Swindon Local Safeguarding Children Board
Serious Case Review Briefing; May 2018
Serious Case Reviews S & D

Safe Sleeping Guidance - At all antenatal, new birth and 6 week contacts, the Health Visitor should discuss safer sleeping guidance that is contained within the red book. Time should be taken to check understanding and ensure parents know where to find the guidance for future reference. Further information on safe sleeping can be accessed at The Lullaby Trust

Escalation; Professionals across all agencies should feel able to **challenge** decision-making via the LSCB Escalation Policy. Learning from reviews has highlighted the need for all practitioners to be clear about their responsibility to raise concerns about decisions made regarding the welfare of a child. Disagreements are likely to arise around thresholds, roles and responsibilities, communication, the need for action or lack of action. The **safety of the child is the paramount** consideration in any professional disagreement and any unresolved issues should be addressed with due consideration to the risks that exist for the child.

Conference, Core Groups and Strategy Meetings; Child protection conferences, core groups and strategy meetings are the key forum where decisions are made about a child's future, safety, health and development.

Case Reviews highlight that **attendance by all agencies** involved with the child is vital to obtain an accurate picture of the level of risk for the child (GPs are particularly key to these discussions). Timely reports, the sharing of relevant information and record keeping are also vital to obtain an accurate picture of the level of risk and to map out what is happening for the child.

The South West Child Protection Procedures provide more information about the process and the involvement of professionals.

Book onto the LSCB Conference & Core Group Training

Serious Case Reviews S & D

In late 2016 Swindon LSCB published two SCRs following the deaths of two babies as a result of co-sleeping. The cases are not connected and occurred 6 months apart.

Both SCRs confirmed that all professionals had provided clear safe sleeping advice to the families. However, both families were within the child protection system and it was felt that there would be learning for organisations. The LSCB is keen to share the learning points identified.

All agencies have made changes to their own and multi-agency procedures (i.e. Great Western Hospital reviewed their discharge process to better support patient safeguarding). An action plan is in place to address the recommendations and is monitored by the LSCB.

Disguised Compliance & Capacity to Change; 'Disguised compliance' involves a parent or carer giving the **appearance of co-operating** with agencies to avoid raising suspicions, to dispel professional concerns and ultimately diffuse intervention. *(NSPCC Learning From Serious Case Reviews)*

Disguised compliance can lead to a focus on adults and their engagement with services rather than on the needs of the child. Case reviews highlight that professionals sometimes delay or avoid interventions due to parental disguised compliance.

Professionals may become over optimistic about progress being achieved; practice can be characterised by a **false optimism** about the parent's **capacity to change** and there is often insufficient challenge of parents. It is important to establish the facts and gather evidence about what is actually happening, rather than accepting parent's presenting behaviour or their version of what is happening for the family and child.

Professionals may find themselves **distracted** with the needs of the parent or their chaotic lifestyle which prevents them focussing on the child or how their parent's behaviour and lifestyle are affecting their development and their lived experience.

Book onto the NEW LSCB Working with Resistant Families Training

Communication and Information Sharing; Communication between agencies can be disjointed and there is evidence of gaps in communication between organisations. SCRs S & D highlight concerns around communications between health organisations and IT systems working in isolation. It is important for agencies to **maintain clear, timely lines of communication** and keep the focus on the needs of the child.

It is also important to recognise that children who are cared for by adults who are themselves in receipt of support may need additional support. Support plans for these children (at whatever level) are likely to be more effective where there is joined up working and communication between services that support adults and services that support their children.

Adult Services within the organisation should ensure that staff are aware of their duties in relation to the 'See the Adult, See the Child' protocol and the South West Child Protection Procedures and that each division has a way of monitoring the safeguarding processes

Neglect; Neglect is a serious form of harm and is a factor in 60% of national SCRs (*NSPCC*). Both families and professionals can become overwhelmed and demoralised by issues of neglect and children may experience repeated attempts by professionals to try and improve the situation.

Opportunities are often missed to evidence neglect and understand the child's lived experience. Identifying and managing the risks associated with neglect are key in cases where neglect is suspected or identified.

Apart from being potentially fatal, neglect causes great distress to children and leads to poor outcomes in the short- and long-term. Swindon LSCBs Neglect Framework includes information for practitioners on how to work with children and families where neglect is a concern.

Concerned about a child? Contact the Multi-Agency Safeguarding Hub (MASH); 01793 466903 / fcp@swindon.gov.uk