Harrow Local Safeguarding Children's Board

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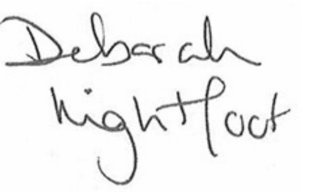
Letter from the Chair:

A warm welcome from the Chair of the Local Safeguarding Children's Board (LSCB) in Harrow, Deborah Lightfoot. As a Board we are working to build the ties between the parents, carers and young people and children, as well as volunteers and professionals in Harrow, as safeguarding is everyone's business. This bi-annual newsletter will bring news of Harrow's safeguarding learning – through the work of CDOP (Child Death Overview Panel) and local and national Learning Lessons and Serious Case Reviews.

Harrow Local Safeguarding Children Board has a responsibility to ensure that agencies are "fit for safeguarding". An annual self assessment audit is completed, which looks at senior management commitment to safeguarding, policies and procedures and ensures that safeguarding and promoting the welfare of children is at the heart of activity, regardless of whether or not safeguarding children is a core function of that agency.

We look forward to engage everybody in safeguarding children within our Borough and hope this newsletter provides information for you. Please contact for any queries or questions and let us know what you think of this newsletter.



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Local Learning in Harrow

Serious Case Reviews (SCRs) are inquiries when a death occurs, or a serious injury is sustained by a child where it is suspected or it is known that abuse has occurred. Local Safeguarding Children's Boards conduct serious case reviews to derive multi agency lessons from the cases. Learning Lessons reviews are carried out on a multi agency basis where there are less serious concerns, but a need for local learning.

Re Amy –Learning Lessons Review

Amy was a child born to a young mother. Concerns were raised in Amy's young babyhood regarding the vulnerability of her mother but it proved hard to engage with the family. There were four occasions when Amy was brought to Accident & Emergency. These were when she was 5 weeks old, 7 weeks old, 6 months old and when she was thirteen months old. When she was ten months old, her maternal grandmother reported that Amy had bruising, but this was only partially investigated. Her mother claimed that the bruising was the result of Amy falling on hard toys. On the last occasion, 21/03/11, when Amy was 13 months old, she was presented to a local walk in clinic with extensive bruising to her body and a fungal infection to her feet and was transported to A&E. There were clear concerns of non accidental injury by one of her carers, and Amy was discharged from hospital into foster care.

Edi Carmi, the independent overview writer, has recently finished her Learning Lessons report in Harrow in September 2012 and recommendations from agencies have been collated.

The agencies involved were Police CAIT, General Practitioners, health visiting services in Harrow and Southwark, Harrow Children's Social Care, Northwick Park and St. Thomas and St. Guy's Hospitals.

The report has both urgent and more long term recommendations regarding practice with young children, young mothers who have mental health concerns and the liaison between agencies, particularly across borough boundaries.

It raises issues of practice with:

- Practice with transient families
- The assessment and identification of fathers and partners
- Escalation of concerns between agencies
- Health visiting resources
- The Child Protection Conference Process
- Closure of cases

There are also significant lessons for all agencies regarding the preparation of review for Learning Lessons exercises, such as the independence of report writers and delay.

All Learning Lessons and Serious Case Reviews identify good and effective practice.

Child Death Overview Panel

The Children Act 2004 introduced the need to have a CDOP and Harrow's CDOP started in April 2008 in accordance with Chapter 7 "Working Together to Safeguard Children (2006 guidance updated 2010").

The role of CDOP:

The CDOP reviews the deaths of all children, up to the age of 18 years, who are living in Harrow at the time of their death.

The aim of CDOP is to look at the service provided by agencies to identify if there are gaps in the provision and to ensure that appropriate support and care have been put in place for the family following the child's death.

Where lessons can be learnt from individual cases the panel will identify actions that need to occur and feedback to the agency concerned. CDOP also has responsibility for identifying any themes that may occur in relation to child deaths and make recommendations about them.

Where the death is sudden and unexpected it is dealt with via a rapid response meeting which is attended by all professionals who have known the child. At this meeting professionals share relevant information about the circumstances leading to the child's death and identify who is going to offer bereavement support to the family/carer.

According to the Office for National Statistics (ONS) 4,476 children who died in the year ending 31 March 2009 were registered in England. 4,409 were registered as occurring in the year ending 31 March 2010.

- Data on registrations of deaths which occurred in the year ending 31 March 2011 and 2012 is not yet available. Assuming that the number of deaths in these two years is the same as the number of deaths which were registered as occurring in the year ending 31 March 2010, then approximately 17,700 children have died since the statutory responsibility to review child deaths was introduced on 1 April 2008. Approximately 76% of these child death reviews were completed by 31 March 2012.

HARROW CDOP KEY CONTACTS

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Who does the CDOP consist of?

There is a fixed core membership on the Child Death Overview Panel (CDOP), with key organisations that are represented in the LSCB. Police, Social Care, Paediatricians and Child Health professionals are all part of the Panel.
The panel meets on a quarterly basis.

What have we found in Harrow?

Since establishment in April 2008, the Panel have reviewed the deaths of 88 children. From these reviews the Panel have identified that in 16 deaths there were one or more factors which could have been modified to potentially prevent the death, this accounted for 18% of all child deaths.
4 of the main themes of the modifiable factors were:

- Baby Car seats
- Baby slings
- Infants choking on small objects.
- Antenatal Care

In accordance with Working Together to Safeguard Children all LSCBs need to keep information about each child's death. The data will help inform strategic planning on how best to safeguard and promote the welfare of children in the area. This information is then discussed by the CDOP to ensure lessons are learnt about how to reduce the incidence of preventable deaths in the future.

What have we done?

1. Put out a national notification to all CDOPs regarding the safety of Baby car seats and Baby slings.
2. Raised local awareness of babies and infants choking on grapes or other small objects through Health Visitor training.
3. Review of antenatal practices including early booking and anomaly scans.
4. Written recommendations made to GP practices.

Child Death Overview Panel

The Serious Case Review Subgroup has been considering the findings of a report by Ofsted from October 2011, Ages of concern: learning lessons from serious case reviews. http://www.ofsted.gov.uk/resources/ages-of-concern-learning-lessons-serious-case-reviews

Ofsted reports have consistently highlighted that babies less than one year old and older children have been the subject of a high proportion of serious case reviews. This report provides a thematic analysis of 482 serious case reviews that Ofsted evaluated between 1 April 2007 and 31 March 2011. The main focus of this report is on the reviews that concerned children in two age groups: babies less than one year old and young people aged 14 or above.

Key findings

The report has identified recurring messages from the reviews that concerned babies less than one year old. In too many cases:

- there were shortcomings in the timeliness and quality of pre-birth assessments
- the risks resulting from the parents' own needs were underestimated, particularly given the vulnerability of babies
- there had been insufficient support for young parents
- the role of the fathers had been marginalised
- there was a need for improved assessment of, and support for, parenting capacity
- there were particular lessons for both commissioning and provider health agencies, whose practitioners are often the main, or the only, agencies involved with the family in the early months

practitioners underestimated the fragility of the baby.

A notable feature of the cases about young people over the age of 14 is the wide diversity of incidents that resulted in serious case reviews. Although the lessons learnt tend to be quite specific to the particular cases, the reviews found that too often:

- agencies had focused on the young person's challenging behaviour, seeing them as hard to reach or rebellious, rather than trying to understand the causes of the behaviour and the need for sustained support
- young people were treated as adults rather than being considered as children, because of confusion about the young person's age and legal status or a lack of age-appropriate facilities
- a coordinated approach to the young people's needs was lacking and practitioners had not always recognised the important contribution of their agency in making this happen.

As a result of discussions regarding these two areas of particular vulnerabilty, the LSCB is considering learning with practitioners regarding working with babies, and has been coordinating work around vulnerable teenagers, extending to those who are missing, exploited, vulnerable to self harm, or domestic abuse. The **Wish** Centre - Women's Integrated Services **Harrow** offers counselling support to vulnerable young women. WSIH and the LSCB are hosting a half day of speakers and information on Self Harm Day, 1st March at Harrow Civic Centre. Please contact Ijaz ijaz.valiji@harrow.gov.uk for more information.