Luton Safeguarding Children Board

June 2nd 2017

Joint statement on Serious Case Review Report on Child J

Child J died, aged 13 months, in November 2015. A criminal trial in July 2016 found his mother and her boyfriend guilty of offences connected to Child J's death. The three Safeguarding Children Boards of Luton, Ealing and Hammersmith & Fulham, join together in expressing our condolences to all family members for the loss of this little boy. Child J died in Luton, but most of his life had been lived in London., Although the Serious Case Review was commissioned by Luton Safeguarding Children Board, the three safeguarding boards have continuously worked closely together during the production of this report.

As soon as the terribly sad news of Child J's death became known, each of our boards began to review our local ways of working based on what was known at the time about the circumstances leading to Child J's death. Each of our boards therefore has its own programme of actions and assurance in response to particular issues. However two findings in the report are of national significance. Consequently, as chairs of three different safeguarding children boards, we wanted to come together and draw attention to these two issues - they affected Child J but affect many other children across England.

. The first of these is about an important national programme - the Family Nurse Partnership (FNP) - and how it works in practice locally when cases are handed over across geographical boundaries. Locally we all value the FNP - a voluntary home visiting programme for first time young mothers, ordinarily aged 19 years or under. A specially trained family nurse visits the young mother regularly, from the early stages of pregnancy until their child is two. When a mother is receiving a service from FNP the family nurse fulfils the role of health visitor. When the mother leaves the FNP programme the expectation is that the mother and child should transfer back to the health visiting service who would provide a level of service based on their assessed needs. However, as we saw in Child J's case, this handover does not always happen.

Each board is already carrying out actions around this finding. A risk that all boards are trying to reduce is about families who deliberately set out to avoid contact with services when concerns start to arise, a risk which is increased each time they move from one place to another.

The second issue that all three of us wanted to respond to on behalf of our boards is that there is no national framework in England that requires professionals to carry out an assessment when a family with a Child in Need plan moves into a new area. Current case transfer arrangements between local authorities for 'children in need' do not require that an assessment of the child is undertaken, by the receiving local authority, prior to deciding if the plan should continue - potentially leading to those children's needs being overlooked. Systems for managing the transfer of case responsibility are less robust than those for children with child protection plans despite many 'children in need' living in very risky situations. As chairs we will be raising this issue nationally with the aim of achieving awareness of the risks that go with it, and ultimately the introduction of a common practice framework across England for managing the transfer of children in need.

When a child has died in tragic circumstances it can be understandably hard for the professionals who were involved to discuss their practice and the context in which they worked. This review, however, was characterised by openness from everyone who worked with Child J. On behalf of our three boards, we would like to thank them. We would also particularly want to put on record our thanks to those members of Child J's family who contributed to the review.

Fran Pearson - Independent Chair Luton LSCB

Sheila Lock - Independent Chair Ealing LSCB

Jenny Pearce - Independent Chair Hammersmith & Fulham LSCB