Hillingdon LSCB Response to the Serious Case Review in relation to Baby W.

1. INTRODUCTION

- A serious case review has been carried out as a result of four fractures incurred by Baby W who was living with his mother and father at the time. Investigations identified that the fractures were non-accidental and following a police investigation, a full file of evidence was submitted by the Metropolitan Police to the Crown Prosecution Service. Papers have been sent by the Metropolitan Police to the Crown Prosecution Service but no decision has been made yet as to whether anyone will be charged with causing the injuries to Baby W.

- On 23rd September 2015 the Hillingdon Safeguarding Children Board serious case review subcommittee considered the case and agreed that as a child had been injured and abuse or neglect was suspected, the case met the criteria for a serious case review. Relevant background information which informed this decision was that Baby W lived with his mother and father. The family had been known to children's social care in boroughs outside of Hillingdon due to Mother's history of alcohol misuse; substance misuse; mental health difficulties; eating disorder and being a victim of domestic violence during a previous relationship. At the time of Baby W's injury, the baby was subject to a child protection plan and Father was subject to stringent bail conditions that included not having contact with Mother or approaching the family home. This was following admittance by Father of assaulting Mother.

2. REVIEW PROCESS

- Following agreement by the subcommittee that the case met the threshold for a serious case review, the chair of Hillingdon Safeguarding Children Board commissioned this review and appointed Dr Sonya Wallbank and Jane Wonnacott as lead reviewers.

- The lead reviewers worked with a small team of senior professionals from within Hillingdon who represented the organisations who had contact with Baby W and his family. This team consisted of:

    - Hillingdon Safeguarding Children Board Business and Development Manager

    - Named Nurse Safeguarding Children for Central and North West London NHS Foundation Trust

    - Designated Nurse Safeguarding Children, Hillingdon

    - Named Nurse Safeguarding Children, The Hillingdon Hospitals NHS Foundation Trust
    - Metropolitan Police Representative
    - Assistant Director, Safeguarding and Children's Service Improvement
- Each organisation prepared a chronology and outline of their involvement and the review team agreed questions that would need to be considered by the review.
- The review aimed to understand events from the point of view of practitioners working with the family and the lead reviewer arranged to talk to individual practitioners with the member of the review team representing their organisation.
- Mother and Father were contacted and offered the opportunity to contribute to the review, neither wished to do so. The panel recognised that their feelings could change following conclusion of the criminal investigation and agreed that they would be contacted again at that point. .

LSCB ACTIONS

Hillingdon LSCB and Safeguarding Adult Board (SAB) have formed a Case review Sub-Committee that meets quarterly and is chaired by the LSCB business manager. This sub-committee considers recommendations from serious case reviews. The sub-committee has clear terms of reference and reports directly to the operational LSCB and SAB. An annual report will be produced for both boards. The procedures for a serious case review, serious adult review and domestic homicide review are published on the Hillingdon.gov website

Recommendation 1:

Hillingdon Safeguarding Children Board should conduct a multi-agency review of practice where the ‘toxic trio’ have been identified as a feature of the case in order to establish:

- Information being shared by families both within and between agencies is being tested and challenged appropriately
- Referrals are being made to children's social care in an appropriate time frame
- Professionals’ learning needs in relation to the ‘toxic trio’ and its’ impact on parenting, especially relating to assessment and record keeping skills.
- That supervision is being effectively utilised by all agencies to support and challenge assessments and safeguarding decisions across the system

This recommendation has been written into the audit programme for 2017/18 and findings from the audit will be reported back to the LSCB Executive Board.

Recommendation 2:

The Hospital Trust should be asked to establish a system whereby records in relation to an individual are accessible to all departments within the hospital

This recommendation is being progressed through the Hospital Trust Board.

Recommendation 3:

Children's social care should review their assessment format in order to ensure that, where first time parents are being assessed, all of their previous contact with health, police and children's social care is sought. This should include mental health, drug and alcohol misuse, accident and emergency and GP attendance. Assessments need to be scrutinised to ensure that the role of the father and their background history is clear at the earliest possible time.

Recommendation 3a:

Children's social care should ensure that the quality of children and family initial assessments is reviewed to ensure that they meet the required standard.

Recommendation 3b:

Children's social care need to ensure that an appropriate amount of time is given to the process to enable a thorough assessment to take place. Where the decision to outsource this service is made, further consideration needs to be given to the use of quality indicators and assurance tools from the provider to ensure transparency regarding quality concerns.

These actions have been completed and the Board are satisfied that the assessment process is thorough.

Recommendation 4:

The clinical commissioning group (CCG) needs to review the time that a GP has available to identify and risk assess first time parents where the 'toxic trio' exists to ensure that appropriate referrals are being made to children's social care and other specialist services (if necessary).

This recommendation has been completed

Recommendation 5:

Hillingdon Safeguarding Children Board should ensure that all partners comply with the London Child Protection Procedures regarding practice where there have been direct threats made against a child.

This recommendation has been completed. Agencies are reminded of response via multi agency training and own agency safeguarding training.

Recommendation 6:

Hillingdon Safeguarding Children Board should conduct a multi-agency review of practice to identify professionals' learning needs in relation to identifying on-going and changing risk; disguised compliance; positive bias and group think

This action is part of the Board audit programme 2017/18

Recommendation 7:

Hillingdon Safeguarding Children Board should conduct a multi-agency review of practice to assure itself that where risks are identified and a referral is not made, the rational is appropriate and documented clearly within the records.

This action is part of the Board audit programme 2017/18

Recommendation 7.1:

Hillingdon Safeguarding Children Board should ask health organisations to provide evidence that there is a comprehensive understanding across all professionals regarding their individual professional responsibility within the safeguarding system.

This action has been completed and the Board are satisfied that health organisations are aware of their responsibilities.

Recommendation 8:

Maternity services should review the effectiveness of their current safeguarding arrangements as currently the system does not ensure effective supervision and challenge.

Maternity have reviewed the current service provision and have subsequently restructured the service to incorporate a midwifery safeguarding lead, safeguarding training and supervision to ensure that staff have a clear reporting mechanism when they have a safeguarding concern.

Recommendation 8.1

The role of the Named Midwife within the maternity services needs to be reviewed for job role conflict and ambiguity with the managerial role

Maternity services have reviewed the named midwife role as part of the service review as above.

Recommendation 9:

The lack of case management for high risk and vulnerable mothers within Maternity services need reviewing as it is creating risk within the system. There is too much reliance on single professionals to carry the riskier cases in the absence of an effective case management approach that is shared amongst the safeguarding team as a whole.

Maternity have reviewed the current service provision and have subsequently restructured the service to incorporate a midwifery safeguarding lead, safeguarding training and supervision to ensure that staff have a clear reporting mechanism when they have a safeguarding concern. High risk Mothers will be assigned to the safeguarding Midwifery role.

Recommendation 10:

CNWL to reinforce the London Safeguarding Children Board Threshold Guidance and ensure that when the toxic trio has been identified the duty to refer is fully considered. Health visitors should access supervision and support for decision making dilemmas in this area.

Recommendation completed and all staff trained regarding thresholds and clear discussions take place in supervision.

Recommendation 11:

The Hillingdon Local Safeguarding Children Board needs to ensure that the London Child Protection Procedures regarding good practice at child protection conferences is followed.

Recommendation completed

Recommendation 11a:

Children's social care should work with partner agencies to review the effectiveness of the quality assurance mechanisms for child protection conferences in order to ensure that they are having a positive impact on outcomes for children

This action is part of the Board audit programme 2017/18

Recommendation 12:

Hillingdon Safeguarding Children Board should develop a statement of expectation regarding the core elements of effective supervision underpinning safeguarding practice and seek assurance from all organisations that their arrangements meet these expectations. The statement should consider the findings of this review in

relation to the need to ensure that professionals are supported to develop their capacity to think, challenge themselves and others and manage the emotional impact of the work

This is currently being reviewed by corporate HR.