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Description automatically generated**Introduction:**

**Evidencing Impact:**

Infant Injury

**Serious Case Reviews and Local Child Safeguarding Practice Reviews**

A **Local Child Safeguarding Practice Review (LCSPR)** is a locally conducted multi-agency review in circumstances where a child has been abused or neglected, resulting in seriousharm or death, and/orthere is cause for concern as to the way in which agencies have worked together to safeguard the child.

The purpose of a review is to establish whether there are lessons to be learned about the way in which local professionals and agencies work together to safeguard children; identify what needs to be changed and, as a consequence, improve inter-agency working to better safeguard and promote the welfare of children.

Prior to 2019 these reviews were called ‘Serious Case Reviews’, which was conducted in the case of Child V and Child W.

**Local and national learning tells us that babies and young children are particularly vulnerable to abuse and neglect.**

The East Sussex Safeguarding Children Partnership (ESSCP) undertook two ‘Serious Case Reviews’ in 2019 regarding infants known as Child V and Child W. Both reviews involved non-accidental injuries. Tragically, in the case of Child W, they died from their injuries. In both cases there was significant involvement by agencies.

During March and May 2020, the ESSCP was notified of three significant incidents involving non accidental injuries in babies. There was limited involvement by agencies with the families and no concerns about multi-agency working were raised.

The full report and learning briefings can be found on the ESSCP website here:

* [https://www.esscp.org.uk/East-Sussex-SCP-SCR-report-Child-W-FINAL](https://www.esscp.org.uk/wp-content/uploads/2021/06/East-Sussex-SCP-SCR-report-Child-W-FINAL-.pdf)
* [https://www.esscp.org.uk/ESSCP-Infant-Injury-Learning-Briefing-2020](https://www.esscp.org.uk/wp-content/uploads/2020/07/ESSCP-Infant-Injury-Learning-Briefing-2020.pdf)
* [https://www.esscp.org.uk/East-Sussex-SCP-Infant-Injury-Learning-Briefing-II-2021-FINAL](https://www.esscp.org.uk/wp-content/uploads/2021/04/East-Sussex-SCP-Infant-Injury-Learning-Briefing-II-2021-FINAL.docx)

**Key learning:**

The following learning points on infant injuries were identified in the partnership reviews, and in [case reviews nationally](https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/infants).

1. **Recognising the impact of parents’ experiences and behaviour:**

* The impact of parental vulnerabilities or experiences, on an infant’s short and long-term development and wellbeing, sometimes go unseen or unexplored by professionals.
* Parents who may need additional help to meet their babies’ needs and keep them safe include: parents who have had adverse childhood experiences; parents with substance misuse problems, including using cannabis; parents with mental health problems; parents with disabilities and learning difficulties; young parents; parents who are care leavers; and parents who are experiencing, or have experienced, abuse as an adult.
* Locally, case reviews identified the importance of good quality assessments. Any assessment can be an opportunity to get an objective, evidenced-based picture of a baby and their family. Assessments should be focused on the needs of the infant, and used as an opportunity to identify the need for intervention and prevention.

1. **Identifying infants that may be more vulnerable to abuse and neglect**

* There were a number of recurring factors in reviews, which increased the vulnerability of some infants to abuse and neglect. Infants who may be more vulnerable include: babies born prematurely; babies born as part of a multiple birth, or who have a sibling also under the age of two; babies born with disabilities, chronic health conditions, complex health needs or learning difficulties; and babies whose siblings are, or have previously been, on a child in need or child protection plan.
* Some practitioners demonstrated good awareness of these increased vulnerability factors, but it was not always recognised.

1. **Identifying when parents may be struggling to meet their infants’ needs**

* Case reviews identified that parental needs sometimes overshadowed risks to the infant. There is a need to focus on how the challenges that parents face may affect their infants’ health and wellbeing.
* This is why locally, we identified the importance of robust recording and information sharing, including between midwifery and health visiting and GPs.
* Signs that a parent could be struggling include: a pattern of missing their babies’ healthcare appointments, or not bringing them at all; a reluctance to engage with services; seeming to ‘favour’ one child over another; a baby showing signs of poor weight gain, alongside other concerns.

1. **Professional over-optimism and lack of curiosity**

* While in some instances professionals gave good practical help and support in response to concerns, there was not always consideration of the long-term impact of these concerns on the infant.
* For example, practitioners who regularly encountered high levels of need in their work sometimes become desensitised to circumstances that would otherwise have been classed as concerning. Likewise, there was sometimes a lack of professional curiosity when exploring perceived ‘low-level’ concerns. Professionals sometimes minimised cannabis use as a significant risk factor or explore its impact on parental ability to keep the child safe. The birth of a new baby was also sometimes seen as a ‘fresh-start’ for a family – which meant that professionals did not always reflect on pre-existing parents in behaviour which could pose a risk to their new child.

1. **Understanding roles and relationships around the child (including Unseen Men)**

* A critical issue in case reviews was the lack of understanding of family dynamics. Knowing about who is involved in the baby’s life is important in being able to identify patterns of behaviour that could pose a risk. For example, in some cases key information about other significant adults, such as mothers’ partner, was not known. Practitioners accepted the lack of involvement by fathers without exploring further, such as a father not attending baby’s healthcare appointment/s.
* Pre-birth and any subsequent assessments did not always include information about significant adults living at the same address, such as grandparents, and/or did not fully explore the reasons why a grandparent or other family members took on a caring role for the baby.

**Evidencing Impact:**

In April 2023 professionals from agencies, who worked with the children involved in the reviews, attended an ‘evidencing impact’ event. The event considered the impact of the learning from the reviews on local practice; what impact there has been on children and families; as well as any barriers to effective multi-agency working.

Professionals at the event identified the following changes to practice since the Infant Injury reviews:

*Systems and processes*

* Maternity records are now fully electronic enabling post-natal notes to be accessed easily by professionals. There is also much better sharing of information between midwifery and health visiting services. This means that professionals working with a family are now able to check records and develop a comprehensive understanding of the child within their family/care network.
* Work has taken place in children’s social care to improve the timeliness of completing pre-birth assessment work, including improving the level contact with the prospective parents within the assessment process. As part of this work, the operational instructions for pre-birth assessments were reviewed and relaunched with front-line teams. An audit the following year found that the process was embedded with teams: nearly all cases were judged outstanding or good; there was good multi-agency information sharing, management oversight and decision making, and the timeliness in allocation and assessment had all improved since the previous audit.
* Considerable work has taken place across the general practice network in East Sussex to strengthen GPs knowledge and response to unexplained injuries and/or bruising in non-mobile children. Primary Care are encouraged to ensure children on child protection plans are seen, or have contact, with a clinician on the day an appointment is requested (and when this happens in a surgery this is done by a permanent clinician in the surgery where the child is registered).
* All services gave examples of how they better consider and engage fathers and other significant males, in assessment and support work. Examples provided included introduction of mental health screening of non-birthing partners, better understanding of risks posed by fathers/male carers in referrals received by SPOA, and training from ‘Dads Like Us’. All agencies noted a shift in culture and updated systems, to better record father/male carers details in care plans, and in assessment work.
* The procedure for requesting a child protection medical due to concerns about non-accidental injury has been reviewed and improved with the development of a new referral form and clear documentation of the outcome of the referral which enables appropriate monitoring and quality assurance of decision making. Outside of meetings there is better networking and use of escalation processes if required. The Police are also attending more CP medicals. Learning from local reviews and ICON has been included inductions for Emergency Department and Paediatric doctors in East Sussex.
* The introduction of a specialist Health representative in MASH means that information from Health systems can be gathered quickly enabling timely decision making on safeguarding concerns. MASH and SPOA managers also meet regularly with safeguarding leads in Health to discuss cases and troubleshoot issues.

*Practice and practice knowledge*

* The guidance provided to professionals on bruising and/or injuries in children who are not independently mobile has been strengthened within the [8.1 Unexplained Injuries to Young Children | Sussex Child Protection and Safeguarding Procedures Manual](https://sussexchildprotection.procedures.org.uk/tkyslh/the-child-protection-plan/unexplained-injuries-to-young-children#:~:text=Any%20injury%20and%20its%20explanation,either%20accidental%20or%20non%2Daccidental.). A leaflet for parents, on what happens next if their baby has a bruise or unexplained injury, was also created. Wider visibility and easier access to procedures provides professionals with the guidance and tools to act quickly and appropriately in these situations. A deep dive audit on unexplained injuries in under 1s, conducted by the ESSCP QA Subgroup in 2021, identified good practice by professionals in both cases.
* Across Sussex, agencies have signed up to ICON – an evidenced based preventative programme, designed to support parents better understand and safely respond to infant crying. The ICON message is: ‘I’ infant crying is normal; ‘C’ comforting methods can help; ‘O’ its OK to walk away; and ‘N’ never, ever shake a baby. The ICON message has been shared across the partnership with agencies reporting (in the 2022 section 11 audit process) that ICON is embedded in local practice. While agencies are never complacent it is encouraging that there have been no child deaths across Sussex involving abusive head trauma (AHT) over the past three years. This follows three suspected AHTs in 2019/20.
* Agencies across the partnership report their staff feel more empowered to challenge decisions and there is a culture of supportive professional challenge across the partnership. For example, since 2020 bi-monthly meetings between health and social care have been established as a forum to discuss any issues or provide clarification on roles and responsibilities.
* Fathers and partners can now access Health in Mind (East Sussex IAPT - Improved Access to Psychological Therapies Service). Birthing and non-birthing people in the pregnancy or 12 months post-natal period are offered priority access to the service and are identified at the point of referral (self or via professional). The Specialist Perinatal Mental Health Service (SPMHS) invites partners/ dads to attend appointments with the consent of the patient and can also offer advice and signposting.

**Next steps:**

Colleagues attending the evidencing impact event identified the following areas for future focus:

* Although all agencies report that staff are aware of the ICON message, more needs to be done to ensure that ICON is embedded in to practice, including within key services such as social care, and where there has been a high-turnover of staff.
* The partnership should support a campaign to improve quality of referrals – to ensure that child gets what they need. Practitioners making referrals should be supported to include better information about what is needed, what has been tried, history and current concerns, and what is not known.
* The partnership should continue to seek ways to promote a culture of professional challenge.
* The partnership should publicise that Strategy Discussions can be requested by any agency, not just by social care.
* The partnership should support ways to think creatively about ways of working, in particular where there are capacity issues.

One of the agreed three priorities for the ESSCP in 2023-25 will be ‘embedding learning’, which includes a focus on ensuring that learning from the 2020-23 priority on safeguarding infants is embedded, and will include the above actions.

**Learning for practice**

The ESSCP invite you to discuss the issues raised in this briefing in your team meetings or during group supervision. We encourage your responses to be included in your team minutes and forwarded to the safeguarding lead within your organisation.

**Points for discussion:**

* How confident are you in sharing the ICON message? Does your team regularly use ICON in conversations with parents?
* How do you consider a parents’ adverse childhood experiences and how this can impact on their parenting? Do you have any examples of how you have considered this?
* What factors might make babies more vulnerable? How do the assessment tools you use in your team support you to consider additional vulnerabilities?
* Do you routinely ask about other significant adults in a baby’s life? Do you have any examples of how you have creatively engaged fathers or other male carers?
* How do you consider the ‘lived experience’ of a baby?
* When was the last time you used the Pan Sussex Child Protection and Procedures Manual?