city & hackney safeguarding children board

CHSCB Response

Serious Case Review - Child H

April 2016

1. Introduction

1.1 In July 2014, the Independent Chair of the City and Hackney Safeguarding Children Board (CHSCB), Jim Gamble QPM, decided to initiate a Serious Case Review (SCR) following the death of a six week old child, Child H.

1.2 Medical advice indicated that Child H had died as a result of inflicted injuries.

1.3 The Chair's decision to undertake the SCR was made in line with Regulation 5 of the Local Safeguarding Children Board Regulations 2006 and consistent with the statutory guidance set out in Working Together to Safeguard Children (2013) (since revised in 2015).

1.4 The SCR itself was not determined by any particular theoretical model and was carried out in accordance with the underlying principles set out in statutory guidance. Its overall purpose has been to look at what happened and why, to identify the learning for both child and adult-facing organisations and to make recommendations for either improvement or the consolidation of good practice.

1.5 The details of the SCR's findings are set out below, although it is important at the outset to emphasise the author's conclusions that the death of Child H could not have been anticipated by any of the services or professionals involved with the family.

1.6 It is also important to emphasise that no-one has been held to account for Child H's death.

1.7 Whilst this case has been subject to a full criminal investigation, no further action has been taken in this regard. A full review of evidence by the Crown Prosecution Service (CPS) and a Queens Counsel (QC) from the CPS Special Case Unit was unable to establish with certainty when the injuries occurred and who was caring for Child H at the time of death. No other charges have been deemed suitable to pursue.

1.8 The findings and associated recommendations of the SCR have been accepted by the CHSCB.

2. Learning Disabilities and Learning Difficulties

2.1 The SCR identifies two main cross-cutting themes as having relevance to the multi-agency arrangements for the safeguarding and protection of children and young people.

2.2 The first relates to the issue of whether parents or carers are considered to have either a **learning disability or a learning difficulty** and the actions that result or should result as a consequence.

2.3 This case has served to illustrate a confusion, which is not uncommon, about eligibility for services provided by multi-agency Adult Learning Disability teams. The review identifies that this often arises from a lack of clarity about what constitutes a learning disability and can be linked with an inaccurate, interchangeable use of the terms “learning difficulty” and “learning disability”.

2.4 The review does illustrate positive practice in terms of the potential causes for concern being identified immediately by the GPs and maternity services, appropriate referrals being made and subsequent good liaison and collaboration between maternity and health visiting services.

2.5 However, the SCR also highlights confusion across the network of agencies as to whether Child H’s mother had a learning disability, how that should be assessed and addressed and how the relevant specialist services were configured and accessed. The SCR identifies that there was no referral to learning disability services until shortly before the death of Child H.

2.6 Indeed, whilst both parents were noted as co-operating with the specialist assessments undertaken by both children’s social care and adult mental health and that those assessments were generally thorough, the SCR finds that the issue of the intellectual impairment of Child H’s mother and its potential consequences was not given adequate weight by either of these services.

2.7 Three related recommendations arise from this finding including:

2.8 The Board should promote, across all agencies, a clearer understanding of the nature of adult Learning Disability and the thresholds for eligibility for Learning Disability services.

2.9 To meet this recommendation:

- Practice guidance and pathways for "maternity and early years services" have been produced by Homerton University Hospital NHS Foundation Trust (HUHFT) to support health staff working with people with a learning disability who are to become parents.

- The CHSCB has published these details on its website and in its March 2016 "Things You Should Know" briefing, alongside other important information concerning Hackney's Adult Learning Disabilities Service.

- The CHSCB has included in its multi-agency training programme for 2016/17 courses to support practitioner understanding of the needs and possible impact on children when a parent has learning disabilities, and the local threshold for eligibility for engaging the Adult Learning Disability Service.

- Scheduled events following the publication of this SCR will further reinforce related learning.

2.10 East London NHS Foundation Trust (ELFT) to provide reassurance to the Board that appropriate assessment guidance is in place, that this guidance is explicit with regards to engaging relevant specialists when learning disabilities are either known or suspected, and that ELFT staff adhere to this guidance.

2.11 To meet this recommendation:

- The Chair of the CHSCB has written to ELFT formally requesting this reassurance which will be considered by the Serious Case Sub Group of the CHSCB and formally reported to the City and Hackney CHSCB Executives.

- The CHSCB has requested ELFT review its assessment guidance in line with the findings of the SCR and circulate any revised advice to all relevant front-line staff in ELFT on completion.

- Both the CHSCB and the City & Hackney Safeguarding Adults Board (CHSAB) will work with ELFT to publicise and disseminate relevant guidance to the wider partnership as necessary.

- ELFT has consistently promoted child safeguarding across its staff group, supported by a comprehensive joint protocol with children's social care. ELFT continues to review its arrangements in this regard.

- ELFT is in the process of reviewing its single agency audit process to ensure there is specific evaluation of how well mental health assessments consider other areas of need.

2.12 The Board should require the London Borough of Hackney to review the local protocol for assessment as required by statutory guidance in Working Together 2015. LBH should ensure this protocol is understood by staff and clearly sets out and clarifies how statutory social care assessments are informed by, and inform, other specialist assessments, including those on learning disabilities.

2.13 To meet this recommendation:

- The Chair of the CHSCB has written to the Interim Director of Children's Services formally requesting this reassurance which will be considered by the Serious Case Sub Group of the CHSCB and formally reported to the Hackney CHSCB Executive.

- Hackney Children & Young People's Services (CYPS) has reviewed and updated the local protocol for assessment and in partnership with the CHSCB will disseminate and publicise the protocol to all staff.

- Hackney CYPS has reviewed and amended its single agency auditing processes to ensure there is specific evaluation of how well assessments are informed by / inform other specialist assessments.

3 Psycho-Social Meetings

3.1 The second cross-cutting theme in the SCR relates to the partnership's understanding of the "**psycho-social**" arrangements in operation at Homerton University Hospital NHS Foundation Trust (HUHFT)

3.2 The SCR revealed some confusion across a range of agencies in respect of the role and purpose of "psychosocial meetings" in maternity services, with this area attracting one recommendation.

3.3 The CHSCB should require HUHFT, in light of the issues identified in this review, to review their arrangements for psychosocial meetings.

3.4 To meet this recommendation:

- HUHFT has committed to review the terms of reference and in partnership with the CHSCB, take action to communicate these across the partnership.

4. Inter-agency liaison and Information Sharing

4.1 The SCR identifies learning about improving the interface between maternity services and Primary Care Psychology (PCP) Services and also the importance of adult facing services (across HUHFT and ELFT) "Thinking Family" and considering child safeguarding and welfare issues during their day to day work. The associated recommendation is set out below:

4.2 The CHSCB should require HUHFT, in light of the issues identified in this SCR, to review their arrangements for liaison between maternity services and PCP and, promote awareness of child safeguarding issues.

4.3 To meet this recommendation:

- HUHFT has reviewed the arrangements and the PCP has already made changes to their administrative processes so that, if patients do not engage with the service following a GP referral, a referral back to the GP, requesting re-assessment, is automatically triggered.

- Training sessions with PCP have also been planned by HUHFT to ensure there is a clear focus on children and young people and their associated safeguarding needs when work is being undertaken with their parents / carers.

- HUHFT is currently reviewing its arrangements for the promotion of child safeguarding issues across its staff group.

4.4 The SCR also concludes that information was not shared comprehensively across the network of agencies with regards to serious illness in the immediate family and the death of a relative. The SCR finds that had this happened, there should have been a re-assessment of the family's circumstances by Children's Social Care Services.

4.5 Whilst not attracting a specific multi-agency recommendation, the CHSCB continues to promote the importance of information sharing, working with partners to develop a strong culture whereby professionals are supported to appropriately share information, with the protection of information not being placed before the protection of children.

5. Avoidable Drift and Incomplete Case Recording

5.1 The SCR concludes that there was some "*avoidable drift and incomplete case recording*" within children's social care. These factors are not uncommon findings in the context of many other SCRs.

5.2 Whilst the author is clear that more conventional approaches to managing casework are not guaranteed to prevent them, he expresses a view that these aspects could be linked to the service model, with an emphasis on the issue of management oversight and how this is applied when more senior staff (Consultant Social Workers) lead on a case and undertake the assessment.

5.3 In terms of the Hackney model itself, this has been in operation since 2007 and has been subject to a range of formal inspections, pilot inspections and both internal and external evaluations. Whilst being different to more traditional models of social work, there is a strong evidence base derived from these processes that demonstrate Hackney's front-line social workers are delivering high quality services for children and young people.

5.4 The CHSCB recognises this position, recognises the benefits of the Hackney model and is alert to the quality assurance framework in place overseeing practice. Equally, however, the CHSCB recognises the need to be reassured that the risk of similar circumstances arising again has been mitigated as far as reasonably possible. In response to this area, the SCR has recommended the following:

5.5 The London Borough of Hackney should provide reassurance to the Board that its quality assurance arrangements for all individual cases (including those where a Consultant Social Worker is working directly with a family) are sufficiently robust to test the quality, thoroughness and timeliness of social work activity.

5.6 To meet this recommendation:

- The Independent Chair of the CHSCB has formally written to the Interim Director of Children's Services requesting that the Hackney CYPS report to the Hackney Executive and provide reassurance that the quality assurance arrangements are robust and set out the action taken to minimise the risk of a similar circumstances arising again in the future.

5.7 In addition to the recommendations arising from the SCR Overview Report, the CHSCB maintains ongoing oversight of all single agency recommendations made by member agencies as part of their Individual Management reviews, regularly scrutinising actions and their related impact on improving safeguarding arrangements for children and young people.