



## **Serious Case Review Into The Death of Child E**

**Born in February 2002**

**Died in December 2007**

### **Synopsis**

#### **1. Introduction**

This is a summary of a serious case review conducted by Sandwell Local Safeguarding Children Board in accordance with Part 8 of 'Working Together to Safeguard Children' (2006). It was undertaken as a result of the tragic death of a child.

#### **2. Serious Case Review**

Child E was tragically murdered but there was no evidence of any significant harm to the child in respect of the care provided during the child's life and nothing has been identified during the review process to indicate that the child's death could have been predicted and hence not preventable.

However, it was felt that there were lessons to be learnt for the future about the way in which professionals and organisations work together to safeguard and promote the welfare of children.

#### **3. Agencies Involved**

Sandwell MBC Children and Young People's Services – Social Care and Education  
Health – GP, Midwifery, Health Visiting, Mental Health Trust  
West Midlands Police

#### **4. Involvement of Family Members in the Review**

Family members were invited to contribute in the review process, however they declined to be interviewed.

## **5. Conclusions**

The main finding of the review was that no factors were identified in any agencies work with the child or the family that would have made the death of the child predictable and therefore it was not preventable. However there were some important lessons for professionals and organisations that were felt to be significant to safeguarding and promoting children's welfare in the future: -

## **6. Recommendations**

### **a) Police**

It is recommended that Sandwell LSCB negotiate with West Midlands Police for a sampling audit to be undertaken by the board to ensure compliance with the 2005 Domestic Abuse Policy

### **b) Sandwell & West Birmingham Hospital Trust**

It is recommended that Sandwell & West Birmingham Hospital Trust should consider developing a policy and standards on the midwife to health visitor handover process

### **c) Sandwell PCT**

1. It is recommended that Sandwell PCT develop and implement written guidance (including an information sharing template) to facilitate the sharing of information between general practitioners, health visitors and school nurses.
2. It is recommended that Sandwell PCT ensure that all GP's and Practice staff attend safeguarding children training which includes the Framework for Assessment of Children in Need (FACiN) with particular emphasis on the effects on parenting where there is mental health issues.
3. It is recommended that Sandwell PCT institute a procedure on the removal of records from GP surgeries.
4. It is recommended that Sandwell PCT undertake an audit of the take up and the impact on practice of the FACiN training.

### **d) Early Years (Children's Centres)**

It is recommended that the early Years (Children's Centres) establish a procedure to follow up non-attenders and "hard to reach" families.

## **f) Sandwell Mental Health Trust**

It is recommended that the Sandwell Mental Health and Social Care Trust develop a protocol appertaining to non-attenders and their discharge from the service. This will need to include clarity on recording follow-up, clarity of responsibility about reinstating contact, and liaison with and notification to the referrer.

## **7. Review Process**

Sandwell LSCB has approved an action plan in respect of the above recommendations and a commitment made by the agency representative on the LSCB on behalf of their agency to implement the action plan.

The action plan includes timescales and each agency will be required to report progress on the implementation of the action plan to the Quality Assurance and Audit sub group of the LSCB.

In due course, the LSCB will receive a progress report and will be required to make a judgment as to whether the action plan has been implemented in full. The LSCB Chairperson with the respective agency will address any outstanding actions on behalf of the LSCB.