Briefing on Serious Case Reviews

Child E (Published by Bromley LSCB, February 2015)

Background

In March 2014 Child E tragically died at the age of 12 weeks. At the time of his death he was a Looked After Child in the care of Bromley Children's Social Care. Due to concerns about neglect and because both parents were in prison, he was placed with his twin brother in the care of a maternal aunt. Unknown to professionals, he was staying in a caravan due to the aunt locking herself out of the home address for a few days. In the early hours of 5th March 2014, Child E was found on the makeshift bed on the floor of the caravan and was not breathing. Child E had been sleeping with of his 2 siblings, a cousin and the maternal aunt.

Child E was one of twins born to parents who also have three older children. The family are part of a large extended family from an Irish Traveller background and had spent most of their lives moving between and living in a number of different Local Authorities in London and the South East Area of England.

Both of Child E's parents have criminal convictions and have spent periods of time in prison and both were known to have a history of drug and alcohol abuse. Both parents and an older sibling Child B were arrested on September 2013 for burglary offences and both parents were remanded to prison. Child B was remanded to the care of the local authority and placed with foster carers. The other two siblings (Child A and Child C) were placed with the maternal aunt initially under Section 20 (a voluntary agreement). Bromley Children's Social Care subsequently initiated care proceedings on all five children.

In July 2014, the Coroner confirmed that the cause of death was Sudden Unexpected Death in Infancy (SUDI) and decided that there would be no Inquest and no criminal proceedings have been instigated. At that time, a Serious Case Review (SCR) had already been started by Bromley Safeguarding Children Board (BSCB). The SCR Panel chaired by the Independent Chairperson agreed to continue with the SCR given that it was clear that the review would highlight learning for partner agencies. The Serious Case Review was particularly complex in that it covered more than one local authority area and numerous services across the different boroughs.

It is important to state that none of the practice issues identified in the Serious Case Review contributed to the tragic death of Child E. Indeed, neither parent identified any actions by the agencies involved that might, with hindsight have been helpful to their family or that might have prevented the death of their child. This review has highlighted learning for all agencies and areas of practice which could be improved. Most of these areas of practice have been identified and addressed by the agencies themselves. The Bromley Safeguarding Children Board will alert the London Safeguarding Children Board of considering any improvements to the collective response to safeguard children who move between local authorities.

Key Learning Points:

- Sadly, in the UK around 300 babies die each year from sudden infant death syndrome (NHS data 2013). Public Health information on co-sleeping should be regularly reviewed to ensure the key safety messages are available to the whole community, including those who may not have access to mainstream public information.

- The Review recognised the challenges to the children's services of how to respond to the needs of children who live in a community who are mobile and where there is unlikely to be any sustained engagement by practitioners. Some families will have lived in several local authority areas and therefore may be known to multiple children's services, police, schools, GPs, health visitors etc. In these situations, gathering information as part of undertaking assessments and to make decisions on determining risk can often be a complex task. This is compounded if family members have numerous aliases and changes of address. In these circumstances it is important that sufficient resources are available to enable information to be gathered in a prompt and coordinated manner (including enquiries of the Disclosure and Barring Service). This means that agencies who hold information need to provide it in a timely and assured way to the practitioner who is coordinating gathering the information.

- Practitioners need to be culturally aware of the traveller community and sensitive to the impact of any interventions on the children.

- Communications between agencies need to be accurate and sent in a timely way. Assessments should be carried out according to the relevant procedures. It is essential practitioners and managers approach these core elements of their work professionally.

- Where there are concerns regarding neglect and there is a pregnancy, Children's Social Care should always consider holding a pre-birth child protection conference. If this is deemed not appropriate then the reasons should be recorded on the file.

- Changes in staff is inevitable. Managers must consider the impact on care planning for the child and keep any disruption and delays to a minimum.