Local Learning Lessons Review

Baby "0"

For the attention of	Harrow Safeguarding Children Board
Report written by	Alison Renouf *Harrow Safeguarding Partnership Manager*
Written on behalf of	Case Review Group Chaired by Catherine Knights *Director of Quality, Central and North-West London NHS Foundation Trust (CNWL)*
Date	2.3.23

Baby "O"

Sue Sheldon, Interim Assistant Director of Safeguarding, Designated Nurse Safeguarding Children & CLA, Lead for Child Death (Harrow), initiated a local learning lessons review into the death of Baby "O" who died shortly after birth. The referral was made on behalf of the Child Death Review Service NWL CCG.

The outcome of the review was discussed, and the recommendations agreed, at the Harrow Strategic Safeguarding Partnership on 21st February 2023 and Harrow Safeguarding Children Board on 2nd March 2023.

The outcome of the Review - agreed actions

1. ### Recommendation: A pathway is developed for un-booked pregnancies.

   This to ensure pregnant women are routinely asked where they are booked and, when they aren't booked, has a stepped approach to ensuring they are booked. This also to recognise that some women might simply need a reminder, whereas at the other end of the spectrum, some women will require a pro-active response which may include multiple attempts to engage the mother and home visits – including a joint visit between the professionals most suited to the circumstances of the mother/ parents. The pathway to have different tracks depending on how far along in the pregnancy is. The guideline will identify the lead professional.

2. ### Recommendation: The London CP Procedures are amended to emphasise the risk to women being un-booked in pregnancy

   Draft amendments to be proposed to the Editorial Board of the London Child Protection Procedures.
   UPDATE: The London Child Protection Procedures were amended to reflect the proposed changes in the update on 31st March 2023.

3. Recommendation: That a midwifery outreach service is set-up to support vulnerable women with their pregnancies
4. Recommendation: That the mother is offered support and accommodation on a long-term basis
5. Recommendation: A multi-borough service is developed for women at risk of repeat removals

   It is recommended that a specialist service is developed across a multi-borough footprint, to work with mothers at risk of repeat removals of their babies. This to support them to plan their pregnancies and work towards being able to keep any future children. Such a service would need to provide consistent, long-term support for mothers who have had a child removed as it takes time and commitment to build trust with women who have experienced the trauma of having a child removed from their care and likely have long histories of trauma as well.

   Such a service is part of the maternal mental health long term plan and already exists in principle but has not gone live due to lack of funding. The plan is for the service to be jointly resourced by maternal health services and social care service.

6. Recommendation: In the absence of a specialist service, to develop a pathway to support parents who have children removed

   [To include parents whose unborn baby was likely to be removed but was still born or died prior to being taken into care].
7. Recommendation: CSC To review the decision to NFA the police referral in March 2022 that the mother was pregnant again.
8. Recommendation: To encourage dialogue between adult and children's services

   In particular, to increase children's social workers' understanding of the fact that, in most cases, adults cannot be compelled to accept support. Also, to explore ways to encourage and develop dialogue between CSC and midwifery so that mutual understanding of roles and responsibilities and the remits of the respective services is maintained and enhanced.
9. Recommendation: The partnership to review the NHS *Patient Safety Incident Response Framework* with a view to implementing it, as appropriate, across agencies

   https://www.england.nhs.uk/patient-safety/incident-response-framework/

Recommendation: Housing – safeguarding training and engagement in CP processes

- That senior leaders in Housing are engaged in complex cases to allow, where appropriate, for normal processes to be over-ruled in the best interests of a child [unborn in this instance].
- Housing to review job roles and determine what level of safeguarding children and adults' training is required for assessment officers; housing prevention and solutions officers; and other relevant roles [Managers to have a higher level of training]