Richmond and Kingston LSCB

Learning and Improvement summary: working with young parents

This summary pulls together learning from a number of national and local learning lessons' and Serious Case Reviews (SCRs) about working with young parents.

Richmond LSCB 2013 Child G Kathy Godwin

This learning lessons' review was not published. The 7 week old baby died as a result of SIDS (Sudden Infant Death Syndrome). The mother was Looked After (Section 20). The mother and baby were accommodated in a foster placement. The father was also a young person. Delays were identified in preparing a multi-agency assessment in relation to the parental capacity to care and to plan for the future of the baby. There were also cross-borough issues.

Camden LSCB 2016 Child B Keith Ibbetson

Child B, a baby was shaken once by her parents, resulting in permanent disability. The young parents had been known to a number of services in Camden, including mental health services and a young parents' support service following a domestic abuse incident. Child B's mother had briefly been looked after by a London local authority as a child. Child B's parents received a number of services for short periods of time leading to a lack of continuity and fragmented service provision.

Recommendations included: Camden LSCB should seek evidence as to how information on the dangers of shaking small babies is delivered in antenatal settings; Camden LSCB should seek evidence that providers of antenatal services in Camden are asking women about domestic violence; LSCBs and training providers should take account of the 'halo effect' of seemingly cooperative parents; the LSCB should work with commissioners to ensure perinatal services are consistent and accept post-natal as well as antenatal referrals; the LSCB should consider what steps can be taken to improve effectiveness of risk assessments for children affected by domestic violence.

Find the report here: **library.nspcc.org.uk**

Surrey LSCB 2016 Child AA. Ruth Parry.

The baby suffered a serious non accidental head injury at 10 weeks of age. AA's older sibling had been subject to a child in need plan after AA's birth. Concerns about the family included: young age and immaturity of parents; lack of support from family or friends; dependence on professionals for money, food and equipment for the children; poor living conditions. Mother was a young carer for her mother, was subject to a Child in Need plan and received services from CAMHS. Issues identified include: the differences of opinion between children's social care and the community health services, which were compounded by a lack of clear and current assessment and co-ordinated planning.

Recommendations include: guidance for social workers on assessment should include joint visiting with other professionals to share perceptions and views; risks to new born babies should be fully understood with the expertise of community health professionals in this area acknowledged; inclusion criteria for the Family Nurse Partnership should be revised to include young parents who have a second or subsequent child.

The report can be found here: **library.nspcc.org.uk**

Kingston LSCB Family L learning lessons' review 2016. Caroline Mark, Sarah Johnson, Sian Thomas.

Two young children went missing in Kingston in early 2016. There is learning about communication, responding to injuries, child in need planning and Sect 47 strategy meetings, transient families, identifying people when home visits are made and flagging vulnerabilities on all databases. This learning lessons' review was not published.

Find more information here:
http://kingstonandrichmondlscb.org.uk/media/upload/fck/file/Kingston%20%20LCSB%20LL%20Exec%20Summary%20Family%20L%20Final.pdf

The Government has published a triennial analysis of learning from serious case reviews 2011-2014. Out of 24 reviews, where the mother's age was known, in 54% of cases, the mother was aged under 19 years. There is evidence of additional pressures for young, unsupported parents, particularly young mothers.

Issues raised included: denial of pregnancy and/or concealed birth of the baby; estrangement from the new mother's own parents; temporary housing or supported accommodation; lack of support from the baby's father and/or an unstable relationship with the father:

"A very young single mother, with a history of unstable accommodation, who appears to have been receiving very little support from either family or professionals midwives were informed by Mother that [baby's] father was not involved. There is no record that the father was present at the time of the birth."

Good practice was often identified in the work that the teenage pregnancy midwifery teams could provide to first time teenage mothers, offering them a targeted level of support during their pregnancy.

Find the report here:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf