Kirklees Safeguarding Children Partnership

A Learning Lessons Review in Kirklees:

(Child E - Steven)

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?

In August 2018, KSCB were informed of the death of a 4 month old baby. The death was suspected to be an overlay through sleeping in his mother bed. This baby had been subject of a Child in Need Plan following a pre-birth assessment as the Mum's previous children were in the care of their Father. Both of the baby's parents were known to have mental health difficulties and concerns in relation to alcohol misuse. The Child in Need plan ended on the 9th July 2018.

Background:

In August 2017, at her antenatal booking appointment Mum didn't disclose her alcohol and mental health issues, including the overdose she had taken the previous month. Nor did she mention that her 3 older children no longer resided with her as a result of her issues. In November 2017, her midwife and CAFCASS made a referral to Children's Social Care, a pre-birth assessment was started which concluded that a Child in Need (CiN) plan would help support the family and manage any risks to the unborn child.

For the duration of her pregnancy the Mum appears to engage fully with all antenatal, CiN and health (including mental health) appointments. There is little reference to the Dad of the baby, with whom the Mum is still in a relationship. This baby is born in April 2018 and there are no concerns noted regarding the baby's health, development or care and though there is little detail in any agencies records in relation to the Dad it is clear they are still in a relationship and caring for the baby together with no apparent issues.

On 28th May 2018, there is a domestic dispute as the Dad attends the Mums home wanting to stay but the Mum refuses as he is under the influence of drink and drugs and she has her older 3 children with her on their first overnight unsupervised stay. At the subsequent CiN meeting it is noted that the Mum "acted protectively" by calling the police. She was not the person who contacted the police, though by refusing the Dad entry in the home was clearly prioritising the needs of her 4 children.

The Dad is present at the CiN meeting on 7th June and he is advised to address his mental health difficulties, alcohol misuse and unstable housing. It is made clear he is not to have unsupervised access to the baby. At this stage the status of the parent's relationship is not clear, nor is the Dad's place of residence.

On 12th June the Dad is assessed by the mental health team following him being seen on a bridge threatening suicide. During the mental health assessment it is noted that, the Mum, informed the team that Dad of the baby could not return to the family home due to Social care assessing him as not being safe around their new-born son due to his substance misuse. At this time the Dad continues to access mental health services though does not engage with CHART as advised. There is no apparent liaison between the parents' mental health teams despite them still being in contact with each other at this time.

On 4th July, the health visitor is contacted by the new social worker who asks what the date of the next CiN meeting is. It is subsequently recorded in Children's Social Care's records that a CiN meeting is held at Mum's home on the 6th July, however as only the social worker and Mum were present this would more accurately be called a CiN visit. Mum is informed by the new social worker that the CiN plan is closing as "parents are caring for the child well and addressing mental health concerns."

Between 15th and 26th July Mum reports to her health visitor, mental health team and GP on separate occasions that her mood was low due to the restricted access to her older children, the Dads deteriorating mental health and ongoing housing issues. Although not alcohol specific, Mums CPN discussed her wellbeing, support network and coping strategies. However, again, a possible relapse into alcohol use and the impact of her ability to care for the baby does not appear to have been discussed.

On 23rd July, Mum contacts Dads mental health team stating he was angry, in drink, swearing and banging his head against a wall. There is no indication of where this incident is taking place, whether the baby is present, whether Mum is safe herself and no liaison with either the Police or Children's Social Care.

On 26th July, Dad cancels a mental health appointment as he is looking after his son. This was not challenged though they were aware that he should not have unsupervised contact with the baby.

Later that night the Mum contacts the police stating the Dad is at her home, in drink, being physically aggressive towards her.

This incident is discussed in the Daily Risk Assessment Management Meeting (DRAMM) the next day and it is clear from the police and social care records on the incident that Mum was stating that Dad was at the property. No agency appears to have noticed that the incident was called into the police at 10.30pm which would be an unusual time for a supervised contact visit to a 4 month old baby, especially as the attending police officer records that the baby was asleep upstairs at the time. The Dad was arrested at the incident and given bail conditions not to go within 100m of the house, not to contact Mum, directly or indirectly, except via services to arrange child contact.

Dad continues to struggle with his own mental health and breaches the non-contact bail condition with Mum.

Between 7th and 16th August the Mums CPN and Community Care Officer visit her 3 times and acknowledge the domestic violence incidents and her low mood. Neither worker appears to have discussed a possible relapse into alcohol misuse and the impact of her stressful current situation and low mood on her parenting capacity.

On 23rd August, in the early hours of the morning the Police are notified by the ambulance service of the sudden death of this baby. Mum reports that she had been drinking wine with her friend during the afternoon then had returned home with the baby and when she went to bed at 11pm she took him into bed with her.

Overview and Analysis

Strengths and Protective Factors

Mum is engaged with services to address her mental health needs and with her health visitor to meet the child's needs.

The child is well cared for and healthy with no concerns regarding Mum's care of his needs and their interaction.

Safe sleeping advice is given to Mum on 4 separate occasions.

Risk/Harm/Danger

Dad's unstable mental health and substance misuse posed a direct risk to the child and also impacted on Mum's well being

Domestic abuse from Dad to Mum does not appear to have been fully assessed and understood.

Contact between child and his Dad was expected to be facilitated by the Mum despite the domestic abuse.

Lack of understanding of the risk that Mum's former issues with alcohol posed.

Grey Areas

Throughout the period of the review it is unclear whether the parents were still in a relationship and where Father was living.

At the domestic abuse incident in July 2018 it is unclear why the Dad is at the home.

Effectiveness of sale sleeping message

Complicating Factors

Mum's alcohol misuse and mental health.

Dad's substance misuse and mental health issues.

Unstable Children's social care workforce during the time meant that Mum did not have regular Child in need meetings and multiple changes of Social worker

There was a lack of clarity about the post CiN support arrangements.

Voice of the Child

The child does not appear to have been considered in assessments of Dad's mental health.

The child is described in health visitor's records as a happy, well cared for and engaged child.

Analysis

The risk of a return to alcohol misuse due to the stress the Mum was under from her unstable and at times violent relationship, ongoing mental health issues of her own and other issues such as a difficult relationship with her ex-partner and housing does not appear to have been discussed or addressed.

Information sharing within and between agencies could be improved, especially when considering the Father of the child.

Safe sleeping advice given to Mum was not effective in reducing the risks

Learning for Professionals and Multi-Agency Working

Workforce understanding of the risks of domestic abuse, particularly the risks associated with post separation are poorly understood.

Victims of domestic abuse are given the responsibility of keeping their children safe from the perpetrators of abuse without an assessment of their capacity to do so.

Perpetrators of violence, though identified as the source of risk to children, are not directly worked with to address concerns

Relationships characterised by domestic abuse and between people with alcohol, substance and mental health issues rarely end without include periods of reconciliation and contact.

Clear, up-to-date records and effective, comprehensive information sharing are the foundations on which effective child safeguarding practice are built

The support arrangements post Child in Need were not clear and co-ordinated and the circumstances under which Children's Social Care may want to consider re-opening a Child in Need case after the closure are not specified to the agencies who remained in contact with the family.

For those agencies primarily addressing parental issues, child safeguarding does not appear to feature in their assessments, decisions or direct work.

The safe sleeping advice, given consistently to mother, was not effective in reducing the risks to this child

The risk of a return to problematic alcohol use by mum was not understood, assessed or managed.

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

https://www.lullabytrust.org.uk/safer-sleep-advice/

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/

For more information about Local Reviews and this case visit:

https://www.kirkleessafeguardingchildren.co.uk/safeguarding-2/safeguarding-processes-and-systems/safeguarding-practice-reviews/