Harrow Local Safeguarding Children 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. This bi-annual newsletter brings 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 LSCB has a responsibility to ensure that agencies are "fit for safeguarding" and to encourage improvement.

At our July LSCB Executive Board, members agreed a revised Rapid Response service in Harrow, which will be led by the Designated Nurse, Sue Dixon and Designated Doctor, Ruby Schwartz. This will respond to unexpected child deaths in Harrow. The proposal will go to Harrow CCG (*Clinical Commissioning Group*) Board.

Please contact us with any queries or questions, let us know what you think of this newsletter, and forward it on to your colleagues.

Deborah Lightfoot

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Functions of the CDOP

In accordance with Chapter 5 '*Working Together to Safeguard Children*' (March 2013), the LSCB is responsible for ensuring that a review of each death of a child (up to the age of 18, excluding stillborn babies and lawful terminations of babies) normally resident in the LSCB's area is undertaken by a Child Death Overview Panel (CDOP).

The functions of CDOP:

1. Reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
2. Collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
3. Discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
4. Determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
5. Making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
6. Identifying patterns or trends in local data and reporting these to the LSCB;
7. Agreeing local procedures for responding to unexpected deaths of children;
8. Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required.

In 2012 the panel met 4 times, in March, June, October and December. In total 22 cases were reviewed, of which all 21 were expected deaths (i.e. were thought likely to occur in the previous 24 hours) and one was an unexpected death. 21 cases were deemed to have had no modifiable factors and one case was identified to have had modifiable factors, this was in a case where a child died from meningococcal septicaemia. This has led to a public health initiative to ensure that families are aware of what to do to detect meningococcal disease early.

No death has resulted in a serious case review and none of the children who died were known to social care or the police. 50% of the cases were perinatal/neonatal deaths; 19% of cases were congenital/chromosomal abnormalities; 14% of cases were due to a chronic medical condition; 9% of cases were malignancy; 4% of cases were due to an acute medical or surgical condition; 4% of cases were due to infection; 73% of cases were of Asian ethnicity and there was a 50/50 split of males and female deaths".

Child Death Overview Panel Process

[redacted]

[redacted]

EXPECTED
(Anticipated 24 hours prior to death)

Form Bs are distributed to agencies involved with the family

All Form Bs are returned to the co-ordinator within 3 weeks

Information from Form Bs is collated and summarised in Form C

Agenda and case listing is sent to panel members prior to meeting

UNEXPECTED
(Not anticipated as a serious possibility 24 hours before the death)

Within 24-48 hours there may be a joint home visit by the Designated Doctor & Police

Within the next 5 days a Rapid Response Meeting is held involving all agencies connected with the family

A secondary Rapid Response follow up meeting may be required depending on the circumstances of the case

Result of Coroner's report/inquest obtained prior to CDOP meeting

Case discussed and reviewed at CDOP meeting

Learning Lessons

This LSCB (Local Safeguarding Children Board) newsletter is produced twice a year to pass on important learning from child deaths in the UK, and local and national case reviews, including Serious Case Reviews.

Harrow LSCB has recently completed a learning lessons review regarding two school-aged children, Ben and Claire (anonymised names) who faced neglect in their mother's care. The family had considerable multi agency support and intervention from 2004. All agencies found it hard to respond to chronic neglect. Under-identification of neglect as a child protection issue is common in serious case reviews. A great deal of support was offered by individual agencies to the family and whilst in a crisis, the mother would accept some help, but was unable to sustain her cooperation with practitioners. There was delay over several years in the recognition of the child protection threshold and even when safeguarding concerns were accepted, there was a lack of understanding of the mother's capacity to change or accept support. Agencies were working in isolation, despite procedures, and there was a lack of joined up working, with a need for leadership and coordination. There was weakness in health information transmission processes and a lack of a *Think Family* approach. (*Think Family* is a Department of Health initiative to encourage joint working based on a family-centred model of delivery. The aim of this project is to improve outcomes for parents with mental health illness and their families by establishing a '*think child, think parent, think family*' model to service planning and delivery).

When the core group did identify that legal intervention was required, this was delayed and there was a lack of a total formal family assessment.

Delays were primarily around the lack of understanding of the:

- extent of harm suffered by the children due to the mother's neglect;
- mother's capacity to change and / or accept help to compensate for her limitations.

Practice recommendations for discussion and application

- Importance of a *Think Family* approach for all professionals and a wide consideration of children as young carers.

- The challenge of assessing risk in cases of neglect, including the use of strategy meetings – explicitly considering parental capacity in terms of:
    - The current and likely future impact on children
    - The ability to accept help to compensate for parental limitations
    - The likelihood of any change over time

- Schools are encouraged to consider strategies to engage parents, where there are attendance concerns, including formal processes and legal action.

- Health record keeping and GP flagging on files for vulnerable families.

- Use of core groups and CP conferences to assess progress, and risk, and practise professional challenge.

- Importance for history taking and reflection for transfer in of cases.

The LSCB is currently offering learning seminars re Ben and Claire to local professionals. Contact the LSCB on 0208 424 1341 for further details.

Learning Lessons

June 2013 saw the release of the SCR (Serious Case Review) Family W, which is particularly pertinent for midwives and GPs

- **Family W (LSCB is not identified to protect the anonymity of the children)**
Review into the circumstances of mother M and the "adoption" of four children, A, B, C and D, over the course of 16 years. A, B, C and D were brought into the care of the local authority following the birth of child D. Child D was conceived, following repeated attempts at artificial insemination of child A, at M's direction, over a period of two years. The family was known to a wide range of agencies. Issues identified include: an illegal adoption; the neglect, emotional abuse and social isolation of the adopted children; the physical abuse of the youngest child; the children's home schooling to avoid scrutiny of their care. Recommendations include: ensuring that multi-agency guidance on the safeguarding of children who are electively home educated is informed by the findings of the review; LSCBs should remind General Practitioners of the potential safeguarding implications of miscarriages in girls under the age of 16.

Practitioners may also find this SCR helpful regarding an older young person, living in semi-independent accommodation.

March 2013 - **Wakefield - Christine**
Death of Christine, a 17-year-old girl on 12th March 2012, at the hand of her sister's ex-boyfriend, Michael. A friend of Christine was also murdered and her sister kidnapped, Michael tried to flee the country but was caught and arrested; he has been sentenced to serve a minimum of 34 years. Christine had been known to children's services since 2007 and was living in supported independent living at the time of her death. History of: challenging and risk-taking behaviour; drug and alcohol use; going missing from home; suspected child sexual exploitation (CSE) by older men; and disclosures of domestic abuse made against an ex-boyfriend. Recommendations include: activities to raise awareness of CSE risks to young people, particularly those over the age of consent; and an action plan for addressing domestic abuse between young people.

Both these reviews can be found here: http://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/serious_case_reviews_2013_wda94557.html

Ofsted reminds us of the vulnerability in particular of older teens, and babies under 1 year in their report from 2011 ***Ages of Concern***, which can be found here: http://www.ofsted.gov.uk/resources/ages-of-concern-learning-lessons-serious-case-reviews

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