Bedford Borough Safeguarding Children Board

Rosie
Serious Case Review
Practitioner Briefing
November 2018

Why have we published this practitioner briefing?

To help practitioners and their managers understand the key findings from a serious case review (the review) concerning 'Rosie' (not her real name). The review was commissioned because when Rosie was three and a half years of age she was found to be suffering from life-limiting and life-changing neglect within her family home. As a result, Rosie required urgent hospital treatment and will have ongoing health and care needs into the future. Practitioners who have taken part in the review recognise that there are opportunities to learn from Rosie's case, and for improvements that can be made in practice.

Who should read this briefing?

Anyone whose work brings them into contact with children, young people and their families, especially those providing care in frontline health services (e.g. maternity/health visiting services, GP practices, all hospital settings). The review also has relevance to those working in early years settings.

How was the review carried out?

The review was carried out in line with statutory guidance. Whilst reviewers recognised the requirement to understand practice from the viewpoints of individuals and organisations involved at the time, the retrospective nature of the review identified key episodes and points of contact where action *could*, and at times *should*, have been taken to safeguard Rosie's welfare. An audit of inter-agency practice in six current cases concerning 'neglect', undertaken as part of the review, helped to shine a light on current practice, previous learning from other reviews and the impact of the Pan-Bedfordshire neglect strategy. There were some positive findings from the audit.

Rosie's parents were informed of the review, but they did not engage and we therefore did not hear their views. The overview report is thus based on an integrated chronology of contacts with services and from the input of practitioners and managers at two practitioner learning events.

What are the main areas for learning and improvement?

1. Children suffering from neglect (and other forms of child maltreatment) may be **'hidden in plain sight'**. Rosie was not only seen by professionals she was also seen within her community and the seriousness of her neglect would have been evident particularly in the period leading up to her hospitalisation. The review findings support the NSPCC & BBSCB campaign **Neglect Matters** to raise awareness of neglect to a wider public audience. A recommendation is also made to support initiatives aimed at building 'social capital' with communities.

2. The review highlighted the importance of timely **pre-birth planning and assessment** in offering early help/support to vulnerable parents and in ensuring the future safety and well-being of the unborn child. Relevant pre-birth planning and assessment guidance is already included in the BBSCB procedures http://bedfordscb.proceduresonline.com/index.htm. The guidance helpfully highlights two key questions for practitioners to consider when deciding whether a pre-birth assessment is required: '**Will the new born baby be safe with these parents/carers?' 'Is there a realistic prospect of these parents/carers being able to provide adequate care throughout childhood?'**

3. The review found that more needs to be done within Bedford Borough to promote collegiate working, respect and mutual understanding of others' roles and responsibilities. This includes sharing knowledge of what a service offers, as well as what it does not offer. The new **'shadowing project'** is an area of good practice in promoting productive inter-agency working relationships and the review findings strongly support this initiative.

4. The review raises concerns about the delivery of health care to Rosie that was 'task focused' and failed to appreciate the wider aspects her **health, development and daily lived experience**. It is important that those who provide health care to children have the required competence to do so including knowledge of normal child growth and developmental milestones. This may be a training issue. Access to advice & support from a specialist paediatric and/or safeguarding professional is also key.

5. Finally, the review highlighted the finding of a three and half year old who was not attending any **early years' provision or groups**. Such provision helps children's developmental progress, socialisation and 'readiness for school'. It also provides an additional safety net for vulnerable children and their families and a source of additional parental support.

How does this review build on the learning and improvement from other local reviews?

This review also refers to practice issues from other recent local reviews, the importance of genograms and chronologies of significant events, as well as access to supportive and reflective supervision. Working with parents who are resistant to services, and who show partial or disguised compliance, is a challenging aspect of child safeguarding and one that calls for authoritative practice. Professional curiosity, respectful uncertainty, and being able to challenge parents and other professionals continues to be a key message for learning and improvement.

Where can I access the full report?

Via the BBSCB website www.bedford.gov.,uk/lscb. It has been written to be concise and accessible. We hope that you will read it in full.

Where else can I find out about learning from SCRs involving neglect?

The NSPCC provide concise and helpful themed summaries of learning from serious case reviews; the summary of learning from cases involving neglect can be found here:https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/neglect/

Further reading/resources

Pan Beds Interagency Child Protection Procedures:http://bedfordscb.proceduresonline.com/index.htm

Brandon, M., Glaser, D., Maguire, S., McCrory, E., Lushey, C., Ward, H. (2014) *Missed opportunities: indicators of neglect – what is ignored, why, and what can be done? Research report* London: DfE.

Working Together to Safeguard Children: (2018) London: DfE.

Lushey, C., Barlow, J., Rayns, G., Ward, H. (2018) *Assessing parental capacity where there are concerns about an unborn child: pre-birth assessment guidance and practice in England* Child Abuse Review 27:97-107.

Royal College of Nursing (2017) *Getting it right for children/young people: Self-assessment tool for general practice nurses and other first contact settings providing care for children and young people* London: RCN.