Learning from the Review

Baby B Serious Case Review

A briefing note of key learning and practice improvement

Themes:

- Information sharing
- Family histories
- Anonymous concerns
- Management decision making
- Safety planning
- Professional boundaries

In November 2013 Baby B, aged 10½ months, was admitted to hospital and was found have life-changing injuries. Baby B was found to be demonstrating the symptoms of Shaken Baby Syndrome. Baby B's mother's partner was convicted of causing Grievous Bodily Harm and was imprisoned. Baby B's mother was convicted for neglect and received a suspended prison sentence.

In 2019 the East Riding Safeguarding Children Partnership decided that it was appropriate to commission a Serious Case Review into the circumstances of Baby B's injury. This can be read in full on the ERSCP website. This briefing is designed to pull out the key messages for safeguarding practitioners from the SCR.

Key Learning Points

Information sharing

- Practitioners must ensure that they are complying with current legislation, statutory guidance and agency polices relating to information sharing.

Family history

- When gathering information, practitioners should analyse and critically evaluate the information they receive in order to establish how much weight can be given to it.
- Incidents should not be seen in isolation but should be considered within the known history of a case and subjects so that patterns can be discerned.
- Where new information comes to light previous decisions should be re-considered.

Anonymous concerns

- Concerns made anonymously should be treated as seriously as those that are not anonymous.

Management decision making

- Management decisions regarding significant events should be clearly recorded on case records on the day the decision is made so the information is accessible to other staff during and outside office hours.
- Managers should make clear their expectations in regard to the purpose of assessment, areas to cover and expected timescales for visiting and providing the manager with an update. This should be included within an assessment plan.

Strategy meetings

- Strategy meetings must be held in a timely manner and attended by all practitioners who can provide relevant information about the situation under consideration and people of sufficient seniority to make decisions.
- Minutes from strategy meetings should be recorded in the case record of all agencies involved in the meeting and should include a record of the arrangements for review.

Safety plans

- Safety plans should be clearly written, proportionate to the identified risk and should include arrangements for monitoring and review.
- Safety plans should be shared and understood with all parties involved in delivering the plan, including family members and friends.

Professional boundaries

- Where professionals have personal or professional relationships with a service user or someone closely involved with the service user there is the potential for professionals boundaries to become blurred.

YOUR NEXT STEPS

1. Circulate and discuss the issues of this briefing within your team.
2. Review your personal and collective practice in the areas identified.
3. Attend the workshops that the ERSCP will be delivering in relation to the learning from this and other SCRs.

Find the full Serious Case Review at:
www.erscb.eastriding.gov.uk/child-safeguarding-practice-review/

Further information: erscp.enquiries@eastriding.gov.uk

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