**Learning Summary: a young parent with complex needs**

## Summary

Following a Rapid Review into the non-accidental injury of a very young baby, who had been subject to a Child in Need Plan at an earlier point, Oxfordshire Safeguarding Children Board undertook a workshop for managers to walk through the information and highlight additional practice learning points. The aim was to identify strengths in practice and areas for improvement, in relation to individual agency practice and partnership working. The circumstances did not meet the criteria for a Child Safeguarding Practice Review (CSPR) and there are no long-term effects from the injuries.

Key issues to be explored related to the vulnerability of the young mother and further learning as to how agencies developed a shared understanding of her vulnerability as a new parent, her ability to communicate as a person with suspected autism, her needs as a mother who had been sexually abused as a child and referring her to the appropriate services within the safeguarding system. These themes have been a feature of another Rapid Review and will be part of a CSPR that the OSCB is due to commence and the learning from this review will be shared with the CSPR author.

## Key Findings

- **Mother's vulnerability and the need for a full assessment and detailed care plan** – there were a wide range of vulnerabilities including depression, self-harm, suspected autism, living with parents in neglectful circumstances, being both victim and perpetrator of domestic abuse, engaging in risky behaviours whilst pregnant, experience of sexual assault whilst pregnant and as a late teenager, sexual abuse as a child and being a young parent. There was evidence to suggest that a holistic assessment of all these needs was not fully carried out and some of the issues were 'lost' so her full level of need, risk and vulnerability were not used to inform the Child in Need plan which was superficial and lacked a focus on outcomes. A full assessment of parental capacity was required. The midwifery Health and Social Care score was lower than it should have been had all relevant information been gathered. Living with her parents was seen as a protective factor, when in fact it increased some aspects of risk and neglect, which appear to have been overlooked.
- **The impact of Covid-19 on Health Visiting contact with the family –** there was evidence to suggest that changes in practice resulting from Covid-19 in the first lockdown in March 2020 had impacted on the level of contact with the family. This was in line with NHS England advice and local risk assessments and decision making. These changes were no longer in place during the second lockdown in November 2020. The Health Visiting service had used skype and face time for contacting mother. Previous case reviews have noted the need for professional curiosity. (This is one of the OSCBs 'top ten learning points from local case reviews'). The Rapid Review group concluded that the advent of Covid-19 has placed greater need for professionals to be curious as to why families might decline face to face contact (citing Covid concerns) and to have conversations with wider safeguarding partners when determining how to manage contact with vulnerable families.
- **Information shared between different health services –** the chronology raised the concern of how well health services share information with each other and the importance of sharing when safeguarding concerns take priority. They noted that this could have been done much better and was considered important as it impacted on what was understood regarding mother's vulnerability. The services included CAMHS, health visiting and midwifery services. Previous case reviews have noted the need for sharing information appropriately where there are safeguarding concerns and the OSCB has some 'Golden Rules' of information sharing as a result.

**Themes in common with other Oxfordshire reviews**

- Professional curiosity and analytical thinking
- Understanding the impact of parental history of abuse and suspected autism on parenting capacity, particularly for a young parent
- Effective multi-agency working to see the full picture particularly in relation to information sharing

**Learning points for practitioners**

- Ensure all factors are taken into account in an assessment and that they inform an outcome focussed plan and use tools well do this e.g. PAMs assessment for parenting capacity; midwifery Health and Social Care scoring
- The social worker had a good relationship with the mother who shared a number of key issues but some of these then got 'lost' in the later assessment and planning stages which were undertaken by different practitioners in other parts of the Children's Social Care system
- Living at home with her parents was seen as a protective factor but some of the concerns like neglect in the household were not considered fully
- The midwifery Health and Social Care score was lower than it should have been had all relevant information been gathered. A full assessment of parental capacity was required.
- Mother was both a victim and a perpetrator of domestic abuse and the risks in terms of her behaviour as a perpetrator were not taken sufficiently into account
- The need to persevere and take advice if a family are reluctant to engage or see you face to face - be curious about what else this might be about.

**Learning point for managers**

- Face to face visiting at key points in a new parent's life is crucial. Where this is not possible link up systematically with other practitioners who are seeing the child and family in person; Covid restrictions and changes to working practice will continue into the future
- Make sure that where there are changes in workers all information about the family and child's history and knowledge about risk and vulnerability are passed on to the new worker and does not get lost
- Ensure that there is shared ownership of complex cases; remember to call other practitioners and check your understanding and what plans are in place
- Put in place and use the right systems for information sharing between professionals for both current and historical information e.g. between midwives and health visitors and mental health services with good handovers across professional disciplines
- Ensure that practitioners have the right qualifications and skills to undertake complex assessments
- It is important to note on records future risk and vulnerability for a parent in these circumstances and the GP informed so that the parent is fully supported if there are any future pregnancies.

**Learning points for the safeguarding system**

- Oxford University Hospitals will review the access to the Neuro-Developmental Pathway for 17/18 year olds subject to discussion

- Oxford Health are creating a local partnership protocol to complement the national guidance with respect to risk assessing families whilst social distancing restrictions remain in place. This will focus on the learning with respect to (1) professional curiosity and (2) wider conversations with safeguarding partners when families decline face to face contact and will be shared across the partnership.
- The Family Solutions Plus model launched in November 2020 in Children's Social Care should help reduce risk of passing from the MASH to the assessment team and onto the team providing the intervention with different workers supporting each stage. In this instance some of the complexity of need was 'lost' in those transitions. Learning from this review should be part of training at the Front Door and in the new service going forward.
- OSCB Health Advisory Group to review the learning about information sharing across different health disciplines.

**Which other services might have been considered to support the family?**

- The family was receiving health visiting support at Universal Partnership Plus level and were not eligible for Family Nurse Partnership. Home Start services were considered but were not providing home visiting services at this time due to COVID-19 restrictions.
- Other services that could have been considered include Autism Oxford for a full assessment; CAMHS community in-reach service; the Infant Peri-Natal Service in adult mental health services for over 18 year old parents; CAMHS peri-natal service for under 18 year old parents.

**Take the time to reflect ….**

- Do the family understand what you mean and have you taken any learning difficulty into account and thought about supporting them to have a full assessment of that difficulty?
- Where there are also worries about mental well-being, a history of abuse and sexual assault have you thought about the impact of this on a new parent?
- Have you thought about risk factors if a parent is both a victim and a perpetrator of domestic abuse?
- Have you really been persistent and sought advice if someone does not want to engage but is very vulnerable?

**Did you know? The following links offer useful further information and guidance:**

- OSCB neglect webpages
- PAMS assessment *Parenting Assessment Manual (PAM)*
- Golden rules of information sharing *The Seven Golden Rules for Info Sharing*
- Threshold of needs matrix *Oxfordshire Threshold of Needs 2019*,

**If you do one thing……**take all information into account about family history, risks and vulnerabilities and make sure they are shared in full with other professionals