7 Recommendations

- Robust processes and practices should be followed for mother and baby foster placements.
- All practitioners – including foster carers - should be aware of how to escalate issues.
- Practitioners should aim to have one single multi agency plan rather than individual plans.
- Learning from serious case reviews should be also disseminated to adult practitioners, in order for all services to 'Think Family'.

You can **read the full Serious Case Review** at:

http://www.safeguardingchildreninstockport.org.uk/serious-case-reviews/

You can also find related practice information at: https://greatermanchesterscb.proceduresonline.com/chapters/contents.html

1 How did we review?

A hybrid model of the SCIE Learning Together methodology was employed with an independent author. This involved individual agency information submissions, interviews with professionals and development of a multi-agency chronology.

2 Background

This case involved a young woman living in a parent and baby foster placement with her 6 month old daughter. Mother had been known to services as a child due to a number of adverse childhood experiences. She met Child E's father in 2014 when living with her maternal grandparents but due to behaviour change and missing episodes, their relationship broke down and she was accommodated under Section 20. In 2015, she became pregnant with an older sibling to Child E and agencies became concerned about domestic abuse. In 2016, Child E's sibling was born, and they were placed in parent and baby foster care. Ultimately, concerns increased, and Child E's Mother took the decision to leave the baby in foster care and move area to be with the child's father. In 2017, another areas Children's Services were informed that she was pregnant, this time with Child E. Child E was born prematurely in March 2017 requiring neonatal care in a local hospital. Child E was made the subject of an interim care order in May and remained in hospital until discharge in June 2017. Child E and Mother then moved to a different parent and baby foster placement.

6 Other risk factors

Cross border information sharing - Both Child E's mother and father spent time in different geographical areas. Practitioners should consider the importance of sharing information between agencies across geographical borders.

Lack of compliance with the plan – There were a number of times when Child E's mother did not follow the plan she had agreed. For instance, she did not attend the Freedom Programme despite agreeing to go. Practitioners should consider risk assessment in light of non-compliance.

Lack of focus on the father – In this case the father seems to have been perceived as entirely negative by professionals. Practitioners should consider how to ensure there is a strong focus on the whole family and as much as possible fathers are included case discussions.

3 Incident

In September 2017, Child E had been out with her mother and they returned to the placement in the afternoon. Child E was put to sleep in her cot. The foster carer noted two occasions on which she heard 'unusual' noises from Child E. She became concerned when she checked Child E and found her to be floppy and unresponsive. The foster carer telephoned an ambulance and the child was taken and admitted to hospital. Medical examination showed that Child E had suffered a serious head injury, and had been found to have multi-location subdural haemorrhage, extensive retinal haemorrhages and encephalopathy characteristic of inflicted head trauma, caused by shaking.

5 Parent and Baby Foster Placements

The review highlights the complexity of the role of the foster carer in parent and baby foster placements, and their contribution to the on-going assessment of risk. Although the foster carer is not the assessor, their observations make a significant contribution towards the assessment process.

There was no agreed approach to escalation between the foster carer and the social worker and the purpose of the daily log was not clear. Practitioners, including foster carers, should be clear about the escalation process

4 Domestic abuse

Domestic abuse had been a factor between both parents since the first pregnancy in 2015. Learning from the review found that it is important for practitioners to fully assess and understand the risks presented in domestic abuse relationships. In this case there was over optimism regarding Child E's mother and father being willing or able to separate. Practitioners should explore how realistic the expectation of permanent separation is to assist with strategies to address the risks associated with domestic abuse relationships. Practitioners should consider the likelihood of fathers having a lifelong relationship with their children and how to ensure that this is safe for the child.

Safeguarding Children in Stockport