7 Minute Briefing:

Redbridge 'Baby T' Serious Case Review Learnings

Further information:

- View the full report from Redbridge Local Safeguarding Children Board
- View professional curiosity 7 minute briefing
- Find out more about contextual safeguarding from NSPCC
- Visit our website for information on Modern Slavery
- View a comprehensive collection of other case reviews in the UK here

What is a Serious Case Review?

When a child dies, or is seriously harmed, as a result of abuse or neglect, a case review is conducted to identify ways that local professionals and organisations can improve the way they work together to safeguard children.

Case reviews contain important lessons about how professionals can improve practice to better protect children. These recommendations can be relevant to other safeguarding boards across the country.

Overview of report

Female C was babysitting Baby T when she became unwell.

Baby T was taken to hospital and found to have sustained a head injury, where she later died. Female C was convicted of manslaughter and sentenced to six years imprisonment.

Mother was an asylum seeker and reported imprisonment, religious persecution, physical abuse and rape. She has two other children by a different father in Vietnam and had suffered post-natal depression. Mother had no English language skills and relied on interpreters when meeting professionals. Mother and Baby T were moved accommodation by Home Office several times. Mother began working illegally and paid Female C to babysit Baby T.

Redbridge Local Safeguarding Children Board (LSCB) agreed to conduct a Serious Case Review (SCR).

Recommendations to Safeguarding Partnership (2)

Health colleagues are aware of importance of obtaining comprehensive information from pregnant asylum seekers so all health needs can be addressed.

There should be appropriate access to interpreters to remove barriers for communication, which can increase vulnerability.

Practitioners should be aware of policy and practice in relation to modern slavery.

Learning (1)

Early Help support was of a practical nature, which was good for mother but work did not progress into nurturing or therapeutic support. An Early Help Assessment was not completed although there was sufficient time for one to be done.

During the antenatal period, discussions between the specialised midwife and specialist health visitor did not take place and a new birth visit was not completed within recommended time frames.

Recommendations to Safeguarding Partnership (1)

Professionals should ensure they are being professionally curious in order to understand the wider situation someone may be in.

Learning (2)

Mother was based in Hackney, Croydon and Cardiff for short periods of time, which made it difficult for her to make connections and receive effective support from agencies.

'Contextual safeguarding' could be usefully applied to the children of asylum seekers such as Baby T because of a range of factors which can impact upon their safety and wellbeing. Arguably, poverty drove mother to work illegally which necessitated leaving Baby T in the care of an unregistered childminder.

Lack of appropriate interpreter may have led to pertinent information being missed.

There were missed opportunities for referrals to MASH as professionals believed mother was already being supported by social care.

The issue of 'hidden males' in families is recurrent in SCRs where children die or suffer significant harm. Practitioners should employ more professional curiosity to understand these roles in a child's life and speak to other relatives/friends to capture this understanding.

Whilst there is no evidence that mother's mental health issues affected her parenting of Baby T, perceiving the child to be a 'protective factor' may have been a factor in the absence of a referral to Children's Social Care at the time her GP referred her to mental health services.