Worcestershire Safeguarding Children Board

Learning & Improvement Briefing 15- April 2019

Serious Case Review Isaac

The Worcestershire Safeguarding Children Board (WSCB) decided to undertake a Serious Case Review in respect of a baby who will be referred to as Isaac. It was agreed that the criteria for carrying out a Serious Case Review as defined by Working Together to Safeguard Children 2015 had been met.

Isaac was 12 weeks old when Mother found him to be unresponsive and called an ambulance. Despite medical attempts Isaac did not survive and the initial assessment was that the death was resultant from a co-sleeping incident. Evidence collected by the Police found that Mother and Father were drunk the previous evening and Isaac had been placed on Mother's bed by a relative. Parents were arrested and following further investigation by the Police no charges were made. The siblings of Isaac had been subject to a Child in Need Plan (CiN) which was closed when he was 17 days old.

A number of recommendations were made for the Board and these are being implemented. One of the recommendations was to ensure that the key learning was disseminated to all practitioners and this is being undertaken by the delivery of events and the production of this Learning and Improvement Briefing. It is your responsibility as a practitioner to read this briefing and follow any guidance given.

The full review can be found at: https://www.safeguardingworcestershire.org.uk/serious-case-reviews-library/

Learning From The Review

Assessment and the impact of alcohol on parenting:

The review found that whilst there were initial concerns about the alcohol consumption of Mother and Father: these were not fully explored by professionals from any agency. Over time, parental minimisation of alcohol use was accepted by professionals and a serious incident was perceived as an isolated occurrence. Therefore the impact of parental alcohol use on the capacity to parent was not recognised and the lived experience of the children was unknown.

Given the prevalence and acceptance of alcohol use in society, it is possible that practitioners may normalise periodic excessive drinking and fail to recognise the serious consequences that non-dependent drinking can have on parenting capacity.

What needs to happen:

Practitioners should always ask parents about their alcohol consumption if relevant. An alcohol assessment tool (Audit Tool C) is available at: https://www.gov.uk/government/publications/alcohol-use-screening-tests

- Some parents may need signposting to specialist services such as Swanswell but for others who are not alcohol dependent they may need to be made aware that whatever the level of alcohol consumed this could have an impact on their children.

Assessment and the impact of alcohol on parenting (continued)
A DVD showing one of the ways that the impact of alcohol can have on children can be found by clicking here:

The initial concern should not be minimised or forgotten when working with the parents.
Safer Sleeping guidance can be located in the West Midlands Child Protection procedures (Section 3.10)

Voice of the Child
When children and young people speak directly to Practitioners it is not sufficient to just record what has been said. If the voices of young people do not inform assessments and subsequent interventions, it is likely that they will not feel listened to, intervention may not be appropriate and concerns could escalate.

What needs to happen:
Practitioners should ensure that the voice of the child informs assessments and interventions.
A Learning and Improvement Briefing on the Voice of the Child can by clicking here.

Early Help support
Early Help Support lacked coordination and therefore had limited impact. There was a lack of clarity about the role and purpose of Early Help which contributed to a limited understanding among partners about Early Help and the responsibility of relevant agencies to support delivery of the Early Help offer through Universal services.

What needs to happen:
Practitioners should be aware of their role in the provision of Early Help and be professionally curious. An Early Help assessment and guidance can be found here http://www.worcestershire.gov.uk/eha

Child in Need process
A Child in Need Plan should focus on the assessed needs of children and families. Intervention or support to meet these needs should be explicit about expectations, outcomes and available resources to support the implementation of a Plan. Without this focus and clarity practitioners may develop a false reassurance about the effectiveness of support provided to children, young people and families, the issues of concern may be lost and the needs of the children may be overlooked.

Effective partnership between agencies is essential when implementing a Child in Need Plan. Without the engagement and contribution of all relevant professionals it may be difficult to understand the significance of some events or disclosures by children, important opportunities for intervention may be lost and the Plan will have limited impact.

When the siblings of an unborn baby (UBB) are subject to a Child in Need Plan it is important that there is an opportunity within multi-agency CiN meetings to;

- discuss the impact of a new baby on the family circumstances
- include the UBB on the Plan with specific reference to risks and vulnerabilities
- ensure there is multi agency agreement prior to closure of the Plan.

Practitioners should ensure they have read and understand the Child in Need guidance and the Unborn Baby Pathway and guidance