Executive Summary

REPORT TO

DERBYSHIRE SAFEGUARDING CHILDREN BOARD CONCERNING

THE SERIOUS INJURIES TO

BABY L

In order to preserve anonymity substitute initials have been used in this summary.

1. Outline of the case

1.1 This baby was born in December 2005. The parents had lived together for between two and three years but were not married. The baby was their second child, the first having died shortly after his premature birth. The couple moved to the area early in 2005 and by the summer were well known to several agencies, particularly the GP. In autumn 2005, father self-referred to disability services, because he was worried that his epilepsy might cause him to damage the baby. This raised concerns across health and social work agencies. Father was quickly established to be of aggressive temperament with regular outbursts and threats.

1.2 An initial assessment, based on a home visit between social worker and midwife, found the house in a poor state but overall concluded that there were strengths in mother's regular attendance at antenatal appointments and the couple's preparedness for the new baby.

1.3 Concerns about father's aggressive behaviour led to a pre-birth planning meeting. The agreed plan was to refer the family to Sure Start and to maintain regular contact with health services.

1.4 When the baby was born he and his mother were kept in hospital because of his jaundice. Following another episode of anger and threats by father in which he was barred from the hospital for 24 hours, concerns were raised about possible domestic violence. A further multi professional meeting took place and it was agreed that social services would keep the case open until contact with Sure Start was established.

1.5 Once mother and baby were discharged, they went home and had regular midwifery contact, with health visiting contact after the first week. This was shortly before Christmas. There were a number of calls to the GP and some concerns about possible postnatal depression. Delays in informing social services of the hospital discharge meant there was no social work contact at this time.

1.6 The chronology reveals repeated contacts with a range of services in late December and early January. With hindsight, a number of professionals recall aspects of concern but it is clear that no-one anticipated the events that followed.

2. The injury

2.1 Medical evidence is unequivocal that the baby suffered serious injuries to his brain as a result of shaking when he was approximately five weeks old. Neither parent has admitted responsibility, nor has either parent implicated the other parent, or any other person.

2.2 The baby is now subject to a Care Order under Section 31 of the Children Act 1989 and contact with the birth parents has been terminated.

2.3 The baby's injuries have had an extremely serious impact on his functioning and capacity and it would be fair to say that his life chances are fundamentally compromised.

3. Overview of practice

3.1 Throughout the enquiries that have informed this report there has been no sense that anyone has withheld information and there has been good cooperation. Established procedures and practices were followed throughout work with this case. While there were some delays in calling the first Planning Meeting, these have probably only become an issue because of subsequent events.

3.2 It is also apparent that both health and social care agencies had a significant level of contact with this young family, often at the level of two or three times in a single day. There was not, however, much shared awareness of the level of involvement between children's and adult services.

3.3 Much of the focus of concern was generated by the boisterous and aggressive behaviour of father, which may have distracted attention from the needs of his partner. Only with hindsight have professionals reflected on indications that mother may have been finding it difficult to cope.

3.4 At the same time, there was a significant underestimate of the level of stress for this family, as a result of their individual and shared histories and in particular regarding the death of their very premature first child. Of particular significance was the failure to review case records held in a neighbouring authority on the mother.

3.5 Some of the agencies that might have contributed to shared knowledge about this family were not thoroughly engaged in the multi-agency process. This is true to some extent of the GP, who was not invited to the pre-birth meeting. It is also true of Housing, whose role as a bell-weather agency is often underestimated.

3.4 Key issues arising from this enquiry include:

- the implications of the changing roles of the children's workforce, especially the role of social workers;
- the importance of understanding thresholds for interventions and recognising circumstances where concerns should be elevated;
- the dangers of exclusively strength based assessments that avoid consideration of worst case scenarios and analysis of risks;
- the importance of promoting community understanding of good parenting, particularly the risks to babies of shaking;

- the potential for pro-active community based services in children's centres;
- the implications for services in areas of high deprivation and the risks of professionals effectively limiting the life chances of children by identifying local parenting standards as 'good enough' in a given community;
- recent government Green Papers on social exclusion and the care system have focussed on the need to prioritise early – and often sustained – interventions with vulnerable families, where vulnerability is recognised at a lower threshold than at present.

3.5 It is important to remember that shaken baby incidents are of a qualitatively different nature than some other, more systematic, forms of maltreatment. They appear to be a response to extreme stress experienced by the parent of a very young child who may be a loved and wanted child. As such, they may well be repeated. They are often hard to predict and may therefore only be avoided by a programme that combines knowledge of the risks that shaking a baby carries with more intensive interventions and support for new mothers. These are likely to be particularly needed in areas of deprivation, but the research evidence is also clear that babies can be shaken in diverse socio-economic circumstances.

4. Longer term issues in this case

4.1 The parents remain resident in the community and are of an age where further pregnancies are likely. It will be important to reach an agreement between agencies about responsibility for work undertaken *before* as well as *during* any future pregnancy if there is to be a possibility of a fair assessment of their parenting capacity in the future.

4.2 In the case of each adult, there is a need to explore and address:

- the impact of their past life and experience on their present functioning;
- the impact on them as individuals of the characteristics they bring to their relationship;
- the parenting task in the light of this.

4.3 This work is likely to require assessment and support from psychiatric services, most probably those associated with children. Consultations with leading psychiatrists working in this field suggest that it is likely to require sustained intervention.

5. Recommendations

As has previously been noted, the incident which has affected baby L could not have been predicted, although it is clear from the evidence that his potential quality of life in other respects could have been enhanced in some areas. The recommendations that follow are intended to provide

pointers to better practice. Those marked with an asterisk may have implications at a national level.

Inter-professional practice

1. When considering the safety of children exposed to an adult who may pose a risk to them, all information known by agencies about that adult should be ascertained to inform the risk assessment of that individual. Advice should be taken from those with experience (e.g. adult mental health) as to whether guidelines can be drawn up to assist professionals working with and risk assessing very difficult people. This might include a communication strategy, so that communication is channelled through a few key professionals. It would be helpful to review the recommendations of the Who's Holding the Baby project with a view to developing streamlined teams for inter-professional neo-natal support.*

2. Attention should be given to the calling of and invitation to multi agency meetings of professionals, particularly including invitations to GPs of children registered, or likely to be registered, with their practice.

3. In any case where there has been a pre birth and/or pre discharge meeting it is essential that all parties to the meeting are given timely information of the birth and subsequent discharge of baby and mother from hospital (i.e. two working days maximum). Where there may be child protection concerns in a child under 5 years of age, the health visitor must be notified of the date of discharge once confirmed, and certainly by that date.

4. There should be clarity at multi agency planning meetings about the threshold for referral back to social services when ongoing situations of risk are being managed/ monitored by another agency.

5. The role of Housing in providing contextual and ecological evidence for assessments and attendance at multi agency meetings should be recognised. *

6. Communications between children's services and mental health services should not be assumed, even when working in the same building. More effort is needed to share information and analysis of shared service users.

7. All professionals should be aware of the procedures for re-registering patients who have been de-listed by GPs.

8. The links between stress, anger and aggression, in particular the stress of living in ecologically impoverished communities, have been noted above and it would be helpful to explore the potential for interagency developments to provide positive emotional and mental well-being in areas of high deprivation.

Social work practice

9. Assessments should wherever possible obtain relevant case histories from other areas. This should be **required** in any case where there is evidence of recent (within 5 years) involvement.*

10. Managers should remain vigilant in checking the veracity and sources of information contained in assessments.

11. There remains a need to improve the quality of analysis in assessments in order that effective planning can be achieved.*

12. An understanding of the importance of balancing strengths with identified risks should be central to the assessment process and to the supervision of assessment.*

Health

13. All health professionals should encourage unregistered, vulnerable families to be registered with GPs in their area.

14. Health professionals should be clear about the arrangements for obtaining information on patient files held by the PCT following de-listing by a GP.

15. Robust and realistic arrangements should be made for supervision and support of staff when the relevant Named or Designated Nurses from the Safeguarding Children Team are absent, particularly if it is a lengthy absence.

16. A system should be introduced so that information regarding children who are admitted to (or born in) hospital, where there may be child protection concerns is communicated to the Named Nurse for the area in which the child lives.

17. GPs (and their Practices) should share information with Social Services in situations where they recognise that adults may pose a risk to children, even if they are aware that Social Services are already involved.

18. There is an important need to develop effective interventions to respond to the bereavement of parents, particularly very young parents. Ideally this could be provided through health visiting or other aspects of community nursing. The links between bereavement and mental health difficulties need to be understood in this respect.*

Professional development

19. A number of the issues raised above have training implications at a single or inter-agency level. Further issues for inter-professional development are noted below.

20. There is a need to resolve the understanding of the assessment of risk within the assessment processes now being implemented.*

21. There is a need for professionals to develop a more sophisticated understanding of approaches to strengths based work and to learn to apply this in the context of transparent planning and evaluation of outcomes.*

22. Shared learning about the analysis of problems would help to build stronger inter-professional decision making*

23. Shared learning around genuinely empowering practice is particularly important for workers in areas of high social and economic deprivation, as is more understanding on the networks and histories of such communities and should be included in the training priorities of Local Safeguarding Boards*.

24. Training for the CAF and lead worker roles needs to be sensitive to local issues and circumstances and to incorporate the development of professional confidence to identify and communicate concerns. A particular focus should be given to training community midwives involved in pre-birth use of the CAF.

25. All professionals involved in assessment require more detailed understanding of the assessment of parents and parenting.*

Sure Start/Children's Centres

26. Children's Centres should recognise the need for careful planning and focussed work with families, particularly where positive models of outreach are required.

27. Children's Centre staff will need to develop skills in working with families where robust, legally backed interventions are required and in raising concerns where referred families do not make contact.

Policy Development

28. The fast changing nature of children's services and the impact on thresholds will remain a concern for some time to come and policies will need to be flexible enough to withstand regular review so that they can be adapted over time as new systems become established. This relates particularly to thresholds and to the emergence of lead professionals, as well as to the introduction of early intervention strategies.

29. Consideration should be given to establishing a coherent parenting training strategy across all agencies.

30. Consideration should be given to bidding for a pilot of the new home visitation programme.

Other issues

31. Where there are regular cross boundary movements of families (as between Derbyshire and Nottinghamshire, for example) there may be some value in developing a protocol for easier and swifter access to client information. *