Serious Case Review S
&
Serious Case Review D

Statement of the Independent Chair

November 2016

Swindon LSCB is today publishing two SCRs following the deaths of two babies in 2015 as a result of co-sleeping. The cases are not connected and occurred 6 months apart but the SCR process concluded at the same time. There are clearly similarities in that the babies died in similar circumstances but both of the Serious Case Reviews confirmed that all professionals had provided clear safe sleeping advice to the families, however both families were within the child protection system and it was felt that there would be learning for organisations.

Any death of a child is a tragedy and our thoughts are with their parents and families.

The overall purpose of a Serious Case Review is to identify learning from the way practitioners and organisations worked together to improve safeguarding practice. There were some similar areas of learning identified in the SCRs but overall the quality of the work was not the same in both reviews.

SCR S

SCR S concerned an 8 week old baby, who died after co-sleeping with her mother on a sofa. All partner agencies involved in this case engaged positively in the process of the SCR and in developing the action plan in response to the recommendations in the SCR Overview Report and those of the individual organisations.

Overall, the SCR found good evidence of multi agency working with this family, this included a strong commitment by all practitioners, a clear focus on children and practitioners acting as advocates and that safeguarding procedures were effective. The identification of neglect in 2015 by practitioners meant that care proceedings were initiated and there was evidence of all professionals providing safe sleeping advice.

The learning from this SCR also highlighted the following key issues, which required consideration and improvement. Firstly, the challenge that exists in the legal process to evidence the impact of neglect. There was a clear impact of the time spent by mother in intensive care during pregnancy and the impact this had on the mother's health and ability to care for her children. There was evidence of gaps in communication between GPs and social workers and between health organisations. There was a delay in a community paediatric assessment and issues around cover arrangements for a vulnerable baby when the health visitor was unavailable and the workload of safeguarding midwife.

Each partner organisation has considered and agreed its own recommendations on identified areas where it was felt that practice could be improved and the Overview Report made 5 overarching recommendations for the LSCB, which have all begun to be addressed. These include the LSCB meeting with the CCG and NHS England to discuss the expectations around GP engagement, capacity of the safeguarding midwife and community paediatricians and the LSCB has already engaged with the local Family Justice Board to share the learning from this SCR.

Each organisation has made good progress to address the recommendations for their own agencies and examples of progress include:

Acute Hospital

Great Western Hospitals NHS Foundation Trust has since made significant improvements to how safeguarding concerns are recorded on their electronic patient record system and in their transfer documentation.
An investment has also been made to strengthen the safeguarding team within the Trust, which has now been expanded to include further midwifery and nursing expertise. This will improve the specialist support available to staff. In addition, a multidisciplinary safeguarding ward round has been introduced across the Maternity Unit and Special Care Baby Unit to address any safeguarding concerns. The Trust continues to provide information on the risks of co-sleeping to all new mothers as a routine element of both ante-natal education and post-natal care.

Local Authority Children, Families and Community Health

A number of improvements have been implemented, the most significant is a revised social work evidence template for care proceedings, that clearly sets out guidance to be considered when a child is to be removed, in the interim, from a parent. Practice across the children's social work- and legal team has been strengthened, through training, to ensure there is a joint understanding of the impact of neglect on a child. The LSCB escalation policy has also been updated and re-launched to ensure timely escalation of concerns, across all agencies. The recruitment to a Named Nurse has further strengthened practice within the Health Visitor teams that leads to better assessment, analysis and recording of their intervention

SCR D

SCR D was initiated following the death of a 2 week old baby who had been co-sleeping with his mother. The SCR identifies areas of good practice with this family- the continuity of health visitor and social worker for over 18 months provided stability. Prompt visits were undertaken by professionals to mother and child after hospital discharge. Issues and reinforcement of the need for safe sleeping practices were addressed by practitioners. The refuge was assertive and challenging and the specialist hospital obtained psychiatry input to manage mother's behaviour.

However the SCR also highlighted areas where practice was not effective and there was clearly learning for a number of partner organisations. These included assessments of insufficient rigour and a lack of recognition of the capacity to change by mother and the impact of the mother herself on professionals. The ineffectiveness of the multi-agency child protection processes themselves and that care proceedings were not initiated, the organisational issues around social workers and their managers, health visitors, midwives and the IT systems. In addition, the lack of escalation by any of the agencies about their concerns for the child.

The SCR identified the areas above where it was felt that practice could be improved and the Overview Report made 8 overarching recommendations for the LSCB, which have all begun to be addressed. The LSCB is meeting with the CCG and NHS England to discuss the expectations around GP engagement and the safeguarding midwife and the hospital discharge planning arrangements and IT system. The LSCB has already reviewed and implemented its escalation policy to encourage all practitioners to challenge and raise their concerns both within and between organisations. It has revised its LSCB training programme and will be requiring assurance that social work and health visitor workloads are at appropriate levels

Each organisation has also made good progress to address the recommendations for their own agencies and examples of progress include:

Local Authority-Children's Social Care

A number of improvements have been implemented since the Ofsted inspection in 2014, a recruitment and retention campaign reduced vacancies to below the national average. This also means case load sizes for social workers are gradually reducing. There was also an increase in case work supervisors in the social work teams, which also better, enable more robust case management and oversight. Changes in social work processes have occurred to support managers, for example in relation to legal planning on

cases, and the application of an improved escalation policy. A number of training opportunities have also been identified to support practice across our entire workforce including Health Visitors and Social Workers, for example, training to improve the workers understanding of neglect, disguised compliance, and improve their assessments. Work has also been undertaken with the local hospital to better ensure a more robust discharge planning meeting arrangement is in place.

Acute Hospital

Great Western Hospitals NHS Foundation Trust has since made significant improvements to how safeguarding concerns are recorded on their electronic patient record system and in their transfer documentation. This is helping to ensure all healthcare professionals have easy and timely access to the same information throughout the patient journey. The Trust continues to provide information on the risks of co-sleeping to all new mothers as a routine element of both ante-natal education and post-natal care. It also continues to educate all staff on their obligations to escalate any safeguarding concerns.

CCG- Clinical Commissioning Group (CCG)

In response to these reviews of Child D and Child S the CCG has reviewed the quality of safeguarding arrangements, for example by reviewing their safeguarding children policies and governance structures. In addition the CCG will, in agreement with all the providers it commissions services from, and with the LSCB, ensure the following two connected actions are the immediate priority to drive improvements for safeguarding children across the health economy of Swindon:

1. To develop safeguarding children specific 'Performance Dashboard' that captures both the arrangements in place and collects data as a measure of the safeguarding children activity that flows from these arrangements. These will be quarterly reporting requirements to the CCG. The time scale for implementing this Safeguarding Children Dashboard is within 3-6 months of the publication of these reviews.

2. The CCG will embark upon a schedule of announced 'safeguarding children specific quality visits' to all providers (irrespective of who commissions them) to evaluate safeguarding practice at the service delivery level and to test out existing safeguarding children pathways, for example within maternity services and paediatrics. As a minimum the CCG will conduct six such visits annually starting with the health services identified within this review. The first will commence no later than January 2017.

With regard to the issues raised through these SCRs relating to General Practice the CCG will work with NHSE to conduct an urgent review of all the GP practices safeguarding children arrangements including the support that is in place to ensure the quality of safeguarding complies with national standards and will develop 'child protection process specific' performance indicators for General Practice, for example the attendance at and contribution to child protection case conferences. The timescale for completing this review of General Practice safeguarding arrangements is within six months of the publication of these SCRs.

Monitoring the Impact of Learning

The LSCB and individual organisation's action plans will be subject to regular monitoring and challenge and the use of audit activity to continually monitor progress against areas for improvement.

The key areas of learning from these two Serious Case Reviews have already been disseminated through partner agencies, discussed in workshops at the recent SSCB Annual conference, which involved over 300 practitioners and fully integrated into the LSCB training programme.

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