# The West Sussex Safeguarding Children Board's Response to SCR O Serious Case Review

## Introduction by independent Chair

This tragic case centred on a concealed pregnancy and the subsequent death of a new born baby. The mother admitted to killing her infant, and was subsequently found guilty of infanticide.

The circumstances outlined in this serious case review are unusual and have challenged all the professionals involved. The family were not known to any services locally, yet a baby died and lessons should to be learned.

The independent review stated that it is hard to see how any professional or organisation could have prevented the death of Baby O. Even those close to the Mother were unaware of her pregnancy. Despite systems within West Sussex being described as proactive in trying to engage with families, it was clearly very difficult to support this mother in managing her relationships and decisions at this time. This mother is Eastern European and the review pointed out the need to thoroughly assess how services can engage with hard to reach communities and with those for whom English is not their first language.

The report is clear in stating that ultimately it is parental choice whether services are taken up. It can be difficult for professionals to respect parents' wishes, whilst differentiating between those children whose needs will be fully met within their family and community and those who may not receive the services they need. West Sussex health, social care, police and other frontline services, will review a number of practices including what practitioners should do if a woman does not seek professional advice until late in her pregnancy.

I welcome both the report and the actions agreed by professionals as described below designed to improve professional awareness of

- Our understanding of what prevents parents from engaging with services designed to provide support and care during pregnancy and labour.
- The interagency response when professionals identify families who haven't engaged with services?
- What we know about how a pre-school child became invisible to universal services?

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## Background

SCR O was commissioned by West Sussex Safeguarding Children Board following the death of a new born baby, known as Baby O. The pregnancy had been concealed from both professionals and Mother's partner. Mother admitted that she killed her infant, was subsequently found guilty of infanticide and was sentenced to a two year community order with a rehabilitation requirement.

Baby O had a four year old half sibling who was at home at the time of the baby's death. Apart from attending for immunisations, Baby O's sibling (Child 1) had not been seen by any early years' practitioners since the three month developmental check and it was therefore agreed that the review would consider service provision in respect of both Baby O and Child 1.

The Independent Reviewer, Jane Wonnacott was asked to consider three primary questions in the delivery of the review:

- What do we know about what prevents parents from engaging with services designed to provide support and care during pregnancy and labour?
- What is the interagency response when professionals identify that families haven't engaged with services?
- What do we know about how a pre-school child became invisible to universal services?

## Recommendations

All recommendations and learning from the Serious Case Review will be shared with front line staff working with children and their families in West Sussex via a special bulletin circulated post SCR publication. The WSSCB recognise that the recommendations and learning should be shared with a wider range of professionals who don't work directly with children and young people but are connected to communities and therefore able to support and engage in creating a culture of community curiosity.

Five recommendations were made;

## Recommendation 1:

**West Sussex Safeguarding Children Board should work with relevant local organisations and the Pan Sussex Procedures group in order to rationalise procedures and produce a consistent approach to late booking and concealed pregnancies which includes a risk assessment to determine whether a referral to children's social care is required**.

### The Board's Response:

The Board recognises that there were inconsistencies between the multi and single agency procedures relating to a pregnant woman's late presentation to health services, and that the Pan-Sussex procedures in relation to this required updating.

**The Board's Actions:**

West Sussex, Brighton & Hove and East Sussex jointly deliver the Sussex Child Protection and Safeguarding procedures. This work is overseen by the Pan-Sussex Policies and Procedures sub-group. The sub-group has implemented a review of the procedures relating to late presentation and concealed pregnancy. Currently the procedures assume the two are always linked, however the WSSCB acknowledges that there will be instances when a pregnant woman presents late, but is not intentionally concealing her pregnancy. The procedures will therefore be updated to reflect the need for professional judgement when considering the causes of the late presentation.

Work to develop a robust approach to information gathering and risk assessment in relation to late presentation and concealed pregnancy is underway, coordinated by the embedded Midwife within the Integrated Prevention and Earliest Help service.

**Recommendation 2:**

**West Sussex Safeguarding Children Board should seek assurance that procedures in relation to late presentation of pregnancy are effective in influencing practice.**

**The Board's Response:**

The WSSCB understands that the child protection procedures must be useful and usable documents, which support the workforce in continuously delivering best practice. Key to this is ensuring that the workforce knows when and how to access them.

**The Board's Actions:**

In November 2017 the WSSCB is holding Safeguarding week; a week of safeguarding focused professional development activities aimed at practitioners across the children and adult workforce. Activities throughout this week will highlight the child protection procedures.

Once the procedures in relation to concealed pregnancy and late presentation have been updated the WSSCB will disseminate these across all relevant sections of the workforce. In April 2018 the WSSCB Quality Assurance group will undertake work to identify the impact of this dissemination on practice.

Quality Assurance work streams across the WSSCB and partners agencies will provide us with assurance in relation to the effective implementation of the procedures in relation to late presentation of pregnancy. This includes a joint audit across Health and the Multi-agency Safeguarding Hub into responses to late presentation.

**Recommendation 3:**

**West Sussex Safeguarding Children Board should ask all organisations providing health care to review arrangements for interpreting services in order to ensure that practitioners have timely access to the appropriate service in the range of languages required and know how to use it.**

**The Board Response:**

The Board acknowledges that this review highlights the variability of access to robust translation services across the health workforce, and that this can impact on the level of engagement by vulnerable service users. The Board is keen to challenge agencies to improve the quality of translation provision in order that the needs of service users, across our diverse community in West Sussex, can be met.

**The Board's Actions:**

The WSSCB intends seek reassurance about the effectiveness of arrangements for interpreting services currently in place across health organisations in West Sussex. An agreed framework for this review is being developed by the WSSCB Case Review group. Reporting will be requested from the following agencies: Western Sussex Hospitals Foundation Trust, Brighton and Sussex University Hospital NHS Trust, Sussex Partnership NHS Foundation Trust, Sussex Community NHS Foundation Trust, Surrey and Sussex Healthcare NHS Trust, South East Coast Ambulance Service, and IC24.

In recognition of the significant role of GPs in delivering health services to the community, the WSSCB will ask the three West Sussex Clinical Commissioning groups to undertake a review of the arrangements for interpreting services currently in place in Primary Care in West Sussex.

**Recommendation 4:**

**West Sussex Safeguarding Children Board should work with the Midwifery Child Health Outcomes Group in order to share the findings of this review and develop a joint approach to the dissemination of good practice relating to engaging with communities on first booking appointments.**

**The Board Response:**

In 2016, learning from the WSCC Early Years Needs Assessment and anecdotal feedback from midwives, identified that Eastern European families may be presenting for maternity support later than the average across the whole population. In response West Sussex Public Health bought together research and data leads, and representatives from Midwifery services and the WSCC Communities directorate to begin a piece of work to better understand if and why this was the case. The work of this group and triangulation (consideration as a whole) of data, highlighted that further effort was required to ensure equitable access to first bookings for maternity services across the population of West Sussex. This included, but was not limited to, action in relation to Eastern European families. A number of barriers to timely presentation to maternity services were identified. These included:

- Families requiring longer than the average appointment time to manage language difficulties and prevent miscommunication
- Families from countries with different models of maternity care not necessarily understanding or feeling confident in, the model of care available in the UK.

### The Board's Actions

The WSSCB is supporting the delivery of an action plan in partnership with the Midwifery Child Health Outcomes Working Group. This is being delivered through the WSSCB Improving Practice group, and links with the ongoing work, considering NICE (National Institute for Health and Care Excellence) recommendations around pregnant women accessing antenatal care who are seen for booking, and improving public health outcomes for families through maternal bookings.

### Recommendation 5:

**West Sussex Safeguarding Children Board should work with partner agencies to scrutinise how early help services are engaging with families from communities that are currently underrepresented or hard to reach.**

### The Board Response:

The WSSCB acknowledges the importance of delivering services that meets the needs of our diverse community in West Sussex, and ensuring that our services reach out to those groups within our community that are underrepresented or who experience increased barriers to accessing support.

The local authority was responsible for the recommissioning for the delivery of the Healthy Child Programme (HCP) and the new contract commenced in April 2017. The HCP provides a number of mandated development checks and access to child health clinics . The specification for the contract incorporated clearer information sharing practices and more integrated working, including the co-location of multi-disciplinary teams into IPEH Hubs to ensure a consistent approach to universal service delivery, encompassing prevention, early identification and earliest intervention particularly for vulnerable groups.

### The Board's Actions

The WSSCB intends to work with our partner agencies, in particular through the Integrated Prevention and Earliest Help service, to scrutinise the impact of our work in this area.

All IPEH hubs now have their Hub Profile; this provides information and evidence of where vulnerable and diverse communities live in the County. A plan of action to more assertively identify and encourage take up of universal services will be put in place in each Hub; this includes the further development and use of the Children's Learning and Wellbeing Audit Tool (in line with the Continuum of Needs) to identify potentially vulnerable young children . Hub Advisory Boards have been designed in line with the IPEH approach and membership will be reviewed to ensure that harder to reach communities have a voice at this level. A further focus has been placed on the importance of all partners working together to achieve better outcomes for young children by signing up to the 1001 Critical Days Manifesto. The 1001 Critical Day action plan is being co-ordinated by IPEH and supported by a recently seconded Public Health Midwife who will work with midwives, health visitors and IPEH staff to ensure that the needs of the most vulnerable are met and that there is assertive outreach to communities that find it harder to access services.