City of York Safeguarding Children Partnership

For all the children of York to grow up in safety and always to feel safe.

# 7 Point Briefing – Learning from Practice – Baby L

1

A young woman, D, became pregnant to her partner, P, this was the first child for both young adults. The couple were in a relatively new relationship and although the pregnancy was unplanned, both parents appeared committed to their unborn child. Due to a complex social background for D, it was unclear if, or what, wider family support would be available for these parents once the baby was born.

2

D had experienced a number of Adverse Childhood Experiences (ACEs), including exposure to domestic abuse and poor parenting. She had a history of self-harm and was under the care of mental health care professionals. D chose to stop taking her medication for her mental health issues during her pregnancy. She also expressed concern to a number of professionals that she had ongoing feelings of self-harm but stated wouldn't act on them as she was pregnant, however she was concerned how she would respond to these thoughts when the baby was born.

3

The community midwife recognised this young couple and their unborn child were vulnerable and, with consent, a referral to children's social care was made early in the pregnancy. A Family Early Help Assessment (FEHA) was completed and a decision was made to formulate a FEHA plan rather than to step up to Child in Need. This was despite the multiple vulnerabilities; the difficulties professionals were having engaging P in assessments and D continually expressing concern about her ability to self-care after baby is born.

The FEHA reviews were attended by relevant professionals and the plan did reflect the need for antenatal support and mental health care for D pre and post-delivery. However, there was no clear plan to actively engage D and P in parenting support.

4

Soon after the birth P told a midwife he had 'shaken' Baby L when she wouldn't settle. The Midwife referred the case to Children's Social Care and strategy meeting was held with good attendance by agencies. The subsequent safety plan doesn't reference supporting parents with feeding and settling or Ds significant mental health issues. The case proceeded to an ICPC and there was a decision that the threshold for a Child Protection Plan was not met. This decision appears reasonable with the minutes identifying risks and protective factors. However, the subsequent CiN plan was not SMART with no reference to the role of the Health Visitor and no clear plan re ensuring safety of Baby L.

5

At just over 3 months old a HV observed bruises to Child L's face. The subsequent initial and review strategy meetings and section 47 inquiries try to establish the chronology of events in terms the numerous previous reports of observations of bruising to Child L's face.

Of significance was a consultation 9 days earlier when a practice nurse noted a bruise to Child L's face. Instead of taking action forward herself by seeking safeguarding advice she sent a message to the GP safeguarding practice lead. This led to a series of miscommunications and a failure to recognise and respond to a an injury in an immobile child as directed in local multiagency guidance.. It is of significance that the GP practice was not aware of the previous section 47 enquiries and had not been requested for information towards the assessments.

6

Subsequent to the strategy meetings and prior to the second ICPC a single assessment was commenced. This assessment and subsequent plan was of poor quality. Notably there appears to be no consideration that the bruises may have been caused by someone other than P. The ICPC was well attended by agencies. The subsequent child protection plan appropriately identified the need for continued parenting support however there was no reference to seeking legal advice which would have been appropriate given the outline of the case. Subsequent Core Group meetings were recorded poorly, in particular, the rationale behind the Local Authority initiating care proceedings.

7

**Learning Points**

The assessment following the initial referral should have included a greater understanding of the impact of maternal mental health, a formal parenting assessment and a far greater involvement of P in assessments.

Given the presenting concerns were focussed on both D and P's ability to safely and effectively parent, there should have been a far greater focus on supporting this young couple to prepare for their first child by offering a structured parenting programme.

Primary Care professionals did not take forward their individual professional responsibility and follow local multiagency guidance in responding to injuries in an immobile child This led to a delay in the multiagency child protection response (this has been the subject of an internal investigation within primary care)

All multiagency action plans should be SMART and should fully reflect and address the identified areas of risk, roles and responsibilities of all agencies and expectations of the family whilst remaining child focussed

When a non-accidental injury to a child is suspected safety planning should be realistic and must fully consider who the possible perpetrator could be.

When any assessment or section 47 enquiries are undertaken information must be gathered from, and outcomes shared with, all relevant agencies.