7 minute Learning Summary

Serious Case Review – Darryll

Case Summary

In February 2018 Ms D woke to find her 15 day old baby, Darryll, was not breathing. Darryll was resuscitated at hospital but sadly died 5 days later. He had been co-sleeping with his mother and the inquest returned a verdict of misadventure.

Significant concerns were subsequently raised about the vulnerability and emotional wellbeing of Ms D who was a care leaver and who had recently suffered a significant bereavement. She was caring for her sibling's children on the night of the incident and had smoked cannabis.

Ms D had several significant and known vulnerabilities. Due to the severity of the risks she was placed in an out of borough placement. She settled well and wanted to remain there. However, her housing application was not recognised as that of a care leaver and she was housed back in Wandsworth.

Ms D had positive relationships with key workers and had developed a Pathway Plan, however, no-one had been allocated to focus specifically on Darryll. Professionals knew about Ms D's use of cannabis, which she used it to control her anxiety and help her sleep. However, there is no evidence of professional curiosity about the circumstances around this. A referral to Children's Social Care (CSC) had been made by health services and this concluded that she did not need targeted parenting support. Information sharing between the Family Nurse Partnership's (FNP) and health visitor (HV) did not take place and assumptions were made regarding the level of intervention she would receive. The full pre-birth assessment was not sought by Wandsworth CSC, and there was some delay in allocating a worker.

Cannabis is a risk factor when co-sleeping and is a recurring key feature in safe sleep cases. The likely impact of cannabis use on Ms D's parenting capacity was not fully recognised or explored by the agencies and it appears that services may have focused on her support needs over the safety and welfare of Darryll. Practitioners involved with Ms D could have demonstrated more curiosity about the vulnerabilities of young babies, especially where there are known risk and vulnerability factors.

Recommendations

1. To ensure the learning from this review is disseminated across the multi-agency safeguarding partnership to practitioners and managers.
2. To seek assurance that the actions identified by each partner agency, as a result of this review, have been managed, implemented and embedded in a timely manner.
3. To inform the Family Nurse Partnership National Unit of the findings of this review to allow them to consider the learning and shared with local partnership arrangements and supervisors.
4. To promote learning, as a public health message to the wider population, about the importance of avoiding co-sleeping and unsafe sleeping arrangements with babies.
5. To seek assurance about the quality and effectiveness of joint working arrangements for those services who work with care leavers who are pregnant and who require housing support.
6. To review the information sharing protocol and practice around sharing of pre-birth assessments (closing summaries and full assessments) to confirm that they are provided to the relevant professionals and agencies that are involved with the mother/father; consent to share by mothers/fathers should not be seen as a barrier to the professional network and guidance should include advice about how to overcome any barriers which may arise as a result of consent issues.
7. All organisations across the partnership to ensure all agencies use of the threshold document is proactively considered, especially when consent is withheld and there may be a need to re-evaluate decisions taken on individual cases.
8. To seek assurance that all multi-agency safeguarding training courses and relevant resources relating to risk assessment include explicit reference to the risks associated with cannabis use and the potential impact during the antenatal period and on parenting capacity.

1. Vulnerabilities

- Care leaver with a history of Adverse Childhood Experiences.
- Young parent
- Recent family bereavement
- Known mental health issues
- Cross borough moves
- Cannabis use

Practitioners did not exercise the level of professional curiosity required when such vulnerabilities and risks were identified.

Cannabis use has become increasingly common and practitioners may need to mitigate against becoming desensitised to the fact that it is an illegal drug which can have detrimental effects on parental capacity and family functioning.

Practitioners should be aware of the importance of 'safe sleeping' arrangements and the risks of co-sleeping with babies.

2. Health

Ms D was referred to the specialist midwifery team due to a history of anxiety and depression. Referrals were also made to the MASH team of the other London borough, the perinatal mental health team, antenatal drug service and FNP.

They were briefly known to the FNP in another borough, however the Wandsworth HV was not invited to the pre-birth meeting and was not involved in the discharge planning and was not aware of the Ms D's vulnerabilities.

Single agencies are not able to make decisions or assumptions about thresholds and eligibility for intervention on behalf of other services.

A new reporting format has been created to more accurately capture the discussion and decisions from discharge planning meetings

3. Children Social Care

The Local Authority has a duty of care to support care leavers up to the age of 25 years.

When significant events in a young person's life, (particularly as a care leaver) occurs , such as becoming a parent or the bereavement of a significant family member, this should trigger practitioners to reflect upon whether a review of the 'level and frequency' of the support being offered is required.

Practitioners should be aware of and promote learning about the importance of 'safe sleeping' and the risks of co-sleeping with babies, understanding that the message may need to be adapted according to the families individual living circumstances.

Practitioners should be aware of the increased risks to babies when parents have transient lifestyles.

The importance of recognising, and exploring early adverse experiences can provide context to understanding their current circumstances and behaviours. The weight of the Ms D's earlier life experiences and how this may impact on her parenting capacity was not given due consideration.

Ms D did not disclose Darryll's father's identity, something may be a cause for considerable curiosity or concern. Effective information sharing in a timely way, may have resulted in more timely assessments, decision making and better co-ordination of the support.

4. Housing

Ms D had settled in another Local Authority had friendship groups, support, was attending further education and wanted to remain living in the area. She stated she felt safe.

Ms D had a legitimate claim to be able to apply to any local authority where she had a local connection, and had the right to apply to multiple local authorities for housing.

However her application was not recognised as that of a care leaver, her additional vulnerabilities were not assessed and she was treated as a homeless application.

5. Multi agency

Multi agency partners working with young parents who are also care levers, should contact the lead professional to advise of their role and if there is anything they need to be made aware of or alerted to.

As a result of this review the threshold guidance has been updated. Organisations should ensure their agencies are familiar with and use the guidance in order to have a clear understanding of roles and responsibilities. Multi agency practitioners across the partnership need to use of the threshold document, particularly where consent may have been withheld and there may be a need a review of decisions.

The guidance, recommendations and learning from this review will be disseminated to both internal and commissioned multi agency trainers.

All multi-agency safeguarding training courses and relevant resources relating to 'risk assessment' will include explicit reference to the risks associated with cannabis use and the potential impact during the antenatal period and on parenting capacity.

The Wandsworth Safeguarding Children's Partnership will ensure the Lullaby trust delivers advice on 'safe sleeping' and make available guidance and training on safe sleeping across the partnership.

6. Good Practice

- The pre-birth assessment and closing summary conducted by the other Borough's Children's Social Care is a well thought through and proportionate piece of work.
- The midwifery service acted appropriately in contacting Wandsworth CSC to escalate their concerns about the Ms D's refusal to grant entry to them when they visited.
- The midwifery service achieved meaningful engagement with the Ms D resulting in her being open about her difficulties and family issues.
- The specialist midwifery service applied professional judgement in ensuring antenatal care was transferred despite there being no guidelines to do so.
- The midwifery service made a referral to Wandsworth CSC despite being told that the previous social work department had closed the case.

7. Impact

The following 3 questions are suggested to promote discussion:

1. What are your key thoughts and reflections?

2. How can we ensure the learning is embedded and how will we know this?

3. How can we integrate the learning into team or service improvement plans?

Resources

Safe sleeping advice can be found https://www.lullabytrust.org.uk/

Keeping in mind the vulnerabilities of young babies: a triennial analysis of serious case reviews 2011 to 2014, p. 35 University of Warwick & University of East Anglia, May 2016. https://learning.nspcc.org.uk/media/1343/learning-from-case-reviews_infants.pdf

Royal College of Nursing - Safeguarding children & young people: Roles & competencies for healthcare staff

Section 20, Children Act 1989 Relevant child: An 'eligible child'

Children Act 1989 & Children Leaving Care Act 2000

Homelessness Reduction Act 2018—as it applies to Care Leaver's