Local Child Safeguarding Practice Review – Babies with Injuries

Independent Author

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1. Introduction to the review

1.1 This review was undertaken to consider systems and practice within and between partner agencies in Swindon, specifically with regard to the assessment and safeguarding of infants prior to and following a non-accidental injury.

1.2 In order to identify learning and consider the need for improvement action, the review reflected on the learning identified in recent rapid review meetings[1] and whether there was additional learning following further consideration of these cases. It also considered changes made following these rapid reviews and other learning locally that has led to improvement action, to consider the current position.

2. Process

The review was commissioned following rapid review processes[2] that were undertaken on three babies in Swindon. Single agency learning was identified and improvement actions were agreed as part of this process. The Independent Chair/Scrutineer of the Swindon Safeguarding Partnership considered the cases and consulted with the national Child Safeguarding Practice Review Panel. It was agreed that a review be held to consider whether any further lessons could be learnt regarding the way that agencies work together to safeguard babies in Swindon[3]. An independent lead reviewer was commissioned to undertake the review[4].

The lead reviewer was given access to the rapid review information and was asked to seek updates on improvement actions taken since the meetings were held. A questionnaire was sent to those who had made recommendations and this report considers the progress made.

In 2020, a multiagency audit was undertaken by the partnership, which considered cases where safeguarding concerns had been identified during pregnancy, in order to consider the impact of the Swindon Unborn Baby Protocol[1] on the safeguarding of unborn babies. The lead reviewer also considered the relevant learning from the audit.

In order to consider what happened during the professional involvement with the families of the babies considered by the three rapid reviews held, the lead reviewer arranged consultation meetings with the professionals involved at the time. The meetings involved discussions about practice and systems learning from these cases.

[1] In all of the three cases, the babies had suffered fractures.
[2] A rapid review is undertaken in order to ascertain whether a Local Child Safeguarding Practice Review is appropriate, or whether the case may raise issues which are complex or of national importance and if a national review may be appropriate. The decision is then made along with the national **Child Safeguarding Practice** Review **Panel.**
[3] It was agreed that this learning review would be undertaken rather than individual child safeguarding practice reviews after consultation with the National Child Safeguarding Practice Panel in July 2020.
[4] Nicki Pettitt is an experienced safeguarding professional/lead reviewer. She is entirely independent of SSP and partner agencies.

The families of the three children were invited to meet with the lead reviewer to discuss their experience of the professional involvement with their families, with the aim of identifying any additional learning. Only the parents of Child 3 accepted and they were spoken to during the course of the review. Their engagement with the process was helpful and appreciated.

In respect of the cases considered, details of personal family information are disclosed in this report where it is essential to the learning established during the review. This is a proportional response as the review was held to consider wider practice and systems, using these three children to provide examples.

3. The children considered by the review

Child 1 was a nine-week-old baby who was found to have a number of fractures that appear to be non-accidental and from more than one incident. Prior to the fractures being identified there were a number of professional contacts with the child and family, and on one occasion an unspecific mark was seen on the babies neck and the mother reported to the professional that she had previously noticed other marks which had cleared up quickly, including to the abdomen and arms. The baby was safeguarded and has made a full recovery.

Child 2 was a seven-week-old baby with a number of fractures, thought to be non-accidental. There were no concerns for the baby or its sibling prior to the incident, however the baby was seen at the hospital emergency department with a reported BRUE (Brief Resolved Unexplained Event) where the parents stated the baby had stopped breathing for around 10 seconds, which included their lips going blue. The baby was safeguarded and is reported to be thriving.

Child 3 was an 11-week-old baby with fractures, bruising and a bite mark. The mother was known to have mental health issues and possible alcohol dependency, but there were issues about information sharing regarding these risks during the pregnancy. A number of agencies were involved pre-birth. In the days prior to the injuries being identified, there was an anonymous referral to the MASH and an appointment with an out of hours GP who saw bruising to the babies face. Child 3 has been safeguarded and is making good progress.

4. Learning from the rapid review meetings and update on improvement actions

4.1 Learning was established through a robust consideration of the cases during the rapid review meetings that were held following the injuries to the babies. There was unacceptable significant delays in two[5] of these cases being referred to the SSP for a serious incident rapid review meeting, and then in the notification to the national CSPR panel, which is considered further below. Once the process started, detailed agency chronologies were provided to the rapid review meetings, which have since been made available to the independent lead reviewer along with a record of the analysis and the views of the independent chair/scrutineer.

4.2 The rapid reviews for all three babies found a need to increase awareness of the Unborn Baby Protocol across the partnership.

4.3 In respect of Child 2 issues were identified at the rapid review meeting about the need for consideration of a review by Hospital Paediatrics into the clinical issues they have identified from this case including BRUEs. A serious incident full Root Cause Analysis (RCA) investigation was undertaken in regard to Vocares[6] involvement in the case. The report of this RCA was available to the lead reviewer. Significant learning was identified in VOCARES review in regard to the pathways used, the handover from the call handler to the clinician, information sharing at the handover, 'wellness bias[7]', the lack of a safeguarding referral, the BRUE event not being seen as a successful resuscitation, the need for more awareness of the condition laryngomalacia[8], and disparity in the audit scores. Recommendations have been made by the RCA that focus on this learning. This review will not repeat them.

4.4 Child 3's rapid review identified learning regarding;

- Child protection processes and case management across perinatal mental health services
- The response to anonymous referrals and the scope of the resulting health checks
- Information gathering and strategy discussion in the MASH including the coordination / invites / minutes of strategy discussions
- The need to consider and involve fathers

[5] In respect of Child 1 the referral was eight weeks after the incident and in the case of Child 2 it was 12 weeks. This appears to be because of some discussion between partners about the need to refer a case and operational demands.

[6] Vocare are sub-contracted to provide NHS 111 services in Swindon with hhome visiting and face to face appointments delivered by Medvivo. South West Ambulance Service provide emergency responses.

[7] This is most likely if the clinician is aware that a recent examination showed no concerns, as was the case with Child 2.

[8] Laryngomalacia literally means 'soft llarynx' and is the most common reason for noisy breathing in children.

- Improving the exercise of professional curiosity
- The impact of COVID across agencies
- Mother and baby risk assessment form was not completed at booking, this means that the midwifery safeguarding team and mental health midwife were not aware of the concerns until the 32 week perinatal mental health appointment
- Impact of maternal mental health on unborn and new born babies

Communication

4.5 Partner agencies were asked to provide responses to a questionnaire, as part of this process, asking for updates on any changes since the three rapid reviews were undertaken. All of those who agreed to make changes during the rapid review meetings provided feedback[9] and the following was found:

- A 'seven minute briefing' has been written and shared across partner agencies in respect of responding to injuries in non-mobile babies.[10] A number of agencies have confirmed that they are being proactive in using this briefing in meetings, in training and when considering cases with professionals.
- Partner agencies provided assurance that the SSP Newsletter is actively shared with all staff. The newsletter includes links to the policy on Suspected Bruising or Unexplained Injury in a child who is not independently Mobile, the 7-minute briefings, and the multi-agency child protection standards published in April 2020[11].
- A resource pack has been written regarding the importance of professional curiosity[12]. It is available on the SSP website and was shared across the partnership. Like the 7-minute briefing, the expectation is that the pack will used in team meetings and as part of group/individual supervision. Training on professional curiosity will also be part of the SSP's new learning & development offer.
- The SSP is currently undertaking an audit of strategy discussions held on babies under one year. The key themes identified in the rapid reviews of the three babies have provided the focus for the audit.

[9] All of the individual responses to be shared with the SSP PRG.

[10] https://safeguardingpartnership.swindon.gov.uk/downloads/file/550/7_minute_brief_-_suspected_injuries_in_non_mobile_babies

[11] The standards outline the expectations of agencies and professionals who work with children who require a statutory child protection response. https://safeguardingpartnership.swindon.gov.uk/downloads/file/423/multi-agency_standards_for_safeguarding_children_2020

[12] https://safeguardingpartnership.swindon.gov.uk/downloads/file/554/ssp_resource_pack_professional_curiosity

- Members of staff across community health services are completing the Level 4 supervision course, which will have a positive impact on safeguarding supervision to the relevant professionals.

- The Swindon Safeguarding Partnership Policy and Procedures group provided assurance that they are in the process of reviewing the following:

- Guidance for health professional's attending/contribution to strategy discussions

- Policy on Suspected Bruising or Unexplained Injury in a child who is not independently Mobile

- Unborn baby protocol

- Multi-Agency Standards for Safeguarding Children

- The MASH and EDS are aware of the SSP review of guidance that aims to ensure that health professional's attend and meaningfully contribute to strategy discussions, and the expectation that practice improves in this area. (A recommendation from this review is included concerning this issue.)

- The Named Nurses at GWH and the professional lead for School Nursing have reviewed the hospital liaison form. When a child is taken to A and E, the form is completed and returned to the Named Nurse administrator who ensures that the practitioner is notified and saves the form to the child's electronic file. This form will alert if a referral has been made into MASH. A review of the impact this information sharing is being undertaken in February 2021 to ensure this process is timely and efficient. The outcome and impact will be reviewed as part of this work.

- Monthly meetings are being held between the Named Midwife in GWH, the FNP Supervisor and the Named Nurse for Safeguarding in Swindon Community Health in order to share information and monitor pregnant woman where there are known vulnerabilities and safeguarding risks.

- There is limited evidence of progress in the plan to increase and improve 'walk the floor' activities[13]. This is largely because of the on-going pandemic. Planning for this in the future requires a further focus and a recommendation is included below.

- The CP Conference team is now using the SSP Multi-agency Standards to hold partners to account in relation to their participation in conferences. This includes monitoring of attendance and the provision of reports which have been shared

[13] The Service Manager, Quality Assurance & Review Service (SBC) at GWH undertook a walk the floor exercise in Nov 2019 in both ED and Maternity and this was presented to the SSP.

with parents and are submitted in a timely way. The quality of this participation is to be considered in a multiagency audit.

- NHS 111 and Medvivo have provided updates to the review. They include:
- While COVID 19 has had an impact on their services, they also have more capacity with a large intake of new clinical staff. A plan is in place to provide training, support and oversight to these new staff, with on-going quality assurance of their work. Due to the pandemic most of the training is provided via Zoom, including inductions and higher level safeguarding training. Immediate Level 1 safeguarding training is provided face to face.
- Daily reviews of all children under 1 who come into the service are held in order to review if there are any concerns relating to NAI.
- Increased video consultations for the Out of Hours Service, with clear guidance around patients that are suitable for this service, and safeguarding is considered within this.
- They are monitoring levels of safeguarding referrals and providing targeted input and training as required. A staff survey is also being completed to consider if there are barriers to making safeguarding referrals. Noted was an issue about the difficulties in gaining feedback from CSC on the outcome of referrals made, which was shared with the CSC representative on the PRG.
- All clinicians and agencies have received written reinforcement of the non-mobile baby process/pathway.
- Non-Accidental injury audit in all under one cases currently being carried out.
- Information about non-accidental injuries has been given an increased prominence in the safeguarding material provided for 111 staff, and training is being devised with the CCG.
- All cases of injuries in children where there has been agency involvement will be discussed at the risk committee to review if there have been any missed opportunities or learning.
- A case study is being shared with staff to highlight the risks around wellness bias and the need to check concerns with social care. This will include the key findings from the RCA undertaken in regard to Child 2.
- South Western Ambulance Service undertook a campaign of raising awareness of injuries in non-mobile children. Training was delivered to all staff during their annual development day in 2018/2019 with key messages reinforced via the use of poster campaigns and articles in weekly bulletins distributed to staff.

- GWH undertook a literature review in 2018 to identify best practice/evidence for the investigation and management of BRUEs which was then discussed at the relevant peer review/consultant meetings following a previous SCR.

- A Hospital Trust consultant paediatrician is undertaking a data review of all CP medicals/skeletal surveys undertaken in past two years. This work is contributing to the Under 1's position statement group.

- Difficulties in ensuring multi-agency attendance at safeguarding discharge planning meetings was identified as an on-going issue, along with the need for the process to be managed effectively and in a timely way by CSC. While this is being challenged on an individual basis by hospital staff, particularly with social workers, this requires a wider systems consideration to include the communication of the need for such meetings to those involved in this work. This is being considered by CSC and the hospital trust outside of this review as part of the new multi-agency safeguarding group.

4.6 A rapid review process has now been embedded within the partnership and across agencies. It brings together senior leaders from the statutory partners to discuss possible Serious Incident Notifications to the national panel. This mechanism has been used successfully and in a timely manner very recently. Individual agencies have also reviewed the way that they consider if a case or incident meets the criteria for a referral for a rapid review.

4.7 A number of partner agencies have acknowledged that they are yet to be assured that the changes they have made have resulted in a positive impact on practice and ultimately for children. This requires further consideration by each agency in their on-going quality assurance and audit work. There was also feedback that agencies are not necessarily confident about how other agencies are providing a service during the on-going Covid-19 pandemic, and their belief that this needs to be communicated across agencies. This has been shared with the partnership during the review in order for a timely response.

4.8 While information was shared in the responses about partner agency's attempts to mitigate the impact of Covid-19 on their agencies work with children and families, and the existence of impact assessments, this remains an area where further work is required to consider the longer-term impact.

5. Other relevant learning considered

5.1 In 2020 a multiagency audit was undertaken by the SSP which considered cases where concerns had been identified during pregnancy in order to consider the impact of the Swindon Unborn Baby Protocol on safeguarding babies, in pregnancy and beyond,[1]. The learning from this audit was also considered during this review. The relevant points were:

- There was insufficient evidence that some professionals in agencies used the protocol and there was little evidence that it was having a positive impact.
- There needs to be more use of targeted support in pregnancy in order to prevent escalation of concerns post-birth.
- There is a need for any pre-birth assessments and other information available to be shared widely among professionals involved with a family.
- The audit found that there is good identification of needs by midwifery and prompt referral for assessment/support.
- A need for improved awareness of the impact of particular issues in pregnancy. For example if the mother is a victim of rape, parental substance misuse, or parents with a learning disability.
- Improved awareness of the voice of the child.
- Need for improved information sharing and recording.
- Insufficient staff awareness amongst some agencies and knowledge of key issues that can cause risk to unborn babies.
- Inadequate partnership working to jointly and accurately assess risk.

5.2 A number of these issues were also found in respect of the babies considered in this review.

6. Learning from meetings with professionals

6.1 The opportunity was taken to consult with professionals who had been involved with the three babies who were considered at the rapid review meetings. Those who knew the families were invited to attend an event where they were asked to reflect on the cases and others they have worked with. This process was undertaken in order to enable the partnership to understand what helps and hinders the safeguarding of babies, using these cases as examples. The professionals were asked to be open and reflective in a supportive setting and they were assured that the purpose of the review is not about blame or an investigation, but about understanding practice and systems to identify learning.

6.2 Learning was identified during and from these meetings. Those involved fed back that they found it useful to discuss the children and their involvement in a multi-agency forum with an independent facilitator in order to consider the learning from the case/s. They also reflected on the impact of being involved in a case where a child has been seriously injured and where there is the scrutiny of a review. Supporting staff at this time, particularly with the need to undertake such events using video technology is an on-going issue for partnerships during the Covid-19 pandemic.

6.3 Additional learning was gained from directly engaging with staff. The partnership needs to consider the following in order to determine if any further improvement actions are required:

- It is a reality that professionals sometimes have to make decisions about children without the benefit of wider information and background history, other than that reported by the parent/carer. In the case of Child 3 the out of hours GP did not have access to any wider health systems and was not aware of the mother's mental health history or the recent anonymous referral.

- Parents can be persuasive and it is understandable that professionals may believe them. However, these cases show that all professionals need to ensure that they are willing to consider that the parent may not be protecting their child or may have harmed them.

- Caring for a new baby can lead to increases in parental mental health issues and domestic abuse. The focus following the birth of a baby tends to be on the mother. Key advice (particularly during the COVID pandemic) on safer sleeping and safe handling tends to be provided to mothers and there is an expectation this is then shared with anyone else who will co-parent the child. This can be a risk if the information is not then shared. In the case of Child 3 both parents 'roomed in' while the baby was in SCBU however and hospital staff provided support to both, which is good practice.

- Child 3's mother did not engage with mental health professionals after the discharge from hospital. It had been a difficult birth at 35 weeks and the baby had been in the SCBU for 12 days. It is known that there can be a negative impact on bonding between parents and their child when a new baby has to spend time on SCBU. A survey completed by Bliss (an organisation for the parents of babies born sick or prematurely) in 2018 showed that most parents felt their mental health got worse after being on the neonatal unit. Professionals involved at the time were reassured by how mother appeared to be managing. A decision was made that there was no need for a discharge planning meeting of any kind as the mental health worker did not feel it was necessary. The decision was made having given consideration to both the mental health workers and the mother's view without considering the need for optimum information sharing and consideration of risk to the baby. CSC were not informed of any concerns at the time.

- The timing of Child 3's discharge coincided with the suspension of face to face visits from SCBU outreach staff, health visitors and nursery nurses in the team, and early help providers such as Baby Steps, due to COVID 19. The health visitor undertook one home visit shortly after discharge and told the review that the mother reported some mental health concerns, predominantly low level anxiety. The health visitor said that she was unaware of the discharge

notification which was sent from SCBU that stated mother had a serious mental health history, although there was evidence this was sent. The health visitor did not record her visit either in the parent held red book (due to the pandemic and caution about handling at visits) or on Capital 1, as would be expected of a new birth visit.

- Early feedback states that the pandemic has led to increased isolation for new families, and it is possible this was also an issue in the case of Child 3. It is known that the baby's father was working long hours, and that the baby's mother had serious and complex mental health issues and was not meaningfully engaging with support. There was a degree of professional optimism in regard to the support the father could provide and that the mother would seek help if she needed it. There is emerging information that parents are less confident in accessing MH support during the lockdowns linked to the COVID 19 pandemic.

- In regard to mental health following the birth of a baby, the focus tends to be on the mother. Research from the National Childbirth Trust found that more than 1 in 3 new fathers (38%) are concerned about their mental health. It states that one in 10 fathers have PND and appear more likely to suffer from depression three to six months after their baby is born. All professionals providing support to families with a new born baby need to be aware of this. Those involved in these cases acknowledged this was not something that is often considered or pursued.

- The anonymous referral into the MASH regarding Child 3 included concerning information about Mother shouting at the baby. At the time the CSC I.T system was changing from ICS to Care Director and this created capacity and recording issues in the MASH. The decision was made to ask the health visitor to go and see the family and an email was sent to them. The health visitor informed the review she did not see the email and raised issues about the number of emails received and the lack of time to read them all.[14] This is clearly is not an effective way of communicating a potentially serious issue to a professional who is required to undertake a piece of work with a family. The review has been assured that individual health visitor email addresses are no longer being used, and that regularly checked duty inbox's are being utilised and that this system is more effective.

- When a small mark was seen on Child 1's neck by the community nurse working as part of the health visiting team, she felt that mother's explanations were reasonable and did not consider that mark was a bruise that needed consideration beyond the GP appointment that she was told was being attended that afternoon. The community nurse took an additional step of

[14] The review has shared concerns about the capacity of the health visitor to fulfil her role, and the need for further consideration.

speaking to the GP surgery and left a message for the GP asking them to look at the mark as well as to consider issues to do with the babies feeding which was the original reason for the appointment being made. There is no evidence that the GP who saw the child received or considered the message. The community nurse had only received level 1 safeguarding training and wasn't aware of the policy for suspected bruising or unexplained injury in a child who is not independently mobile. When professionals with limited experience and training undertake visits this can lead to issues being missed. Arguably this also goes against the NMC code of conduct with regards to delegation.[15]

- As details of Child 1's attendances to hospital had not been shared with the health visiting service, this additional information was not available prior to the visit where the mark was seen. The rapid reviews on all three cases and the reflective events noted that there are systemic hurdles to information sharing across a number of agencies, for example between hospital/s and the health visiting service, between mental health services and midwifery, and between GPs and midwifery.

7. Learning from the discussions with family

7.1 The parents of Child 3 spoke individually to the lead reviewer and a representative of the SSP. They spoke about the experience of having a premature baby during the Covid 19 pandemic and the additional challenges this posed. The impact included limitations imposed on the support available to them from family members. They said this additional isolation had a negative impact on their mental health.

7.2 The father acknowledged he was unprepared for being a parent and that while he was shown a DVD about safe handling, more hands on support with how to manage a new baby would have been helpful. He also spoke about how hard it was to acknowledge his mental health difficulties and to ask for support, particularly when he felt that professionals expected him to be the strong one who would support his partner and safeguard his child. Child 3's mother also stated that a focus on the man in a family is crucial, and that their experience was a total focus on the mother, even when the father was present. A recommendation has been made in respect of this.

[15] Delegation - The Nursing and Midwifery Council (nmc.org.uk).

8. Conclusions and recommendations

8.1 The review has been shown evidence of a renewed focus on the response to injuries in non-mobile babies, which includes consideration of the potential significance of BRUEs, information sharing and professional curiosity. The review has received updates in regard to what has been achieved, what is on-going and what is outstanding in all relevant areas of safeguarding. This is timely as OFSTED have announced that abuse of babies has increased by a fifth during the COVID pandemic.

8.2 There has been good cooperation and engagement from agencies with this review process, which has allowed us to identify the learning. It is recognised that actions have already been taken in relation to some of the individual agencies' identified learning in this case, and that changes have been made.

8.3 The focus of the review has been on professionals being able to recognise that responding appropriately to an injury or BRUE episode with a non-mobile baby is essential to ensure that further, more serious injuries are prevented. There also needs to be a focus on supporting families to ensure that they practice safer handling of babies and understand their frailty. In January 2020 the Child Safeguarding Practice Review Panel announced that they have commissioned a new national thematic review which will look at non-accidental injury in children under one. It will be helpful to the SSP to consider the learning identified in this national review, to see what additional work they may wish to undertake.

8.4 The Child Safeguarding Practice Review Panel stated in their annual report 2018-19 that partner agencies need to think in terms of human factors when it comes to the need to share information and consider risk. They state that 'ccomplexity of practice requires sophisticated conversation, hard wired into the DNA of our child protection practitioners'. They ask 'how do we help people talk to each other within a context of high-risk, high-volume and limited resource, often when practitioners are fearful of reprisals from families, employers and society at large?' The cases considered above, like many others nationally, show that this remains one of the main challenges for Safeguarding Partnerships and professionals. The 'sophisticated conversations' required helping professionals to consider potentially difficult areas, including over-optimism, engaging resistant families, meaningfully engaging with fathers, and keeping the focus on the child.

8.5 Learning has previously been identified in the area about the need to focus on both parents, and actions are being taken. (For example following the serious case review in respect of Child G.)

8.6 Those involved in the review and the Swindon PRG agreed that the following recommendations are required, and ask that the SSP agrees and actions them.

Recommendation 1

That the SSP seeks assurance regarding attendance of the appropriate health professionals at strategy meetings, including when strategy discussions/meetings are held out of hours.

Recommendation 2

That the SSP requests feedback from all partner agencies, with clear timescales, for when they intend to reinstate or implement 'walk the floor' activities[16].

Recommendation 3

In light of the learning from these cases, and the findings of the Child Safeguarding Practice Review Panel in their annual report 2018-19 (see 8.4 above) the partnership should consider how they can encourage and support all professionals (including those working in the different areas of health) to talk to each other and collaborate, so that that all information is known and considered.

Recommendation 4

The SSP to ask all partner agencies to review their systems and practice to ensure that fathers or male partners are equally considered by their services.

[16] The feedback received from the rapid reviews clarified that this was one area where the expected progress had not been made.