city & hackney
safeguarding
children board

Statement – Jim Gamble QPM, Independent Chair CHSCB

Child H was just six weeks old when she tragically died in hospital from the injuries inflicted upon her.

Whilst a full criminal investigation has been undertaken, no one has ever been held to account for her death. The Crown Prosecution Service (CPS) state that this is due to the available evidence being unable to establish with any certainty how, when, where, and by whom the fatal injuries were inflicted.

When this Serious Case Review (SCR) was commissioned, one of the objectives was to consider the role of multi-agency partners. Having carefully examined all aspects of the report, I fully concur with the SCR author's findings that the death of Child H could not have been anticipated by any of the services or professionals involved with the family.

However, whilst the SCR identifies good practice by the GPs and maternity services, it also identifies a number of areas for improvement and makes constructive recommendations for the Board and partners to address. All five recommendations, the details of which can be found in the SCR report and CHSCB response, are accepted and have either been fully addressed or are work in progress, being subject to an action plan and regular scrutiny by the Board.

The SCR found that both parents cooperated with the specialist assessments undertaken by children's social care and adult mental health; and that whilst these assessments were generally thorough, they could have given greater consideration to the mother's intellectual impairment.

Other key issues include the consideration, identification and understanding of learning disabilities and some confusion about eligibility for services provided by the multi-agency Adult Learning Disability Service.

The SCR also exposed a need for a better shared understanding concerning the role and purpose of "psychosocial meetings" in maternity services, the need to promote awareness of child safeguarding issues and the need for the Board to confirm that the quality assurance arrangements for individual cases are sufficiently robust.

I am in no doubt that the multi-agency partners on the Board are committed to seeking out every opportunity to learn and improve. For my part, I will be working with them to ensure we build on our strong relationships to further develop a shared language that delivers an unambiguous understanding of the issues we face and the services we individually and collectively provide. I will also ensure that when lessons are identified that we move the recommendations forward with the pace and urgency they require.