Sunderland Safeguarding Children Board

Serious Case Review Learning Bulletin
Baby E

This learning bulletin outlines the learning from the Serious Case Review for Baby E that was published by SSCB on 6 September 2016. The SSCB expects that this bulletin will be used by every team in every setting to review the team's practice against the learning, identify what the team needs to do and engage actively in transforming practice.

Serious Case Review (SCR) Learning Bulletin
Baby E

Theme of SCR	Incoherent early help/failure to assertively escalate concerns/limited assessments and poor risk assessments/neglect/parental substance misuse/parental mental health issues/absence of focus on children and their lives/domestic violence and its impact
Date Published	6 September 2016

Case details :

Family History

- The family is White British with English being their first language
- Baby E is the fourth child to Mother and first to Father
- Baby E had 3 older siblings
- Parents have a history of alcohol and drug misuse
- Family were well supported by Maternal Grandparents
- A number of referrals were submitted to Social Care around older children which never culminated in Child Protection or Child in Need Plans
- History of domestic violence between Mother and Father of three older children
- Father of three older children has history of ongoing medical issues, including mental ill health
- Father of three older children has convictions for violent offences

Baby E

- Fourth child of Mother and first of Father
- Born 2013 and died in September 2013, aged 8 months
- Baby E found not breathing at home, attempts made to resuscitate
- Post-mortem showed unascertained cause of death

Family Involvement with SCR

- Mother and Father of Baby E would not engage with SCR
- Maternal Grandmother did engage with SCR

Key Points of Learning:

Indicators of risk and vulnerability – emerging themes included:

- Children's Services response to referrals from other agencies
- School's response to concerns about the children
- The use of Common Assessment Framework (CAF)[1]
- Multi-agency partnerships and collaborative practice
- Failure to question or challenge decisions taken by Children's Services
- Managerial oversight and supervision

Findings from Serious Case Review

Patterns of Management of Systems

- Managerial oversight is central to supporting critical thinking, challenge and good assessments in multi-agency work and this was not evident in this review
  - Key frontline practitioners were not well supported by good quality reflective supervision
  - No managerial overview of safeguarding practices in school
  - Absence of any robust recording systems in school, which left these and

[1] *The Common Assessment Framework (CAF) is a national standard for assessing needs and deciding how best to meet them through a simple process. It avoids duplication of effort and improves referral between agencies. It's key to the early intervention that's needed to prevent problems arising or escalating.*

possibly other children vulnerable
    - Absence of strong managerial oversight and challenge in key agencies

- Concerns, which appeared low-key and were not incident or crisis-driven, were not given high enough priority and this left the children, especially Baby E, vulnerable
    - Lack of clarity across agencies about thresholds
    - Referrals seen in isolation from each other
    - Cumulative risks to children unassessed

Patterns of Professional-Family interaction

- Professionals were too parent-focused. The lack of engagement with the older children meant their experiences, wishes and feelings were not fully considered
    - No evidence of 'child's voice'
    - Concerns around children's behaviour and extent of parental drug misuse recorded, but no follow up work proposed or undertaken

- Understanding the presence and role of males in families is critical to understanding family functioning and assessing risk
    - Males not considered or assessed in terms of their role and relationship within the children

Patterns of Professional Bias

- There are conflicting views between professionals about the impact of illegal substances on parenting capacity and the extent to which the use of cannabis increases the level of risk to children and unborn babies

Patterns in Multi-Agency work

- There was a lack of robust multi-agency collaboration and challenge across agencies regarding decisions, plans and threshold
    - No challenge of poor practice
    - Agencies looking to Children's Services to take action, when no action taken, accepted without challenge

Patterns in the Use of Tools

- Single agency risk assessment tools, where they exist, are neither recognised nor valued by other agencies and the absence of a multi-agency risk assessment tool made sharing information and assessing risk more difficult. This increased the risk of professional tensions
    - No multi-agency risk assessment taken, left children vulnerable and cumulative impact of risk not recognised

Learning and Improvement Workshops are being held on learning from SCR's and information can be accessed at SSCB Training

The Overview Report was published on 6 September 2016 alongside two other SCRs re: serious harm to babies and a thematic report which pulls together the learning from four baby SCRs. The other Baby SCR will be published in due course. The report and accompanying documents can be accessed at SSCB SCRs and Documents