A Learning Lessons Review in Kirklees:

(Baby Darren - LLR 1)

This briefing has been produced to provide practitioners and managers with the key learning. A Learning Lessons Review (LLR) takes place after a child is seriously injured and abuse or neglect is thought to be involved and it is believed lessons can be learned from the way in which the local authority, their board partners or other relevant persons have worked together to protect the child.

What was the story?

Baby Darren was born on 6th November 2015 to parents who both have mild learning difficulties. The baby will be referred to as Darren; his mother is Sarah, and his father is Peter. Peter's mother is called Patricia. All names are pseudonyms.

Between March 2015 and January 2016 the family came into contact with community midwives, health visitors, hospital staff and social workers. For a short period of time Darren was made subject to an interim care order and placed in his grandmother's care with Sarah and Peter's contact limited to 5 hours per day. The legal proceedings were considered to be flawed inasmuch as the parents were not informed of the initial hearing despite assurances from the local authority legal representative and the social worker that they had been. This resulted in a Human Rights Act application from the parents.

Background:

In March 2015 Sarah was confirmed pregnant by a Senior Nurse Practitioner (SNP1). Between March and November, when baby Darren was born, the parents were seen by a number of health professionals, some of whom had concerns about the ability of the parents to care for the baby once born. SNP1 was concerned enough to have a conversation with a community midwife (CMW1) regarding safeguarding issues. The Community Midwife told the health visitor (HV1) said she thought they would need a lot of support and looked unkempt and dirty.

In July Patricia informed Housing Solutions that Peter needed a spare room so that when he has a 'melt down', he could retreat to the room until he is calm. Patricia had explained that Peter had all day support from either her, her husband or a carer and was rarely left alone. She said she would be taking time off work when the baby arrived in November. The GP was aware of this issue too as he wrote a letter for housing stating that Peter needed an additional space (bedroom) to allow him to "to have time out space when he is having anger and emotional issues".

In September a Health Visitor (HV1) carried out an antenatal contact at home. Sarah and Peter were excited about the baby coming. Sarah said she had previously suffered from depression, mainly due to the abuse she experienced as a child from her parents and Uncle. The couple had made some preparations for the birth of the baby. The house was dirty and cluttered.

In October the case was reviewed by the Safeguarding Midwife. No other agency was involved and no safeguarding concerns were noted. The Safeguarding Midwife asked the community midwife to complete an early intervention referral form with Sarah and Peter to be able to offer additional support before the baby was born. There is no record to confirm this was done.

On 6th November baby Darren was born. The ward midwife became concerned about Sarah and Peter's ability to care for Baby Darren upon discharge, she wrote her concerns on the Integrated Care Plan and discussed them with the safeguarding midwife who said an early intervention midwife should visit the home on a daily basis because the health visitor will not be visiting until Darren is at least 10 days old. A few days later WM1 contacted the supervisor of midwives to say she was concerned about the couple's long term parenting ability. She was advised to contact children's services which she did on the same day. The duty social worker said the family would need additional support but was not sure if the case reached the threshold for a referral. The social worker suggested WM1 should complete an early intervention referral form which she did that same afternoon. Following further "concerns" raised by undocumented staff, WM1 contacted Children's social care again and at this time a decision was made to instigate a s.47 enquiry. It is not clear who made this decision or why. Social care then sought advice from the legal department and an Interim Care order was sought to make Patricia Darren's main carer.

On 27th November the first Looked After Child review took place. The independent reviewing officer suggested that a parenting assessment be arranged. The reviewing officer noted that no care plan, placement agreement or contact plan had been completed and suggested that these needed to be done.

At a social work visit a few days later a contact agreement was drawn up which limited parental contact with Darren to 5 supervised hours a day, this number appears to have been chosen by Patricia and there is no clear rationale behind it.

In December the case was transferred to the LAC team and the new social worker visited, she left the home unclear about why an ICO had been sought and this was consequently discharged as the LA could not establish the threshold for intervention.

Overview and Analysis

Strengths and Protective Factors

WM1 – had concerns and was tenacious about following these up

LAC team immediately identified concerns about the legal arrangements and challenged these.

Risk/Harm/Danger

Assessments were not completed in a multi-agency way nor were they balanced by strengths and protective factors

Grey Areas

Record keeping was sparse making it difficult to ascertain the decision making process

Statement in one SW report that Peter was a perpetrator of violence towards Sarah – there is no evidence of this in police records or indication of where this information has come from

No assessment of parenting capacity

Complicating Factors

Decision making compromised by turnover of social work managers

Lack of clarity of the role of the LA solicitor

Social worker who went to court was inexperienced

Voice of the Child

GP and Housing failed to consider the need and safety of the new born baby when recognising father's need to have space for his "anger and emotional issues"

Lack of forward planning considering the needs of the child

Analysis

Earlier appropriate use of Early Help would have given time for professionals to share information, build relationships with the parents and wider family and assess concerns, strengths and support needed.
Lack of managerial / IRO oversight and challenge in Children's Social Care and Health led to reactive rather than proactive responses
Greater understanding of learning disabilities would have assisted in appropriate assessments of the parent's capacity to care of Darren
Some agencies did not follow safeguarding procedures

Learning for Professionals and Multi-Agency Working

Professionals need to have a sound, judgement free knowledge of Learning Disability and how this may impact on parenting capacity.
Assessments should be completed in a multi-disciplinary way
Management oversight and support is crucial for inexperienced workers
The relationship between children's social care and legal services needs to be better defined
Records need to be kept up-to-date and should record who is making key decisions and why
All agencies to have a good understanding of Early Support Services

For more information about National Reviews and learning visit:
https://www.gov.uk/government/groups/serious-case-review-panel

https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/national-case-review-repository/

Relevant Tools & Multi-Agency Responses for this case include:

KSCB Working with Parental Learning Disability Good Practice Guidance, please click here
West Yorkshire Procedures for 'Children at Risk where a Parent has a Learning Disability', please click here

For more information about Local Reviews please click here