KS Serious Case Review (SCR) Learning Notes

We need to learn from SCR's and implement changes to practice. The following issues were identified in this SCR, they have also been raised as issues in the listed previous SCR's.

What Happened?

Baby KS was born into a complex family structure with a history of domestic abuse and violence.

KS was 8 weeks old when found lying on their back in bed with Mum. Baby was blue and not breathing.

Mum and partner were later found to have had drugs in their system at the time of the death.

The family had previously been known to Sandwell Children's Services and a Multi Agency Referral Form (MARF) had recently been completed.

A post mortem carried out stated that the exact cause of death was 'inconclusive'.

Safeguarding is everyone's responsibility

Are you aware of, and do you implement, Sandwell's pre-birth procedures appropriately?

Do you know your organisations escalation procedures?

Are you able to recognise and overcome disguised compliance and how do you exercise professional curiosity?

How do you ensure your assessments are not over optimistic?

Are you aware of the significance of frequent missed appointments by individuals, particularly in the case of pregnant women?

Do you understand your risk assessment responsibilities and link decisions to Sandwell's Multi-Agency Thresholds Document?

Where appropriate, do you ensure connection between adult services such as drug and alcohol and mental health services?

	2015	2016	2017
Information sharing	GS	HS	JS, KS
Disguised compliance		HS	JS, KS
Professional curiosity		HS	JS, KS
Over optimism	GS	HS	KS
Application of Thresholds	GS		JS, KS
Pre-birth procedures		HS	JS, KS

Sandwell Safeguarding Children Board

If in doubt ask for advice from your line manager, Safeguarding lead or Sandwell Safeguarding Children Board: 0121 569 4800