Press Release

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Suffolk Board that safeguards children to oversee leadership, management and supervision of early help to families

Board makes clear need for individual implementation plans by March this year

The Suffolk Safeguarding Children Board has today published the Independent Overview Report into the death of Baby E who died in January 2016 at the age of 17 months from Sudden Unexpected Death in Epilepsy.

Baby E was a 17 month old infant child who was found by his mother cold and blue on Thursday 21 January 2016. He was taken to Ipswich Hospital by ambulance but attempts to resuscitate him were not successful. Concerns were raised that he may have died some hours prior to his arrival at hospital.

A Serious Case Review (SCR) is commissioned by a Local Safeguarding Children Board under statutory guidance issued by HM Government to provide sound analysis of what happened in a particular case and why, and what needs to happen in order to reduce the risk of recurrence. The purpose of a Serious Case Review is not to apportion blame following the death of a child but to set out key areas of learning for professionals and agencies to improve safeguarding practice.

"The Local Safeguarding Children's Board (LSCB) is a partnership of all the agencies who work together in Suffolk to protect children." said Sue Hadley the Independent Chair of the Safeguarding Board in Suffolk. "In January 2016 the Board was alerted to the sad death of Baby E. Due to our concerns about difficulties in this baby's life and the care given we appointed an experienced independent person to write this important report."

This Serious Case Review (SCR) report published today has highlighted that staff working in 'early help' services should be given more support to assess risk, including more effective supervision and case management where practitioners working with families have increasing concerns.

"The Serious Case Review was undertaken by an Independent Lead Reviewer, Jane Held, who is an experienced LSCB Chair and has led a number of SCR's. She was supported by a multi-agency Review Panel, chaired independently by Alan Caton, also a very experienced LSCB Chair. The Board has accepted all her recommendations to improve practice." Sue Hadley said.

The Report, while setting out key learning for agencies and how the Safeguarding Board will hold them to account to deliver improvements, found overall practice in this case met required standards and there was some good, effective professional work in difficult circumstances.

"There were many individual examples of good communication between professionals about practical and environmental factors and frontline practitioners communicated and discussed actions regularly." Sue Hadley said. "There are further examples of good practical advice, sound record keeping and positive support from the NHS. The work of the school and the Family Support Practitioner were also rightly highlighted as examples of the tenacious and committed efforts that were made to work with and support the family of Baby E."

The report consists of a factual context and brief narrative chronology, commentary on the family situation and their input to the SCR, key events during Baby E's life, analysis of practice, learning review points from the Review and conclusions and key learning and messages from the Review for the LSCB.

"A key learning from this report is that the leadership, management, and supervision of early help cases has to be enhanced to ensure practitioners see all the issues. For example, the behaviour of the adult family members and the impact of this on the effectiveness of the work was not fully recognised and analysed." Sue Hadley said. "In addition, confusion about who was co-ordinating the plan was added to this lack of oversight and in effect no one was clearly leading the multi-agency *Early Help* plan and process."

The report recommends that it is essential to ensure that staff in all partner agencies have access to a coherent framework to support them to work effectively with families without recourse to Child Protection systems, with helpful tools, systems and processes and which gives the same weight to the importance of Early Help as it does to Child Protection systems.

The Safeguarding Board has also made clear the importance of supervision and management where practitioners are working with families where the practitioners have growing concerns.

"In the management of neglect cases the rationale for professional judgements should be clear, based on research and evidence based practice." Sue Hadley said. "In Baby E's case it is noticeable that there was a lack of the use of any screening or risk assessment tools which would provide a far stronger evidence based analysis of either parent's capacity to care safely and well for Baby E and to put his needs first."

"It is important to recognise that working with challenging and avoidant families is difficult but at all times the focus must be on the child." Sue Hadley continued. "We have to see assertive, confident practice as the norm including as the report sets out a revised and better understood neglect strategy in order that any similar cases to Baby E that need additional input are effectively identified.

The Safeguarding Board has already finalised an updated neglect strategy and assessment guidance for practitioners.

"I am encouraged that we have already seen some changes to working practices." Sue Hadley said. "As a Board we have made clear that we have to see individual agencies implementation plans by March this year."

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For requests to interview the Independent Chair of the Suffolk LSCB please telephone Ashley Riley on 07835 309718 or at ashley@ashleyrileycommunications.co.uk

For a full copy of the report please visit www.suffolkscb.org.uk where a copy can be downloaded from 0830 on Wednesday 22 February 2017.