SSCB statement re: KS Serious Case Review

On the publication of this serious case review, Audrey Williamson, independent chair of the Sandwell Safeguarding Children Board (SSCB), said:

“Following a serious incident involving a child, we always undertake a full, thorough and detailed review to see if any lessons can be learned and changes made to improve services.

“This was a very sad case in which a two-month-old baby died, and the cause of death was unascertained. Our thoughts are with the family.

“This independent review established that there was no action any professional could have taken to prevent this tragic death.

“However, there were a number of recommendations for agencies in light of this case around safeguarding services. These recommendations focused largely on better information sharing and making sure procedures are followed.

“Sandwell Safeguarding Children Board and partner organisations have accepted the serious case review and its recommendations and taken action in response.

“We have:

- improved pre-birth procedures and assessments, including looking in more detail into family history;
- set up an Unborn Baby Network where professionals from different organisations can identify antenatal vulnerable women early, share information and ensure a joint understanding of thresholds for pre-birth assessments;
- implemented a new policy and increased awareness through multi-agency training and manager workshops on working with families with complex needs, including those who don’t engage with services;
- improved policies and briefings for health staff and GP practices around missed appointments in relation to children and vulnerable adults.

“The learning from this case is helping agencies provide more effective support to families who need it and improve the way they work together to identify and respond to concerns before children are born.”