Date

Practice Briefing

0518Gareth SCR

On 31st October 2018 Gareth, a one-month old baby collapsed at home. His mum Gemma and Dad John who were caring for him at the time called an ambulance and he was transported to the Emergency Department of a local hospital. Gareth was found to have multiple injuries and unexplained bruising was recorded to his abdomen, arms and legs and he had intracranial bleed and a fractured clavicle.

SCR Details

During the period within the scope of this review, Gemma was open to the Leaving Care Team and she had a Leaving Care Worker. There was a gap in follow through from actions agreed in supervision. The Leaving Care worker did not progress with these and this is reported in the internal report produced by a Senior Manager in the Prospects service. That is, that no consideration was given to Gemma being pregnant and an assessment of the support she might need. The primary focus of work with her was on housing and financial needs.

While Gemma was not a child and had disengaged with the Leaving Care Service would the same approach been carried out if it was one's own child? That is, she was pregnant, she had financial needs, she was about to be, and later was, evicted from her home and she had a relationship that although there were no known concerns was 'tricky' by her own report.

There was a gap in practice on the part of Service to pursue the pre-birth process and although this was highlighted by the manager, it was not progressed by the worker

In addition, no referral was made to Children's Social Care. The reason that no referral was made to Children's Social Care was because the Leaving Care team had assessed as 'no concerns'. This was based on their assessment of their work with her prior to the pregnancy.

When she became pregnant, there was insufficient risk assessment and Pre-birth work to make an informed decision that there were no risks to the unborn.

When Gemma moved, the Leaving Care Team appropriately kept her case open which at the time was not mandatory. However, this did not result in any meaningful impact on outcomes for her or her child as they had very little to no contact in that time period. A number of visits were made to her home and she was not there.

There was no alert or investigation about where she might be or her safeguarding and the safeguarding of her unborn child.

Although Gemma did not want to have on going involvement from the Leaving Care Team, it was incumbent on the Leaving Care workers to ensure her safety and well-being and the health and safety of her unborn.

Useful links:

1. www.gscb.org.uk
2. Injuries in Non Mobile Infants Protocol

The test often used here is that of a responsible parent i.e. as a corporate parent. The corporate parent would not have allowed their child to have been out of contact when she gave birth. She only came to the attention of the Leaving Care Team when Gareth sustained significant injuries in the care of his parents.

Gemma was visited regularly and there was clear and focussed work on ensuring that she had support to remain in her home.

A month's rent was paid by the Local Authority to avoid an eviction

However, there were other risks that she was not supported with. Case records and records indicate that she was firstly 'good with money'. However, she had not managed the rental arears and she was not able to negotiate to pay rent. It is not clear what work was carried out with her to support her to learn skills in negotiating arears etc.

The second concern was in respect of Gemma's relationship with her partner John. The relationship is recorded as being 'on and off'. When she was 6 months pregnant, she informed the worker that she has 'broken up' with him and she had also lost her private accommodation.

The relationship had not been fully explored with her in terms of relationship support and advice. Gemma reports that the relationship is 'tricky'. This had not been discussed with her in detail, nor had it been assessed as to the meaning of 'tricky'. Records suggest that John gets 'frustrated and depressed' because he did not have a job. How did this play out in the relationship and how did it manifest itself towards Gemma if at all? The G.P surgery informed the auditor that Gemma always came to appointments with John and they had not seen her on her own. This could have been explored further – that is, whether there was any coercive control.

The Pre-Birth Protocol was not followed. Using the pre-birth assessment could have highlighted that Gemma had a number of risk factors that could have been identified: social history of abuse, experience of care, poor housing and at 6 months pregnant being evicted and she had an unstable relationship that was 'on and off' with John.

There was insufficient professional curiosity about the relationship between Gemma and John. Their relationship was important in respect of safeguarding Gareth.

Subsequent recordings note that Gemma was not at home when workers visited and she was not answering text messages. When she gave birth on 29th September 2018, the Leaving Care Team did not know where she was or that she had given birth.

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SCR Findings

1: GSCE (Gloucestershire Safeguarding Children Executive) to monitor the implementation plan for revised pre-birth protocols across agencies including further audit of purposive sample of vulnerable young parents including care leavers

2: Leadership team within Children's Services to appraise effectiveness of the improvement plans currently being implemented in the leaving care service (now being managed exclusively by the Local Authority)

3: Leaving care service to develop and revise supervision policy to ensure supervision not only takes place but offers sufficient guidance and challenge for practitioners

4: Training for all staff regarding pre-birth assessments and when working with care leavers

5: GSCE (Gloucestershire Safeguarding Children Executive) to prioritise identifying and working with invisible family members in training and practice development activity

6: Children's Services to look at how early help services can work with the leaving care services to ensure that robust early help assessments and plans are implemented. These plans should be framed in such a way that their purpose is to provide greater support for care leavers who become parents

7: The midwifery service to review recording systems and provide appropriate training to ensure that necessary detail is captured in case records

8: Findings of this review to be shared and to contribute to wider debates regarding how services respond to vulnerable adolescents and the meaning of the corporate parent to young people who have left care

9: Leaving care service to develop links with housing advice agencies and providers regarding the young people who may come into contact with their services

Research and practice shows that young people who have been looked after will have the best chance of success as adults if those providing transitional care and other support take the following principles into account in talking to the young person and when making any decision:

- Is this good enough for my own child?
- Providing a second chance if things don't go as expected;
- Is this tailored to their individual needs, particularly if they are more vulnerable than other young people?"

Volume 3: planning Transition to Adulthood for Care Leavers 2011

Useful links:

1. www.gscb.org.uk
2. Injuries in Non Mobile Infants Protocol