Learning from Case Reviews to Support our Practice in Safeguarding Unborn Babies and Under 1s

BCSSP
Bath & North East Somerset
Community Safety & Safeguarding Partnership

Swindon Safeguarding Partnership

Wiltshire Safeguarding Vulnerable People Partnership

Aim of the workshop is to use Learning from Local and National Case Reviews to….

- Raise awareness and understanding of the increased risk to unborn babies and under 1s
- Explore key vulnerabilities in families that can increase risk and protective factors
- Hear about tools and guidance that can support you in our work with children and families

Themes from Under 1, Rapid Reviews & Child Safeguarding Practice Reviews across BSW

Domestic abuse

Unknown or unassessed fathers and other adults in a child's life

Sudden Unexpected Death in Infants SUDI in the context of known vulnerabilities

Use of cannabis by parent

Non accidental injuries

Pause for thought

National Context: Child Safeguarding Practice Review Panel

“Responsibility for how the system learns the lessons from serious child safeguarding incidents” (WT 2023)

Oversight of all statutory case reviews relating to children, including:

- Rapid Reviews
- Child Safeguarding Practice Reviews

Annual Report 2021-2022

- 32% – related to under 1s
- Non-fatal physical abuse biggest factor

Annual Report 2022-2023

- 36% (142) – related to under 1s
- 33 related to SUDI/SUDC

THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Recognising and Responding to the Vulnerability of Babies

- Understand the roles and risks pertaining to **all** adults around very young children
- Highlights issues with risk assessment and management not being effectively achieved in cases involving babies
- Exploration and recognition of contextual factors, such as parental mental health and trauma, when assessing risk
- Parental and family stressors most significant factor in escalating risk – early identification of these is critical
- Communicating with families:
    - Ensuring all parents received the same information
    - Providing information that parents could understand
    - Missed opportunities to engage with fathers as a protective factor
- Working with families who find it hard to engage
    - Difficult behaviours of fathers – unchallenged or avoided
    - Not understanding the reasons for disengagement or challenge
- Invisible men – not knowing who the babies were in contact with

Information Sharing and Gathering

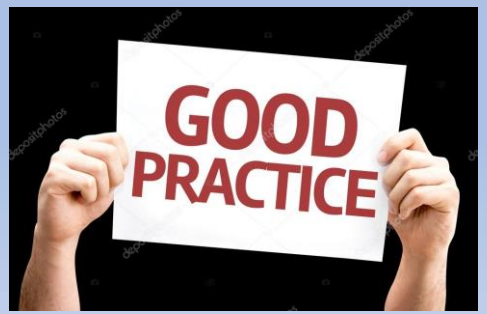
- Information sharing and gathering (within and between agencies)
- Vital information not identified or sought; information partial or inaccurate; crucial information not responded to
- Poor record keeping and documentation
    - Not clear if information gathered (particularly in relaiotn to safe sleeping)
    - Not clear who present during discussions
    - Information on fathers not included (not clear if included)
    - Paternity recorded inaccurately
- Parental information taken at face value and not challenged
- Partial information liked to insufficiently robust risk assessments
    - Missed opportunities to identify and address needs
    - Not able to fully assess parenting capacity
    - GPs not being involved in safeguarding processes
- Poor information sharing between agencies – not all cognisant fo wider risk to family
- Lack of link up between children and adult services – important information on offenders not shared
- Agencies not responding or responding differently to information from some referrers – e.g. neighbours

Good Practice and Learning

- ✓ Persistent approaches in engaging parents
- ✓ Asking questions around risk, including domestic abuse
- ✓ Successful identification of fathers, engaging accordingly and assessing risk

Learning:

- ✓ Use of genograms
- ✓ Assessments consider contextual factors (e.g. parental trauma, poverty, race, ethnicity and culture)
- ✓ Communicating safe sleeping policies



Local Picture (2021 to date)

BaNES

7 notifications to the National CSPR Panel

3 relating to under 1's & 1 relating to an under 2 year old

CSPR's relating to under 1's – Baby M

Swindon

7 notifications to the National CSPR panel

1 relating to under 1's

Published 'Babies with Injuries' in 2021as a result of 3 Rapid Reviews in relation to under 1's

Wiltshire

9 notifications to the National CSPR panel in total

6 notifications relating to under 1s

CSPRs relating to under 1s – CSPR Eva

Local Practice Themes – Case Reviews

- Professional curiosity
- Challenges of working with avoidant behaviour
- Focus on the child – understanding their lived experience
- Understanding the wider family context and network – risk and protective factors
- Information sharing, recording and gathering
- Domestic abuse/parental mental health – not recognising the wider impact
- Working with and engaging fathers

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Local Practice Themes – Audits

- **Working with fathers**
  - Limited engagement
  - Assessment - understanding the history and parenting capacity
  - Recording of information about fathers
  - Work remains focussed on mothers
- **Information sharing**
  - Gap in informing GPs of concerns
  - Triangulation of information
  - Sharing of information with health
- **Use of assessment tools**
- **Record keeping**
  - Use of and maintaining chronologies to support understanding of themes
- **Professional curiosity**
  - lack of exploration of detail to understand impact on the child and inform risk assessment

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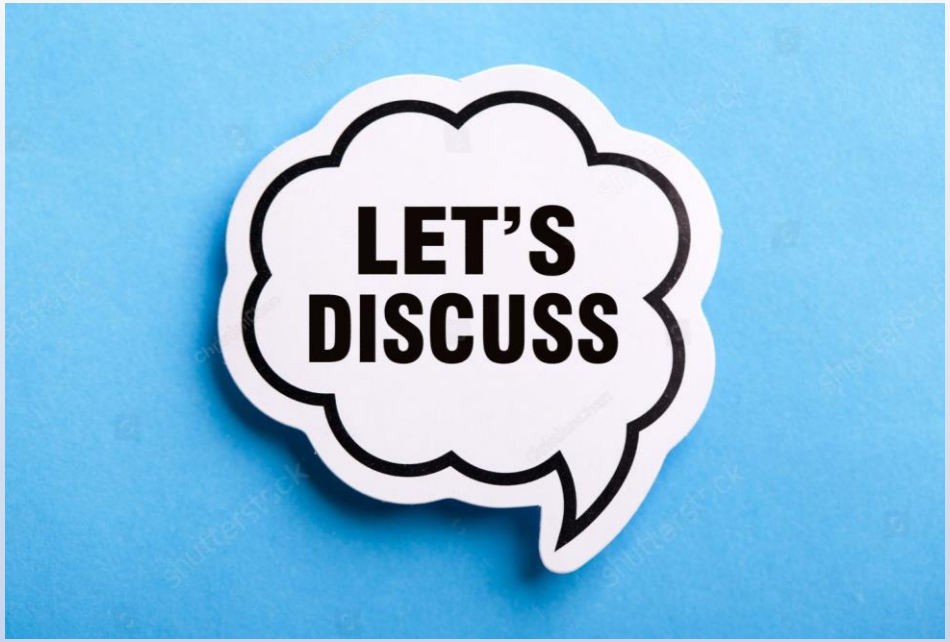

Do these themes resonate with you?

Why are these themes difficult to shift?

Tools to Support Practice

- NPSCC Grade Care Profile 2 Antenatal (Part of national pilot)
- ICON – Coping with Crying https://iconcope.org/
- DadPad - https://thedadpad.co.uk/
- Vulnerability and Protective Factors in Pregnancy and Early Parenthood resource Vulnerability_and_protective_factors_in_pregnancy_to_early_parenthood
- BSW Pre-birth Protocol BSW_bruising_in_non-mobile_infants

Bruising in Non-Mobile Babies

If they can't cruise they can't bruise

National and local case reviews have indicated that ***staff have sometimes underestimated the significance of the presence of bruising or minor injuries in children who are not independently mobile***

A bruise or injury must never be interpreted in isolation and must always be assessed in the context of medical and social history, developmental stage and explanation given for it by the parents/carer

Patterns of bruising suggestive of physical child abuse in infants include:

- Bruising or injuries in babies or children who are not independently mobile
- bruises to the face, back, abdomen, arms, buttocks, ears or hands
- multiple or clustered bruising
- imprinting and petechiae (for example pinch marks, grab marks particularly around the face)
- bleeding from the nose or mouth

http://www.wiltshirescb.org.uk/wp-content/uploads/2019/02/FINAL-Multi-agency-guidance-Bruising-and-injuries_non-mobile.pdf

- We all need to be aware of the increased vulnerability of this age group – we need a whole system response to safeguarding these children
- We should use opportunities when working with parents of unborn babies and under 1s to engage in a way that increases protective factors
- Early recognition of risk enables us to provide the right help at the right time and at the earliest opportunity
- Use relationships and contacts to reinforce key messages about safe sleeping and responding to crying