Key recommendations

SSCB ensures that communication processes between midwifery and health visiting services and GP services are formalised to ensure that all relevant risk factors are shared. Further that SSCB report this issue to the D of H and D of E and suggest that national guidance should be issued about information sharing and risk assessment with pregnant women.

SSCB be updated regarding progress in embedding the use of the Common Assessment Framework and the Team Around the Child by all agencies.

All relevant agencies should satisfy the SSCB that assessment processes include due consideration of the involvement of fathers and/or partners in the child's life. Where possible this should include their effective involvement in the assessment process.

SSCB request that the borough councils work with the housing associations to ensure that they have sufficient understanding of the relationship between the local authority and the LSCB with regards to safeguarding.

SSCB, through the section 11 audit, work with district and borough councils to ensure that when they commission services there are appropriate safeguarding quality assurance systems in place.

SSCB to develop a protocol with all district and borough councils in Surrey to ensure that there are arrangements in place that mean that where there are serious case reviews, there are suitably qualified independent professionals to undertake IMRs and be members of serious case review panels.

That police and children's service consider and report on mechanisms to improve information sharing, building on the development of the Police Central Referral Unit.

SSCB, in accordance with a previous serious case review, to consider how to ensure that all agencies improve professional curiosity and assertiveness.

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surrey safeguarding CHILDREN BOARD

LEARNING FROM A SERIOUS CASE REVIEW

Child Q

www.surreycc.gov.uk/safeguarding

The SSCB conducted a SCR as a result of events in 2011 where child Q was found face down in bathwater. He subsequently died. It was suspected that the mother had left Child Q and an older sibling unsupervised in the bath for an extended period of time
This review highlights the extreme vulnerability of young children who because of their total dependency on their carers, are at greatest risk of abuse.

Synopsis

Child Q's mother had a troubled childhood and adolescence. She had a history of behavioural problems in school and was known to Social Services because of safeguarding concerns. She had a history of substance misuse and was considered to suffer from depression. She could be aggressive and she stood trial for murder, however the case was dismissed against her.

Child Q's father had a significant history of drug and alcohol misuse. Apart from this, very little is known about him although it is noteworthy that he is significantly older than mother and there are some indications that she may have been fearful of him.

Between June 2008 and June 2009 there was limited agency involvement with the family. In 2009 there were two occasions when the police were involved because of mothers disputes with a neighbour and alcohol abuse. Mother experienced postnatal depression and was treated with anti-depressants. In 2010 mother was pregnant with Q and there were further neighbour disputes and allegations that mother was smoking cannabis. After Child Q was born routine postnatal care was provided but mother was hard to engage. There were further neighbour disputes involving police and the housing trust and there were further allegations regarding drug misuse. In 2011 mother was arrested because she was drunk and aggressive and was threatening the neighbour and her child. Later in 2011 there was a further neighbour allegation about Mother's use of cannabis. Later in the month the Police found an abandoned damaged vehicle, registered to father. Inquiries established that the windows had been smashed by mother following an argument when father threatened to leave and take the children. Mother returned to the GP reporting worse depression and was prescribed stronger anti-depressants. Mother refused counselling and mediation services and believed the solution was to move house.

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The main lessons that have emerged

Relevant information from Mother's early history was not accessed by the midwifery service or the health visitors because she did not volunteer the information and the GP did not share it with midwifery.

The need for better-integrated working prior to child protection concerns being identified to ensure better early intervention. The importance of the Common Assessment Framework and Team Around the Child processes being understood and adopted by all agencies.

The importance of all assessment processes including effective assessments of men, particularly fathers.

The need for agencies who do not work directly with children and who are commissioned by agencies, whose prime responsibilities are not to children to be better integrated into the LSCB safeguarding systems.

The need to consider whether the current information sharing arrangements between police and other agencies are sufficiently refined to ensure that all information is shared when necessary.

The dangers of concentrating too closely on the needs of the adults which can lead to the children being overlooked and the importance of professionals being sufficiently curious and assertive enabling them to ask the right questions. Particularly the need for professionals to take seriously information that is provided by family and neighbours, as this is often information that is not known to the professional system.

This review highlighted that if there had been improved assessment and intervention with this family it is probable that mother would have received additional support with parenting. It is likely that this would have resulted in greater oversight of the children's development and it is possible that it could have resulted in better health promotion messages being shared with mother .This might have stopped her from leaving the children unattended in the bath.