Serious Case Review Learning Bulletin
Baby O

This learning bulletin outlines the learning from the Serious Case Review for Baby O 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 O

Theme of SCR	Non-accidental Injuries in baby i.e. bruising and a transverse fracture of left femur/neglect/resistant and unco-operative parenting/mental ill health/ hard to reach family/limited assessments and poor risk assessments/ limited focus on children's life experiences/incoherent early help and poor multi-agency cooperation
Date Published	6 September 2016

Case details :

Family History

- The family is White British with English being their first language
- Baby O is the second child to Mother and Father
- Baby O has one older sibling
- Mother was subjected to domestic violence in an earlier relationship
- Mother suffered depression
- Father experienced anxiety and depression
- Mother smoked throughout both pregnancies
- Mother and Father separated for over a year during period under review
- Mother did not engage with professional help and support offered
- Father had very little contact with professionals involved with Baby O
- Mother became seriously ill a few weeks after Baby O's birth, her illness affected her ability to care for the children and she sadly died in 2014

Baby O

- Second child of Mother and Father
- Baby O's immunisations were not up-to-date
- Baby O and sibling removed to care of Paternal Grandmother after being left at home alone by parents
- Born 2013 and suffered a severe transverse fracture to her leg aged 6 months old
- Paternal Grandmother was prosecuted in relation to this injury

Family Involvement with SCR

- Father and Paternal Grandmother did not engage with the SCR

Key Points of Learning:

Indicators of risk and vulnerability:

- Mother suffered depression
- Father experienced anxiety and depression
- Mother smoked throughout pregnancies
- Limited involvement of Father and his difficult relationship with Mother
- Mother was resistant and uncooperative with professional help and support offered
- Mother's illness affected her ability to care for children i.e. Baby O's medical appointments were missed, immunisations not up-to-date
- Mother's neglect of her own health and failure to take medical advice

Good Practice Identified

- There were some good examples of joint working and information sharing between the health professionals involved, particularly the Health Visitors, in keeping the children as the central focus

- The school acted promptly to identify that Baby O was being left at home alone

Findings from Serious Case Review

Finding 1

There was a lack of an effective system, collaborative working and a tool for tracking patterns of neglect over time. The pattern of neglectful parenting was not tracked or consistently monitored.

- Within Children's Services there were delays and gaps in allocating and managing the case
- No multi-agency tool for identifying, tracking and monitoring neglectful care
- No shared framework across agencies for assessing issues and the risks for the children

Finding 2

There was a lack of robust multi-agency collaboration from Children's Services.

- As the case progressed beyond Early Help, there was insufficient multi-agency co-ordination and planning to address the needs of the children. Child in Need meeting and reviews not held which left professionals unclear about what was happening and resulted in delay and a lack of intervention

Finding 3

Understanding the presence and role of males in families and the circumstances and history of the extended family is critical to understanding family functioning and assessing risk.

- Professionals focused mainly on Mother
- The involvement of Father and Father's family was not fully understood nor assessed

Finding 4

Working with non-compliant families – 'disguised compliance'.

- Working with this family was complex because Mother, despite her vulnerability, avoided professionals and consistently failed to take the children to health appointments or attend to her own medical needs. Occasionally, she would co-operate and appear to be willing to change
- Mother's own very low self-esteem and poor sense of worth appear to have led her to following self-destructive behaviours

Finding 5

Planning for Baby O (and her sibling) May to August 2013 was flawed and drifted leaving the children insufficiently safeguarded.

- The legal status of the children was not resolved when they were placed with Paternal Grandmother - not all the checks required were successfully completed
- The Section 47 enquiry was not completed and an Initial Child Protection Conference was not held
- There was no formal interagency plan in place
- Care Proceedings were under way but this did not provide an interagency framework for protecting and planning for the children
- Practitioners involved in the review felt that they had not been provided with the right legal advice or training about Regulation 24 placements.

Recommendations from Serious Case Review

- SSCB to implement the Graded Care Profile (GCP) for interagency use in cases of neglect. This should be completed urgently within the next 6 months. The GCP has recently been positively evaluated by the NSPCC. A workshop with external

facilitation should be held within 3 months to discuss and plan • As in the Baby P SCR, SSCB to promote effective joint working through designing and developing regular multi-agency workshops and other opportunities for front-line practitioners and managers to share issues and discuss priorities across local services • SSCB to consider carrying out an audit of Section 47 enquiries to test whether cases are proceeding to Initial Child Protection Conference when appropriate
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