Serious Case Review

Briefing

Child E

The Background

Child E was 18 days old when an ambulance was called in December 2014 as he had stopped breathing. He died later in hospital. It quickly became apparent that his injuries were not consistent with the explanation given by his mother. Following criminal proceedings his mother has been found guilty of his murder.

The Review

The case was considered by the Portsmouth Safeguarding Children Board (PSCB) under Regulation 5 of the Local Safeguarding Children Board Regulations 2006. It met the criteria for a serious case review as laid out in HM Government **'Working Together to Safeguard Children', 2013 (now 2015).**

An Independent Social Work Consultant with substantial experience in Child Protection and Quality Assurance was commissioned as the lead reviewer to complete the work.

Agencies were asked to provide a narrative critiquing their own involvement with the family and their practice; and to support the process two practitioner events were held where views of those workers directly involved in the case were sought.

The full findings of the Serious Case Review (SCR) are set out in the Overview Report that has been published on the PSCB website. The publication of this report was delayed in order to ensure that it did not prejudice the criminal investigation and other proceedings into Child E's death.

Safeguarding Concerns

- During her pregnancy with Child E, his mother (Mrs X) received no antenatal care and was, at least partly, in denial about her pregnancy
- Whereas Mrs X had been seeing her GP 2 to 3 times a month, during her pregnancy she had withdrawn from all medical appointments.
- Child E was born at home with the assistance of an ambulance crew, which had only been called when she had been in labour for 3 days and was in the final stages.
- Mrs X and Child E were taken to hospital following his birth and were there for 4 days. During this time a heated argument was witnessed between Mrs X and her partner Mr W. Maternity Services referred Mrs X and Child E to Children's Social Care and an assessment was started.
- Whilst in hospital Mrs X disclosed she experienced mental health issues and domestic abuse.

27th February 2018

Findings

1: Better use of early help and intervention - Early signs of neglect were not shared between professionals because no use was made of the mechanism for doing so (i.e. Early Help Assessment).

2: The role of supervision for all agencies - The review highlights the necessity of good reflective supervision and management scrutiny in all agencies. This is particularly prevalent in families such as this where the issues are complex.

3: Assessment of the impact of specific parental issues (DA, alcohol misuse, parental mental health) - Information was held about both adults that was not widely shared and as a result the information was not considered in terms of the impact of their issues on their parenting capacity.

4: Exchange of information between agencies - In the referral and assessment process, the exchange of information between agencies is crucial. Poor exchange of information is likely to result in the wrong application of thresholds and subsequently flawed assessments. In this case the exchange of information between agencies was left wanting particularly in relation to the adults' respective histories.

5: Risks associated with concealed pregnancies - The risks associated with concealed pregnancies are well documented within literature. Within SCRs, families where concealed pregnancy is an issue form a small but significant number. Agencies need to have a shared understanding of these risks and their role in dealing with them.

The recommendations made to address these findings and the action taken thus far, can all be found in the Board's response to SCR Child E, here on the SCR Page of the PSCB website. This page also includes the full SCR Child E Overview Report.

Useful Resources

On the Resources for Professionals Page of the PSCB website you can find the PSCB Thresholds Document; the Inter-Agency Contact Form; and the Early Help Assessment.

Having different professional perspectives within safeguarding practice is a sign of a healthy and well-functioning partnership. These differences of opinion are usually resolved by discussion. These differences are most likely to arise in relation to:

- Criteria for referrals
- Timeliness of interventions
- Outcomes of assessments
- Service provision
- Roles and responsibilities of worker
- Information sharing and communication

If a professional cannot resolve the difference through discussion, they should liaise with their manager and/or safeguarding lead and follow the steps outlined in the conflict resolution/escalation policy

The unborn/newborn baby safeguarding protocol aims to enable practitioners to work together with families to safeguard unborn/newborn babies where risk is identified. The protocol provides an agreed process between health agencies, social care and other agencies working with the mother and her family on the planning, assessment and actions required to safeguard the unborn/newborn baby. If an appointment is made very late for antenatal care (after 20 weeks of pregnancy); or if a woman arrives at the hospital in labour; or following an unassisted delivery (where a booking has not been made) the reason for this must be explored. The process as set out in the protocol should be followed and an Inter-Agency Contact Form should be completed and sent to the MASH as a matter of urgency.

The PSCB offers a comprehensive range of multi-agency safeguarding training that includes taught courses on:

- Early Help
- Child Protection
- Supervision
- Manager's
- Vulnerable children - missing, exploitation and trafficking

A full list of both taught and online courses offered by the PSCB and details of how to book on these can be found here