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**Child V Serious Case Review**

**Addendum**

October 2023

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**Background to report**

* 1. The Child V Serious Case Review (SCR) was commissioned by East Sussex Local Safeguarding Children Board (LSCB) in 2018 following recommendation to the Board’s Independent Chair that the circumstances met the criteria for a review.
  2. The SCR report was approved by the East Sussex LSCB at an extraordinary Board meeting in September 2019.
  3. In October 2019 the East Sussex LSCB transitioned to the East Sussex Safeguarding Children Partnership (ESSCP), because of the changes set out in the statutory guidance Working Together to Safeguarding Children 2018. Working Together to Safeguard Children 2018 also set out changes to how safeguarding practice reviews were conducted.
  4. Due to an ongoing criminal investigation and planned court proceedings (which were severely delayed due to COVID-19 and other circumstances) the report was not published. Learning from the review was shared across partner agencies and included in a published ‘infant injury’ themed learning briefing.
  5. The East Sussex LSCB advised both parents that a SCR was to be conducted. Due to the ongoing criminal investigation the ESSCP were unable to approach the parents for comment until September 2020, when they declined to contribute. Following the conclusion of the criminal investigation and court proceedings, the ESSCP and lead reviewer again approached both parents for their views. Neither parent wished to contribute.
  6. In May 2023, the East Sussex Safeguarding Children Partnership was informed that both parents pleaded guilty to ‘child cruelty’, that includes the issue of ‘wilfully assaulted and/or ill-treats’. Both parents received suspended sentences and rehabilitation activity requirements.
  7. After careful consideration, the ESSCP has agreed to publish the original report with this addendum, rather than revising the 2019 report to fit with the updated safeguarding practice review guidance. The report still effectively highlights recommendations and lessons learned for the wider safeguarding system. However, the original 2019 report contains more reflection and details on the case than is expected in current guidance.

**Impact of learning on local practice**

* 1. As is standard practice for all safeguarding reviews in East Sussex, the action plan arising from the Child V SCR was signed-off by the ESSCP Steering Group and was regularly reviewed by the ESSCP Case Review Group.
  2. Learning on infant injuries, from the Child V SCR, became a priority area of focus for the ESSCP. In the same period as the Child V SCR, the ESSCP was also undertaking the Child W SCR, following the death of an eight-week-old baby who died from non-accidental injuries. There were many similarities in learning from both reviews, highlighting the fact that babies and young children are particular vulnerable to abuse and neglect. Following on from this, the ESSCP decided to focus on ‘safeguarding Infants’, as one of its key priorities, to ensure that action arising from the two reviews was coordinated and the profile of safeguarding infants was raised across partner agencies.
  3. In April 2023, an ‘evidencing impact’ event was held with front-line practitioners and managers, some of whom were involved in the original case. This event was used to consider how the two reviews had impacted on local practice and outcomes for children and families. The following examples of how the Child V SCR has impacted on local practice are taken from the action plan and the evidencing impact event:
* The guidance provided to professionals on bruising and/or injuries in children who are not independently mobile has been strengthened within the [8.1 Unexplained Injuries to Young Children | Sussex Child Protection and Safeguarding Procedures Manual](https://sussexchildprotection.procedures.org.uk/tkyslh/the-child-protection-plan/unexplained-injuries-to-young-children#:~:text=Any%20injury%20and%20its%20explanation,either%20accidental%20or%20non%2Daccidental.). A leaflet for parents, on what happens next if their baby has a bruise or unexplained injury, was also created. These tools were shared and publicised via regular communication networks, via a series of bitesize training lessons on ‘Safeguarding Infants’, and the Pan Sussex Conference in November 2021 which was focused on the theme of ‘Safeguarding Infants’. Wider visibility and easier access to procedures provides professionals with the guidance and tools to act quickly and appropriately in these situations. A deep dive audit on unexplained injuries in under 1s, conducted by the ESSCP QA Subgroup in 2021, identified good practice by professionals in both cases.
* Maternity records are now fully electronic enabling post-natal notes to be accessed easily by professionals. There is also much better sharing of information between midwifery and health visiting services. This means that professionals working with a family are now able to check records and develop a comprehensive understanding of the child within their family/care network.
* Work has taken place in children’s social care to improve the timeliness of completing pre-birth assessment work, including improving the level of contact with the prospective parents within the assessment process. As part of this work, the operational instructions for pre-birth assessments were reviewed and relaunched with front-line teams. An audit the following year found that the process was embedded with teams: nearly all cases were judged outstanding or good; there was good multi-agency information sharing, management oversight and decision making, and the timeliness in allocation and assessment had all improved since the previous audit.
* Considerable work has taken place across the general practice network in East Sussex to strengthen GPs knowledge and response to unexplained injuries and/or bruising in non-mobile children. Primary Care are encouraged to ensure children on child protection plans are seen, or have contact, with a clinician on the day an appointment is requested (and when this happens in a surgery this is done by a permanent clinician in the surgery where the child is registered).
* The process for requesting child protection medicals has been reviewed and improved, with the development of a new referral form and clear documentation on the outcome of the referral. Regular meetings check that processes are happening in the way they should, and improved documentation enables appropriate monitoring and quality assurance of decision making. Outside of meetings there is better networking and use of escalation processes if required. The Police are also attending more CP medicals. Learning from local reviews and ICON has been included inductions for Emergency Department and Paediatric doctors in East Sussex.
* Across Sussex, agencies have signed up to ICON – an evidenced based preventative programme, designed to support parents better understand and safely respond to infant crying. The ICON message is: ‘I’ infant crying is normal; ‘C’ comforting methods can help; ‘O’ its OK to walk away; and ‘N’ never, ever shake a baby. The ICON message has been shared across the partnership with agencies reporting (in the 2022 section 11 audit process) that ICON is embedded in local practice. While agencies are never complacent it is encouraging that there have been no child deaths across Sussex involving abusive head trauma (AHT) over the past three years. This follows three suspected AHTs in 2019/20.
* Agencies across the partnership report their staff feel more empowered to challenge decisions and there is a culture of supportive professional challenge across the partnership. For example, since 2020 bi-monthly meetings between health and social care have been established as a forum to discuss any issues or provide clarification on roles and responsibilities.

1.11 In March 2023, the ESSCP held an extraordinary Board meeting to discuss local evidence – including learning from case reviews, quality assurance activity, and the voice of children – and propose future priorities for the partnership. One of the agreed three priorities for the partnership will be ‘embedding learning’, which includes a focus on ensuring that learning from the 2020-23 priority on safeguarding infants is embedded. A multi-agency action plan will be developed, overseen by the ESSCP Steering Group, which will include the monitoring and evaluation of the impact of partnership activity.