CHILD SAFEGUARDING PRACTICE THEMATIC REVIEW

NON – ACCIDENTAL INJURY & NEGLECT CHILDREN UNDER 1 YR.

INDEPENDENT AUTHOR: BRIDGET GRIFFIN

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Introduction

Cambridgeshire and Peterborough Safeguarding Children Partnership (CPSCP) were notified of four separate significant incidents involving four babies, from different families, whose ages ranged between seven – ten weeks. Four separate Rapid Reviews (RR)[1] took place in short succession where similar themes emerged about multi-agency service provision. It was concluded that one case (Child D) met the criteria for a Child Safeguarding Practice Review (CSPR), and the remaining three cases should be considered as part of this CSPR. The Child Safeguarding Practice Review Panel[2] agreed with these decisions.

Methodology

When considering the methodology for this CSPR, CPSCP were conscious of the following:

- Comprehensive multi-agency information had been shared at all the Rapid Reviews (RRs).[3]
- Analysis and appraisal by RR members of the multi-agency service provision was comprehensive.
- Significant single learning had been identified and was being actively progressed.
- Existing workstreams were progressing relevant areas of multi-agency service development.

Therefore, it was concluded that an independent reviewer (Bridget Griffin[4]) would be appointed to provide objective analysis and oversight of the learning from the individual rapid reviews, review how the learning has been progressed and identify any gaps. Relevant guidance[5] has underpinned this CSPR.

CSPR Focus: As only one of these cases met the criteria for a CSPR (Child D), the review has focussed in detail on the circumstances of this case and the services provided. The remaining three cases are referenced, where the key line of enquiry is relevant to their circumstances.

CSPR Scope: The scope of this CSPR covers the period of antenatal care up to the significant incidents. Where known, the history of the family has also been considered.

Practitioner & Family Involvement. Practitioners directly involved in providing services to the families were invited to give their perspectives, these perspectives have been included in this CSPR. In addition, during the course of this CSPR, 580 practitioners completed a survey as part of the Section11 Audit.[6] This survey included relevant questions about multi-agency work including information sharing, decision making, knowledge of (and confidence in using) the protocols referred to in this CSPR. The findings of this survey are being used to inform the work plan for CPSCP. As one case met the criteria for a CSPR, careful consideration was given to inviting family members to share their perspectives. However, due to the complex criminal and care proceedings that are ongoing it was determined that inviting mother to participate in this process would be confusing and potentially unhelpful at this time. This will be re- considered once current court processes have been finalised.

[1] After notification of a significant safeguarding incident, local safeguarding children's partnerships may decide to convene a Rapid Review (RR). The core functions of a RR is to; gather the facts about the case, as far as they can be readily established at the time, discuss whether there is any immediate action needed to ensure children's safety, share any learning appropriately and decide whether the criteria for a CSPR is met.
[2] Child Safeguarding Practice Review Panel
[3] The purpose of a Rapid Review is to gather facts about a case, identify immediate learning and decide whether the criteria for a Child Safeguarding Practice Review has been met.
[4] Bridget Griffin CQSW, BA, MA, Accredited SCIE Reviewer
[5] Working Together to Safeguard Children DfE (2018).
[6] Section 11 (s11) of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children.

The significant incidents

Name	Age	Significant incident
Child A	**9 wks.**	Emergency services called to home address. Child A found to be in cardiac arrest. Transported to hospital where skull fracture and healing rib fractures were identified. Parents arrested. Ongoing criminal investigation & care proceedings.
Child B	**10 wks.**	Bruising & mark on lip noted at 8-week check by GP. Strategy meeting led to a home visit by a social worker (SW) where marks on Child B were noted. Child Protection Medical (CPM) identified recent bruising & 3 rib fractures. Ongoing criminal investigation & care proceedings.
Child C	**8 wks.**	Mother attended A&E with Child C – mother reported tripping on 2 occasions whilst holding the child. Skeletal survey identified child had a skull fracture & 4 rib fractures. Interim Care Assessment Order. Result of Court proceedings –child's injuries a result of accidental falls - child returned to parental care.
Child D	**7 wks.**	Concerns about neglect raised by family members – strategy meeting led to a social work visit. Child D admitted to hospital. Child Protection Medical concluded there was significant failure to thrive/significant neglect. Mother, Maternal Grandmother & partner arrested for neglect. Ongoing criminal investigation & care proceedings.

Summary of multi-agency involvement

Name & Ethnicity	Summary of multi-agency involvement	The family
Child A White British	**At time of incident:** GP & 0-19 Healthy Child Programme : Health visiting service. **Historic:** Child & Adolescent Mental Health Service (CAMHS) & Adult Mental Health Service (AMHS)	Father & mother in household **Historic:** diagnosis of maternal depression at 10 yrs. Bipolar Disorder at 15 yrs. Non – engagement with AMHS – case closed.
Child B Ethnicity: White British	**At time of incident:** GP & 0-19 Healthy Child Programme: Health visiting service. **Historic:** CAMHS & Adult Mental Health Service.	Father, mother and sibling (2yrs 10 months) in household. **Historic:** Mother 17yrs : history of anxiety/low mood/poor sleep and at 19yrs : Persistent insomnia. Non engagement with psychological services.
Child C White British	**At time of incident:** GP & 0-19 Healthy Child Programme: Health visiting service.	Father, mother, sibling (1 yr. 2 months) in household. **Historic**: Nothing known.
Child D White British	**At time of incident :** GP & 0-19 Healthy Child Programme : Health visiting service. **Historic:** Children's Social Care, Multi-Agency Safeguarding Hub (MASH).	Mother, Maternal Grandmother (MGM) & MGM's partner in household. Mother: moderate learning difficulties. **Historic :** Long term history of neglect and sexual abuse in childhood. Child protection plans throughout childhood. Long standing concerns about mental health of maternal grandmother & her partner.

Key lines of enquiry

The following key lines of enquiry were agreed by Cambridgeshire and Peterborough Safeguarding Children Partnership (CPSCP) at the start of this CSPR.

KLE 1. Why are existing and embedded policies (Pre-birth Protocol and Bruising in Babies) not being used ?

The CPSCP policies relevant to this question include the 'Cambridgeshire and Peterborough Pre-birth Protocol' (2019) and 'Bruising in pre-mobile babies: a protocol for assessment, management and referral by professionals'(2021). Both protocols have been the subject of extensive dissemination across multi-agency services and training has been, and continues to be, provided to the multi-agency workforce. Supervision is routinely provided (in the case of the GP practice, is routinely available) to front line practitioners/clinicians in relevant agencies where these protocols are discussed.

What happened in these cases ?

Pre- birth Protocol

Child D. Four key practice episodes have been selected highlighting when the Pre-birth Protocol should have been followed.

Key Practice Episode (KPE) One : Midwifery involvement & handover to the 0-19 Healthy Child Programme – health visiting service . During the involvement of midwifery services, mother of Child D (Ms D) was reported as 'open and honest' about her history of childhood neglect by her parents and the involvement of Children's Services. Ms D did not mention that she had a moderate learning difficulty although this was recorded on her records which were accessible to the midwifery team. Ms D was cared for by the community midwife with some contact with the specialist midwife for mental health as a result of Ms D's symptoms of moderate depression. Ms D reported that she was supported by her sister, her presentation, self care and engagement with staff raised no concerns. Two antenatal scans indicated that Child D may have a possible skull abnormality, with the second scan reducing these concerns. No abnormality was identified at birth. No risks or safeguarding concerns were raised by the midwifery team and the case was handed over to the health visiting team. During this handover, the history of involvement by the midwifery team was discussed which included the advice by the Safeguarding Lead for Midwifery that the case did not meet a threshold for referral to Early Help. The health visiting team recorded the information and placed Ms D on the targeted antenatal pathway.[7]

Appraisal: The view of Rapid Review members was that the constellation of Ms D's vulnerabilities with specific reference to; her long standing adverse childhood experiences, moderate learning difficulties, uncertainty about family support and reports of moderate depression/anxiety, should have led to a referral to Children's Services under the Pre-birth Protocol. A lack of curiosity/knowledge about the impact of these vulnerabilities, with particular reference to the impact of Ms D's extensive childhood adversities, was felt to be a key contributory factor.

Key Practice Episode Two : 0 - 19 Healthy Child Programme – health visiting service. Antenatal Visit. Prior to the birth of Child D, the health visitor (HV) visited Ms D at the home of the maternal grandmother and her partner. During this visit Ms D was noted to have poor self care, she was described as 'unkempt'. Ms D spoke about her anxiety and said she had a fear of dying, she

[7] The pathway outlines the national definitions of the level of need identified for the support required: universal, targeted or specialist.

said she was lonely and that her accommodation was unsuitable. It was also noted that Ms D was looking forward to the birth of Child D - she had suitable equipment and engaged well with the HV. Maternal grandmother and her partner were not present during this visit.

Appraisal: When appraising this visit, the view of Rapid Review members was that there was insufficient curiosity or authoritative practice demonstrated at this visit about the potential difficulties Ms D would face in providing suitable care for her child, particularly in light of Ms D's known moderate learning difficulties and adverse childhood experiences. The Pre-birth Protocol should have been instigated at this point by a referral to Children's Social Care. It was concluded that the reason this did not happen was due to a lack of curiosity about what may lie beneath Ms D's narrative about becoming a new parent which displayed overly optimistic, possibly naïve, concepts and ideas about what this would be like. The known history of extensive childhood adversity and moderate learning difficulty was not factored into considerations of potential risk/vulnerability – *new information was not examined in the context of known prior facts.*[8]

Key Practice Episode Three: Contact Centre/MASH. Just over one month prior to the birth of Child D, an anonymous referral was made to Children's Social Care (CSC) through the Contact Centre, expressing concerns about the unborn baby. Concerns included that Ms D was not able to care for herself, had a history of involvement with Children's Social Care in childhood and concern that the baby would be neglected. The Child Information and Advice Officer (CIAO) at the Contact Centre contacted Ms D to discuss these concerns. No concerns were raised during this conversation - Ms D reported she was excited about her baby's arrival and had family support. A decision was reached that there was no further action needed by Children's Social Care. A letter was subsequently sent to Ms D giving information about a local children's centre and advising Ms D to contact her midwife/health visitor if she had concerns, the case was then closed.

Appraisal: A review by Children's Social Care (CSC) of decision making in this case identified a number of important key systems issues at the initial contact stage. It has been recognised that insufficient weight was given to the concerns expressed by a family member when they made the initial referral and that the extensive history of social care involvement with Ms D throughout her childhood should have led to an assessment under the Pre-birth Protocol.

When reviewing the Rapid Review minutes and the agency submissions for this case, as part of this CSPR, there appeared to be a varied understanding about what was meant by the 'front door' (in relation to referral into CSC). Agencies interchangeably referred to the 'contact centre', the 'integrated front door (IFD)' and the 'Multi-Agency Safeguarding Hub (MASH)' when describing this 'front door' and also interchangeably referred to the 'contact centre manager' or the 'IFD manager' as making the decision to take no further action. It is understood that the process at the time was that referrals made to CSC are initially triaged by the contact centre before a decision is made about next steps, including whether to pass the referral to MASH/CSC.

Key Practice Episode Four: the 0-19 Healthy Child Programme New Birth Visit. After a birth notification was received, a new birth visit took place 21 days later at Ms D's accommodation. No concerns about feeding or handling were noted, positive and warm affection was observed. Child D was weighed, her weight was low – indicating a drop in 2 centiles.[9] Maternal wellbeing was reported as satisfactory although Ms D reported a traumatic birth experience. Home conditions were observed to be cramped and dirty. Two clinic appointments and a home visit were arranged. After this visit, the pathway was changed to 'universal provision' as it was concluded that the needs in the family did not meet the threshold for a "targeted" pathway.

[8] Rapid Review Member quote
[9] A centile chart is commonly used to plot the growth of a baby (including height, weight and head circumference) and to compare with the average expected at a particular age.

Subsequently, the planned home visit did not happen due to the HV's leave and limited capacity in the service and Child D was not brought for the two clinic appointments. Two days after the last arranged clinic appointment was due to take place, Child D was admitted to hospital where it was determined that Child D was suffering from significant neglect.

Appraisal: A review of this KPE by the 0-19 Healthy Child Programme concluded the following:

- The date allocated for the new birth visit was in line with the stretched mandated contact for new birth visits (by 14 days - 21 days)[10]. In practice this means that new parents and their baby wait for a longer period after the birth before a visit by a health visitor. Whilst in some cases this does not pose difficulties, for others such as Ms D and Child D, this delay may have implications – this is discussed further under Key Line of Enquiry 2.

- The information shared by the midwifery team regarding Child D shortly after birth did not include information about Child D's mild jaundice. Mild jaundice of this type does not require medical treatment and this information is not routinely shared with health visitors. However, with the benefit of hindsight, it was felt that together with the constellation of maternal vulnerabilities this information was important to share with the Health Visiting Team to inform interventions/care.

- The decision to place Child D on the universal pathway was not in line with the risk assessment policy and was inappropriate given the existing concerns. The tool in place that guides practitioners/managers in this decision making requires improvement.

- Cambridgeshire and Peterborough Foundation Trust Local Growth Monitoring Policy stipulates a drop through two growth centiles requires onward referral – this did not happen. The Joint Healthy Child Programme (HCP) Venture Cambridgeshire Community Services (CCS) Growth Policy and relevant NICE[11] guidance indicates a different approach. These policies are not aligned, and this causes confusion.

- There should have been a home visit to Child D to follow up on the home conditions and monitor Child D's weight – the stretched capacity of this service at the time meant that there was very limited capacity to provide cover when staff were on leave.

- Ms D's non-attendance at clinic did not prompt any further action to ascertain her reasons for non – attendance and the records did not indicate that close monitoring of Child D's weight was required. The confusion about the policies (as above) meant that the need to monitor Child D's weight was not clear.

Bruising in Pre-mobile babies' protocol

Child B - Primary Health Care- GP Practice : During the 8-week check at the GP practice, two bruises and a mark on Child B's lip was noted. Child B's mother (Ms B) reported that Child B inflicted the bruises himself and that he 'bruised easily'. During the following week Child B was seen on two further occasions at the GP practice for minor childhood ailments, no concerns were noted at these appointments. A subsequent review of the records, concerning Child B's initial presentation, led the GP practice to seek advice from the safeguarding lead paediatrician who advised that, in line with the Bruising in Pre-mobile Babies Protocol, a referral must be made to Children's Social Care

[10] This stretched mandated contact had been agreed by the relevant NHS trust in response to the covid pandemic and had taken longer than anticipated to reduce the stretched targets back to original time frames post pandemic due to staffing pressures.
[11] National Institute for Clinical Excellence

(CSC). The referral was made, although this was received by CSC over two weeks after the initial presentation.

An immediate strategy meeting took place on the day the referral was received followed by a visit by a social worker. Further marks were noted on Child B who was admitted to hospital in order for a child protection medical to be completed. The following day the acute hospital made contact with CSC stating that Child B was fit for discharge. Contrary to the Bruising in pre-mobile babies protocol, the child protection medical had not taken place. After escalation by CSC, the child protection medical took place and Child B was made the subject of an Interim Care Order.

What action has been taken in response ?

When exploring why the Pre-birth and the Bruising in Pre-mobile baby protocols were not followed in case of Child D and Child B it is clear that, amongst other issues, contributory factors included a lack of experience of relevant staff and staff turnover. A detailed review by relevant agencies and members of the Rapid Review has led to the following actions to address the key issues that contributed to the practice in these cases.

Child D: Key Practice Episode 1 & 2 : Midwifery Services & 0- 19 Healthy Child Programme (handover to the 0-19 Healthy Child Programme and antenatal visit). In response to this learning, practitioner understanding of psycho- social history/parental adversity is being enhanced by use of genograms. There has been a focus on communication between midwifery and the health visiting service regarding vulnerable women and a more robust local pathway is in the process of agreement across the Cambridgeshire Community Services and Cambridgeshire and Peterborough Foundation Trust 0-19 Healthy Child Programmes.

Recommendation 1: CPSCP to review the new pathway between midwifery and health visiting services and quality assurance activity to be undertaken (CCS and CPFT, in association with midwifery services) to evidence impact.

Child D: Key Practice Episode 3: Contact Centre/MASH. A review by CSC has established that at the time this referral was received, decision making at the Contact Centre was made by a child information and advice officer not a professionally qualified worker. All case decisions, made at the initial contact stage, are now overseen by a qualified social worker. In response to the concerns identified in this case, an independent audit of pre-birth cases referred to MASH was completed. This audit raised a number of issues regarding the variation in practice when providing a pre-birth response. This led to the establishment of multi-agency joint working group. This group identified a number of important issues that required attention:

- A consistent approach at the earliest possible stage (at minimum 13 weeks gestation) to multi-agency assessments and interventions is required in cases where there has been a history of concerns.
- Legal advice should be sought to ensure that, where needed, the public law outline process is started as early as possible.
- Risk assessments during perinatal and antenatal care require strengthening.

In response, the following action has been taken:

- The Pre-birth Protocol has been reviewed and amended to take account of the above and to tighten the process of referral, decision making and assessment. This protocol has been agreed by the CPSCP and is in the final process of sign off. A process of dissemination, including briefings and training opportunities (such as CPSCP webinars), has been planned (see recommendation 5.).

- Practitioner briefings and dissemination of the audit findings have taken place (led by the independent auditor) involving practitioners in MASH/the Contact Centre, child protection chairs/independent reviewing officers, managers, and senior managers within CSC.

- An unborn baby panel was established in Cambridgeshire and Peterborough to provide a multi-agency forum to discuss the needs of unborn babies at the earliest possible point (who are not in receipt of statutory intervention[12]). The purpose of this panel has been to discuss present and potential risks and agree a plan of action. Implementation of these plans has been overseen by this forum. Since this time, there has been a decoupling of Cambridgeshire and Peterborough county councils. The panel currently remains in place in Peterborough.

- A multi-agency review of MASH/the Contact Centre has been progressed by establishing a MASH Implementation Group led by the CPSCP independent chair. An action plan has been agreed and is in the process of implementation, this includes agreeing the terminology that will be used when referring to the first point of contact with CSC to avoid confusion.

Child D: Key Practice Episode 4: 0-19 Healthy Child Programme (HCP) New Birth Visit

- The pressures on the 0-19 Healthy Child Programme (HCP) are recognised as considerable - existing capacity is not sufficient to meet demand. These pressures have arisen as a result of qualified health visitor staff shortages and the increased complexity of need believed to have resulted from the C-19 Pandemic and the cost-of-living crisis. Recruitment to these posts is difficult as there is a national shortage of qualified health visitors, this is recognised at a national level and attempts to address are currently underway with the Department of Health & Social Care (DHSC).The risks posed have been raised with the Trust Executive and are articulated on the organisational risk register. The risks are escalated on a monthly basis to the performance and risk executive and a revision of the workforce staffing model is currently underway.

- The new pathway for vulnerable women, in the process of implementation, is intended to improve communication between midwifery and health visitors.

- The tool that informs reviews of antenatal waiting lists, to determine the level of need and level of service response (Universal/Targeted/Specialist), has been reviewed and a new tool has been developed.

- The Cambridgeshire and Peterborough Foundation Trust Local Growth Monitoring Policy has been reviewed and amended to reflect the relevant NICE guidance and thereby provide clarity to practitioners, this revised policy is now operational. The policy has been shared with staff and consistency of approach has been achieved across the Joint Venture.[13]

- Growth training updates including e-learning have been provided across the HCP.

Recommendation 2 : The risks and the revised workforce model within the 0-19 HCP (commissioned through Public Health), across Cambridgeshire and Peterborough, to be discussed and monitored through Cambridgeshire and Peterborough Executive Safeguarding Partnership Board.

[12] Statutory intervention in these circumstances means the statutory involvement of CSC under Sc47 of the Children's Act 1989.
[13] The Joint Venture provides oversight and governance of the 0-19 HCPs across Cambridgeshire Community Services and Cambridgeshire & Peterborough Foundation Trust.

Child B: Primary health care – GP Practice. The reasons why the Bruising in pre-mobile babies protocol was not followed, and the delay in referral to CSC by the relevant GP practice, has been the subject of an internal review by the GP practice. Oversight and advice has been provided by the responsible Integrated Care Board (ICB) Safeguarding Team. Action to address the learning has been taken forwards which has included:

- A task group was established to review awareness and application of the Bruising in pre-mobile babies protocol, to understand whether the current protocol was sufficient and what organisational factors may impact on its use. An initial staff survey identified that a significant number of clinicians were not aware of this protocol. A revised protocol has been written and publication is in progress. Once publication is achieved, this will be disseminated through a trust wide newsletter, direct communication to all GP practices and during monthly GP safeguarding forums.

- A review of internal communications has been conducted and action taken to achieve prompt and effective communication between staff members in the practice and with partner agencies/services.

- Training for all clinical and support staff on relevant local protocols and national guidance has been provided.

- Oversight of safeguarding practice is maintained by the relevant Integrated Care Board Safeguarding Team.

In addition, during consultation with practitioners and clinicians, the following was raised:

Consideration needs to be given to the use of varying policies and procedures within Cambridgeshire and Peterborough were a mark or bruise is identified in a non-mobile baby as this may have potential to cause confusion within clinical practice.

It is understood that there are currently two policies in place; the CPSCP policy and one used by Cambridgeshire Community Service (CCS). The reason for this is because CCS work across multiple partnership board boundaries who all have slightly differing bruising in non-mobile baby policies. The CCS policy advises to refer to the local partnership board policy as this takes local primacy. This is highlighted by the ICB Safeguarding Team during the supervision and training that is being delivered.

KLE 2. How do services respond to pressures on new parents not previously known to agencies ?

Only one child and family (Child D) were known to the three statutory partners[14] prior to the significant incident. In all four cases, the child and family were known to primary universal health services such as a GP practice, midwifery and the 0-19 Healthy Child Programme in Cambridgeshire and in Peterborough.

In terms of the pressures on the new parent/s, there was little information contained in records relating to the fathers; one father was reported by mother to have no contact with the child (Child D) and was not identified in multi-agency records, the fathers in the remaining cases were known to be living in the households but it appears that only maternal needs/pressures were documented including :

- Prior/current history of maternal mental ill health/history of anxiety (Child A, B, C & D)

[14] Police, Children's Social Care and Health

- Moderate learning difficulties – maternal (Child D)
- Physical disability – maternal (Child C)
- Maternal reports of a traumatic birth (Child A & D)
- Maternal reports of a fractious/ *inconsolable/* crying baby (Child A)
- Maternal reports/reports of feeding difficulties (Child A, C & D)
- Isolation/lack of family support (Child A & D)

The questions arising are:

- How have universal health services responded to the findings and recommendations contained with the relevant Child Safeguarding Practice Review Panel report[15] ? This report was focussed on non-accidental injury to children under 1 and stressed the vital importance of exploring the role of father's/male carers in families at an early stage. Panel members identified areas of good practice in this regard (such as ICON[16]) and a systems approach to identifying male care givers and linking family records.[17]

- Could services have better identified/ explored the pressures on the parents at an early stage in order to explore and attempt to meet needs/escalate the case to a higher level of intervention? (see Rec: 5)

Recommendation 3: Universal health providers should identify good practice examples of identifying and working with fathers. These should be shared with practitioners and used within training. Assurances that this work has taken place should be provided to Cambridgeshire and Peterborough Safeguarding Children Partnership Board.

Exploring the impact of parental learning difficulties and providing a response.

Child D: The previous section has detailed the multi-agency service response to Child D. The appraisal of practice has identified that the needs/vulnerabilities of Ms D should have been more clearly understood and identified, and a higher level of multi-agency service intervention provided, at an early stage. In addition to the actions that have been taken to strengthen multi-agency service delivery in relevant areas, there has been a multi-agency focus on meeting the needs of parents with a learning difficulty.

Informed by a recently published Mortality Review (concerning children with learning difficulties and autism)[18] and a Learning Difficulties Summit (concerning adults with learning difficulties and autism), Cambridgeshire and Peterborough Integrated Care System (ICS) has set out relevant key priorities for Cambridgeshire and Peterborough ICS. The various work streams now in place are addressing a range of issues including identifying, understanding, and responding to the needs of adults with learning difficulties. This work will inform and strengthen the multi-agency response.

Exploring the impact of parental physical disabilities and providing a response.

Child C: Child C was known only to primary health providers which included the GP practice, midwifery and the 0-19 Healthy Child Programme**.** There are considerable differences in the circumstances of this case when compared to the other children and families. In this case, the

[15] *The Myth of Invisible Men. Safeguarding children under 1 from non-accidental injury caused by male carers*. Child Safeguarding Practice Review Panel September 2021
[16] ICON (**I**nfant crying is normal, **C**omforting methods can help, it's **O**K to walk away, **N**ever ever shake a baby) ICON is a nationally acclaimed effective evidence-based programmes providing support to parents/caregivers to cope with infant crying.
[17] Cambridgeshire Community Services

conclusion of the court process (initiated after the significant incident) was that Child C's injuries were accidental. A significant contributory factor was concluded to be a mild, but important, maternal physical disability. This physical disability was known to the health services involved in the care of Child C but not identified by mother, or by practitioners/clinicians, as impacting on the care provided to Child C - there were no prior concerns about the care provided to Child C or the other child in the family. No systemic gaps in identifying and meeting the needs of parents with physical disabilities/needs have been identified and therefore no service development work is indicated.

Exploring the impact of mental ill health/anxiety and providing a response

Child A: Child A was known only to primary health providers which included the GP practice, midwifery services and the 0-19 Healthy Child Programme. The records accessible to the GP, midwifery and the HCP documented that mother of Child A (Ms A) experienced significant childhood adversity and a history of mental ill health, she had received services from Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS). This history included a diagnosis of depression at the age of ten years and of Bipolar Disorder, with some signs of Obsessive-Compulsive Disorder, at the age of fifteen years. Therapeutic services were offered to Ms A but were not consistently taken up, with records showing multiple cancellations/rebooking and poor attendance. Subsequent counselling was provided, the extent of her engagement with this service was unclear in the records. At the time of Ms A's pregnancy, she was not in receipt of mental health services.

No concerns about Ms A's pregnancy or Child A were identified by services involved and Ms A was provided with a universal health visiting service. There was no antenatal contact with Ms A, a new birth visit took place at 21 days, in line with the stretched mandatory target. A 6–8-week check of Child A was completed by the health visitor at 7 weeks and 4 days where an assessment was completed, advice and guidance provided - no concerns were identified. Subsequently Ms A contacted the health visiting service on two occasions expressing concern about Child A's *continuous crying/being inconsolable* and of feeding difficulties. The health visitor responded by providing advice and guidance, signposting to ICON and made an appropriate timely referral to the feeding clinic - an appointment at the feeing clinic was provided within 3 weeks of the referral. It is not known whether Ms A accessed ICON and the significant incident happened before she could attend the appointment at the feeding clinic.

Child B: Child B was known only to primary health providers which included the GP practice, midwifery services and the 0-19 Healthy Child Programme (HCP). The records accessible to the GP, midwifery and the HCP documented that mother of Child B (Ms B) had a history of mental ill health. At the age of seventeen, Ms B reported to the GP a history of anxiety, low mood and poor sleep. A referral was made to Child and Adolescent Mental Health Services, Ms B did not respond to contact from this service. At nineteen, Ms B reported persistent insomnia to the GP, a referral was made to the Adult Mental Health Psychological service, Ms B did not respond to contact from this service.

At the time of her pregnancy with Child B, Ms B was not receiving mental health services. No concerns about Ms B's pregnancy, her mental health or Child B were identified. Ms B was provided with a universal health visiting (HV) service. There was no antenatal contact with Ms B, a new birth visit took place at 18 days in line with the stretched mandatory target. Ms B reported that she had been prescribed medication by her GP for depression, there were no concerns about the care of Child B. Bruising was noted by the GP two days before the planned HV 6–8-week check of Child B, this check was rearranged, and so delayed, as a result of capacity issues within the 0-19 HCP. The 0-19 HCP service were not aware of the bruising seen by the GP and Child B was admitted to hospital before this check could be completed.

Child C: Information held within the 0-19 HCP recorded a history of maternal low mood after the birth of sibling 1 and anxiety after the birth of Child C. A universal health visiting service was provided. There was no antenatal contact, a new birth visit took place at 21 days, in line with the stretched mandatory target. No concerns about weight, handling and care of Child C were recorded. Ms C reported that Child C struggled with feeding, advice was provided. At the 6–8-week postnatal contact, Ms C reported Child C was prescribed medication by the GP for reflux and review by the GP was planned. Ms C reported feelings of anxiety and additional support was offered which was declined by Ms C.

Child D: The history of Ms D has been detailed in the previous section. In summary, Ms D was known to have mental health difficulties in childhood. She had experienced a long history of neglect and there were concerns about child sexual abuse. Shortly before the birth of Child D, Ms D spoke about her anxiety, loneliness, and fear of dying.

Child D was provided with a universal health visiting service. There was antenatal contact with Ms D and the new birth visit took place at 21 days, in line with the stretched mandatory target. Ms D's low mood was identified at this visit – this was linked to Child D's birth that Ms D described as traumatic. She was encouraged to self-refer to 'Mind'.[19]

Comment: Responding to mental ill health

Three cases involved harm to a child that was significant/life threatening. Two as a result of non – accidental injury, one as a result of significant neglect. Common themes shared by all three were maternal mental ill health prior to the birth of the babies where no/minimal treatment had been accessed, and a description of a traumatic birth in two.

It is understood that in at least one acute trust, the midwifery service ask questions of maternal emotional wellbeing during pregnancy and post- natal contact using evidenced based tools[20] to better identify any anxiety or depression. This is good practice but does not fully take account of the potential risks posed by a history of mental ill health, where no treatment has been accessed.

The questions that arise are:

- How is historic maternal mental ill health, particularly when no treatment has been accessed, considered as a possible risk factor?
- When this is combined with a traumatic birth experience, how are the constellation of risks assessed and responded to?

The author acknowledges, it is the choice of individuals whether they chose to accept offers of mental health support and in these case the parents did not chose to accept all services that were offered. The services offered were appropriate and were in line with expected service standards. The risks potentially posed by a history of mental ill health, and lack of uptake of treatment, are included in recommendation 1 and in the workstreams identified at the end of this KLE. For these reasons, the author has made no recommendations regarding mental health support and risk assessment.

[19] Mind - a national charity promoting/supporting the needs of people with mental ill health.
[20] Whooley tool (for depression) and Generalised Anxiety Disorder (GADS) tool

Exploring the impact of a traumatic birth and providing a response

As identified in the previous section, two of these births were described by the mothers as 'traumatic'. A relevant thematic CSPR by Norfolk SCP[21], examining life threatening non – accidental (NAI) injuries to six babies, identified that a traumatic birth/maternal self-reporting of a traumatic birth was a common factor in at least four of these cases.

It is understood that where a birth is clinically indicated to have been traumatic, mothers are offered support from the obstetrician and senior midwife and that both a clinical interpretation and parental perception would be considered. Health visitors would also consider the impact of a traumatic birth, and it is understood this would be indicative of the need for targeted or a specialist pathway/offer of support (this would include consideration of the father's potential experiences of trauma at the birth). Follow up care would involve observations of maternal and paternal mental health and assessment of the interactions and relationship with the child. Specialist advice can be sought from the perinatal mental health champions and/or the clinical psychologist in the HCP to consider how best to support the family, or to consider a referral to a specialist service.

In the cases of Child A and Child D, the response by the health visiting service was to refer to an appropriate local service or, in the case of Child D, provide information and encourage a self-referral to 'Mind'. In both cases, the significant incident happened prior to Ms A and Ms D accessing relevant services.

Responding to a traumatic birth

The questions that arise are:

- How seriously is maternal self – report of a traumatic birth considered in the context of historic mental ill health?
- How are the possible risks to a baby considered?
- Can a consistent service response be provided at the targeted or specialist level, described above, in these circumstances alongside consideration of additional complexities (such as a fractious/crying baby and/or where there are feeding difficulties)?

Exploring the impact of feeding difficulties and/or a fractious/crying baby and providing a response.

Maternal reports of difficulties in feeding their babies was evident in three cases and reports of a baby who excessively cried was reported in one case.

Child A: Ms A reported feeding difficulties to the health visitor when Child A was three weeks at the new birth visit describing Child A as *continuously crying and inconsolable.* Ms A was signposted to ICON[22]. At the 6 – 8-week check both parents were at home, Mother did not reference these problems but called the HV the following day concerned about feeding difficulties and questioning 'tongue tie'. The HV appropriately made a prompt referral to the feeding clinic, however, the significant incident occurred before this appointment.

Child C: Ms C reported problems with feeding Child C to the GP who appropriately identified a problem with reflux and after two appointments, and a change in medication, this problem appeared to resolve.

Child D: After the birth of Child D, hospital staff observed that Ms D did not have appropriate equipment for feeding Child D and support to organise feeding was provided. Further observations

[21] Norfolk Safeguarding Children Partnership: Thematic Serious Case Review NAI. 2019
[22] ICON (**I**nfant crying is normal, **C**omforting methods can help, it's **O**K to walk away, **N**ever ever shake a baby) ICON is a nationally acclaimed effective evidence-based programmes providing support to parents/caregivers to cope with infant crying.

of disorganisation around feeding, including a dirty home environment/ lack of sterilization and Child D having oral thrush were identified at the new birth visit.

The later referral from family members concerned that Child D was severely malnourished led to Child D's hospital admission when it was concluded that there was significant failure to thrive and chronic neglect.

Service response: 0-19 Healthy Child Programme

It is understood that thorough assessments are completed by health visitors when in contact with parents and children regardless of which level of services are being provided (universal/targeted/specialist). These assessments take place at the antenatal contact, new birth visit, 6–8-week check and during any continuing contact with the family. There are a wide range of components that make up this holistic assessment using the Solihull approach.[23] Formulating a plan to cope with any difficulties (such as feeding difficulties/ coping with a crying baby) is integral to the approach.

Comment: Responding to feeding difficulties and/or a fractious/crying baby

More recently, the HCP has responded to changes in terms of operational and clinical delivery of the service offer, this has included adjustments related to the triage of cases based on levels of need identified as universal/targeted/ specialist from the revised DOH guidance 2021. Changes were also made to service delivery as part of the C-19 response, and this included pausing the previously offered Health Visitor drop-in clinics. In terms of staffing capacity, there has been growing concerns with the recruitment and retention of Health Visitors which is not unique to Cambridgeshire or Peterborough and indeed is a national issue.

During the period when the children were receiving services from the Healthy Child Programme in Peterborough and in Cambridgeshire, the services were contending with significant pressures. Low staffing levels and staff sickness over the winter of 2022/23 were at the highest recorded levels with Peterborough HCP contending with only 60% staff capacity.

A crisis in recruitment, and the national pressures on health services as a result of the Covid pandemic, were continuing to impact. The result of this capacity crisis led to difficult decisions that had to be made about the services that could be provided in both Cambridgeshire and Peterborough. During the period just prior to the significant incidents involving the four children, antenatal visits were not routinely taking place, stretched targets[24] were in place for mandatory new birth visits and 6 – 8-week developmental checks.

It is clear that the support provided by the 0-19 HCP by health visitors is critical in providing care, support, containment, and advice in these early weeks of a child's life. Providing regular opportunities for parents to engage with an experienced professional builds trusted relationships that enables difficulties to be raised, facilitates access to (and nurtures engagement with) specialist services when these are needed. The necessary response to the capacity crisis reduces the level of support provided to new parents and risks compromising the benefits of establishing trusted relationships. The services provided to the children at the centre of this review were as follows:

Child A : Universal provision, no antenatal contact. New Birth Visit (NBV) in line with stretched mandatory target. 6 - 8-week check within timescales.

[23] The key aims of the Solihull approach is to promote understanding of children's behaviour within the context of developmental issues, promote the development of parent/child relationship, increase confidence and self-esteem in both parents and children, give parents a strategy for repair when things go wrong.

Child B: Universal provision, no antenatal contact, NBV in line with stretched mandatory target. 6-8 - week check did not happen prior to the incident as capacity issues led to delay.

Child C: Universal provision, no antenatal contact**.** NBV in line with stretched mandatory target. 6 - 8-week check within timescales.

Child D: Universal provision, NBV in line with stretched mandatory target. Follow up appointment delayed due to capacity issues in service. Child D admitted to hospital before reaching 8 weeks of age (therefore 6-8 week check not completed).

In summary, there was no antenatal contact in 3 out of 4, delayed NBV in 4, no 6–8-week check in 2 out of 4. It is understood that the antenatal provision has recently been reinstated and the crisis in the capacity of the 0-19 HCP is the subject of review at the executive level in the relevant trust. A revised Healthy Child Programme staffing model has been proposed and presented to Cambridgeshire Community Service and Cambridgeshire and Peterborough Foundation Trust Executives, further discussions are taking place with a clear implementation plan in progress (see recommendation 2).

Exploring the impact of isolation and providing a response

Midwives and health visitors routinely asked new parents about the support that was available from family and kinship.

Child A: Ms A was largely alone in caring for Child A as father worked away from home.

Child B: Not known as not explored.

Child D: Ms D spoke about support provided by her mother and sister. However, she also spoke about feelings of loneliness. Due to the overly optimistic view held by Ms D about the support she might receive from her family, and the limited professional appreciation of the multiple psycho – social needs in the extended family, the isolation experienced by Ms D was not fully understood.

Isolation has the potential of presenting considerable pressures on new parents. When this is combined with factors such as previous mental health difficulties (Child A & D) , a traumatic birth (Child A & D) and an inconsolable crying baby (Child A) the combination of these factors require close attention and should be regarded as presenting high levels of potential risk to a child.

Partnership activity

The CPSCP has carried out a considerable amount of work on pre birth activity and process. This has been driven through a dedicated multi agency Pre Birth workstream and Chaired by a dedicated Pre Birth lead. The workstream involved consultation with both practitioners and service users as well as drawing on national good practice in this area. The learning from this review, was considered by the workstream, including how Universal health service providers consider how risks will be considered in determining levels of intervention by the 0-19 Healthy Child Programme and risk assessments by midwifery services in community and acute trusts. The workstream have developed a revised Pre- birth Protocol and resources. Workshops were delivered to support staff with the changes and these were well received.

Due to the amount of work undertaken in this area, there are no recommendations regarding this KLE.

KLE 3. How can a clearer understanding for all agencies be achieved on the process for, and what can be achieved from, Child Protection Medicals including a better understanding of use of skeletal surveys ?

All four children underwent a child protection medical, and a skeletal survey was carried out for three children.

Practice issues arose in relation to child protection medicals and skeletal surveys on three separate occasions in two of these cases:

Child B: When bruising to Child B was noted at the GP practice, in the line with the Bruising in pre-mobile babies' protocol, Child B should have been referred for a child protection medical. The reasons why this protocol was not followed have been discussed. Subsequently, Child B was admitted to hospital following a social work visit, with a request for a child protection medical (CPM) to be undertaken. The next day, the acute hospital notified CSC that Child B was fit for discharge, no CPM had taken place. At the insistence of CSC, a CPM and a skeletal survey took place which identified the injuries.

Child C: Child C was admitted to hospital and considered fit for discharge before a CPM and skeletal survey had been carried out. This was contrary to the strategy meeting decisions. Again at CSC insistence, a CPM and skeletal survey took place which identified the injuries.

Members at the Rapid Reviews and at the CSPR panel identified that there is evidence of national challenges in relation to the knowledge, and nuanced understanding, held by multi-agency practitioners of the clinical guidance, decision making and results of, child protection medicals and skeletal surveys. It was reported that this can cause multi-agency confusion and at times can have a detrimental impact on multi-agency working.

On a national level, experienced panel members were of the view that a robust system wide approach to child protection medical services, which can be flexible and meet the best interests of the children, is needed.

Locally, a virtual training briefing (SWAY) has been launched about the child protection process. This is a promising local development which is aimed at improving multi -agency practitioner knowledge and understanding of child protection medicals and skeletal surveys.

KLE 4. Strategy discussions – how can this CSPR feed into work already being undertaken to ensure that the right health representation is achieved ?

These cases highlighted the importance of ensuring that strategy meetings include the right health representation. Panel members stressed the need to ensure that decisions about child protection medicals are informed by inclusion of appropriately trained and skilled consultant paediatricians at strategy discussions and, where attendance of such a paediatrician is not possible, arrangements should be routinely in place to gain their views. These views should be sought before, during (where possible), and after a strategy meeting, and in subsequent strategy meetings and safety planning for a child.

CPSCP are currently addressing the issues raised in KLE 3 & 4 through the MASH Implementation Group. An audit of cases examining the specific issues of the timeliness of strategy meetings and multi-agency membership is in progress. Learning from this audit will form part of the MASH

Implementation Work Plan and will be monitored through CPSCP therefore no recommendations are required.

Conclusion

This CSPR has reviewed the services provided to four children who suffered serious harm within the first 10 weeks of life. Most of the services involved were at the universal level of multi-agency service provision. Immediate learning was identified by Cambridgeshire and Peterborough Safeguarding Children Partnership during the Rapid Reviews, this learning has been progressed. The key findings in this CSPR are focussed on the vital importance of gaining a full understanding of the vulnerabilities in families, especially at a time when a new child is entering the family, and the pivotal place occupied by universal health services, in the form of GPs, health visitors and midwives, in safeguarding children from harm.

Summary of Recommendations

Recommendation 1: Cambridgeshire and Peterborough Safeguarding Children Partnership to review the new pathway between midwifery and health visiting services and the quality assurance activity undertaken (CCS and CPFT, in association with midwifery services) to evidence impact.

Recommendation 2: The risks and the revised workforce model within the 0-19 HCP (commissioned through Public Health), across Cambridgeshire and Peterborough, to be discussed and monitored through Cambridgeshire and Peterborough Executive Safeguarding Partnership Board.

Recommendation 3: Universal health providers should identify good practice examples of identifying and working with fathers. These should be shared with practitioners and used within training. Assurances that this work has taken place should be provided to Cambridgeshire and Peterborough Safeguarding Children Partnership Board.