Sunderland Safeguarding Children Board

Serious Case Review Learning Bulletin

This learning bulletin outlines the learning from the Serious Case Review for Baby W and Child Z 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 their team needs to do and engage actively in transforming practice.

Serious Case Review (SCR) Learning Bulletin
Baby W and Child Z

Theme of SCR	Neglect/parental substance misuse/young parent and teenage pregnancy/concealed pregnancy/incoherent sporadic interventions/poor identification of risk and vulnerability/limited early help/start again syndrome. Non-accidental injury in non-mobile baby
Date Published	6 September 2016

Case details :

Family History

- The family is White British with English being their first language
- Baby W is the second Child to Mother
- Fathers of both children not involved in either child's life
- Concealed pregnancies for both children
- History of Social Care involvement with Mother and her siblings as children
- Mother lived with her Grandparents
- Baby W had one older sibling
- Family were well supported by Maternal Great Grandmother

Baby W

- Second child of Mother
- Born 2012
- Suffered skull fracture aged 11 weeks

Family Involvement with SCR

- Mother engaged with SCR
- Maternal Great Grandmother and Great Grandfather engaged with SCR

Key Points of Learning:

Indicators of risk and vulnerability:

- History of Social Care involvement with mother and her siblings as children
- Concealed pregnancies for both children
- Mother's lifestyle (drinking, taking drugs and leaving children with inappropriate carers)
- Lack of robust family support available for Mother
- Number of referrals into Children's Services around Mother's care of children led to Child Z being made subject to a Child in Need Plan
- Mother's failure to engage with professionals

Good Practice Identified

- The practice of the Contraceptive Service Nurse in sexual health services was good, not only did she complete a referral to Children's Services, she verbally contacted the midwife and the GP, informing them of the referral and late booking of pregnancy
- There was evidence within health documentation of prompt written information sharing between the midwifery service and the health visiting service when Mother presented late with both pregnancies
- Midwife completed referral to Children's Services on Baby W and demonstrated persistence in chasing up the outcome of the referral, due to concerns that the pregnancy was well advanced at 32 weeks and there was 'concealment of pregnancy'

Recommendations from Serious Case Review

1. SSCB must ensure that the recommendations previously identified in SCRs relating to Unborn Baby Procedures have been actioned by each agency and that agencies understand through audit how well frontline practitioners and their managers access and apply the Unborn Baby procedures
2. (a) SSCB should ensure that practitioners have access to information about the tools available to them within their own professional context and on a multi-agency basis to use in assessments and opportunities to develop skills in their use; these should include tools to assess risk, neglect and assess parental capacity to change; and tools to build and maintain single and multi-agency chronologies
   (b) SSCB should ensure that practitioners are supported by their own agencies and within a multi-agency context to increase their understanding about what 'good assessments' look like
   (c) SSCB must develop its performance and quality assurance framework to ensure that key assessments are routinely and randomly audited on a single and multi-agency basis and the learning from these are fed back to the Board and its partners
   (d) SSCB should assure itself that all partner agencies ensure that their staff use and maintain chronologies of 'significant events' in families, and effective systems are in place which specifies when and how multi-agency chronologies should be established
3. SSCB should, as a matter of some urgency, ensure that the work to develop a multi-agency Neglect Strategy is being addressed and progressed. This strategy should include information and guidance about the specific tools to be used to inform assessment of Neglect as well as the training requirements, standards and competences required of frontline staff
4. (a) SSCB must be confident that in key agencies, quality supervision of frontline practitioners and their managers is not compromised by broader organisational issues such as time constraints, capacity issues, and workload pressures. The Board must ensure that when partner agencies undergo significant organisational change, it is provided with reports from those agencies, which demonstrate how risks to existing safeguarding practices and processes have been assessed and how they will be and are being managed
   (b) SSCB should require key agencies to evidence how they provide a structured learning environment to their practitioners and managers and what frameworks for reflective 'clinical' supervision (individual and/or group) and other forms of case-based consultations are in place

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