DORSET SAFEGUARDING CHILDREN BOARD
SYNOPSIS OF LEARNING FROM SERIOUS CASE AUDITS
December 2016

Serious Case Audit Family C19

INTRODUCTION AND BACKGROUND TO THE CASE

The DSCB completed a Serious Case Audit in 2016 in relation to a baby who was made subject to a child protection plan as an unborn baby. Pre-proceedings were commenced before birth with a plan to remove the child via an interim care order as soon as possible after birth. Parents did not engage with child protection or the legal processes and were not informed of his likely removal due to concerns they might flee across borders. Father was known to have a violent history and threats had been made to professionals which were reported to Police. A draft birth plan was developed but it is not clear how far this was completed and concluded. The baby was born at home prior to the reported due date and there was confusion as to what the plan was regarding ensuring the baby's safety. After a stand-off, the baby was transferred to hospital.

LEARNING

Referrals, Process and Practice

- The pan-Dorset Protocol for the Protection of the Unborn Child although in place since 2014 was not used fully in this case and it unclear whether practitioners were aware of it.
- The midwives had developed a clear birth plan which they consider had been shared with Police and Social Care, but this was not recorded by Social Care or accessed by Police Officers on the night of the baby's delivery.

Leadership and Decision Making

- There was no identified lead professional for the night-time situation as it unfolded. This led to uncertainty in removing the baby and professionals were not able to coordinate their responses and agree a plan to manage the situation.
- A clear decision maker should be identified by the professionals present at a situation if there is no access to the identified lead professionals. This professional should have access to the most up to date information. The lead and decision maker may or may not be the same person.
- A multiagency professionals meeting should be convened and coordinated through the lead professional at any stage to ensure that planning for any potentially volatile situations can be safely managed.
- The Social Care Out of Hours Team had led professionals at the scene to believe that they would attend however; they later said that they could not. This gave false reassurance to the attending practitioners and led to a delay in removing the baby. The Out of Hours Social Care Team should be clear when communicating with professionals whether they are able to attend a scene and if not, agree what role they are able to play.

Information Sharing

- There was no information shared by Social Care with their Out of Hours Team in preparation for the birth of the baby, despite concerns that parents would seek to birth at home. The Out of Hours Team accessed the Social Care record but no information regarding the Birth Plan had been recorded by the daytime Social Care Team.
- Any Birth Plan should be on a standard template and be shared widely and each agency should be clear about who the key professionals are and how it is made available to agency professionals on internal systems. This should be agreed at a professionals meetings and discussed at initiation of the event.

Working with Violent and Unpredictable Families

- When there is a display of controlling behaviour in this case, by a father towards mother, domestic abuse should be considered and the case should be referred to a Multi-Agency Risk Assessment Conference (MARAC)
- Police flags and warning markers are clear in their internal systems and in this case linked the baby and the parents in relation to the volatility of their behaviour, but these were not fully understood and accessed by the control room on the night of the incident.
- Both parents used various methods not to engage with professionals and services and therefore the level of coercion used by father towards mother was not recognised or assessed. The impact of a potentially dangerous dog at the scene also impacted on the decisions that were being made by professionals. Professionals should access training opportunities on how to best manage violent and threatening families

ENSURE THIS REPORT MAKES A DIFFERENCE

There are lessons to be learned for anyone who reads this. Please ensure you consider how you work with families with young babies, particularly those who are non-mobile and where are volatile family members.
Please complete some feedback in respect of this learning by answering the questions in the survey below.

PLEASE GIVE US YOUR FEEDBACK

Think about the learning points in the Synopsis of Learning you have just read and send us your thoughts via the following survey:

https://www.surveymonkey.co.uk/r/SB6FYZ6

The comments you provide will be consolidated with those made by others and presented to the DSCB in order for them to work to ensure that Serious Case Reviews make a difference to children's lives.

Please complete your survey by 28 February 2017

Thank you

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