Background:

This Serious Case Review (SCR) concerns Child E, a baby who died whilst in mother's care. Child E was taken to hospital in cardiac arrest having spent twelve hours unchecked overnight in a pram containing heavy duty blankets.
Child E was born into a family where two children had been parented for three years without being known to children's services beyond those universally accessed by all children. The father of Child E did not live in the family home but remained in a relationship with Child E's mother throughout Child E's short life. Child E was known to universal services only and was never subject to a multi-agency plan.

Why it matters:

A Serious Case Review takes place when a child dies or is seriously injured and abuse or neglect is thought to be involved. The purpose of the Review is to:

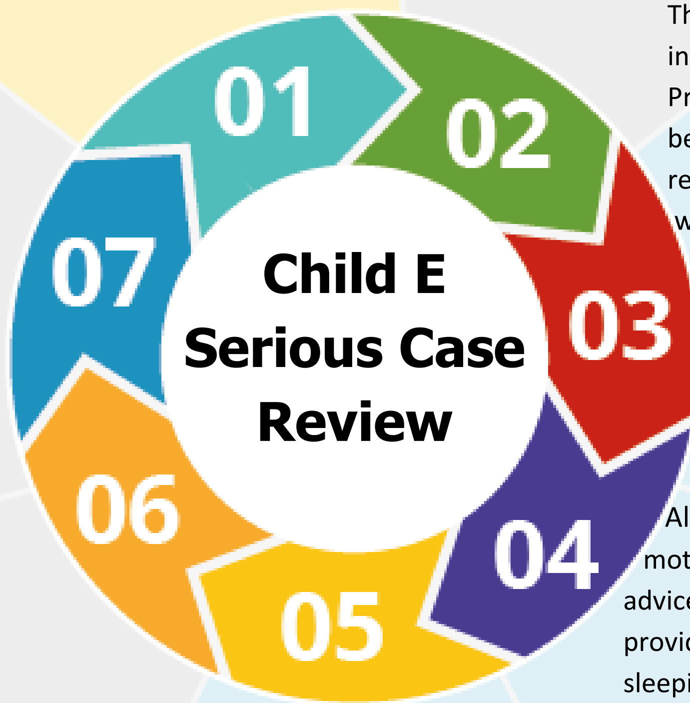
- Establish whether there are any lessons to be learnt from the case and from the way in which local professionals and organisations worked together.
- Identify what is expected to change as a result of the learning
- Try to prevent similar incidents from happening in the future.

What to do?

How can I learn more about this SCR?

The full SCR report was published on the RBSCB website in October 2018

Learning is also incorporated into the multi-agency safeguarding training programme



Information

The use of cannabis has become an increasingly common factor. Professionals need to mitigate against becoming desensitised to the fact that it remains an illegal drug and one which, when used even intermittently, can have highly detrimental consequences for family life. Abstinence from substances is not always a static factor which means that parenting capacity can change / deteriorate very quickly.

Although there was evidence that the mother of Child E was given detailed advice on safe sleeping on 3 occasions. This provides a positive picture of how safe sleeping is being promoted in hospital, midwifery and health visiting services; sadly, she did not heed this advice.

Questions:

How can professionals be reassured that substance misuse that impacts on parenting is ever really resolved or whether some level of risk will always remain?

Is non-attendance at appointments an indicator of deteriorating family functioning?

Learning and Information

1. In order to optimise single agency identification of risk following the cessation of an Early Help Assessment, the rationale for closure should identify trigger points to review necessity for further multi-agency sharing of information
2. Understanding multi-agency referral pathways is crucial to professionals' sharing information with purposeful intent
3. Specialist midwives are best placed to support pregnancy of women with a known drug history
4. Professionals must be ever mindful of the cycle involved in achieving lasting change and that motivation, action and maintenance have equal importance when seeking reassurance that change has occurred
5. Professionals must be ever mindful of repeated indicators of concern and act collaboratively with other agencies to review indictors of risk

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