Skylar - 6 Point Briefing

Background

Skylar was born in hospital and went home to live with both parents shortly afterwards. When they were three weeks old, mother took Skylar to hospital by ambulance reporting a number of health issues. There was no evidence of any concerns following tests and professionals raised concerns about the risk to the child of the mother fabricating illness. Mother had a long history of fabricating illness in her own life prior to having children.

Skylar's mother had a very difficult childhood. She was in the care of the local authority until she was 18. She was a known frequent attender at A&E.

Safeguarding Concerns

The case raised issues about the identification of risk pre-birth and the response to concerns about the future care of a baby where the parent is vulnerable due to their mental health, learning needs and a history of seeking support with suspected fictitious illnesses.

Very little was known about the father of the baby beyond his name and date of birth during the pregnancy. It is now known that he was well known to Social Services in another part of the country due to the physical abuse of his older children

Why was the review carried out?

In 2021 the PSCP agreed to undertake a Child Safeguarding Practice Review, as they recognised the potential lessons could be learned about the way that agencies work together to safeguard children in Portsmouth by the considering a case of a young baby to be referred to as Skylar.

Although there was no known physical harm caused to Skylar, this case was considered a near miss by the Partnership. There were concerns about Mother's mental health and history of fabricated illness, in addition to a lack of escalation and professional challenge.

Points to consider - what can you do?

Reflect on the findings and discuss the implications for your service or practice.

Are your staff aware of fabricated/ induced illness policies and processes? Is there a good understanding of how this can impact a child?

Does your team do everything it can to learn more about the father/partner?

Outline the steps you and your team will take to improve practice in line with the recommendations.

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What needs to change?

Practitioners to remain curious about fathers/partners.

Professionals to feel comfortable when escalating/receiving challenge. Use the Re-think model to aid this.

Ensure all known information is included in Assessments and decision making, historic and current. This includes health summaries and key information from other involved agencies.

Relevant policies and procedures need to be updated to incorporate latest guidance

Professionals in the Children's workforce should feel comfortable in identifying adult safeguarding concerns and referring as appropriate.

Recommendations

- For all professionals to consider the findings from the National Panel report named 'The Myth of Invisible
- 2. Evaluate and embed the Re-think model
- Ensure that all current and historic information is utilised in safeguarding decision making
- Assessments include all information gathered in the MASH
- Unborn baby assessments include more than one visit, all family history and checks with all relevant professionals
- All Social Care staff to include historic (pre-Mosaic) information in assessments
- PSCP to review the findings from this report and ensure they inform the HIPS Procedure for Fabricated or Induced Illness.
- Work with Portsmouth Safeguarding Adults Board to plan for raising awareness about making adult safeguarding referrals when required