Child R

01 Background

Child R was born at home, unexpectedly, at full term; his mother hadn't recognised that she had gone into labour. Child R's mother had a learning disability and lived independently; she was receiving support from Early Help, Learning Disability services and Midwifery services. Child R's mother was also supported by her mother, boyfriend and Aunt; both mother and boyfriend were staying with her at the time of Child R's birth. After birth, Child R was taken to hospital and diagnosed as having suffered irreversible brain damage; he remained critically ill and died 8 days later.

02 Safeguarding Concerns

Child R's mother was assessed to have a moderate learning disability; she had attended a specialist educational establishment and had a statement for special educational needs. Her vulnerability was acknowledged by professionals and she had been the victim of serious crime on 3 occasions. Child R's mother was referred into the Public Service Hub by midwifery for a pre-birth assessment due to concerns around her parenting capacity; she engaged well with support but was anxious about the pregnancy. Child R's mother's boyfriend was eager to take on a parenting role for Child R but had his own vulnerabilities; he had a history of substance misuse and self-harm, epilepsy, attempted suicide and mental health issues.

03 The Incident

Child R was born at home; his mother had not realised she was in labour. Child R's mother's boyfriend and mother were present, but had also not recognised that she was in labour. Paramedics were called but Child R was already partly delivered; there were further complications during birth. Child R didn't show any signs of life and there were indications he'd been in distress during birth; he was transferred to intensive care. Child R was diagnosed with irreversible brain damage and passed away 8 days later.

04 The Review

The Review looked at:

Historical context and insight into mother's cognition and **vulnerability. Safeguarding practice** during the antenatal period including how mother's learning disability was assessed and accounted for in relation to delivery and post birth. How potential neglect and risk of harm to the baby was assessed. Assessment of wider **family support**. Professionals understanding of the **pre-birth assessment** process including scrutiny of the request for assessment, and a review of **PSH response**. Scrutiny of practice after allocation, and the **CAF process.**

05 The Findings

Agencies did not recognise the full extent of the mother and her boyfriend's **learning disability and vulnerabilities**, and were too optimistic of their parenting capacity and support of wider family. **Lots of positive support** to prepare for parenthood was provided but agencies did not **assess and manage the potential risk** to the child once born. The allocation of the case and pre-birth assessment to the Early Help Service instead of as a Child in Need within Children's Social Care further reinforced this. GP was not involved in **partnership arrangements**, despite having a wealth of knowledge into mother's history. This would have enhanced the assessment process and highlighted the need for **historical multi-agency information** to be gathered as part of the assessment process. The mother felt overwhelmed with the level of appointments and didn't fully understand all of the messages that were communicated to her.

06 Recommendations

Pre-birth assessment/planning should be based on **realistic expectations of parenting capacity**; specialist learning disability services should be involved where necessary. All agencies should be aware of, and adhere to, the **GM Safeguarding Procedures** in relation to pre-birth assessments and **challenge** other professionals where those standards are not adhered to. Services need to assess, and be more responsive to, the **parents cognitive ability** and consider the most appropriate means of **communication** and ways of verifying their understanding. This may include the use of **advocacy and visual learning aids** with parents with learning disabilities. Use **chronologies** to inform assessments when there are safeguarding concerns.

07 Implementing Change

1. Reflect on the findings and discuss the implications for your service/practice.

2. Outline the steps you and your team will take to improve practice in line with the recommendations.

Tameside Safeguarding Children Board

Child R - Action Plan

Name of Organisation .....

Team Manager .....

Name of Section & Team .....

Contact Details .....

Identify the learning or recommendations that are relevant to your team and summarise your teams' discussion on those points

1.

2.

3.

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Please ensure you keep a copy of this discussion and plan for your records. Tameside Safeguarding Children Board will ask teams to provide evidence of the discussion, agreed actions and for evidence of improvements to practice.

Child R - Action Plan

What actions have been agreed to improve practice?

What needs to happen?	Who will do it?	By When?	How will you know when it has been done?	How will you know if it has worked?

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