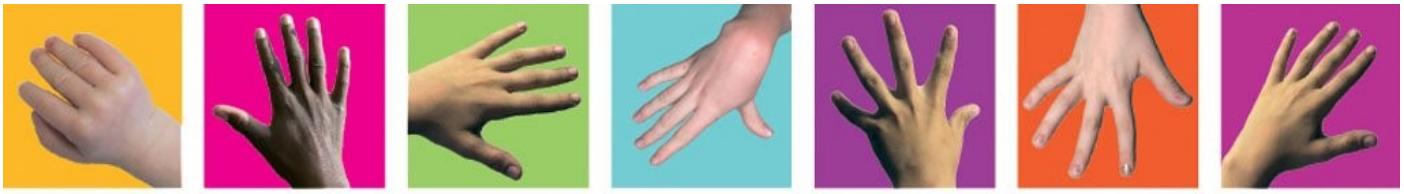


Coventry Safeguarding Children Board

Learning from Serious Case Reviews

An SCR takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. The primary aim of a SCR is to help agencies learn lessons from these events, and to use this experience to improve practice.

SCR reports can be found here.

Baby C—Case Summary

Baby C died at the age of 11 months after being left unsupervised in the bath with their sibling who was 2 years old. The review covers a 22 month period.

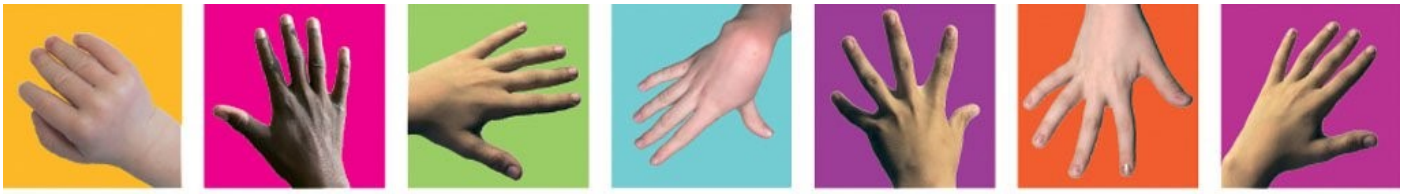
Prior to birth of baby C, mother had reported feeling depressed and isolated. Shortly after the birth of baby C, the relationship between mother and father had ended. Mother and children had moved into new accommodation and reported to the health visitor that she smoked tobacco and cannabis. A support plan was developed. Concerns were raised by the father's ex-partner who's children had been on a recent visit to father, regarding shouting and arguing between father and mother of baby C and baby C's sibling being hit.

Following an initial assessment the parents were offered parenting support via the Common Assessment Framework which was declined. During this period, professionals observed the house to be clean and tidy, and children developing well. A nursery nurse saw the family on a second occasion when baby C was 7 months old when mother reported feeling low and lacking support. The offer of a referral to a voluntary service or CAF was declined. Mother reported arranged an appointment with the GP, however a planned telephone consultation set up by the nursery nurse did not take place.

During a planned home visit by the health visitor the following week, mother disclosed that she had been physically, emotionally and financially abused by the father for the last 18 months and the incidents were becoming worse. An appointment was set up to enable mother to receive support related to domestic abuse which mother did not attend. She was also provided with food vouchers.

A referral was made to Children's services and a child and family assessment was completed six weeks later. The assessment concluded that the children's needs met the criteria for support through the Children and Family First Team at level 3, indicating complex needs. Ten days later, a decision was made that the case should be held at early help which is a level 2 CAF, with a recommendation that the health visitor holds the case.

During this time baby C had attended hospital twice , once for cutting his hand on broken glass and the second occasion where baby C had hurt his finger in a door. Shortly after the decision to open a CAF, baby C was found lifeless in this bath with his sibling, mother had left the children unsupervised in the bathroom for up to 10 minutes.



Analysis

During this period the referral and assessment service were experiencing high referral rates and were managing high caseloads. In the main the response to referrals were appropriate but fell short on the investigation of the repeat referral.

There was evidence of positive communication across agencies, however relevant information was often not communicated and shared with all agencies involved, for example with the midwife.

Observations by professionals of mother and on occasion father showed they provided appropriate care and attention for their children, who were observed to be well cared for.

On occasions professionals did not recognise or address in their assessments the impact of the parent's behaviour and lifestyle choices on their children, including domestic violence, substance misuse and poor mental wellbeing.

The first assessment in response to parental arguments and physical abuse were denied by the parents and the social worker observed no bruising. However 3 weeks had elapsed since the incident and so there was unlikely to be any bruising. None of the children who raised concerns were spoken to as part of the assessment.

Support for the family through the Common Assessment process was offered and declined on more than one occasion but alternative solutions for support were not explored and the parents decisions were not sufficiently challenged by professionals.

We encourage you to discuss this case in team meetings to understand and apply the key learning.

Key Learning

- **Listening to children**

  Referrals made in response to a child's disclosure must result in the professional undertaking the assessment contacting the children/young people who have made the allegation.

  When children/ young people are sharing a safeguarding concern all necessary support should be given to enable the disclosure to be made.

- **Transfer of a case to a different level of need**

  When the decision is made for a case to be transferred to a higher or lower level of priority the decision and rationale for this must be clearly communicated across all partner agencies involved with the family.

- **Improving communication between health professionals**

  General practices managers with the primary health team should facilitate regular meetings between all health professionals involved in the delivery of care for 0 – 5 age group. This will enable regular and on-going discussion about vulnerable families and to coordinated support to vulnerable families.

- **Domestic violence and abuse**

  When professionals identify indicators of domestic violence and abuse, this should be explored further in relation to the impact on children living in this environment and should be shared with all relevant agencies.