THINGS YOU SHOULD KNOW

SSCP Learning Bulletin "Things You Should Know"
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In this issue:

Safeguarding infants is the theme for this issue. The summary of two **case reviews** is on pages 2-3, and a reminder of useful **resources** is on pages 4-5. Different professionals share their views on how we safeguard infants on pages 6-10.

Read on for an excerpt from the **National Panel's first annual report** which identifies themes arising from Child Safeguarding Practice Reviews.

The Child Safeguarding Practice Review Panel: First Annual Report
Section 68-69—the full report is available online

A review of non-accidental injury to babies under one years old

We have been profoundly disturbed by the number of serious incidents involving the non-accidental injury of babies, often resulting in their death or life-long impairment. The level of violence involved, sometimes over a protracted period, is shocking. 27% of serious incidents notified and for which we have a rapid review, involved the non-accidental injury of a baby under 12 months old. Out of 144 rapid reviews 30 reported babies had died and 114 babies survived. However, it is often the case that those who survived did so not because the serious incident was necessarily less violent, but because of the sophistication and speed of medical intervention.

Most often the perpetrators were parents or their partners, other family members or carers. Whilst some families had no involvement with the police or children's social care, other families were well known. 16 rapid reviews reported babies who were subject to a child protection plan at the time they were seriously harmed or died. Perpetrators were often very young parents with minimal social support. Disturbingly, a small number of perpetrators had been previously convicted of serious violence or had their previous children removed because of physical abuse.

For all these reasons, and because we think it will be a matter of public concern, we have decided to focus predominately on this as an area of practice for 2020. We are commissioning a literature review and reviewers to handle the fieldwork discussions with practitioners involved in the selected cases. The review will focus strongly on the motivation and behaviours of male perpetrators. We may decide to undertake further reviews in this area, either to look at related themes, or to undertake a forensic look at an incident.

HM Government, 2020

Somerset Safeguarding Children Partnership

CASE REVIEW "AVA"
5-STEP BRIEFING

1. The Background

Ava is a twin, born prematurely to a young mother. Ava's parents were not in a relationship.

2. Safeguarding concerns prior to the incident

The Young Parent Health Visitor made a referral to Children's Social Care when the twins were a few weeks old, father was said to be 'controlling' and he disregarded medical advice regarding care of the babies. Mother was known to be vulnerable with little family support.

3. The Incident

Ava (then 8 months old) had a period of inconsolable crying followed by an episode of being vacant and unresponsive, and this happened on two consecutive days. Ava's mother called the emergency services and the twins were taken to hospital. An urgent CT scan showed Ava had a head injury—non accidental injury was the likely cause.

4. The Review

Ava's case was referred by the named nurse, and a rapid review took place. The rapid review established that the criteria for a serious case review was not met.
As there were obvious similarities between this case and other Somerset reviews, a desktop review of the case took place to ensure the features of the case were understood and acted upon.

5. Findings

The risk factors identified in the desktop review included:

- Ava's mother was a young, single parent, with little family support
- Twin babies, who were premature with significant health needs
- Complex relationship between the parents, domestic abuse
- Controlling father, who acted against medical advice
- Head circumference was incorrectly recorded. This is a vital measurement to record correctly because it helps to indicate if the baby is thriving or not, and can be an indicator of a bleed on the brain..

6. What we learned from this review

- This case echoes findings from the **Family A Serious Case Review**, and other learning reviews. Robust pre-birth planning was needed.
- The SSCP is committed to promoting the safeguarding of infants across the partnership and asks all agencies to raise awareness of the issues identified, and resources available—see pages 4-5.

CASE REVIEW: "OLIVER"
6-STEP BRIEFING

1. The Background

Oliver is the youngest child, living with his father and mother in Somerset. There are three children under three in the household.

2. Safeguarding concerns prior to the incident

Oliver's mother has learning difficulties and has carers coming into the house, these carers had concerns that the children were experiencing neglect. When Oliver was a few weeks old, the health visitor noted the home circumstances were very poor and made a child protection referral. The three children had a child protection medical, and became designated as children in need. Team Around the Child (TAC) meetings were held. The middle sibling had evidence of biting / scratches which the parents said was caused by the older sibling. There was also evidence of poor supervision and hygiene in the home, for example, father sweeping food up in the lounge and the older siblings eating the food from the pile on the floor—this happened during a professional's visit.

3. The Incident

One of the carers noted that Oliver had a bruise which was not explained. Oliver had investigations at hospital and was found to have non-accidental head trauma.

4. The Review

Oliver's case was referred to the SSCP Learning and Improvement subgroup by a hospital's named doctor for child protection. The case did not meet the threshold for a serious case review so a desktop review was held.

5. The Findings

- The TAC meetings were ineffective; and action plans made were not SMART.
- There were lost opportunities to assess the children—for example, for checking and recording head circumference, and to ensure that bruises on non-mobile babies are taken very seriously:

  "If they don't cruise, they don't bruise".
- Parenting work was insufficient, extended observations in the family home were needed to clarify the level of risk from the reported lack of supervision.

6. What we learned from this review

- This case echoes findings from **Family A Serious Case Review**, and other learning reviews—signs of neglect, ineffective TAC meetings.
- The SSCP is committed to promoting the safeguarding of infants across the partnership and asks all agencies to raise awareness of the issues identified, and resources available—see pages 4-5.

Resources—working with infants

Pre-birth planning

The antenatal period gives a great opportunity to work with families and improve outcomes for children. You will find the relevant chapter of the **South West Child Protection Procedures (SWCPP)** and the Somerset **Pre-birth planning toolkit** at www.sscb.safeguardingsomerset.org.uk/prebirth

Team Around the Family Meetings (TAF)

To embed the holistic partnership approach to early help, Team around the Child (TAC) will now be called **Team around the Family (TAF)**, to support early help ways of working.

The **step up step down protocol** describes the application of 'Step Up' and 'Step Down' mechanisms across Somerset to ensure a seamless journey for children, young people and their families through services. The protocol is available at:

https://sscb.safeguardingsomerset.org.uk/download/3668/

Recognising and responding to neglect

Helpful resources for recognising and responding to neglect can be found are together on a **new webpage** on the SSCP website.

A link to the **relevant chapter of the SWCPP** is given, together with local resources such as the **Somerset Neglect Toolkit**, **training package**, and details of a relevant **Serious Case Review**.

www.sscb.safeguardingsomerset.org.uk/neglect

Learning from Case Reviews

This **brief presentation** gives an overview of the learning from the cases of **Oliver** and **Ava**—see pages 2—3 of this learning bulletin.

(Presentation opens from the SSCP website)

Crying babies

During this challenging time, stress levels at home may be increased and it is important to support families to find **ways to cope with a crying baby**. Infant crying is normal, and it will stop! Babies start to cry more frequently from around two weeks of age. After about eight weeks of age, babies start to cry less each week.

It's okay for parents and carers to walk away if they have checked that baby is safe and the crying is getting to them. **Never, ever shake or hurt the baby** - it can cause lasting brain damage or death.
The **ICON** guidance for coping with crying:

I Infant crying is normal
C Comforting methods can help
O It's OK to walk away
N Never, ever shake your baby

Safer sleep

Berkshire NHS has produced an excellent **video about safer sleeping**, featuring the London Irish Rugby Club. The video can be accessed at:

https://liftthebaby.org.uk/

Remember to promote the key messages:
Never share a bed or fall asleep anywhere with your baby if you have been drinking alcohol, if you take drugs, or you're a smoker.
The safest place for your baby to sleep for the first six months is in a cot in the same room as you.

Safeguarding infants

Safeguarding infants is key as they are vulnerable by the sheer nature of their age and being dependent on others to meet their needs and keep them safe. They are not able to voice their feelings and worries.

As social workers we have a statutory role where there are significant safeguarding concerns for the welfare and safety of a unborn baby and post-birth. Social workers have a key role in assessing risk and supporting families to enable children to remain within their families.

Pre-birth planning is a very important factor when looking at unborn babies and ensuring risks are managed post-birth. Our practice needs to include good multi-agency working, reviewing the history and being curious and tenacious in our practice to ensure a full picture of the family is obtained and importantly understood.

Key Messages

- Be curious - ask questions in your direct work with parents and of professionals involved.
- Don't see incidents in isolation, consider the history and how that impacts on the level of risk.
- Remain focused on the needs and safety of the child, this can be hard if there are lots of diverting factors and constant changes within a family and the level of risk can change very quickly.

Cathy Jones
Operations Manager, Taunton and West Somerset

Don't forget the babies

Small babies are by far the most vulnerable members of society as they are:

- the most dependent for every need,
- the least able to speak for themselves,
- the most likely to get murdered or suffer life-changing injuries,
- long-term neglect of their physical and emotional needs will stunt their development permanently,
- they may also be sexually abused, but least able to disclose what is happening to them.

Therefore as professionals, these highly vulnerable people need our support in two ways. Firstly, their parents and carers need support and education so they can fulfil their role in nurturing babies. Secondly, we need to be really swift and decisive in detecting when the nurturing system is failing, either to remedy through support or to recognise really quickly when this is not enough and be prepared to save the baby by removing to a safe environment.

So, all professionals need to keep developmental milestones in mind: when do babies roll over (and off surfaces)? At what age is it reasonable for them to break their legs accidently? And what about their social development? They will then be alert to why even a tiny bruise on a non-mobile baby is a red flag sign, but equally less likely to be judgemental about a newly-running toddler with a leg fracture. They will be correctly worried about a lack of response and cheery engagement in a six-month old baby but not surprised when a year old toddler struggles with separation.

A bruise on a small baby ALWAYS needs an expert evaluation, and the history is key – is it vague, does it change and improve over time? When someone really drops a baby they are devastated and remember every tiny detail. So often a really major fatal or life-changing inflicted injury to a baby is preceded with minor ones – and this is an opportunity to save a life.

There is always expert advice available from Safeguarding Teams and Designated Professionals and out of hours from paediatricians on call. Even should the apparent injury turn out to have a rare medical explanation it still needs expert evaluation.

So concerned are the National Panel that little babies are still top of the list of killed and injured children and that not much seems to have changed when 'battered babies' were first described in the 60s, that babies are the theme for this year's work. Let no Somerset baby be one of the subjects for enquiry.

Tamsyn Nicole, Designated Doctor, Somerset CCG

Role of the Health Visitor in safeguarding young babies

Health Visitors deliver the 0-5 years section of the national Healthy Child Programme. They offer universal and targeted services in pregnancy and through the first five years of life to all families, with the aim of supporting and empowering parents to promote the best outcomes for their children.

The first contact usually begins with a holistic assessment of the family's health and well-being needs in the antenatal period in the home environment (Covid-19 has interrupted this although virtual visits remain a priority). Pregnancy is a key time in the early identification of health needs. Health Visitors work closely with Midwives during this period where concerns are raised, and will support an Early Help Assessment where required and be part of the pre-birth and the discharge planning meetings.

The maltreatment of children is a major public health problem which impacts significantly on the health and well-being of individuals in childhood and beyond. Prevention and Early Help are key principles in preventing maternal perinatal and infant mental health problems. Emotional self-regulating begins in utero and is "hard wired" by 2 years of age, and most of a child's language and communication abilities are "hard wired" by the age of three years. Babies who experience neglect, violence or fear, abuse or stress, will be more likely to experience emotional health issues in childhood or adolescence, which can impact on all aspects of their lives going forward.

Health Visitors see almost every baby at home between 10 and 14 days post-delivery and are uniquely placed to help babies and parents start to develop the warm, trusting and secure relationships that are the foundation for healthy neurological development for babies.

In recognition of the poorer outcomes for children born to teenage parents, the Public Health Nursing Service has developed an enhanced Young Parents Service which brings together Young Parent Health Visitors, Midwives and other professionals linked with the young parent.

Key to any safeguarding work is good assessment, and good communication between partner agencies. The aim of the health visiting service is to try to prevent wherever possible, rather than cure.

Elizabeth Rendell
Operational Service Manager for Public Health Nursing, Area East

Midwifery's role in safeguarding infants

Midwives have an essential role in safeguarding babies. The antenatal period is a chance to "*affect great change as pregnancy and birth of a baby is a critical window of opportunity when parents are especially receptive to offers of advice and support*" (1001 Critical Days, 2015). Midwives are ideally placed to recognise and respond to any additional vulnerabilities (such as domestic abuse, substance and alcohol use, neglect) that families may be experiencing and in partnership with parents work towards reducing the impact of these on their baby. Midwives are part of a multi-agency team who work collaboratively with our partners in health, Children's Social Care (CSC) and education and the voluntary sector to safeguard children.

Key messages for staff across Somerset:

The Somerset Pre-birth Toolkit
This toolkit should be utilised by any professional working with a pregnant woman and her family. The toolkit provides a link to the **Pre-birth Protocol** which clearly sets out which families may require Early Help and which families must be referred to Children's Social Care. The toolkit also provides essential guidance around what to do should your request for support (from either CSC or FIS) be declined.

Professional liaison
Sharing safeguarding information with professionals working with a family is crucial. It is essential that all professionals are aware of everyone's concerns so that these can be reviewed collectively and a robust plan of care to the support the family created. This is a key principle in the linked professional groups and absolutely crucial during this time of 'lockdown' when vulnerable children are less visible.

Dawn Sherry
Named Midwife for Safeguarding for Somerset NHSFT and Yeovil District Hospital NHSFT

Working across local authority areas

Work is ongoing at a regional level to support working between local areas through the Avon and Somerset Strategic Safeguarding Partnership, exploring efficiencies and regional links. Recent learning in Somerset has reinforced the need for communication with establishments outside the county, particularly where babies are involved.

It's worth remembering that where babies are born outside Somerset and you are picking up concerns, making contact with maternity services in other areas is advisable. There is also an expectation that concerns are shared with Somerset as they arise. Contact details for the Royal United Hospital in Bath maternity services and St Michael's Hospital in Bristol are below:

Royal United Hospital (Bath): 01225 428331
St Michael's Hospital (Bristol): 0117 342 5325

Caroline Dowson
Business Manager, SSCP

Contact the SSCP!

Please note our **new** email address: SSCP@somerset.gov.uk.
The SSCP has a circulation list to send alerts when new newsletters or learning bulletins are published. If you do not currently receive these alerts and would like to sign up to the list, visit our website sscb.safeguardingsomerset.org.uk