7 Point Briefing: Baby Euan: Central Bedfordshire Safeguarding Children Partnership

POINTS TO CONSIDER

- Reflect on the findings and discuss the implications for your service or practice.
- Outline the steps you and your team will take to improve practice in line with the recommendations.

Further reading

- The voice of the child: Learning from Serious Case Reviews OFSTED (2011)
- Multi-agency Safeguarding and domestic abuse Child Safeguarding Practice Review Panel (2022)
- Information sharing advice for safeguarding practitioners Gov UK (2018)

BACKGROUND

Baby Euan died when he was 8 months old. It is believed he died of non-accidental injuries. His post-mortem confirmed, amongst other injuries, fractured ribs and a fractured skull.

Baby Euan had a traumatic birth and was born after a difficult labour by C-Section. He spent time in neonatal intensive care.

His mother lived in three different local authority areas during the time before and after Baby Euan's birth.

SAFEGUARDING CONCERNS

The review found that the periods of the mothers and Baby Euan's life highlighted firstly, the mothers' vulnerabilities with her own co-morbidities and how she dealt with these, and then following the birth with Baby Euan's vulnerabilities.

The review focussed on the following areas.

• Voice and vulnerability of Baby Euan
• Transient -reluctant to engage families, including Information sharing
• Domestic Abuse- Coercive Control-Invisible Males
• 'Intersectional analysis' into race, disability, and health conditions.

WHAT TO DO

- Always respond to your professional instincts based upon evidence!
- Share important safeguarding information and improve communication between staff and agencies, wherever the child is living.
- Identify risk and act on it.

WHY WAS THE REVIEW CARRIED OUT?

Central Bedfordshire Safeguarding Children Partnership suspected that Baby Euan died as a result of abuse or neglect. A Child Safeguarding Practice Review (CSPR) was undertaken to identify learning for agencies and practitioners working in areas involved in this case

FINDINGS & RECOMMENDATIONS

- The Voice of the child to be included in assessments.
- Alternative ways needed for engaging families when there is resistance to bring a child to a health appointment. In particular those families who decline universal services where there are only known low level concerns.
- Information sharing between different geographical areas including between maternity services and GP's.
- Knowledge of intersectionality.
- Knowledge of DA and coercive and controlling behaviour.

WHAT NEEDS TO CHANGE

- Professionals to always include the voice and lived experience of a child in their actions and assessments. This includes babies, and those that are unable to communicate verbally.
- Professionals to take account of a mother's co-morbidities and their vulnerabilities and any risks posed to a child.
- Better knowledge of fathers/male carers and any risks that they may pose to a child but also to the mother.
- Information sharing between different health providers and also different local authority areas.