The West Sussex Safeguarding Children Partnership

Response to a Legacy Serious Case Review: Child U

Serious Case Review (SCR) U was commissioned in 2018 by the then West Sussex Safeguarding Children Board (WSSCB), in line with the 2015 HM Government's 'Working Together to Safeguard Children' guidance. An independent safeguarding specialist, Nicki Pettitt was commissioned as the lead reviewer and author to complete this SCR. The Significant Incident Learning Process (SILP) methodology used to review the case is an accredited and recognised systems-based approach that ensures full participation by the front-line practitioners involved with the family. The review process is overseen and supported by a Review Panel of independent senior staff from involved agencies, that the reviewer uses as a sounding board, and where necessary to provide necessary context on organisational policies and practice.

This case involved the death of a three-month old who died after reportedly falling from his parent's bed onto the floor. It was evident from the postmortem examination that a skull fracture had occurred around three to seven days prior to Child U's death. Prior to his death there were no safeguarding concerns about Child U or his siblings. The review found that the child's mother had a long-term dependency on a prescribed pain killer and no other known predisposing risks were evident. The family were not identified as having any additional needs that required professional involvement. The Case Review Group and the previous Chair of the legacy West Sussex Safeguarding Children Board determined that the criteria for a SCR were met and there may be potential learning to prevent such deaths in future.

The review identified a significant number of areas of good practice across a wide range of West Sussex agencies. However, learning was identified in the following areas:

- The impact of prescription and some over the counter drugs.
- Lack of wide professional awareness of the above, including the impact of withdrawal.
- Importance of information sharing.
- The need for timely communication and challenge when there is uncertainty in a child protection case.

The report and its recommendations were agreed and accepted by the previous West Sussex Safeguarding Children Board. The report has been published by the West Sussex Safeguarding Children Partnership along with this Partnership response. The publication follows the outcome of a police investigation, which concluded that no criminal prosecution should be taken.

Recommendations/ Actions

Recommendation 1:

Due to the delay in a conclusion being reached in the criminal investigation of this case, the WSSCB should give consideration to how the learning from this review is shared in a timely way.

Recommendation 2:

The learning from this review must be shared with the Home Office pathologist who was involved in this case.

Recommendation 3:

The WSSCB substance misuse training should be reviewed to ensure that the risks from prescription and over-the-counter drugs are included, along with the need to share information. The Board should then undertake quality assurance activity to ensure that this has an impact on practice.

Recommendation 4:

The WSSCB should consider the Government's review of prescription drugs to be published in 2019 (see 6.13 above) to determine if the findings can be used to further strengthen safeguarding practice in West Sussex.

Actions Taken to Address the Learning and Recommendations.

As a result of this case the Information Sharing Agreement for Safeguarding Partners and Agencies working with Children and Young People was revised and updated to ensure all agencies are aware of when and how to share information, to ensure proactive safeguarding of children and young people.

Sussex Police have ensured officers are addressing the need to ensure actions based on clear opinions from medical professionals are approved and documented. Moreover, learning from this review has been shared with the Home Office pathologist who was involved in this case.

In response to the recommendation to share learning with partners ahead of the publication of the report an immediate learning handout was produced and communicated to partner agencies across West Sussex. This has been updated to include the published findings of the government's review of prescription drugs and will be communicated across the Partnership to ensure further awareness raising for any new staff and a chance to revisit the key messages for existing staff. The key themes will also be highlighted in a series of multi-agency sessions focussing on learning from SCRs, reviews and audits with the aim of improving safeguarding practice with children and their families.

Additionally, Partnership training was reviewed and now includes the risk from prescription and over the counter drugs in its content relating to substance misuse. The impact of this training will continue to be evaluated and the overall impact of learning from all reviews on practice will be tested using the Partnership's new Quality Assurance and Scrutiny Framework.