7 minute briefing: SCR Child 'D'

Visit www.walthamforest.gov.uk/strategicpartnerships for the full report and other resources

Strategic Partnership Boards
SAFETY SAFEGUARDING WELLBEING

01 What is a Serious Case Review? (SCR)

A review that has to take place when a child is seriously harmed or has died due to abuse and/or neglect and there is concerns about how agencies have worked together.

The purpose of a SCR is to look at **what happened / why / what action** will be taken to learn from the review findings

This SCR happened under Working Together 2015. (Working Together 2018 changed the statutory guidance on reviews and what they are called, which will affect how they are done in future).

02 What happened?

D's mother experienced domestic abuse prior to her pregnancy and had to flee from her abuser, who was his father.

Mother then lived in east London and was isolated with very limited support/friends, and no family. She was living in Newham when she booked for her pregnancy. Before D was born, she moved to Waltham Forest where she lived in a refuge for women experiencing domestic abuse.

When D was 4 months old and at the time of his death, he was in the sole care of his mother. They were living in temporary studio accommodation in Hackney, sourced by London Borough Waltham Forest Housing. The coroner gave cause of death as "unexplained" noting signs consistent with asphyxiation, and undiagnosed brain condition.

03 Second finding

(First finding was only for Newham)

Some practitioners are still not confident about using escalation.

This case identifies 7 occasions when practitioners could have escalated their concerns about the outcome of the referrals they had made to different agencies, which did not lead to the assessment they were requesting.

What needs to change?

Practitioners need to embed escalation as part of positive professional challenge and everyday practice. Escalation includes a practitioner challenging the professional opinion of another practitioner through their own manager or the practitioner's manager. This can be to and from any agency in the partnership. Click here to see a bulletin on escalation which includes the escalation process for children and adults.

04 Third finding

Some practitioners do not always record important information. This results in significant information not being shared when required.

The issue of recording is linked to that of information sharing. If information is not recorded, it cannot be shared with others or used to inform further assessments and multi-agency discussions.

What needs to change?

- Practitioners to reflect on the quality of their own recording and information sharing with other practitioners.
- Managers in all agencies to include more spot checking as part of audit activity to check the quality of recording.
- Practitioners making referrals to MASH to be given individual feedback from their MASH agency reps about the quality of information sharing in referrals to support improvements in practice.

05 Fourth finding

There is a tendency for some practitioners to minimise the significance of parents using alcohol and being over optimistic/reliant about self-reporting of alcohol consumption.

On at least 8 occasions practitioners mentioned alcohol as an issue of concern in relation to D's mother. This was often used together with "historical" or "not dependent on" without any other evidence or commentary to back up the statement. Locally in Waltham Forest alcohol was the third highest potential risk factor identified at end of assessment between 1 April 2018 – 31 March 2019.

What needs to change

Practitioners to be:

- respectfully nosey, ask challenging questions about alcohol use and triangulate information rather than take everything at face value
- clear in their communication with parents about the risk of alcohol use. See NSPCC learning from SCR and bitesize video guide on alcohol for more information

06 What to do now

- Reflect on how the findings connect with areas of your direct practice with families or other practitioners
- Think about what changes in practice you could make now to embed the learning?
- Share this briefing in your next team meeting, with your manager/management team, in your next multi-agency meeting etc.
- Access the links and resources in this briefing

07 What to do next

- Read the full report - only 26 pages
  Access SCR Child D here
- Watch the bitesize video guides on alcohol use and professional curiosity
- Review all the Strategic Partnerships resources to further your learning
- Access Care Grow Live for more advice and information on alcohol and substance use