Thematic Serious Case Review
6 Step Briefing

SSCP
SOUTHAMPTON SAFEGUARDING CHILDREN PARTNERSHIP

The Background

In March 2018 the Southampton Safeguarding Children's Board (hereafter known as the Southampton Safeguarding Children Partnership) commissioned a Serious Case Review into the death of one baby and serious injuries to two others. Due to the similarities in the age of the babies, the background of their parents and the timespan of the incidents occurring it was decided to consider all three cases together.
The thematic Serious Case Review gives an analysis of common issues concerning non-accidental injury to babies whose parents were teenagers and young adults. The review is presented as one report with an assessment of circumstances pertinent to each case

The Review

The review was conducted by an independent reviewer. The review considers a number of areas including; support offered to young parents, assessments of parenting skills and risk to the unborn baby, impact of mental health issues and substance misuse on parenting capability, impact of lack of good parenting experiences, the impact of homelessness, anger management and domestic abuse, robustness of decision making concerning the child protection process, evidencing the child's lived experience within the family, over optimism on the part of professionals and the involvement of police and Criminal Justice.

Key Themes

- All were young parents, and all had experienced childhood trauma and/or Adverse Childhood Experiences
- All the babies were males and of White British ethnicity
- All three babies had received significant injuries, which resulted in the death of one child
- All of the incidents occurred within the same two-month period
- At least one of the parents of each of the children had exhibited violent behaviour in the past
- Alcohol and cannabis misuse feature in all the cases
- All the young parents had experienced homelessness

Key Learning Points

- The need for professionals to recognise adolescent parents as children themselves, whose brains are still developing, is an important lesson arising from this review. Training focusing on brain development, risk taking behaviour by adolescents and the impact of these factors on their parenting ability would be beneficial to professionals working with young parents.
- Comprehensive, robust assessment of risk factors, in addition to the parenting abilities of young parents, is key if children are to be protected from significant harm. This is particularly important when decisions are made to move mothers and babies from supported accommodation to independent living units where there is a lack of monitoring by staff and substantial support to residents.
- The need for suitably qualified staff working with young parents in independent housing is a pre-requisite if the risk posed to young babies by immature, vulnerable parents is to reduce. It is not sufficient for the current service provider to state that their responsibility is to offer intermediate accommodation and to simply signpost young parents to appropriate support services.

Key Learning Points continued

- The review has been made aware that significant concerns have been raised by Police about the number of times and the reasons why they are required to attend the independent living unit provision in Southampton. The provision of independent living accommodation needs to include professionally qualified social care staff to support the parents and babies residing at this unit.
- Recognition of the need for appropriate support to young parents is a finding from the review. In all three cases the involvement of the Family Nurse Partnership (FNP) was seen as the main support to the parents. Additional social work support and Early Help intervention was also required.
- Cases involving vulnerable parents of young babies should not be allocated to student social workers.
- The propensity for domestic abuse, controlling and violent behaviour in teenage relationships has been highlighted in the review. Professional awareness needs to be raised about these issues and consideration needs to be given to introducing a DASH risk assessment and checklist for under children under 16 years old.
- The review has illustrated that informed, evidence-based decisions and challenge, as well as professional curiosity and robust child protection planning, with advice from legal services, is required at Initial Child Protection Conferences and Review Child Protection Conferences
- As is a finding in so many Serious Case Reviews, it is also the case in this review that the need for comprehensive information sharing amongst agencies is fundamental if professionals working with families are to be fully conversant with and understand the risk of significant harm presented to children. This did not happen in the three cases subject to review.
- It is however, recognised that is three years since the review was commissioned. Since then, it is important to note that improvements to information sharing have taken place across the partnership. The review has been informed that the FNP now has a stronger relationship with the MASH and an information sharing agreement is in place for MASH practitioners to request information concerning fathers/partners where there are concerns
- FNP also now ask fathers and involved partners if they will agree to having records open on System 1 (health recording system) to link with the baby. Whilst this is dependent on gaining the permission of those concerned, if it is provided, then the FNP has access to information across the health economy, e.g. CAMHS, GP records where System 1 is used. Solent Trust are also involved in conversations with Children's Social Care, Police and Information Governance Teams as to how the sharing of PPN1 can be more robust with health, whilst fulfilling their statutory and Information Governance requirements. Such changes in practice are to be commended and should improve information sharing between agencies, which can only serve to benefit the protection of children.

Good Practice

- The Southampton Social Worker to visit the office of another local authority to review their records concerning the past history of one of the parents was good practice.
- The dissent by members of a Leaving Care Team and midwives from the postnatal ward with the decision of the pre-discharge meeting to allow one of the babies to go home with his parents was good practice.
- The Team Manager who ensured that one of the babies did not wait for a child protection medical and insisted that an ambulance was called to transport him to hospital, was good practice

The Recommendations

Recommendation 1

(a) All agencies to ensure that professionals working with young parents are aware of the need to recognise that in the first instance parents under 18 years of age are children themselves.

(b) This would be achieved by the provision of training concerning the research findings into the brain development of adolescents, risk taking behaviour and the impact of these factors on their parenting ability.

Recommendation 2

(a) Whilst dependent on the information parents may wish to share, agencies are to be reminded that wherever possible the life history of fathers, including their own childhood experience of parenting, needs to be documented and shared with all professionals involved in working with young, vulnerable parents. Use of the information sharing agreement between the FNP and the MASH is to be encouraged.

(b) The research findings of the University of Bristol (as referenced in this report) on violence in teenage relationships and its consequences for the welfare of mothers and babies should be disseminated to all agencies working with young parents.

(c) Police to continue to recognise that domestic abuse can occur in teenage relationships and use the DASH (Domestic abuse, stalking and harassment) risk assessment, as well as the child at risk element of the safeguarding notification, to assess and share that risk with the relevant partner agencies.

Recommendation 3

Police Officers attending incidents of domestic abuse where children are present should be reminded of the crucial importance of professional curiosity; as embodied in careful exploration, documentation and the reporting of concerns, to ensure that children can be protected from significant harm.

Recommendation 4

The Safeguarding Partnership should consider reviewing as a matter of urgency the appropriateness and safety of the service currently provided to young parents and babies living in supported housing accommodation.

Recommendation 5

Assurance needs to be provided to the Safeguarding Partnership that the seriousness and significant risk of substance and alcohol misuse on the ability of young parents to care for and safeguard their baby/child is fully understood by all professionals by:

(a) Providing training which emphasises the risk of parental substance misuse (especially cannabis) to young babies, and the potential impact on them.
(b) Reviewing the Threshold Assessment Framework so that cannabis/substance use is included.
(c) When undertaking any assessment, cannabis/substance use by a parent is taken into account.

The Recommendations

Recommendation 6

The FNP should be required to review standards of record keeping, ensuring inclusion of the development of babies and children and not simply a focus on concerns. This will ensure a complete picture of a child's lived experience in the care of their parent/s is captured.

Recommendation 7

Agencies to be made aware that where a baby is not registered with a GP Practice by the time of their six week developmental check professionals need to consider this as a safeguarding concern.

Recommendation 8

Careful consideration should be given to which cases are allocated to Student Social Workers. Good quality supervision needs to be provided to the student to ensure that where concerns that a baby/child may be at significant risk of harm, the case can be reallocated when such concerns arise.

Recommendation 9

Chairs of Pre-discharge meetings and Initial/Review Child Protection Conferences should be reminded of their responsibility to ensure that any decision made needs to be evidence based, open to challenge and professional curiosity, and results in robust child protection planning, with advice from legal services.

Recommendation 10

The Safeguarding Partnership to ensure that all agencies recognise their responsibility to partners to share information concerning the safety and well-being of children, particularly in respect of very young, vulnerable babies if they are to be protected from harm. This can be achieved, by ensuring that once received by the MASH, the pathway already in place for such information to be shared with other agencies is utilised, even if the criteria for a Section 47 referral is not met at the point of initial grading.

Further reading and resources

Thematic Serious Case Review, Southampton Safeguarding Children Partnership

Blakemore Sarah-Jayne *Inventing Ourselves: The Secret Life of the Teenage Brain, 2018*

International Research on New Approaches to Prevent Violence and Harm, at the University of Central Lancashire http://www.safelives.org.uk/practice_blog/violence-young-people%E2%80%99s-relationships-%E2%80%93-reflections-two-serious-case-reviews

Children living in households where there is substance misuse

HIPS Unborn Baby Protocol

Family Approach Toolkit