Holly Serious Case Review Practitioner Briefing

Children's Safeguarding Assurance Partnership
Blackburn with Darwen - Blackpool - Lancashire

This SCR was triggered by Holly's tragic death, aged of 8 months, in what were initially unexplained circumstances; although mum has since accepted responsibility for her death. Holly's parents had only just attained adulthood at the time of her birth and were already parents to a 2 year old. The family were only known to universal services, who had had no concerns about the safety of Holly, or the parenting that she received.

Having analysed each agency's involvement with the family, the report concludes that, along with other reviews in similar circumstances, while "it is compelling to believe that there must have been signs, which if responded to differently could have prevented the loss of that life… there is no such evidence in Holly's case." Unusually it makes no recommendations for changes to multi-agency safeguarding practice, although the following themes are worth considering by practitioners from any agency working with children and families.

Non-Engagement

Holly's mum and dad were flagged as vulnerable as a consequence of their young age and attempts were made to engage them with a range of resources for prospective, new and in particular young parents. As they were entitled to do so, mum and dad chose to opt out of the majority of services, or only engaged, as with the health visitor, following a degree of persistence from practitioners. Similarly, medical appointments only tended to be attended in times of acute need, which did lead to some minor conditions persisting longer than was necessary.

When asked, mum and dad tended to offer the explanation that additional support was unnecessary due to the family support that they had. However, there was little evidence of practitioners asking the follow-up question as to the nature of this support. This may have helped develop a better understanding of the exact nature of this support and assessment of any outstanding needs.

Good Practice

The review identified a number of good practice points including:

⇒ The GP practice pro-actively ensured that Holly was registered following her birth; and

⇒ The health visitor supported parents to manage Holly's sibling's nutritional needs, when there were concerns.

Read the full Holly SCR report here.

Exploring vulnerabilities

A typical description of agency records for Holly and her family was as being "factual and practical", rather than being person-centred. As a result, they give little sense of Holly, as a baby, or of mum, as a young parent living away from her own family. Equally records did not provide any understanding of either parents' background or their lived experiences.

Information that has emerged as part of subsequent care proceedings for Holly's sister, has suggested that mum was more vulnerable than was recognised at the time. A more enquiring approach may have developed her confidence to disclose information, including the ending of her relationship with dad, and prompted the offer of additional support, although it is unknown if this would have been accepted.

Babies and Serious Case Reviews

Like 42% of children who were subject to SCRs between 2014 and 2017, Holly was aged under one. This reflects the physical vulnerability of babies and the challenges new parents face, with Holly's mum reportedly having struggled with her crying at night. In response to similar findings of earlier SCR, CSAP launched the ICON: Babies Cry, You Can Cope! campaign. This provides resources for practitioners to help them support parents to deal with persistent crying safely. More information is available here.

Read more learning from case reviews about infants under 2 here