Leicester Safeguarding Children Partnership Board

WORKING TOGETHER TO KEEP CHILDREN SAFE

SCR Learning Briefing

This learning briefing focuses on a Serious Case Review (SCR) commissioned by the Leicester Safeguarding Children Board (LSCB) in 2017. Upon its conclusion in 2019 the report was approved by the LSCB. To avoid the risk of interfering with ongoing criminal investigations at that time, a decision was made by the LSCB not to publish the review in 2019. In line with Working Together Transitional Guidance (April 2018, updated July 2018) the completed but unpublished review was passed from the LSCB to local safeguarding partners (police, health, and local authority) on 29th September 2020. Safeguarding partners are not required to publish completed but unpublished SCRs (Working Together Transitional Guidance, 2018, p.9) however they determined that this learning briefing – outlining the findings of the SCR and subsequent local improvements – would be published to ensure transparency and the wider sharing of learning. In order to respect the rights to privacy of surviving siblings, the full review will not be published. An independent reviewer – Amy Weir MA MBA CQSW – was commissioned to write the Serious Case Review and excerpts from that report are used throughout this briefing.

SCR Introduction and Background to the Review

The Leicester City Safeguarding Children Board (LSCB) agreed to commission a Serious Case Review (SCR) of the death of Baby William aged 4 weeks.

This SCR considers the circumstances in which he died and whether the services, which were received by the family from a range of professionals, provided the best response required to address his needs and to keep him safe.

All the names in this review have been anonymised. The child is known as Baby William within this report.

Baby William was born in September 2017. When he was just over four weeks old he was found to be floppy and unresponsive by his father at home. The baby was seriously ill and taken to hospital and died shortly after arriving. There were no obvious signs of harm, but a subsequent skeletal survey found that he had sustained a number of significant injuries. The cause of death was suspected physical abuse; there was evidence of injuries and fractures of various ages.

These circumstances of Baby William's death led to the decision on 29th November 2017 by the Chair of the Leicester City Safeguarding Children Board (LSCB) to undertake a serious case review. The Working Together 2015 criteria for commissioning a SCR were met.

SCR Findings

- Early opportunities to refer and to assess were not taken. Pre-birth work was not seen as necessary in this case despite the significant previous involvement which both parents had had with Children's Social Care.
- There was a lack of focus on considering father's identity and professional curiosity about his history and circumstances.
- There was a lack of clarity between professionals about responsibilities to coordinate and ensure that timely, information gathering, and effective intervention occurred to keep practice child-centred.
- Not all the contacts and referrals about unborn Baby William to Children's Social Care were treated with sufficient care, thoroughness and gravity and this resulted in delay in identifying the needs of unborn Baby William and in addressing the concerns of fellow, local professionals.
- When the assessment was initiated after Baby William's birth, it was not immediately conducted as a detailed assessment within a multi-agency approach.
- The responsibility for involving partner agencies in assessment and information sharing was compromised at points in this case on more than one occasion and by different partners and local authorities.

SCR Summary View

Some effort was made by all the agencies involved to keep Baby William safe. It was not foreseeable by anyone at the time as it was believed that there was no evidence of any immediate risk to him and that the range of service being provided would protect him.

However, more could have been done to explore vulnerability and risk for this family as set out in the findings of the Triennial Analysis of SCRs 2011-2014 (page 139):

"*When a child presents with indicators of possible maltreatment and vulnerability, or a parent or carer presents with recognised risks, professionals have an opportunity to explore that vulnerability and risk and take steps to intervene and protect the child. This requires a stance of professional curiosity and awareness of possible maltreatment and cumulative risk*."

It is very clear that all the professionals who were involved with Baby William and his family worked to help his parents to care for him and to keep him safe. There was a strong commitment from staff and evidence of efforts being made to support the family.

There were some procedural issues and systemic shortfalls identified but these would have not contributed to Baby William's death.

SCR Recommendations
The agencies involved with the family have identified a number of single agency recommendations for improving practice. The implementation and impact of these actions will be monitored by the Leicester Safeguarding Children Board.

In addition, the following recommendations for learning and improving are made to the LSCB. They reflect the key learning from this review. The Leicester City Safeguarding Children Board should ensure that the following aspects are addressed and arrangements are in place to monitor their effectiveness:

1. LSCB to seek assurance from partner agencies that concerns for unborn babies are being referred at the earliest stage within the pregnancy with a shared clarity about the criteria for such referrals. Clear plans need to be put in place for carrying out assessments with a clear understanding of the pre-birth guidance and principles. Practitioners are required to check out information with each other rather than make assumptions about what is known and what is happening.

2. There should be cross authority and cross LSCB consideration about the actions that are required to improve the provision of detailed information and chronologies between Local Authorities and in providing information to, and from, partner agencies in a timely way even when cases are no longer open in a particular area. This is required to ensure that the welfare and safety of the child, wherever they are living, is the paramount consideration taking into account past history of involvement with children and their families.

3. The LSCB needs to be assured that, in terms of partnership working, Children's Social Care is retrieving relevant historical information and sharing and jointly evaluating that information. The new core training model and implementation of Signs of Safety (SofS) is expected to improve this area of practice significantly.

The Serious Case Review went on to list 16 measures that had been put in place by 2019 to respond to the learning from the review. In the subsequent five years the Leicester Safeguarding Children Partnership Board (LSCPB) has regularly sought assurance that the learning identified following the death of Baby William has not been forgotten.

Children's Social Care has fully implemented Signs of Safety as a practice model as identified within the SCR, with all staff receiving training. This model is well embedded and supports a clear analysis of risks and the impact of family histories to consider how safety can be achieved. The model facilitates multi-agency and partnership working and its implementation has been subject to audit and review, providing assurance around its implementation and effectiveness.

Safeguarding babies remains a business plan priority of Leicester Safeguarding Children Partnership Board (LSCPB) for 2023-2025 and recent work across the partnership includes:

- The update of local multi-agency procedures in line with national guidance for (i) Pre-Birth and Post Birth Planning and for (ii) responding to Bruising, Marks, or Injury of Concern in Pre-Mobile Babies and Non-Independently Mobile Children.
- A multi-agency audit focusing on pre-birth was conducted in 2023 and an audit of multi-agency files of babies under 1 year old subject to child protection plans is scheduled for May 2024.
- Children's Social Care have completed additional quality assurance and an audit of unborn babies subject to Child Protection Plans to provide assurance around compliance with updated protocols and procedures.
- A Designated Nurse has led an extensive roll out of the ICON Programme to reduce abusive head trauma in infants. This has targeted the most vulnerable babies via the statutory and voluntary sector services and faith leaders, ensuring the ICON message 'Never Shake a Baby' is not compromised by cultural or language barriers.
- The ICON project also focusses strongly upon men receiving the ICON message adding support to local guidance 'Practice Principles engaging fathers and male carers' which was produced & disseminated to local agencies following the national review commissioned by the Child Safeguarding Practice Review Panel 'The myth of invisible men: safeguarding children under 1 from non-accidental injury caused by male carers'.
- To support a reduction in overlay of babies (supporting a reduction in cot death) the local designated Child Death Overview Panel (CDOP) doctor and designated nurse have led and developed a Multi-agency Safer Sleeping Risk Assessment Tool. A multi-agency communication plan has identified safe sleep champions across multiple agencies including the voluntary sector.
- A Designate Nurse led initiative: 'Pick up the Phone Midlands Regional Campaign' is facilitating improved information sharing across the regional midwifery and health visiting teams involved in a baby's care.
- Children's Social Care and Midwifery liaise routinely regarding pre-birth referrals. Any 'no further action' contacts are reviewed by management.