VS Local Child Safeguarding Practice Review (LCSPR) Learning Notes

What happened?

VS sadly passed away aged 3 days during the first lockdown. After a thorough investigation, police have taken no further action in regards to this death.

VS and their sibling were known to a number of services in Sandwell. Both VS and sibling had allocated social workers, with a pre birth assessment being undertaken regarding VS. This did not commence until 28 weeks gestation as the original contact with MASH at 11 weeks was not opened as a new referral.

An Initial Child Protection Conference was booked however VS had died before this could happen.

Sibling was subject to a Child in Need plan having previously been subject to Child Protection plan.

Mother was known to have mental health issues and received specialist support for this during her pregnancy with VS—some of this was virtual due to lockdown restrictions. Father of VS had a history of drug offences, violence and domestic incidents and remained on the periphery of plans, assessments and direct work.

What did we learn?

A whole systems approach to safeguarding unborn babies needs to be adopted with clear policies, procedures and processes.

When a child on a CIN plan is neglected, injured or exposed to unassessed risk, these incidents need to be responded to with the same rigour as new referrals

Effective managerial oversight and challenge using existing tools is needed to progress CIN cases

Professionals need to be empowered to challenge lack of progress.

Obtaining a family history with both parents/carers is vital to provide context and background in new assessments and to inform resultant plans.

Professionals must obtain clarity regarding the legality of living arrangements if the child is not living with its birth parents

Professionals need to be curious and ask pertinent questions to better inform their thinking and plans

Learning from CSPRs needs to be owned and addressed across the partnership and the strategic leads need to ensure this is effectively communicated across the whole workforce to inform and improve practice

How can we learn from this case?

How can I feel confident and supported to challenge lack of progression in children's cases?	What tools can I use to help my assessments and understanding of a child/family reach its' full potential?
In what ways can I include all family members, particularly fathers/males, in assessments, plans and direct work?	How can I be professionally curious to establish the facts whilst keeping a positive working relationship?

If in doubt, seek advice from your manager, safeguarding lead or contact the SCSP Business Unit on **SCSP_Business@sandwell.gov.uk**