Derbyshire
Safeguarding Children
Board

LEARNING THE LESSONS – October 2018

SILR15b: Multi-Agency Serious Incident Learning Review

A Multi-Agency Serious Incident Learning Review was commissioned by Derbyshire Safeguarding Children Board in 2015 following the sudden death of a 3 month old baby; considered by the Coroner's Court as being consistent with overlay. This baby lived with his mother and 2 older half siblings; no male adult lived in the household or was involved with the care of any of the children.

There was some historic involvement by professionals with this family in the years prior to the pregnancy, including children's services, predominantly for neglect. Derbyshire County Council's Multi Agency Team (MAT) were involved with the oldest child, due to their behaviour, in the months leading up to the pregnancy remained involved throughout. During this time parenting support was offered to mum but not always taken up.

This pregnancy first became known to agencies following the police attending the family home after an anonymous call regarding the alleged poor state of the premises. Due to the conditions at the home a referral was made by the police to children's social care. Around the same time a separate referral was made by the school of the eldest sibling due to Mother's behaviour towards him in a meeting at school. These referrals were passed on to the MAT involved. A step-up request was made which resulted in a joint visit by the MAT and a social worker where poor home conditions were noted. The decision was for the case to remain with MAT; though the ownership for this decision and the rationale underpinning it was not clear. At the time there was no recognised, evidence based assessment tool around neglect being used in Derbyshire which would have helped to inform this decision.

Other significant factors in the latter months of pregnancy and following birth included continued concerns about the eldest child's behaviour resulting in them being excluded from education, mum's parenting capacity and her ability to cope, and this baby needing to be hospitalised due to concerns around failing to thrive. In addition it was known that mum and baby were sleeping downstairs and that mum did not always wake up during the night when baby cried due to being a heavy sleeper.

The full report is not for publication however, it is important that all multi-agency partners are aware of the learning themes below.

It is recognised that there have been a number of changes to organisational processes and practice since this child's death in response to the serious incident learning review. This briefing is to emphasise lessons learnt and disseminate key messages for current

practice from the review for all multi-agency partners to better safeguard children in the future.

Lessons learned and key messages for current practice

1. The importance of consistently using an assessment tool to better identify and understand the threshold around neglect and to ensure practitioners respond appropriately and proportionately. In Derbyshire the current tool is the Graded Care Profile which can be found on the DSCB website.

2. The importance of using the Early Help process appropriately and practitioners undertaking an Early Help Assessment when needs are escalating to ensure a think family approach is taken. This will ensure that the needs of the whole family are better understood and coordinated support is considered and offered if appropriate.

3. To ensure all practitioners and managers understand the multi-agency Pre Birth Protocol and are appropriately using it to ensure the safety and wellbeing of all pre-birth children, and the wider impact which a pre-birth/ new born child can have on the parenting of siblings. This protocol can be found on the DSCB website.

4. The importance of always considering if a child is being neglected where failure to thrive is identified. If neglect is suspected a child protection referral to children's services must be made and a discharge planning meeting must be convened before the child is discharged from the hospital.

5. To ensure all practitioners and managers understand the messages around baby safer sleep awareness, convey them clearly to parents and are assured they are understood by them. Where circumstances make you suspect unsafe sleep arrangements may be happening these should always be explored and addressed. Click here to access the Guidance to Support Safe Sleeping Practices in Babies and Infants.

6. The importance of regular reflective supervision for practitioners including the analysis of risk and agreed decisions.

7. The importance of recording clearly the continuous manager's footprint on cases. This includes decisions and ensuring agreed actions are completed.

8. The importance of remembering assessment is ongoing and should be revisited if new needs / risks are identified. This may lead to a need for escalation in light of new the new information if threshold changes.

9. The importance of convening discharge meetings with other involved agencies, where children have ongoing concerns that could continue following discharge from hospital. This will ensure those working with the child are better aware of the specific health concerns, their potential impact and how to respond to them.