Learning Summary Child K SCR

March 2018

A summary of the case;

Child K died at eleven weeks of age after being placed in his parent's bed to sleep overnight. Both parents were at the time under the influence of alcohol.

Child K had three older siblings, the two eldest siblings had been on a Child Protection Plan in a previous Local Authority due to concerns of alcohol abuse, domestic abuse and maternal mental health. The Child Protection Plan had ended several years before the family moved to Hampshire and therefore information was not known to all Hampshire agencies.

Engagement with agencies varied significantly. The School and midwifery had consistent levels of engagement with the family. The health visiting service was declined by parents with the exception of annual checks and engagement with CAMHS varied with periods of non-engagement.

Information on the family's history was known to some but not all agencies. Midwifery were not aware of the previous concerns including postnatal depression and Children's Services were not informed of the previous Child Protection Plan when a referral was made.

Learning points for Managers;

- Practitioner awareness of key policies and procedures (Family Engagement Guidance).
- The importance of including and sharing family history in referrals and assessments.
- Ensure the voice/ experience of the child is taken into account in all work with families.

Learning points for Practitioners;

- Promoting participation of both parents at appointments/ meetings.
- Information management and sharing of historic information.
- Awareness of the criminal offence of overlaying when under the influence of alcohol/ drugs.
- The need for Safe Sleep to be discussed with parents for each pregnancy especially if additional vulnerabilities are known

- The need for assessments to be a continuous process including at times of increased vulnerability and include the voice/ experience of the child especially including children with communication difficulties.
- Awareness, understanding and implementation of key policies and procedures including the Family Engagement Guidance.

Themes in common with other reviews in Hampshire;

- The need for high quality supervision to enable practitioners to plan and deliver assessments which are both proportionate and robust.
- The need for effective information sharing within and across agencies involved with the family, including historic information.
- The importance of a Whole Family Approach in working with families.

If you do one thing, take the time to….

- Ensure that relevant historic information is included in referrals and assessments.

How was learning achieved;

- A serious case review was commissioned by the Chair of Hampshire Safeguarding Children Board. Agencies involved with the family were asked to submit written reports and a chronology of events and identify panel members to represent the agencies involved.
- An independent Reviewer was commissioned and systems methodology was used to undertake the SCR.
- The independent Reviewer met with frontline practitioners involved with Child K for individual conversations and as a group in a practitioner workshop.

Training and resources;

HSCB Training

HSCB offers a variety of face to face and online courses.

Online Child Protection procedures

Protocol for Protecting Children who Move Across Local Authority Borders.

Published SCR reports and learning summaries can be found in the resource section of our website under the Learning and Improvement category.

Published SCRs