Learning Summary Child U SCR

February 2018

A summary of the case;

Child U died at seven weeks of age following a significant injury including swelling and bruising to the brain and a fractured skull whilst under the care of her father. At the time of Child U's death there was a Child in Need plan in place.

From early pregnancy there were several agencies involved with the family these included midwifery services, emergency departments, ambulance service, GP, adult mental health team, perinatal mental health services and following a referral Children's Services.

Early in the second trimester of pregnancy mother reported to her GP thoughts of self-harm and suicide ideation a referral was made to adult mental health. After an assessment the case was passed to the perinatal mental health team who continued to work with mother throughout the period of review. At times throughout the pregnancy mother reported that suicidal thoughts had reduced and the unborn baby was seen as a protective factor

At the beginning of the pregnancy mother was under the care of community midwifery provided by the hospital that covered the area in which she was a resident. Early in the pregnancy Mother requested to receive care from another hospital trust and information was transferred. Further along in the pregnancy mother again requested to transfer her midwifery care and was transferred to a third hospital trust where she gave birth to Child U. There was no explanation given by mother as to why she had requested the transfers.

During pregnancy mother disclosed to professionals that she had previously been in abusive relationships but that her relationship with Child U's father was not like that.

Father of Child U was seen on several occasions during the pregnancy and first two weeks of Child U's life and was considered to be supportive and a protective factor. Appointments after two weeks of age were attended only by mother and Child U.

Learning points for Managers;

- Practitioner awareness of key policies and procedures
- Linking of information about all family members/ members of the household
- Information management and sharing

Learning points for Practitioners;

- Promoting participation of parents in multi-agency meetings
- Information management and sharing
- The need for assessments to be a continuous process including at times of increased vulnerability
- Awareness, understanding and implementation of key policies and procedures

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.
- Judgement about risk and the need for intervention is only valid at the time it is made. As circumstances change, more information comes to light, or concerns continue, practitioners may need to re-assess and consider further action.
- The need for effective information sharing within and across agencies involved with the family.
- The importance of involving fathers in multi-agency work

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

- Identify and link all information on all family members/ members of the household.

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 U 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.

HSCB Training 2017/18

Online Child Protection procedures

4LSCB Procedures

Published SCR reports and learning summaries can be found in the resource section of our website under SCRs

Published SCRs