious Case Review (Child C). This review recommended that health visitors and midwives need to ensure information about fathers is included in their assessments.
Reference: The Child F SCR highlights a point previously raised as a result of a SCR: that fathers are not effectively included by health visitors and midwives in their assessment of the overall child's circumstances and care. The LSCB receiving a progress report on the matter can address the points made at the highest level to seek an early resolution.

8.9 North Tyneside LSCB should refresh its local information sharing protocols. In doing so it must ensure so that when information is requested regarding the mental health of a patient and this concerns the wellbeing of a child, this is considered with due regard to the protocol.
Reference: the Child F SCR notes that a request by one professional for information on the mental health of a patient was declined by those who held the information. The local Information Sharing Protocols must be reviewed and changed to ensure that staff are appropriately guided in this matter.

9. Recommendations from single agency reviews

Children's Services

- The Local Authority should review the way in which agencies assess and respond to domestic violence and satisfy itself that the agency processes in place provide effective and proportionate responses. This should take account of any diversity issues.

- The Local Authority should provide guidance to staff on how it will assist separating parents who have challenges to face in managing contact arrangements, about how the Council can guide and assist service users when contact is an issue.

- A review of the information currently provided to families detailing support services to be undertaken. This will ensure information is available in a variety of formats, e.g. leaflets, telephone numbers as well as web site details.

- Where domestic violence is a concern and the protective factor is the parents separating, a contingency plan should be in place, known to all professionals who have worked with the child/family advising what to do should the parents reconcile.

- Training to be developed for staff regarding cultural issues and the impact on parenting and relationships. This should include guidance on how to access support and additional information when necessary.

- Work to continue with Adult Social Care to facilitate joint assessments when there are concerns about both a parent's needs and risks to a child.

- All Children's Social care staff should have an opportunity to be informed of the role of Children's centres and the core offer to families in the neighbourhood.

Newcastle and North Tyneside Community Health Services

- The NNTCH to amend records to include specific question on ethnicity, religion and first language
  The purpose is to ensure that ethnicity forms part of the assessment process for all clients.

  Timescale:- three months

- NHFT, NNTCH and NTW ensure that specific information regarding Domestic Abuse and minority ethnic status and immigration, is embedded into courses dealing with any issues regarding Domestic Abuse and also to include possible sources of specialist information or advice for staff.
  The purpose is to ensure that all staff are aware of the variety of sources that provide specialist information

  Timescale:- six months

- NHFT and NNTCH to complete an audit of the Level 1 Early Pregnancy Assessment forms to audit effectiveness of these assessments and if necessary amend documentation, and if indicated provide training for all relevant staff in its use.
  The purpose is to ensure that staff analyse appropriately the information provided in the Level 1 Early Pregnancy Assessment form.

  Timescale:- Audit three months, training 6 months

- NNTCH promotes the use of CAF in assessment of vulnerable children to inform their work with families.
  The purpose is to ensure the context and dynamics of family makeup are explored holistically and the focus remains on the child.

  Timescale:- six months

- NNTCH If an Initial Assessment is undertaken for reasons of risk due to DV when the alleged perpetrator has left the family, a re-referral should be made when/if the couple re-unite.
  The purpose to re-assess the risk for the child.

  Timescale:- three months

- NNTCH to audit their equality and diversity training to ensure that all members of staff have completed it.
  The purpose is to ensure that staff have an understanding of equality and diversity issues.

  Timescale:- Immediate

- NTW and NNTCH to develop robust guidelines to ensure that when re-organisation takes place and when staff and their patients are transferred between organisations, relevant confidential patient records follow the patient into the new organisation and there is a process to transfer and acknowledge receipt of patients records from the previous record management system to the new organisations' patient management system.
  The purpose is to ensure seamless patient care.

  Timescale:- three months

Northumbria Police

- Officers should be reminded that in cases where CCN's are required, they should include information about all allegations made during an investigation and any information which may have contextual connotations no matter how tenuous they may be.

- Officers should be reminded that incidents should not be taken in isolation and that they should have a holistic look at other incidents and calls to an address when identifying if concerns should be raised in a CCN about a child.

- A database search should be carried out to trace the source of anonymous calls to the police and this is particularly important when the call relates to safeguarding issues around a child.

NHS Primary Care North of Tyne

- A safeguarding alert to be sent to all practices reminding them of:

a. The handover of vulnerable patient care is important and needs to be considered when a patient moves from one practice to another.

b. Highlights the importance of inter-agency information sharing when it could be relevant to child safeguarding.

c. Important information related to one person in a family should be incorporated into the notes of other family members if it is related to safeguarding of a child.

- When a patient presents to the Practice with work related stress careful consideration should be given as to whether communication with the employer is needed

Adult Social Care

- The need for clear and accurate recording should be integral to the recording standards established for care Management staff and form part of the case file auditing process. Where future issues are identified in terms of recording these should be addressed through supervision and other appropriate mechanisms.

- A clear process for handling and monitoring concerns/allegations in respect of provider practice needs to be established within the Adult Social Care Contracts and Monitoring Team. This will ensure that there is a full and clear audit trail as to the actions taken and lessons learnt.

- At the point at which we evaluate and review our care management guidance, we will undertake an Equality Impact assessment to ensure that practices and procedures are culturally sensitive.

- A report will be presented to the North Tyneside Safeguarding Adults Board and the Local Safeguarding Children's Board detailing the progress made to date in respect of joint work between Adults and Children's Services to develop an approach to joined up working based on the 'Think Family' Agenda.

Children's Centre

- A more robust procedure has been developed that ensures requests for Children's Centre information are passed to a relevant member of staff and a face to face discussion offered to the parent. The effectiveness of this process will be monitored by the Children's Centre on a monthly basis.

- A member of The Children's Centre will also attend nursery staff meetings to share good practice and relevant information.

- All Children's Health Visitors will be informed when a child attends nursery with the permission of the parent. The Health Visitor will be given the date of commencement and informed of the day of departure stating the reason for leaving. The admission forms will be amended to include this action and will be monitored by the Nursery Manager/Assistant Manager as part of the Nursery's Quality Assurance System.

- There is a more co-ordinated approach to responding to children's Centre membership forms when they are received where a parent has identified a service. The Nursery to liaise with Children's centre Facilitator to ensure any requests made by parents attending the nursery are followed through and dealt with accordingly.

- A review will be undertaken of the Equality and Diversity training available to staff in the children's centre. The review will focus upon the need that staff have to be engaging, competent and pro-active to be able to discuss with Black, Minority Ethnic parents their feelings of isolation and differentness, living in a predominately white area and neighbourhood. The training to equip staff to be able to sensitively meet this challenge is a requirement and will be the subject of

an Equality Impact Assessment.

Voluntary agency providing services for women experiencing domestic abuse

- Staff to ensure that further investigations are carried out, if advised that police have attended property. However, extreme caution and sensitivity need to be exercised as staff need to ensure that they do not appear controlling.

- Staff to ensure that items identified in Perpetrator and MARAC risk Assessments are shared with Social Services as best practice.

Private Nursing Home Provider

- A full internal review of the agency to ensure any changes in protocols are identified and action taken.

- Better access to occupational health advice to ensure support for the employee and the employer.