Learning Lessons - a Child Safeguarding Practice Review (Rapid Time)

Non-accidental injury to a baby–New born, parental mental ill-health, substance abuse

Learning–missed appointments, professional curiosity, information recording, parenting assessment, how to cope with infant crying (ICON)

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.The review in rapid time aimed to identify systems issues that impact on practitioners in undertaking timely, personalised and effective safeguarding.

This briefing has been produced following a case where a very young baby suffered significant harm Calderdale in 2022 from suspected non-accidental injuries.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?

Mum's pregnancy was identified to be a high risk due to raised Body Mass Index and a family history of diabetes. Both parents suffered with anxiety and depression and during pregnancy mum stopped her medication. Mum experienced a 'normal' delivery however baby transferred to the Neonatal Unit due to respiratory distress for 3 weeks before being discharged home. Mum was referred to the Peri-natal Mental Health Team. The Health Visiting team had made 3 unsuccessful attempts to see mum prior to or after baby's birth.
The baby was under 7 weeks old when brought to the Emergency Department and found to have significant injuries. The baby survived these injuries.

Recommendations.

Recommendation 1

Senior staff within health visiting service to ensure that all Health Visitors are familiar with the stepped approach to ineffective home visits in PHEYS Standard Operating procedures.

Attempts from the Health Visitor to see mum prior to the baby's birth were unsuccessful, whilst not unusual it is believed that following the procedure would have led to a wider discussion with General Practice and Midwifery services. The review exposed concerns around Health Visitor workloads, but also praised the service for maintaining support through antenatal visits.

Recommendation 2

That senior staff within the acute trust monitor and review the current Neo Natal Unit (NNU) ICON action plan

The review identified a reliance on Health Visiting Services for delivering the ICON (Babys Cry, You Can Cope) and that it was not fully embedded in the unit. The NNU record keeping system did not support staff to undertake parenting assessment work in a structured way. The review applauded Calderdale for adopting ICON.

Recommendation 3

The Safeguarding Children Partnership (SCP) reinforce the message to all universal and specialist services working with parents the continued vulnerability of babies under one.

As the baby neared discharge parents reportedly struggled to visit baby every day due to lack of funds thus indicating financial hardship. Considering this together with being first time parents and both suffering from anxiety and depression, opportunities to identify wider family issues were missed. Mum and baby were seen 3 days after discharge at midwifery clinic but then the next professional to see baby was on attendance at Emergency Department 3 weeks later. A collective approach around 'Think Family' would be a positive way forward.

Recommendation 4

The SCP to consider based on the information in this review and the work around 'The myth of the invisible men' whether any additional work is required.

Mum was referred to Perinatal Mental Health Team and reported 'good support' from her partner, however without exploring information about him he was assumed to be a supportive and protective factor. Mums partner was experiencing increased anxiety, but there are no links made to him being a new father. There was a failure to make reasonable enquiries into mum's partner, family status and link information on health records even after the safeguarding inquiry about baby's injuries he was seen as a single man.

Recommendation 5

That the named GP for Safeguarding in Calderdale keep the SCP appraised of the work around recording children's safeguarding issues in father's records and whether e-consult is safe for young infants.

Mum used the online GP service about concerns regarding baby's persistent crying and her worsening mental health. A face to face review was arranged by the GP however mum attended without the baby, but her mental health medication was increased and a referral made to Perinatal Mental health Team.

She used the online service again 2 weeks later to report baby having a blocked nose effecting his feeding, the following day baby was seen at the Emergency Department with significant injuries. Both parents were able to navigate health systems and seek support for their mental health if they chose.

Learning for Professionals and Multi-Agency Working

- Learning from the Myth of Invisible Men report needs to be considered by each organisation and its impact on practice & multi-agency working Hidden-Men. Assessments must consider all the people significant in the child's life.
- Development and improvement of communication and integration between child services and adult services needs to include response to parental mental ill-health and substance misuse and parenting assessments.
- Think Family agenda recognises and promotes the importance of a whole family approach, built on the principles of "Reaching out: think Family" Think Family SCIE guide
- The ICON (I can cope with crying – prevention of shaken babies) roll out to health partners to be audited to understand how well embedded this is. ICON to be further enhanced by wider dissemination to all multi-agencies across the partnership ICON
- Practitioners and managers are encouraged to source the new national information sharing guidance when it becomes available, in the meantime the West Yorkshire Information Sharing (proceduresonline.com) should be used.
- West Yorkshire Consortium Inter Agency Safeguarding and Child Protection Procedures has included a chapter on engaging with fathers, male partners or carers and other significant adults

For more information about Child Safeguarding Practice Reviews visit:

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