BIRMINGHAM Safeguarding Children PARTNERSHIP

Learning from Serious Cases

Briefing Note for Team Meetings

December 2020

Are you sure you know who visits or lives in my house?

Background

A practitioners' learning event has been held into the tragic death of a 6-month-old baby, whose cause of death remains unknown. The review identified important learning for agencies. On the morning of the baby's death an ambulance attended the home address and found the baby to be in cardiac arrest. The baby was transferred to hospital and pronounced dead shortly after admission. At the time of the baby's death, the house was described as neglected and very cluttered with *'cannabis, chicken bones, dirty underwear and dirty nappies'* being found throughout.

The mother, who had four children, first came to the attention of Children's Services in 2011 following the birth of her first child. During the substantial period of partnership intervention concerns were raised around mother's mental health and parenting capacity, particularly at crisis points when the mother's mental wellbeing deteriorated. Following assessment, her first child was removed from her care and placed with relatives via a Residence Order. The next significant period of involvement was some years later in 2018, when concerns were raised about the family home not having any gas, heating or hot water, although the subsequent family assessment concluded that the home was comfortable, warm, contained food, and the children were observed to have a positive attachment to their mother. The mother recognised and reported the deterioration in her mental health. Further assessment found that the maternal grandmother was a source of support and the case was closed.

The baby's putative father, who did not live with the family, was known to agencies due to complex mental health difficulties and serious offending behaviour. It would appear practitioners did not question the role he played within the household.

Key Learning

- There was no consideration of men associated to the household and whether they presented any safeguarding concerns for the children or mother.
- There was insufficient consideration of the mother's ability to understand and/or of her parenting capacity. This led to the mother telling professionals what she thought they wanted to hear, without any challenge.
- Little thought was given to either what was happening in the children's lives when their mother was in crisis or to the ability of family members to take a caring role due to their own needs
- It was uncertain if intervention had a positive impact on the family – or how the impact might be measured. It could not be established if anything changed in the lives of the children whilst professionals worked with the family.
- There was a lack of routine questioning around domestic abuse; in fact, professionals appeared to be uncertain about when, how or even what questions to ask.
- Professionals felt uncomfortable challenging the adults when they were clearly evasive about meeting with professionals or providing information. Multiple appointments were missed. Professionals became grateful for the minimal amount of contact they were able to gain, thus disregarding issues of non-compliance and evasion.

Improving Practice

- It can be difficult for mothers' to openly discuss their partners. Build up trust and find ways to engage the mother to find out the information. Always clarify who the members of the household are each time you visit a family.
- Consider all of the home circumstances and family composition when undertaking assessments.
- Ask a parent about their relationship experiences as this can help in recognising the signs of domestic abuse and identifying the right support.
- When working with a child and their family be aware of disguised compliance and avoidance of engagement, be curious and assume nothing. Don't be afraid to ask questions and take time to understand the 'bigger picture'.
- Keep children at the centre of what you are doing and reflect on what life might be like for them during periods of intervention.
- During supervision consider the use of goal-setting and outcome measurement to discuss the impact of intervention.
- Consider convening a regular multi-agency professionals meeting with those practitioners working with the family to ensure essential safeguarding concerns are shared and all agencies kept up to date.

Next Steps – What you can do

a) Circulate this 'Briefing Note' to all members of your team.
b) Discussion at team meetings should ensure that professionals not only understand but are able to apply the key learning from this case. To support your discussion a **PowerPoint Presentation** has been developed.
c) Encourage your team to attend 'Learning Lessons from Serious Case Reviews', 'Professional Curiosity' and 'Working with Resistant Families'. For more information on these training courses and for future delivery dates, **click here**.

You can access up-to-date multi-agency guidance, BSCP training and learning from Serious Cases on the BSCP website: www.lscpbirmingham.org.uk