7 Minute Briefing: ROWAN

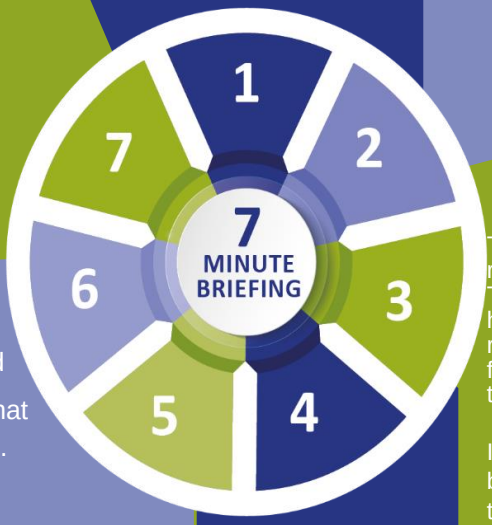
Date: October 2023

1. Background

This is the case of an infant aged 16 weeks, who sadly died after being found collapsed and unresponsive in his cot in the early morning. The parents were very young themselves; mother was 13 years old and father was 14 years old. Both parents were known to Children's Services in their respective local areas and were themselves, previously subject to Child Protection (CP) plans having experienced emotional trauma and witnessed and suffered physical violence. The baby was born at 36 weeks gestation and was subject to a child protection plan under the category of physical abuse. Baby was bottle feeding and no ongoing health concerns had been identified.

2. Key Lines of Enquiry

- What was the quality of the assessments undertaken of Mother and Father who were children and who were in need of help and protection?
- What was the quality of support for Rowan's mother and father as young parents?
- Did their needs and vulnerabilities overshadow professionals Understanding of Rowan's needs as a child in need of protection?
- How was Father's capacity as a young father assessed and supported?
- How well was the parenting capacity of both these parents and their wider families understood, assessed and supported?
- How effective was the multi-agency work in providing and reinforcing safer sleeping advice?



3. Key Findings (1)

There is a need to support young parents and not rely on their own family to provide that support - The importance of taking full account of family history and consideration of the consequences of requiring a family member to take responsibility for ensuring a safe environment and supervising the care of an infant cannot be overestimated.

In this case the parents themselves were children but the focus for professionals was primarily on the safety of the infant and not the parents.

The importance of parenting assessments, including pre-birth assessments was identified as a factor in this case. It can be concluded that given Mother's family history and the dynamics of her relationship with Maternal Grandmother, there was misplaced optimism on the part of practitioners that the specifications of the Child Protection Plan would succeed.

4. Key Findings (2)

Safer sleeping advice – whilst the advice had clearly been given to the family there were missed opportunities for professionals visiting the family at home, to observe the actual sleeping arrangements and reinforce the messages.

There was a close correlation between factors in this case and the risk-factors identified in the Out of Routine report. One of the most important findings in this case was that the risk of SUDI should not be seen in isolation from other risks present in the home environment. There is a need for all practitioners to assess the risk of SUDI and it is not solely the responsibility of health professionals.

5. Good Practice

The GP Practice offered exceptional care to Mother and showed good awareness of Safeguarding Children.

A safe, caring environment was provided by the Short Stay School for Mother during and post pregnancy with exceptional care shown by the Senior Pastoral Worker and DSL.

Excellent care provided by The Family Nurse and Community Midwives with the Family Nurse and Children's Services continuing to visit the family during the Covid Pandemic.

The local authority responsible for Father did their utmost to engage him and to ameliorate the risk of significant harm, culminating in the funding of a permanent move for the family out of area.

6. Recommendations (2)

GP Practices should be informed when a child is subject to a Child in Need Plan, to ensure that information relevant to safeguarding is shared.

The SSCP to seek assurance that the framework concerning safer sleeping is embedded for use by practitioners working with families where young infants are at risk because of unsafe sleeping arrangements

Such a framework should include a requirement that professionals visiting the home should ask to see where a baby is sleeping to seek assurance that the arrangement is safe

7. Recommendations (1)

The 7-minute briefing Learning from Pre-Birth Assessments is to be shared widely with all relevant agencies and published on the SSCP website.

If a vulnerable baby is living in the care of grandparents (with or without the presence of their parent), an assessment of their parenting capabilities and skills should be a pre-requisite before any such placement is made

Partner agencies are to be reminded that when parents are children themselves, their needs and wellbeing should be recognised, and considered a priority, together with that of the need to safeguard their child

Consideration should be given to exploring the possibility of young, teenage mothers being offered the services of the Perinatal Mental Health Team when it is evident that their health and wellbeing is at risk

The FULL REPORT can be found on the SSCP website.