Norfolk Safeguarding Children Partnership

The Norfolk Safeguarding Children Partnership Strategy to Protect Babies From Harm

1. Introduction

1.1 The onset of the Covid-19 pandemic has highlighted risks posed to babies nationally, with a significant rise in reports of children who suffered non-accidental injuries (NAIs). As of 6 November 2020, more than 300 "serious incident notifications" of injury and death involving children were reported by local authorities between April and October, of which almost 40% involved children under the age of one. Ofsted's chief inspector reported that more than half of those babies – 64 in total – suffered non-accidental injuries, eight of whom sadly died.[1]

1.2 Norfolk has considered several Rapid Reviews on babies since March 2020. This is in the context of published Serious Case Reviews on pre-verbal/non-mobile babies in the last two years, namely: the thematic Serious Case Review on NAIs, Case AF, published January 2020; and two cases of babies who died as a result of overlay, Case AB, published June 2019. A national Child Safeguarding Practice Review on Sudden Unexpected Death in Infancy (SUDI) in families where the children are considered at risk of significant harm was published in July 2020. [2]

1.3 The challenges we face protecting unborn children and very young babies have been exacerbated due to lockdown. As a result, the Norfolk Safeguarding Children Partnership (NSCP) has adopted Protecting Babies as one of its priorities alongside Neglect and Child Exploitation. (See Appendix 1, overview of NSCP priorities). There are some clear crossovers with neglect as an issue and, to a lesser degree, adolescents if young parents are struggling with the responsibility of looking after their babies.

1.4 The Protecting Babies from Harm strategy has been written in response to local and national reviews in order to implement the learning in Norfolk. Recommendations from local and national Serious Case Reviews/Safeguarding Practice Reviews (SCRs/SPRs) have been incorporated. (See Appendix 2)

[1] Abuse of babies is up by a fifth during Covid crisis, Ofsted says | Child protection | The Guardian

[2] Safeguarding children at risk from sudden unexpected infant death - GOV.UK (www.gov.uk)

1.5 The strategy covers three main areas: non-accidental injuries to babies; assessing risk to unborn babies, including concealed or denied pregnancy; the capacity of parent/carer to manage crying and safer sleeping.

1.6 The strategy is underpinned by a discrete Protecting Babies Steering Group, chaired by Health, and reports directly to the NSCP Partnership Group.

2. Strategic Aims and Objectives

The NSCP's aspiration would be to eradicate harm to babies in whatever form it manifests itself. In acknowledging that some of the variables involved are beyond the Partnership's ability to control or alter, the strategic aim seeks to:

Minimise the risk of babies, including unborn children, suffering from harm in all forms, and ensuring that their first two years enable their development so that they safely reach their early years milestones.

Learning from Serious Case Reviews, we recognise that we need to be trauma informed to enable the frontline to safeguard effectively and fully understand the experience of the service users, including vulnerable parents and the impact of parenting on unborn, non-mobile and pre-verbal babies. This strategy sets out some parameters to make our objectives achievable with three overarching aims. The objectives/ high level actions we will take to achieve the strategic aim are listed against each strategic statement below.

2.1 **Preventing Non Accidental Injuries: We will work with professionals from all disciplines to implement the learning from Norfolk's thematic Serious Case Review on NAI, Case AF.** Building on a trauma informed approach, we will support staff to have safe and challenging conversations with families and each other to ensure practice is baby focused and risk sensible. There will be specific focus on: respectful scepticism ("thinking the unthinkable"); professional challenge and deference; and giving voice to the baby's lived experience of care.

Objectives and high level actions:

- Ongoing learning events picking up recent cases of NAI with frontline professionals and consultation with them on strategy implementation (see also Appendix 3, Recommendation 1 Case AF – Terms of Reference for operational group)
- Policy review (medical examination and injuries to non-mobile babies) and relaunch
- Review of pathways into services, including barriers
- Improved communication with Primary Care
- Developing robust and dynamic risk assessment to include professional curiosity about parental experience of adversity and the impact of

Adverse Childhood Experience (ACEs) on parents' ability to care for vulnerable babies
- Improved understanding and inclusion of fathers/male partners and other carers.

2.2 **Unborn babies: We will develop practice to better safeguard unborn children and address risks posed by concealed or denied pregnancy.** The definition of neglect incorporates risks posed in utero and we will have transparent and challenging conversations with parents and each other to address reasons why a pregnancy may be concealed/denied, including the impact that this could have on unborn children.

Objectives and high level actions:
- Develop single protocol and pathway for management of concealed pregnancies
- Link with Local Maternity Strategy
- Review of pre-birth assessment policy

2.3 **Safer Sleeping: We will provide the training, tools and resources to families and staff from across the partnership to ensure that safer sleeping messages are delivered to and understood by families with newborn babies.** We will communicate effectively with parents of newborn babies to ensure that they understand the risks posed by inappropriate sleeping arrangements and can provide a safe place for their babies to sleep. Partners from all agencies will reinforce the messages and contribute to robust risk assessments and safety planning for changes in routine to address any underlying issues, including overcrowding, substance and alcohol misuse and parental mental health.

Objectives and high level actions:
- System wide training programme MA & community use - digital
- Resources on JON Norfolk reviewed and expanded
- Comms key messages to be written and launched

2.4 **All Babies Cry: We will provide training, tools and resoruces to famiiles and staff rom across the partnership and underpin our strategy with clear communications under the banner of '*All Babies Cry*'**. We will ensure that all parents are supported to develop their parenting skills to manage crying babies and have access to resources to help them manage anxiety and sleep deprivation. The *'All Babies Cry'* communications campaign will support all aspects of the strategy, recognising that looking after a newborn can be stressful and more so in the context of Covid-19 and limited family support networks.

Objectives and high level actions:
- Develop and embed a system wide approach to understanding developmental stages/risks and resources available

- Bring together a dataset that covers all aspects of the strategy
- Co-ordinated communication campaign

As noted above, data and communication are common threads across the strategic aims. In addition, training needs will be assessed both in terms of specific learning around this age group as well as linking to workforce development across all the NSCP priorities in relation to understanding parental experience of Adverse Childhood Experiences, resilience factors and the impact this has on parenting capacity.

3 Definitions and Terminology

There are a number of definitions and terms that apply to this strategy.

3.1 **Non Accidental Injury (NAI):** Collins dictionary defines NAI as: *damage, such as a bruise, burn, or fracture, deliberately inflicted on a child or an old person*.

3.2 **A concealed pregnancy** or denied pregnancy is defined as *a pregnancy where a woman has not accessed antenatal care before 20 weeks. There is no typical set of circumstances associated with concealed or denied pregnancy, though each presents high risks to the unborn baby / the infant once delivered.*

A concealed pregnancy is when a woman knows she is pregnant but does not tell any health professional; or when she tells another professional but conceals the fact that she is not accessing antenatal care; or when a pregnant woman tells another person or persons and they conceal the fact from all health agencies.

A denied pregnancy is when a woman is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misinterpreted; they may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant. In some cases, a woman may be in denial of her pregnancy because of mental illness, substance misuse or as a result of a history of loss of a child or children.

3.3 **Neglect:** *The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse.*
(Working Together 2018)

3.4 **Terminology linked to Safer Sleeping:** The terms below have been taken from the National Panel's Thematic Safeguarding Practice Review: ***'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm'*** (July 2020)

Bed sharing: *Where the parent or parents sleep in the same bed with their infant. It is often done by mothers or caregivers to extend breastfeeding, to employ easy access to breast for night feeding, and to foster bonding or physical closeness with infants.*

Co-sleeping: *The practice of sharing a bed, sofa, armchair or other surface with an infant for sleep, which can take place intentionally or unintentionally*.

Families with children at risk: *Families whose circumstances indicate high risk of significant harm. The range of circumstances indicating high risk of significant harm included:*

- *current or previous child protection or children in need plan*
- *cumulative neglect*
- *known misuse of alcohol or drugs*
- *domestic violence or criminal behaviours*
- *mental health problems deemed to present a risk to children's wellbeing*
- *unsuitable housing or frequent moves of home*
- *parents who were care leavers*
- *parents who were care leavers*
- *other children removed from care or courts involvement*
- *young parents*

Out-of-routine incidents: *Unexpected changes in family circumstances immediately before the Sudden Unexpected Death in Infancy (SUDI), in which an infant is placed in an unsafe sleep environment. These situations occur across the full continuum of risk. In high-risk families they may be associated with situations where there is escalating safeguarding risk.*

Pre-disposing risks: *Factors that are strongly associated with the incidence of SUDI. Local interventions by partner agencies focus on modification of the risk through universal and targeted services.*

Situational risks: *Where an infant is at risk of significant harm as a result of neglect, domestic violence, parental mental health concerns or substance misuse. In high risk families, these factors are present in combination with factors such as deprivation, worklessness and poor housing conditions. Work by partner agencies to reduce the risk of SUDI in these families often takes place within a framework of statutory intervention.*

4. Principles:

4.1 The NSCP adheres to the following principles in the development and implementation of this strategy:

- We will maintain a clear focus on the unborn child/baby and focus on their lived experience of care and acting as their advocates

- We will have whole system leadership in awareness raising and tackling the risks posed to babies with all partner agencies taking responsibility for professional standards within their organisations.
- We will have clear lines of accountability, roles and responsibility in cases of unborn children/babies
- We will have a shared, multi-agency approach to identification of risks posed to babies and agreed interventions and pathways
- We will demonstrate commitment to equalities and diversity acknowledging that some unborn children/babies are at more risk due to their diverse needs
- We will be culturally competent in this area of work, recognising that parenting is learned and has cultural influences
- We will be competent and confident in recognising and managing the complexity and emotional impact of safeguarding babies, with a focus on 'thinking the unthinkable'

5. Measuring Impact

5.1 In summer 2020 the NSCP agreed that Protecting Babies is a priority for Norfolk and will ensure that the strategy implementation is timely and monitored for impact. This strategy is underpinned by a robust action plan which includes clear deliverables and milestones for implementation.

5.2 Quantitative and qualitative measures to assess and monitor progress will be agreed by each individual workstream. Data will be provided by partner agencies, including NHS providers and Public Health.

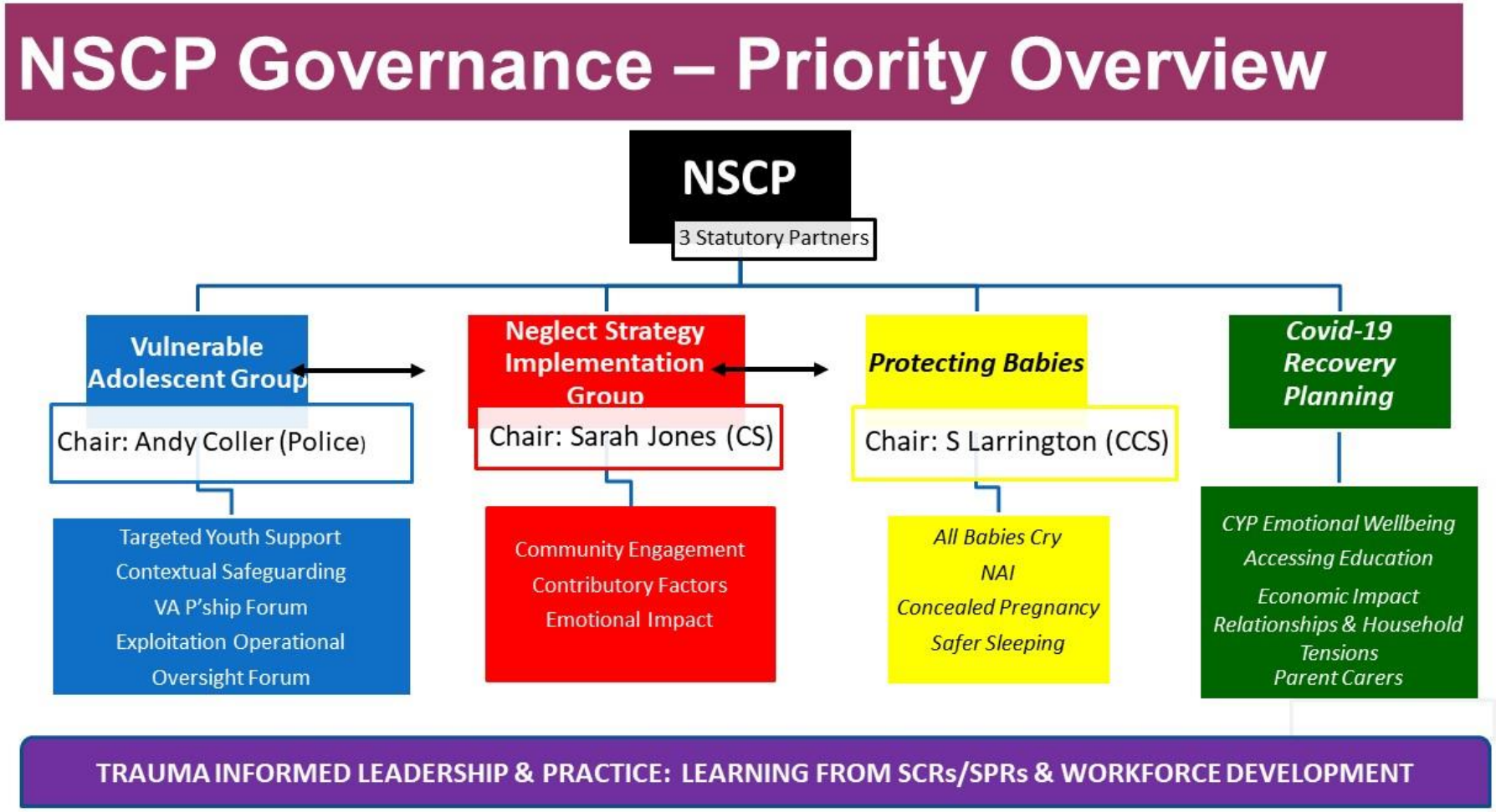
6. Leadership and Governance

6.1 As a priority area, Norfolk's Strategy to Protect Babies From Harm will be governed by a discrete multi-agency NSCP subgroup, chaired by Cambridgeshire Community Services, Head of Service for the 0 – 19 Healthy Child Programme Provider.

6.2 The Protecting Babies Steering Group has clear Terms of Reference and representation from strategic leaders from across the partnership. The Chair reports regularly to the NSCP Partnership Group.

6.3 The Protecting Babies Steering Group is strategic and is supported by three subgroups with identified leads to deliver against the strategic statements set out under Section 4. The Steering Group is responsible for improving multi-agency practice and the subgroup leads will support specific developments against their areas of responsibility, as detailed in the action plan.

Appendix 1: NSCP Priorities Governance Overview



Appendix 2
SCR/Scrutiny recommendations cross referenced with Protecting Babies Strategic Aims

Recommendation		**Cross Ref**
Source: National Child Safeguarding Practice Review: SUDI (summarised)		
Robust commissioning to promote safer sleeping within a local strategy for improving child health outcomes		2.2
Multi-agency action to address pre- disposing risks of SUDI for all families, with targeted support for families with identified additional needs		2.2
Differentiated and responsive multi-agency practice with families to promote safer sleeping in the context of safeguarding concerns and other situational risks		2.2
Under pinning systems and processes with relevant policies, procedures and practice tools that support effective multi- agency practice across the continuum of risk of SUDI.		2.2
Source: Norfolk Serious Case Reviews *NB Case AJ pending publication.*	**SCR Ref**	**Cross Ref**
The NSCP must develop better understanding of the impact of concealed/denied pregnancy and the impact on bonding and parenting capacity*. All concealed or denied pregnancies must be referred to Children's Advice and Duty Service and Social Work assessment; cases should be monitored to assess the extent of the issue, types of interventions and outcomes, including what services are put in place if cases close following the assessment. ** Research shows that when the baby is born there may be poor attachment and bonding, with the mother being psychologically unprepared to look after a new baby. This should lead to psychological or psychiatric input being considered as part of any assessment or discharge plan.*	AJ	2.1
There needs to be ringfenced reflective time for more junior practitioners to explore safeguarding issues in relation to diagnosis/decisions directly with senior Paediatric Consultant colleagues, particularly if they have not been fully involved in the decision-making process.	AJ	2.1
Safeguarding concerns in infants under 12 months, documented in the clinical record, should prompt practitioners to consider more thorough clinical examinations, including monitoring of weight and plotting on centile chart. An action plan to embed the learning across relevant practitioners will be formulated following this review.	AJ	2.1

Source: Norfolk Serious Case Reviews, cont.	**SCR Ref**	**Cross Ref**
There needs to be effective and explicit communication between Social Care and partners involved with family when a case is closed. The decision to close a case by Social Care should be informed by the views of Health Visitors, GPs and other relevant professionals; the case closure process needs to be reviewed by Children's Services to ensure everyone is aware and in agreement. Children's Services also to review standard closure letters to parents to ensure they are more explicit about ongoing involvement with the child via other agencies e.g. Community Care.	AJ	2.1
Children's Services to review the terminology describing different types of Family Network or Rapid Review meeting to make them distinct and linked to the purpose of the meeting. The outcome of that review and any guidance developed to be shared with all partners.	AJ	2.1
The use of cultural genograms should form an integral part in Family Network Planning.	AJ	2.1
A multi-agency task force should be urgently formed in Norfolk, including representatives from the front line, to collate data on serious injuries in similar circumstances to per-mobile pre- verbal children. Task force to oversee practice and better understand the extent of this critical safeguarding issue. The learning identified in this review (summarised as Terms of Reference for the task force in Appendix 2) should inform the work of this group. (see also Appendix 3)	AF	2.1
NSCP are encouraged to build on the work that has been completed during this review and adopt a whole systems approach to the key learning (summarized in Section 10 above.) NSCB are invited to apply the Appreciative Inquiry model to plan how the learning will be implemented.	AF	2.1
NSCP should review and re-launch the 'Safer Sleeping Guidelines for Professionals'. • Relevant partner agencies should ensure that appropriate staff are familiar with the 'Safer Sleeping Guidelines for Professionals' and are adhering to these when working with families where there is a pregnancy or a baby under 12 months of age. • Relevant partner agencies should ensure that agency policies and procedures are consistent with the revised 'Safer Sleeping Guidelines for Professionals'.	AB	2.3
NSCP and partner agencies should continue to evaluate the impact of the film regarding safer sleeping to inform decisions as to how it should be used in the future.	AB	2.3
NSCP and partner agencies should evidence how they will promote a culture change regarding the importance of agencies engaging with all significant carers when working with families	AB	2.3

Source: Norfolk Serious Case Reviews, cont.	**SCR Ref**	**Cross Ref**
Cambridgeshire Community Services should ensure that fathers/partners are specifically invited to be present at the antenatal visit and new birth visit and evaluate the outcomes.	AB	2.3
NSCP should seek reassurance that the partner agencies with roles and responsibilities in respect of unborn children are effectively implementing the Norfolk Pre-Birth Protocol when working with women and girls who are pregnant.	AB	2.2 & 2.3
Children's Social Care should ensure that assessments are suitably robust, comprehensive and analytical with high quality managerial oversight. They should be conducted in accordance with all aspects of the Norfolk Local Assessment Protocol, using the Framework for the Assessment of Children in Need and their Families (as set out in Working Together 2018), underpinned by the Signs of Safety Approach. Assessments should include contributions from partner agencies and where the family contains a child under five years of age a joint visit by the social worker and health visitor should be undertaken	AB	2.3
Children's Social Care should ensure that the Child in Need process replicates that of any other statutory process and that equitable regard is paid to children subject to Child in Need planning. This must be evidenced in supervision and management overview records. Additionally, there must be clear evidence of who was invited to Child in Need meetings, who attended, clear actions and timely minutes of the meeting	AB	2.3
Agencies who work with children and families should ensure that when practitioners are working with a family who lives in social housing and their housing situation is a source of concern, contact is made with the housing provider at an early stage.	AB	2.3
NSCP should develop links with CGL to ensure that: • The learning from this review is shared with CGL; • Working relationships are developed between CGL and agencies working with children and families.	AB	2.3

Appendix 3: Summary of Key Learning

- **Early involvement of trusted adults in the lives of children and adults builds a platform on which future trusted relationships can be built.** Windows of opportunity should be harnessed, and services (such as those provided through the voluntary sector, FNP and the Eden Team) should be strengthened to increase capacity and gaps identified.

- **Dynamic multi-agency risk assessments and risk sensible practice must be strengthened,** the family and the multi-agency network should be fully engaged and the SOS model comprehensively embedded.

- **Respectful relationships** should be promoted and facilitated across organisational hierarchies and the ownership of risk/decision making and collective problem-solving should be improved by routinely promoting information exchange, active dialogue,[3] debate and challenge and through specific multi-agency forums, supervision and training.

- **Breaking the trauma cycle - the cyclical nature of family patterns and difficulties needs to be understood. Awareness of ACEs and impact should be strengthened** (about children and parenting capacity) and a shared multi-agency response delivered.

- **Safeguarding children is a human service, the emotional content of the work has a bearing on how children are safeguarded.** The psychodynamic aspects (including how defences are constructed against the inherent anxiety) need greater attention and ways found to acknowledge the impact and mitigate the risks to enable the workforce to think and act.

- **The multi-agency safeguarding workforce protects children from harm every day and improves their outcomes.** This workforce is the system's most precious resource, opportunities to demonstrate their value should be harnessed. **Celebrate and promote good practice and what works well.**

- **A just learning culture needs to be established** to support the work force in identifying strengths and vulnerabilities so that learning and development can be strengthened.

- **A trauma informed approach is needed** in order to respond to the needs of children and their parents, and the needs of staff**.**

- **Know your children – know your hot spots and prioritise – know your vulnerabilities. Courageous conversations are needed,** this includes

[3] Active dialogue is a conversation, participants are neither passive nor dominant. It features an exchange of information and knowledge, respectful challenge, curiosity and debate.

conversations with families, the front line, commissioners, inspectorates and political leaders.

- **Be conscious about the impact of organisational flux**, inspections and SCRs and take steps to mitigate these risks.

- Find ways to **increase energy and commitment to build partnership working** both at the front line and at a strategic level - be creative and take a long-term view. Develop joint priorities and a shared understanding/language and vision when responding to the learning from this review.

Recommendation 1 Terms of Reference for Task Force

The following is a list of the key learning to inform the terms of reference for the task force:

- Data about NAI to young children to be gathered and mapped – any hotspots to be identified and raised with senior management
- Cases to be audited against audit variables set out in this review
- Any concerns about service delivery in a case to result in immediate action
- NSCP to be kept informed of progress
- Operational and strategic recommendations to be made to NSCP

- **Existing practice framework (Signs of Safety) to be discussed and reviewed to explicitly include:**

  - Dynamic multi-agency assessment, decision making and planning that features curiosity and avoids optimistic or polarized thinking

  - Utilising opportunities for Multi-Agency (MA) reflective spaces to make better sense of the case and improve decision making

  - Scoping and mapping the full network (including GPs, voluntary sector, faith/community links)

  - Importance of information exchange in the form of active dialogue, debate and challenge

  - Importance of joint SW/HV visits, assessments and MA management overview (in line with existing protocol)

  - Use of SOS approach including application of this approach when assessing extended family members that fully explores and evidences both the strengths and vulnerabilities/ risks

  - Consideration of ACE's in parents/carers/associates, the vulnerabilities on parenting capacity posed by ACEs and the dynamic interplay between the vulnerabilities between the couple and with their caring responsibilities

(particularly when a child has specific vulnerabilities linked to prematurity, feeding & or sleeping difficulties, stressful birth experience)

- Full consideration of levels of violence/ violent communication/ desensitisation to violence by those in a parenting/caring role and the impact on MA decision making and wellbeing

- Understanding the child's lived world through observation of their behaviour

- Understanding the relationship between the child and primary care giver/ prime source of safety

- Factoring in prematurity & birth history and the interplay with parental vulnerabilities in assessments of risk

- Recognition that couple reunification is a critical time of risk

- The importance of understanding the role of father's/male partners in the lives of children

- Recognition that MA practitioners have to make decisions/ take action when there is often uncertainty. Establish mechanisms to support risk sensible decision making

- Establish ways in which MA practitioners are supported to consider the likelihood of harm and take action when there has not been an injury or when there is no definitive diagnosis of NAI

- Acknowledge the psychodynamic components of the work that can hamper practice and service delivery and provide a reflective space for these to be explored and contained

- Recognition that the relationship between professionals has an important impact on practice and service delivery, identify the importance of this and establish/signpost ways in which these relationships can be nurtured