Child Safeguarding Practice Review Briefing – baby with a non-accidental injury & parental mental health

Learning - Professional curiosity, child focussed risk-assessments, multi-agency response

A Child Safeguarding Practice Review (CSPR) is undertaken when a child dies or is seriously injured where it was known or suspected that the child suffered from abuse or neglect. This briefing has been produced following a case where a baby suffered significant harm Calderdale in 2020 from suspected non-accidental injury.

The briefing summarises and highlights key learning points from the case, and is aimed at front line practitioners, managers and organisational leads. The briefing focusses on the way in which organisations and professionals worked together to protect the child, and includes positive practice, lessons learned and how services can further improve.

For information visit www.calderdale-safeguarding.co.uk

What was the story?

Over the 2 years prior to the birth of this baby there were reports of domestic abuse and a lack of clarity around where an older half sibling was living. Equally father's mental health condition fluctuated significantly and mother suffered a miscarriage and then went on to deliver her second child, this child was subject to a Child in Need (CIN) plan from birth. Due to a lack of progress on this plan, a number of injuries being noted to the child, and fathers deteriorating mental health a further assessment was completed by Children Social Care when mother was pregnant with this baby. Both children were subject to a CIN plan when this baby was presented to A & E with symptoms of a seizure and was found to have sustained a significant head injury.

Background:

Throughout the period under review, police received numerous reports of domestic abuse and disturbances. Father was arrested but mother did not support any prosecution and often denied any abuse had taken place.
Father was referred to Community Mental Health Services in August 2018 after reporting hearing voices, suffering anger and emotional control problems. He was found to suffer from a disorder different to autism and ADHD.

When mother was 9 weeks pregnant, she made a 999 call reporting assault by father, she discontinued the call and did not repeat the allegation to police when they arrived. Three months later father reported to a psychiatrist that he was having paranoid thoughts, auditory hallucinations, including being told to stab mother, he left the house to protect her and was reported to be drinking heavily. He was diagnosed with personality disorder and disorders linked to multiple drug use and prescribed medication. However, there was another domestic abuse report of father making threats towards mother, including to knock the unborn baby out of her, she declined to prosecute and the case was referred to the Domestic Abuse Hub. Children's social care agreed to conduct a single assessment regarding the unborn child. A further discussion was held at the Specialist Midwifery Panel and referred to the Early Intervention Midwife. Following social care assessment, Mother reluctantly agreed to work with family support. The CIN plan focused on risks from domestic abuse, father's mental health and lack of engagement. When her second child was born and she was then pregnant with her third (this baby) her engagement was poor, father stopped taking psychiatric medication and he began hearing voices again.

Concerns continued and ultimately the baby was taken to A & E by parents with seizure symptoms and a significant head injury identified and deemed non-accidental.

Overview and Analysis

Strengths and Protective Factors

Called police / services in crisis

Nursery placement

Grandparent reporting concerns

Consistency of midwifery

FIT worker engaged with the family

Father was referred to Adult Social care following the domestic abuse incident

Complicating Factors

Lack of referrals into the Domestic Abuse Hub meant the true picture in the home was distorted

COVID restrictions limited extended family giving support and reduced face-to-face contact with professionals, particularly mental health

Hospital paediatric systems do not alert to CIN plans

Inconsistent engagement with Mental Health and substance misuse services

Risk/Harm/Danger

Domestic Abuse by father caused risks to the children in the house and emotional and physical harm to mother

Parents lack of honesty with professionals and poor progress of the CIN plan limited the amount of effective support for the children

Fathers' unstable mental health and substance misuse made the home an unsafe environment

Delays in responding to escalating risk and social worker involvement

Domestic abuse risks assessments were not consistently completed by all professionals

Third child started to reside with mum and stepfather when baby was born and during COVID

Impact of the arrival of another baby in the household exacerbated by COVID lockdown

Voice of the Child

Insufficient attention was given to understanding the 'Day in the Life' of any of the children.

Grey Areas

Lack of understanding of the relationships with grandparents

Cause of injuries to second child

Parental motivation

Lack of understanding as to why the eldest child resided with grandparents

Analysis

Professional curiosity, disguised compliance, lack of challenge, manipulative engagement

Toxic trio

Professional disputes

Over optimism at parental engagement with CIN and FIT

Lack of response to escalating MH

No access visits, untruths and stopped meds

Learning for Professionals and Multi-Agency Working

- Professionals need to be aware of coercion, control, and know how to complete or contribute to Domestic Abuse, Stalking & Honour Based Violence (DASH) Risk Assessments
- Learning from the Myth of Invisible Men report needs to be considered by each organisation and its impact on practice & multi-agency working
- Professional Curiosity and Challenge should be embedded in practice and risk assessments
- Assessments should be child focussed and the impact of the birth of a second or subsequent child should be considered as a potential risk area through pre-birth assessment.
- Development and improvement of communication and integration between child services and adult services needs to include response to parental domestic abuse, mental ill-health and substance misuse.
- Escalation pathways for increased risk need to be clear and in effect for all agencies
- The 'Day in the Life' tool or similar should be used to see from the child's perspective, and to monitor progress or inaction
- Where parents don't engage with services, it may mean that a child's needs are not being met or that risk is increasing; professionals need to be proactive, and ensure actions meet the Childs Timescale (i.e. it is safe for the child to remain in the family). Pathway and Letter for Engaging Hostile and Resistant Families and Was Not Brought guidance can be used

For more information about Child Safeguarding Practice Reviews visit:

https://safeguarding.calderdale.gov.uk/professionals/training-and-development/child-practice-review/