1 PROCESS

Child Z died in the summer of 2017. A serious case review was commissioned by the Rochdale Borough Safeguarding Children Board (now known as the Rochdale Safeguarding Children's Partnership), as the circumstances surrounding the death of Child Z met the criteria for a serious case review as set out in the guidance at the time– Working Together to Safeguard Children 2015. A criminal investigation and coronial inquest also took place and publication of the report was delayed until these were completed.

Child Z
Learning from Child Serious Case Review

2 BACKGROUND

Child Z's older siblings were subject to a CP Plan under the criteria of neglect in 2015. Child Z was added to the plan following his birth in Jan2016. There were concerns about Child Z's weight and growth, so significant support was offered to parents in relation to feeding and weight gain. Medical opinions regarding the cause of Child Z's failure to consistently gain weight were divided and it was not clear whether the cause was organic or environmental.

There were concerns also about the impact of Mum's mental health on the care of Child Z and the availability of support from Dad who had a history of involvement with mental health services.

3 LEARNING

Professional Challenge and Escalation

There were several examples where there was no challenge or escalation in relation to agreed multi agency actions for Child Z.

This included when the pre-birth assessments was not finalised or shared., when recommendations for a period in foster care were not followed up and when a review conference was postponed to allow time for a definitive diagnosis regarding a milk allergy and then the conference took place without these actions having happened.

4 LEARNING

Learning Difficulties and Capacity

An assessment of Mum's capacity to understand the information and guidance provided to her regarding the feeding of Child Z was not carried out.

Mum's capacity to parent Chid Z was linked to her mental health problems. If her learning difficulties had been explored and better understood then the approach by some agencies may have been different.

5 LEARNING

Pathways for Obtaining Medical Opinion

There was an absence of a consistent paediatric view and diagnosis regarding a milk allergy. This lack of clarity potentially led to uncertainty in responding to Child Z's failure to gain weight and contributed to a lack of consistent professional curiosity

The focus on medical opinion meant that professionals were distracted from the more global development delays that Child Z was experiencing which could not be attributed to a milk allergy and were more likely the result of neglect .

6 LEARNING

Response to Aggressive/ Abusive Behaviour

There was no evidence of assessment of the risk presented by the violence with the family. There had been reported incidents of aggressive behaviour between Mum and Dad, where they both acted as perpetrators.

There was also no consideration given to potential issues of control by Dad of Mum's medication and finances and also the appropriateness of using Dad as an interpreter for Mum when these concerns existed.

7 WHAT DOES THIS MEAN FOR ME?

Ensure you are aware of the RSCP multi-agency Escalation Policy

Make sure all relevant information is shared appropriately, and challenge where there are professional differences. See RBSAB Guidance Resolving Professional Disagreements

Ensure you are aware of safeguarding procedures for recognising and assessing neglect and the impact of domestic abuse