

Serious Case Review fact sheet - Child V

Greenwich Safeguarding Children Board commissioned a Serious Case Review following the death of Child V aged 3 months in November 2016. The full report will be published once criminal processes have been completed.

Background: Child V's mother became pregnant in January 2016. Throughout the pregnancy she failed to engage with antenatal services having only one scan before the baby was born in August 2016. The baby was born in a hospital outside of London as she went into labour whilst visiting her sister. No concerns were noted during her labour and she was discharged soon after the birth to her sister's address before moving back to her home address in Greenwich. Her stated intention however was to move to be nearer her sister. In November 2016 Child V was, briefly, in the care of her father. The parents were not living together and (at the request of the mother), father had come to the home of the mother and the baby to care for the child whilst she went shopping. Child V's father noticed that Child V appeared lifeless and he called a friend for advice. Together they took Child V to a local health centre, where emergency life support commenced and the London Ambulance Service were called. Child V underwent CT scans that diagnosed a non-accidental head injury and rib fractures. Brain stem tests were completed, medical care was withdrawn and Child V sadly died.

Key issues:

- The vulnerability of the child V's parents due to their individual mental health problems and isolation
- The challenges that arise when adults fail to engage with services designed to offer them support
- Systemic issues about how agencies worked with the mother in particular and how they responded to her lack of engagement
- Systemic issues in how vulnerable women are supported pre and post birth

Key learning:

Use of Systems: The review has demonstrated the importance of systems that do not rely on the presence of individuals. There were several examples of this in this case.

Better use of early help: Families are much more likely to thrive and have a positive outcome for their children if their difficulties are recognised at an early stage and they receive help. This is also true of help offered to expectant mothers. No use was made of mechanisms for offering early help and although individual agencies offered support to Ms A, this was largely adult focused and not co-ordinated.

Recognition and response to non – engagement in antenatal care: There is a general recognition that a lack of engagement with antenatal services poses a potential risk to the health and wellbeing of mothers and their babies. The mother's failure to engage in any antenatal care was not recognised by many agencies and the safety net of universal services as a way of catching vulnerable children before they slip through the net did not work in this case.

Over reliance on self-reporting and disguised compliance: In this case the mother repeatedly told professionals that she had accessed or would access services without this being triangulated with other professionals or checking records. Her version of events was accepted without challenge and it is important that professionals recognise a reliance on parental self-reporting and be open to the possibility of disguised compliance.

Professional curiosity about fathers: Professionals were not sufficiently curious about the father of the baby. Enquiries were made and responded to with vague responses of his promised involvement; but these statements were not explored further.