Norfolk Safeguarding Children Partnership

# Learning from Safeguarding Practice Reviews

# Case AJ

# Safeguarding Practice Review: Case AJ

This presentation sets out:

- Summary of the case
- Terms of Reference:
  - methodology
  - key research questions
- Areas of Learning
- Recommendations
- The NSCP's response

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# Summary of the Case

- December 2019 of Child AJ dies in hospital aged three months, from head injuries.
- Concerns raised following birth regarding the parents' ability to care for AJ, particularly as the mother had concealed or denied the pregnancy.
- Two referrals were made shortly after the birth resulting in Social Care assessment.
- Parent's behaviours described as odd, focussed on their animals, often not telling the truth (particularly the father) – made it challenging for professionals working with them.

# Summary of the Case, cont.

- Referral to Consultant Paediatrician in October following bruising, attributed to an ill-fitting car seat by parents.
- Family moved to a new house 8 weeks after the birth without telling professionals – Case closed to Social Care. AJ's weight drops during last 5 weeks of life.
- AJ suffers injuries and dies in Addenbrookes, found to have numerous healing fractures to ribs and legs at post-mortem.

# Terms of Reference: Methodology

- Review group made up of key professionals.
- Identify timescales and key themes – Terms of reference
- Signs of Safety used for each key theme.
- 1-2-1 reflective conversations held with 7 practitioners

Parents kept informed of review process.
Consideration of ongoing police investigation.

*NB At time of publication, parents' trial was just concluded; mother was found guilty of neglect and father found guilty of manslaughter and neglect. They have been offered an opportunity to share their views on the safeguarding system if they wish. Any additional learning will be published separately.*

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# TOR: Key Research Questions

- Was there sufficient parenting support and assessment considering the concealed/denied pregnancy and other factors such as adversity experienced by the parents in their childhood?
- Was the safety planning on discharge from hospital adequate to safeguard the child, taking into account complicating factors such as mother's health and the support of a family network?
- How robust are the referral process and management of non-mobile infants with bruising where there is reliance on medical opinion, particularly if there is a professional disagreement?

# TOR: Key Research Questions, cont.

- Decision making, transfer of information and communication at the point of closure: how well were professionals able to monitor AJ's milestones?

- How well are the processes and purpose of a Rapid Network Meetings understood across the Partnership?

# Research Question 1: Concealed/Denied Pregnancy

| WHAT WENT WELL | WHAT COULD HAVE BEEN BETTER | WHAT WE HAVE LEARNED |
|---|---|---|
| Good engagement of a range of professionals, including Social Worker, Health Visitors and Midwives at the time of birth and in the first two months of AJ's life. | Little evidence to support a robust parenting assessment after the birth and before discharge. Litle consideration of peri-natal mental health, lack of attachment and concealment/denial of the pregnancy. | The need for a detailed risk assessment of parenting capacity particularly where parenting engagement and mental health is a concern. |
| Effective response to mother's and AJ's health issues following the birth; both spent time in Intensive Care and were visited by a range of professionals. | Insufficient understanding/assessment of how mother's previous miscarriage may have affected her mental health or may have led to the concealment or denial of the pregnancy. | Where the pregnancy in concealed or denied and mother is said to be 'traumatised' by the birth, a support package should be considered following the assessment. |
| Evidence of good Social Worker management oversight of the case following the birth, leading to a Rapid Network Meeting. | Father's previous abuse: disclosed to the Social Worker and Health Visitor - considered to be a manageable risk. Assumptions made about extent of family network and support. | |

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# Research Question 2: Safety Planning

| WHAT WENT WELL | WHAT COULD HAVE BEEN BETTER | WHAT WE HAVE LEARNED |
|---|---|---|
| Good multi-agency involvement with Mother and AJ responding to their medical needs. | Lack of professional curiosity around the family support network on leaving hospital; few, if any, visits from family members. Also noted in SW case file that 'Family relationships are not fully understood'. | Greater understanding of family support networks before discharge where parental engagement and attachment is a concern |
| | Little evidence of proactively trying to engage or fully understand family support networks. | Greater understanding of the impact of concealed/denied pregnancy and impact on bonding and parenting capacity . |
| Referral by Health visitor to Parents and First Teachers (PAFT) support within two weeks of the birth. | Hospital discharge and safety plans not detailed or robust: no evidence of support for mother's physiological or psychological needs following a concealed/denied pregnancy and a traumatic birth. | Agencies need to have a shared understanding of risks associated with concealed or denied pregnancies and their role in dealing with them. This should lead to psychological or psychiatric input being considered as part of any assessment or discharge plan. |

# Research Question 3: Bruising in Non Mobile Infants

| WHAT WENT WELL | WHAT COULD HAVE BEEN BETTER | WHAT WE HAVE LEARNED |
|---|---|---|
| Management oversight of the case leading to a Rapid Network Meeting within 20 days of the Social Work assessment starting. | Purpose of the Rapid Network Meeting should have been made clear to attendees, by the Social Worker and concerns referred directly to the on-call Paediatrician, not via the GP, as per the Norfolk protocol for injuries to non-mobile infants. | Greater understanding of the referral process after a Rapid Network Meeting across the partnership, particularly for bruising in non-mobile infants. |
| Medical opinion sought immediately after RNM following identification of bruising to AJ's cheek. | Consultant Paediatrician, relatively inexperienced in consultancy role, could have requested that the Senior Colleague examine AJ, rather than seek verbal assurance without an examination. | Opportunities for more junior and senior colleagues to consult and agree on diagnoses and decisions by senior colleagues, particularly when not fully involved in decision-making process. |
| Quick response from GP referring to Paediatrician same day following examination at GP surgery. | Junior Doctors and the Nurse, who were present at the examination, could have been part of the decision-making process with the Senior Paediatrician, when further advice was sought. | Strategy meeting convened as per the Norfolk protocol when an injury is identified to a non-mobile infant. |

# Research Question 4:
# Case Closure & Monitoring Milestones

| WHAT WENT WELL | WHAT COULD HAVE BEEN BETTER | WHAT WE HAVE LEARNED |
|---|---|---|
| Effective interventions by Midwife and Health Visitors ensure that milestones were monitored during first 8 weeks. | AJ's clinical examination at GP2 in the days before her death, did not include her being weighed or plotted on a growth centile chart, which could have alerted professionals to her failure to gain weight. | Weighing and plotting on centile charts should form part of any thorough clinical examination of infants, particularly where there are known safeguarding concerns. |
| Clear recording on SystmOne identified the previous safeguarding concerns on handover to the new Health Visitor. | Case assessed under Section 17, Child in Need, and was closed by Social Care, but it was not clear that the family would still receive some ongoing support. | |
| Good use of GP Safeguarding Lead to trace the family once GP records showed they had moved. | New Health Visitor unaware the case had been closed by Social Care on handover. Time was spent contacting the Social Care office to establish the status of the case. | Process for closing a case by Social Care and informing Health Visitors, GPs and other relevant professionals needs to be reviewed to ensure everyone is aware. |
| Effective intervention by GP1 to contact new Health Visitor and alert to safeguarding concerns and the need for 12-week immunisation. | Midwives record case records on a system called Badgernet and are unable to see records on SystmOne. This may hinder effective information sharing, especially where there are safeguarding concerns. | |

# Research Question 5:
# Rapid Network Meetings (RNMs)

| WHAT WENT WELL | WHAT COULD HAVE BEEN BETTER | WHAT WE HAVE LEARNED |
|---|---|---|
| Good identification of the need for a Rapid Network Meeting, including multi-agency involvement and Maternal Grandparents in the process. | Following the RNM, the Social Worker should have referred directly to the on-call paediatrician rather than go via the GP as per Norfolk protocol for injuries to non-mobile infants. | Review of the Norfolk Vital Signs for Children, Family Network Approach (Feb 2019) and sharing of the guidance across the partnership. |
| | Not made clear by the Social Worker that the meeting arranged was an RNM. It should have been communicated so that the relevant qualified professionals could attend. | Clear guidance on who monitors the outcomes and next steps from RNMs. |
| | Distinction between a Family Network Meeting and an RNM and their purpose is not as clear as it should be for professionals. | Ensure that staff attending RNMs are qualified and have the relevant experience, particularly where there are child protection concerns. |

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# Recommendations

**Recommendation 1.**

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.*

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# Recommendations, cont.

**Recommendation 2.**

There should be opportunities for more junior practitioners to explore safeguarding issues in relation to diagnosis/decisions directly with senior Paediatric Consultant colleagues, both around the time of the medical examination, and also as ringfenced reflective time, as part of a robust peer review process.

**Recommendation 3.**

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.

**Recommendation 4.**

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.

# Recommendations, cont.

**Recommendation 5.**

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.

**Recommendation 6.**

The use of cultural genograms should form an integral part in Family Network Planning.

**Recommendation 7.**

Ensure that the learning from this review is incorporated into an action plan under the Norfolk Protecting Babies Strategy and monitored by the NSCP.

# NSCP's Response

- Protecting Babies is a priority area in business plan
- Protecting Babies Strategy published on NSCP website and comprehensive action plan incorporating all recommendations within this SPR.
- Key strands focusing on Concealed/Denied Pregnancy and Non Accidental Injuries to babies
- Relevant policies and training under review

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# Learning Activities

- Consider how your team assesses and understand risks associated with concealed/denied pregnancies and what steps you can take to improve risk assessments
- Develop ways to communicate effectively with parents where there are concerns about historic abuse and its impact on parenting capacity; sense check their understanding of risks identified
- How well do you work with fathers specifically and parents with mental health issues more generally?  What are the barriers and opportunities?
- Discuss what good partnership working means to you with your team: when does it work well and how can you improve relationships if there is lack of clarity/understanding about processes – what works well?
- Ensure your team is up to date with the NSCP Protecting Babies strategy and action plan
- Discuss the emotional impact of non accidental injuries to babies on yourselves as individuals and the wider safeguarding system.