Practitioner Briefing - Theme: Vulnerable babies (September 2018)

The Newcastle Safeguarding Children Board (NSCB) undertook a 'deep dive' audit of the accidental death of a baby. The audit explored the timeliness and effectiveness of the: Children's Social Care and Early Help response and intervention; practitioner roles and responsibilities, including the Lead Practitioner role; and how well early help interventions meet the demand of family support.

The audit methodology applied a systems approach to consider the circumstances and learning from the case. Systems audits consider the findings and learning of individual cases in the context of the wider population and asks the question '*how and why is it more widely relevant'?* This approach ensures that the learning is applied to the wider system and practice and identifies both what is working well and what needs to improve and be done better (Munro 2004, 2005 and 2011).

Findings from the audit established that: mother was a vulnerable young woman with a long history of abuse and neglect; assessments undertaken by both Children's Social Care and early help lead practitioners (Working Together 2018 pp.14) did not effectively consider and analyse mother's historic information and vulnerabilities, or consider what the likely impact of these might be on her parenting capacity and what any potential risks to the baby might be; assessments did not use research or evidence to inform the analysis of risk and were very much task orientated and parent focused.

At the time that the Early Help Plan was closed the health visitor agreed they would continue to monitor the child through routine assessment visits. The use of the term "monitor" suggests a level of regular oversight. However, the child would not be routinely seen for at least another 5 months.

The audit then asked the question why is this case so widely relevant? Research tells us that:

- 41% of SCRs related to babies under one year old, which reflects the intrinsic vulnerability of babies who depend on their parents for care and survival. Research evidence also indicates that pregnancy and infancy offer a unique window of opportunity to work effectively with families at risk (Cuthbert et al 2011; SideBotham et al 2016)

- Babies of teenage mothers have a 56% higher risk of infant death compared with babies of mothers of all ages (ONS 2016)

- Babies of teenage mothers are three times more likely to die from Sudden Unexplained Death in Infancy. This is without the impact on parenting capacity from parental vulnerabilities such mental health issues, drugs and alcohol use, abuse experienced by the parent themselves, which place babies at even higher risk of abuse and neglect (Public Health England 2016)

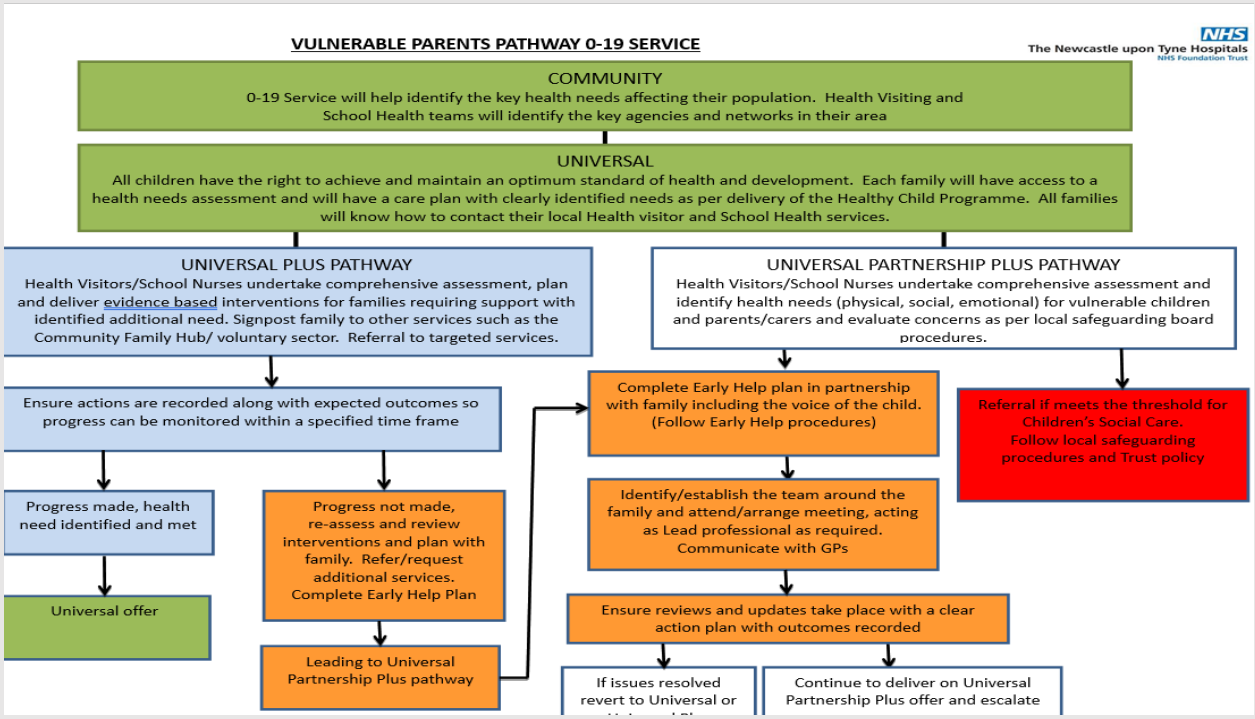
Key learning from the audit highlights the intrinsic vulnerability of **all** babies. However, these intrinsic vulnerabilities are exacerbated when a baby is in the care of a 'vulnerable' parent or parents, and even more so a teenage parent, therefore placing them at much higher risk of unexplained death or death because of abuse and neglect.

It is important that practitioners understand and are mindful of the evidence base and outcomes for children of teenage parents when they are undertaking routine and targeted assessments and interventions.

The importance of holistic, child focused, evidence-based assessments with robust analysis of risk to inform plans, including Early Help assessment and plans, should not be underestimated, and the assessment of parenting capacity must be understood in the context of trauma (Turney et al 2011).

Early help Lead Practitioners and the Team Around the Family (TAF) must be clear about their roles and responsibilities in providing early help interventions and TAF meetings should occur regular to continually assess risk and progress the plan for the child and family.

In January 2018 a Vulnerable Parents Pathway (including teenage parents) was implemented by The Newcastle upon Tyne Hospitals Foundation Trust 0-19 Service. Through the delivery of the core offer in Health Visiting and the completion of the Newcastle Family Health Needs Assessment tool, health needs are identified in partnership with families and care planned appropriate to the family's level of need and reviewed at each contact.



What are we doing?
The NSCB is working with partners from universal, targeted and specialist services to consider how to raise awareness of the risks to babies from 'vulnerable' parents, specifically teenage parents.

It will undertake an audit of the effectiveness of the Vulnerable Parents Pathway and will work with universal and targeted services to strengthen the Lead Practitioner role.

References

Cuthbert, C; Raynes, G; Stanley, K. (2011), *All Babies Count*. NSPCC

HM Government. (2018), *Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children.*

Munro, E. (2004), *The Impact of Audit on Social Work Practice.* London.

Munro, E. (2005), *Improving Practice: Child Protection as a Systems Approach.*

Munro, E. (2011), *The Munro Review of Child Protection: A Child Centred System*. DfE.

Office of National Office for National Statistics. (2016), *Childhood Mortality in England and Wales: 2014*. Table 10. ONS.

Public Health England. (2016), *A framework for supporting teenage mothers and young fathers.* LGA

Sidebotham et al. (2016), *Triennial Analysis of Serious Case Review* 2011-2014. DfE

Office for National Statistics. *Child, Infant and Perinatal Mortality in England and Wales, 2012*, Table 7. ONS,

Turney et al. (2011), *Social Work Assessment of Children in Need: What Do We know? Messages from Research.*

For more information contact: Sue Kirkley, NSCB Co-ordinator susan.kirkley@newcastle.gov.uk