Learning From Serious Case Reviews

October 2021

Changes to the Working Together 2018 Legislation means that Serious Case Reviews are now known as

Local Child Safeguarding Practice Reviews (LCSPRs)

Family T

Serious Case Review in respect of female twin siblings aged 14 weeks who sustained significant non-accidental physical injuries. When the injuries were identified the twins were living in a foster placement due to concerns about the ability of their parents to meet the needs of the twins. There were issues surrounding domestic abuse and parental drug misuse, and Mother of the twins was a looked after child (LAC).

Themes that emerged from the Serious Case Review in to Family T;

- Effectiveness of assessment
- Response to emerging concerns
- Support to parents during care planning for vulnerable babies
- Multi-agency co-operation and information sharing
- Professional understanding of the twins lived experience
- Escalation of professional concerns
- Response to non-accidental injuries in babies

Agencies Involved; Buckinghamshire Children's Social Care, Child Looked After Team, Buckinghamshire Healthcare Trust, Thames Valley Police, Youth Offending Service, Oxford Health NHS Foundation Trust (CAMHS), Barnardo's RUSafe, One Recovery Bucks, CCG,

Areas of Good Practice

Safeguarding is the action that is taken to promote the welfare of children and protect them from harm. preventing harm to children's health or development ensuring children grow up with the provision of safe and effective care taking action to enable all children and young people to have the best outcomes.

- ☆ Practitioners responded to Mother at times of distress to assist her to care for the twins
- ☆ The Community Midwife made a referral to Children's Social Care regarding concerns about cannabis misuse
- ☆ The Housing Support Worker was commissioned to provide additional hours to support the parents when the twins were discharged from hospital
- ☆ Practitioners met to consider how best to support Mother to co-operate with other agencies

National Panel report regarding non-accidental injury of children under 1 by male carers

The Myth of Invisible Men (publishing.service.gov.uk)

Link to the Family T report;

Local Child Safeguarding Practice Reviews - Buckinghamshire Safeguarding Children Partnership (buckssafeguarding.org.uk)

Recommendations

The safeguarding partnership seeks assurance that learning from this review is addressed within the improved process and procedures regarding unborn baby assessments

Consider improvements to the support for looked after children who become pregnant which include:

- Timely communication with Mother (or father) if there are concerns for the baby
- Identification of parental support needs (physical/emotional)
- Clear communication between social workers for the parent and social worker for the baby
- Opportunity for parents to contribute to care plans for the babies

Learning from this Review is addressed within the improved process and procedures for multi-agency assessments with specific regard to;

- Involvement of Fathers,
- Use of historical information to inform analysis
- Contribution of partner agencies to assessments led by CSC

AND assurance is sought about the impact of improved assessments on practice.

Seek assurance that information about the role and responsibility of practitioners from different agencies are included within all multi-agency plans

Seek assurance from partners that multi-agency practice regarding coercion and control is informed by learning from this Review, specifically - when a looked after child becomes pregnant there is a holistic assessment which includes a robust analysis of;

- Historical information regarding both parents
- The quality of the relationship between partners
- Early identification of actions required to safeguard baby (ies)

Safeguarding partners request assurance that there is understanding and confidence amongst practitioners from all relevant agencies to implement the child protection medical procedure

Buckinghamshire Safeguarding Partnership with partner agencies seek assurance that the system to implement a discharge planning meeting is robust and understood by practitioners

Practice learning from this Review is shared with agencies and practitioners across the safeguarding partnership