May 2020

Serious Case Review in relation to Child BF

Response from Cumbria Safeguarding Children Partnership (CSCP)

In June 2017, Cumbria LSCB began a Serious Case Review (SCR) in relation to the services that were provided to Child BF and their family. The review scrutinised the work of the following agencies:

- Children's Services
- General Practitioner
- Police
- Health Visiting Service CPFT
- Maternity Services NCUHT
- Barnardo's
- NSPCC

The full findings of the SCR are set out in the overview report which has been published alongside this response.

There has been a delay in the publication of this SCR due to ongoing legal proceedings. Given the practice considered in this review is now from 3 years ago, a considerable amount has changed to improve practice across the former Local Safeguarding Children Board (LSCB), now CSCP, and its member agencies, and the lessons and recommendations from this SCR are reflective of that.

Individual agencies involved in the review have already taken forward the learning outlined in the report, and the LSCB and CSCP have also been implementing the learning identified prior to the publication of this report.

The table below sets out the main points of learning from the SCR and how the CSCP will continue to ensure practice improves across all services for Children in Cumbria. Any references to learning and actions for the LSCB in the report will continue to be taken forward by the CSCP.

The work to implement the recommendations and to monitor their impact on practice will become part of the long term work of the CSCP and member agencies. The implementation of these recommendations will be managed through the Board and the long-term implications will be tested through the Board's Performance Management and Quality Assurance (PMQA) framework to evidence the expected impacts and these will be reported in the Board's Annual Report.

Gill Rigg
Independent Chair – Cumbria Safeguarding Children Partnership
May 2020

CSCP RESPONSE

THEME 1: Engagement

Finding BF1
There was a recurring concern about the engagement of the parents in this serious case review. The professionals involved in this case recognised this as an issue however and were both persistent and persuasive in trying to ensure the engagement of both parents. Lack of parental engagement can often lead to a case being closed or drift and delay in planning for a child.
Lesson BF1.1
In cases where there are concerns about the capacity of parents to meet their children's needs and where the parents are showing increasing vulnerabilities such as depression or relationship problems, continued non-engagement with assessments and support should be recognised as significantly increasing the risk to the child.
Lesson BF1.2
When lack of engagement is recognised in cases where the parents have vulnerabilities, an approach that provides additional support is good practice.
Recommendation 1
The LSCB should make arrangements to disseminate key messages from this review as widely as possible, including:- The need to challenge poor engagement
CSCP Context / Actions already taken/ CSCP Action
The CSCP will publish a Newsletter following this review which will include links to the relevant CSCP policies – such as: Immobile Infants; Escalation Policy; Transfer-in; Disguised Compliance; Neglect; Pre-birth Protocol. Further workshops will be held on 'disguised compliance'
How will we know
Multi-agency audit will show parents who fail to engage are challenged and cases do not drift

THEME 2: Parental Capacity

Finding BF2
In this case Mother had an extensive history of contact with Children's Services as a child. The need for support was recognised by professionals involved but the risk of physical harm

had not been considered, as neither parent had a history of violence. However there are numerous cases where children have been killed or physically harmed in circumstances very similar to these.
Lesson BF2.1
In cases where an unborn baby of first time parents is thought to be at risk of neglect due to the predisposing vulnerabilities and risks, the possibility that the baby may be at risk of physical harm should also be considered.
Recommendation 2
The LSCB should make arrangements to disseminate key messages from this review as widely as possible, including:- When a baby is at risk of neglect, consideration should also be given to the risk of physical injury.
CSCP Context / Actions already taken/ CSCP Action
Following the publication of this SCR a CSCP Newsletter will be published sharing the key messages CSCP to further embed training and support in analysis and decision making including the use of family history and context
How will we know
Multi-agency audits will show that professionals fully assess risks and these are responded to appropriately

THEME 3: Fathers

Finding BF3
In this case professionals were able to build an early relationship with Father but struggled to maintain the engagement as he became increasingly remote. This compromised the accuracy of the assessment of risk.
Lesson BF3.1
Professionals should ensure that they apply robust professional curiosity in relation to fathers; particularly when they disengage from services and from their parenting role with their child. This curiosity should be supplemented by robust challenge to fathers regarding their parenting role.
Recommendation 3
The LSCB should make arrangements to disseminate key messages from this review as widely as possible, including:-

Ensuring fathers are a key part of the assessment processes and any plans that are in place.

Recommendation 4

The Board should commission an exercise to map the services available to vulnerable families such as the family in this case, and to identify where the gaps in provision exist. Specific consideration should be given to projects that work with fathers and the Board should assure itself that there is capacity to engage effectively with fathers in all stages of assessments. Where gaps are identified consideration should be given to commissioning appropriate new services to fill them.

LSCB Context / Actions already taken/ LSCB Action

The CSCP have a service directory in place which is refreshed regularly

Since this SCR was undertaken the services for 0-19 and Early Help have been recommissioned with input from the CSCP and regard to the learning from SCRs

Our multi-agency audits include a question asking if significant adults who are involved in the lives of children are identified and assessed as part of the assessment and planning for the children.

How will we know

Audits will show that significant males are a key part of the assessment process and plans for children

THEME 4: Assessment and delay

Finding BF4

Delays in starting the Child and Family Assessment had a knock on impact on the timing of the pre-birth assessment; the ICPC; holding the Legal Gateway meeting; implementing the PLO and the specialist psychological assessments, which were only commenced a month before BF's due date.

These delays compromised the effectiveness of the assessment and planning as important information in relation to the parents' mental capacity was not available at the time that the baby was born and when she was discharged from hospital to her parents care.

Lesson BF4.1

Without a prompt and decisive response to a pre-birth referral there will be babies going home from hospital without the required assessment and parenting work being completed. The time available prior to the child's birth needs to be utilised to ensure there is an understanding of the risks and protective factors and a plan that enables those involved to work towards providing preventive and protective interventions as required.

Lesson BF4.2
Where an assessment indicates a significant change in a parent that increases the risk factors they present, this assessment should be shared expeditiously with appropriate professionals who are involved in the Child Protection Plan and PLO.
Recommendation 5
The Board should consider the revised pre-birth referral processes in the Safeguarding Hub and ensure that there is clarity of understanding across agencies and in particular in relation to the exceptions that apply between week 12 and 16 of a reported pregnancy.
Recommendation 6
The LSCB should make arrangements to disseminate key messages from this review as widely as possible, including:- Taking appropriate early action when risks are identified in pre-birth.
CSCP Context / Actions already taken/ CSCP Action
The CSCP will publish a Newsletter following this review which will include links to the relevant CSCP policies – such as: Immobile Infants; Escalation Policy; Transfer-in; Disguised Compliance; Neglect; Pre-birth protocol. Changes have been made procedurally within the Safeguarding Hub which encourages early contact from professionals in pregnancies where risk to the unborn child is evident
How will we know
Multi-agency audit will show that for pre-birth referrals there is a good assessment including family history, relationships and roles within the family, and known risk factors, concluding in a strong plan and appropriate level of intervention.

THEME 5: Transitions

Finding BF5
A number of issues in relation to transitions were identified in this serious case review. Mother's transition between childhood and adulthood, Father move from another area of the country, and Mother's movement between the two areas presented barriers in relation to the effective sharing of information and opportunities for support. This had the potential for professionals to miss or underestimate the risk factors that were present in relation to the unborn baby and the capacity of the parents to care for BF following her birth.
Lesson BF5.1
Professionals transferring cases involving vulnerable parents to colleagues in other areas must satisfy themselves that all relevant information is shared and accurately recorded, and

that there is a shared understanding of the vulnerabilities and risks, particularly if there is a view that a referral to the Safeguarding Hub is required.
Recommendation 7
The LSCB should make arrangements to disseminate key messages from this review as widely as possible, including:- Where a vulnerable parent moves into a new area, professionals must ensure there is effective communication with the area they have moved from.
CSCP Context / Actions already taken/ CSCP Action
The CSCP will publish a Newsletter following this review which will include links to the relevant CSCP policies – such as: Immobile Infants; Escalation Policy; Transfer-in; Disguised Compliance; Neglect; Pre-birth Protocol. A multi-agency thematic audit of cases which have 'transferred in' to Cumbria will be undertaken.
How will we know
Audit will show that there is evidence of relevant information being share with a clear understanding of the vulnerabilities and risks for families.

THEME 6: Multi-agency working

Finding BF6
In this case not all agencies involved with the family were invited to the ICPC or asked for information. There were weaknesses identified in sharing of information within the same agencies but across geographical boundaries.
Lesson BF6.1
It is important for all professionals and agencies that hold relevant information on a child or their family to be invited to contribute to strategy meetings, child protection conferences and core groups. Conference chairs should make particular efforts to ensure that the relevant GP is invited and receives the record of meetings.
Recommendation 8
The LSCB should make arrangements to disseminate key messages from this review as widely as possible, including:- Recognising the important role that GPs can play in gathering information for assessments.
CSCP Context / Actions already taken/ CSCP Action

CSCP to produce briefing on information sharing. CSCP to undertake further workshops at Practitioner forums on information sharing.
How will we know
Multi-agency audits will show there is effective information sharing.

THEME 7: Response to injuries

Finding BF7
Mother attended Accident and Emergency by ambulance with Child BF. It was identified that Child BF was subject to a Child Protection Plan, but there was a delay in notifying the Police, until the next day. A Public Protection Order (PPO) was taken out by the Police and the parents arrested. The delay in notifying the police had the potential to expose BF to risk of harm given that up until the PPO being put in place the parents had free access to BF whilst on the ward. Moreover, the delay exposed the criminal investigation to potential risk as evidence could have been disposed of or the parents could have fled the area.
Lesson BF7.1
Where a child presents at Accident and Emergency and Non-Accidental Injury is one potential cause of the presentation and a referral to Children's Services has been made, early consideration should be made to notifying the police.
Recommendation 9
The LSCB should make arrangements to disseminate key messages from this review as widely as possible, including:- The police should be informed in a timely way when a child is presented at hospital with an injury that could potentially be non-accidental.
CSCP Context / Actions already taken/ CSCP Action
The injury to immobile babies procedure have been reviewed A multi-agency thematic audit of injuries to immobile babies has been undertaken with recommendations being taken forward by the CSCP. A further audit is planned for 12 months' time to evidence embedded learning
How will we know
Multi-agency audit will evidence that professionals follow the procedure for injuries to immobile babies and the Police are informed when it is suspected that injuries are non-accidental

How we will disseminate and evidence the learning

Dissemination of the Learning	Specific Actions	Subgroup(s) or single agency	Deadline	Expected Impact and how it will be tested
The CSCP will ensure that the lessons identified in this SCR are publicised, included in learning materials and disseminated throughout the practitioners in the CSCP	Training materials will be reviewed to ensure the lessons are included. Policies and procedures (P&P) will be reviewed to ensure the lessons are included	Learning & Improvement Subgroup CSCP Board		Practitioners should use the lessons from this review in their everyday interactions with children, young people and their families The CSCP conducts regular surveys of staff and will include a question to ascertain how well the lessons from this review are known, understood and being addressed in practice.
	The website will be updated to reflect the lessons from this review.	CSCP Support Office		
	A specific newsletter will be published to cover the lessons from this review and other recent SCR			
	The LSCB will conduct a number of workshops and a conference to raise the profile of the lessons in this and the other SCR being published.	Learning & Improvement Subgroup		
	Assurance will be sought from all agencies that the lessons from this SCR are being used – this will be done through the 2020 Safeguarding Audit (Section 11)	CSCP Board		