Derby and Derbyshire
Safeguarding Children Partnership

LEARNING THE LESSONS – September 2019

SILR17B: Serious Incident Learning Review

This serious incident learning review was commissioned by Derbyshire Safeguarding Children Board following the death of a young person, where obesity was considered to have contributed to the death.

The full report is not for publication however, it is important that agencies are aware of the lessons learned as below.

This briefing is to disseminate the learning for multiagency staff to promote better outcomes for children in the future

Lessons Learned

1) Holistic assessment, with comprehensive recording / documentation is important in understanding a family's needs. The role that partners and extended family play in the child's life should always be considered.

2) Coordination of services around a family helps to provide appropriate support and learning about what works. This is best undertaken through an Early Help Assessment.

3) The health risks of obesity in childhood are not well understood by practitioners without a health background.   Young children who are overweight and whose parents have difficulty managing their behaviour are at high risk of obesity.

4) A whole systems approach and a multi-agency care pathway is needed for overweight and obese children which includes arrangements for assessment, prevention, management, support and protection. This work has started and, currently, Public Health are leading on the development of an obesity strategy across Derby and Derbyshire.

5) Multi-agency chronologies which describe the nature and impact of support provided can be helpful to identify families where more intensive support or intervention is required.

6) The impact of multiple changes in service provision across organisations can be significant. A co-ordinated 'team around the family' approach should be maintained within a changing service landscape, to minimise disruption and ensure a clear overview of the child's needs and how they should be addressed.