Learning Lessons from a Serious Case Review

Calderdale Safeguarding Children Partnership

Learning - parental mental health/baby with non-accidental head injuries

A Serious Case Review (SCR) is undertaken when a child dies or is seriously injured where it was known or suspected that the child suffered from abuse or neglect. This briefing has been produced following an SCR into a child who was seriously injured in Calderdale in 2018 following Working Together 2015 guidance.

The briefing summarises and highlights key learning points from the case, and is aimed at front line practitioners, managers and organisational leads. The briefing focusses on the way in which organisations or professionals worked together to protect the child and includes positive practice, lessons learned and how services can further improve.

Despite the commitment and efforts of the practitioners working with the family this child was living with multiple risks, and was seriously injured whilst at home. It is believed the serious injuries suffered by this child were non–accidental and the learning from this SCR emphasises what changes may be applied to help partner agencies better respond to vulnerable children in the future.

For information visit www.calderdale-safeguarding.co.uk

November 2019

What was the story?

Mother and Father had an on/off relationship which continued before and after the birth of this child. Mother was receiving support from a number of Mental Health services including the multi-disciplinary perinatal mental health service which provides specialist and tailored care to pregnant women, new mothers and their families, at the time of her pregnancy. This continued after the birth and there were concerns about the impact of her mental health and the medication she was taking on her capacity to parent her newborn and the other child in the family. During this time, other agencies provided additional support to the family. Both children were under the age of 5 at the time of the incident.

The youngest child received significant non-accidental head injuries whilst in the care of the parents which were similar to those found in a baby that has been shaken.

Background:

Following the birth of the second child, Mother displayed OCD symptoms, experienced anxiety, reported being tired, expressed worries that she was unable to cope and was hearing voices, however, at this time she was not considered by Mental Health professionals to present a risk of harm to herself or others.

General concerns arose that the older Child may be socially isolated due to the Mother's reluctance to take the Child to nursery. She appeared to have unrealistic expectations of this child in terms of developmental progress; and held medically unsupported views that the Child was susceptible to rashes caused by contact with others. Some practitioners noted her tendency to overfeed both children and she was unwilling to accept and act upon the advice from them about this and other matters. For example, she was spoken to about co-sleeping with the baby on a number of occasions. About this time, she requested and was provided with medication to help her to sleep. It was reported that she was sharing her hallucinations with the older child.

The agencies involved with this family met on a regular basis and were providing Early Help support at Tier 3 of the Continuum of Need. An Early Intervention assessment was undertaken by one of the agencies which attempted to pull relevant information together. However, the explanations provided by Mother about the status of the relationship with the Father and his pattern of shift work, were accepted by the practitioners and he was not involved in the assessment or interventions. The roles played by other key members of the family were not explored and the significance of these relationships and individuals either as risks or protective factors were not included in the assessment.

Around this time, some concerns about the impact of Mother's behaviour on the children were noted by some of the professionals involved although in general the children were considered to be well cared for. Moreover, it was recorded that the children were regarded as 'protective factors'. The concerns about the impact of Mother's mental health on her parenting capacity were discussed with MAST but no referral was made.

Shortly prior to the incident which resulted in injuries to the child, the Community Mental Health Team discharged Mother from their care, a decision which was not supported by some partner agencies or the Mother herself.

Overview and Analysis

Strengths and Protective Factors

A multi-agency Early Intervention assessment was completed;
Professionals met as a multi-agency group regularly;
The need for closer working between services was identified;
Support was provided to Mother in hospital following birth of both children including the monitoring of her mental health;
Appropriate referral was made for family support;
Joint visits took place between some of the professionals.
There were examples of appropriate challenge between practitioners.

Complicating Factors

There were 2 children in the household under 5;
Mother had a long-term mental health condition and use of associated medication which impacted on her ability to parent effectively;
Regular multi-agency meetings took place, but the significance of some information held by the Mental Health practitioners was not clear to the non-Mental Health practitioners, especially in relation to safeguarding the children;
The Early Intervention assessment focused on the social isolation of the children.

Risk/Harm/Danger

Mother had unrealistic expectations, particularly of the older child's behaviour;
The older child was considered to be socially isolated following withdrawal from nursery;
Mother failed to act on advice, especially re: co-sleeping;
The role of the male in the household was un-assessed;
Children were regarded as 'protective factors';
The impact on parenting of the birth of a second child where there were existing concerns was not explored

Voice of the Child

Some observations of the children were made but the child's voice was overshadowed by the needs of the Mother in this case

Grey Areas

The impact of Mother's mental health condition and medication on her ability to parent was not assessed;
The relationships between the adults and between the adults and children and the significance of this on parenting and on family functioning were not fully explored;

Analysis

Mother's statement that she was not coping was not fully addressed and complicated by concerns (from some agencies) that she was becoming dependent on services;
The role of the Father as a support to Mother and as a Parent was not assessed and his ability and availability was possibly overestimated; the extent to which 'significant others' were either protective or risk factors was unknown;
Mother seemed to have difficulty recognising the children's needs or responding to their cues;
Two systems were operating (Early Intervention and Mental Health support) which at times were at odds - the significance of the information shared was not understood;
There was lack of oversight and child focused analysis when professionals met.

Learning for Professionals and Multi-Agency Working

Beyond information sharing, Practitioners need to understand the significance of role specific information in order to inform assessments of parenting capacity. This relies on those Professionals providing clear information and interpretation/analysis in assessments and at multi-agency meetings;

All practitioners should be aware of the need to safeguard children of adults with mental health needs & always give priority to needs of the child when considering risk. Tools and guidance to assist practitioners when working with parents with mental health conditions are being produced by the CSCP;

The needs of and risks to all children in a family should be considered individually, not just the one about whom there is a concern. In particular, the potential impact of the birth of a second or subsequent child to a family where there are prior concerns needs to be understood to ensure support needs are addressed promptly. The Risk Indicator Tool assists with this analysis;

It is vital that the most appropriate lead agency/practitioner takes the lead in Early Intervention. The decision about how the Lead Practitioner is identified is being formalised in the review of Early Help in Calderdale;

Relevant agencies will be reviewing their current arrangements to ensure they have sufficient focus on parenting capacity when supporting families;

The importance of including 'significant others' and developing an understanding of family relationships and functioning in assessment and interventions by all agencies has been highlighted by this case. These issues are being taken into account in the review of Early Intervention, in work with Adult Services and the CSCP has produced a Safeguard Guide for practitioners on 'Hidden Males/Significant Others';

'Hearing' the child's voice and acquiring an understanding of life as they experience it is critical for practitioners to make sound decisions about children. 'A Day in the Life of a Child' direct work tool provides a way of gaining an insight into the child's life;

Practitioners should have access to safeguarding supervision in their workplace to explore complex cases and maintain focus on the child. This will be tested via the Section 11 self-assessment process. Multi-agency training 'Introduction to Safeguarding Supervision' is available for Managers via CSCP training offer.

When several agencies and 'significant others' are involved with a family, especially where the focus of support is a parent, there is a danger that the child will become lost. Practitioners should identify all agencies and people involved with the family and clarify their roles and responsibilities.

For more information about Serious Case Reviews visit:

http://calderdale-safeguarding.co.uk/professionals/safeguarding-children/training-and-development/serious-case-reviews/