Derby and Derbyshire Safeguarding Children Partnership

Child Safeguarding Practice Review

LDS 19 / OD 20

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1. Introduction

1.1. This Child Safeguarding Practice Review has been commissioned by the Derby and Derbyshire Safeguarding Children Partnership (DDSCP) in accordance with Working Together to Safeguard Children (2018) and the Child Safeguarding Practice Review Panel: practice guidance (2019).

1.2. The review has considered the experience of two babies from two separate families.

1.2.1. **Infant 1** died from oxygen deprivation to the brain as the result of unsafe sleeping with neglect a significant feature of the case.

1.2.2. **Infant 2** had significant medical needs and suffered serious injury with neglect a feature of the case.

1.2.3. A third infant, **Infant 3**, suffered serious non accidental injury without neglect as a feature of the case. This infant's case was not reviewed in detail but will be referred to in this report.

1.3. The purpose of the joint review is to draw out learning arising from both the individual circumstances of these infants and systemic learning arising from their experiences that appear, from analysis arising from the Rapid Reviews, to lead to similar outcomes.

1.4. The joint review is aimed to:

1.4.1. Bring together the themes of the cases to provide better system learning whilst ensuring the individual features of each case are not lost.

1.4.2. Identify improvement measures that should be taken to address where learning has not led to **systemic** practice improvement following previous case reviews.

1.4.3. Deliver a strategic approach to learning and improvement that provides the partnership with clear priorities informed by both the two reviews and previous learning.

1.4.4. Provide evidence to embed learning and improvement in a way that local services for children and families are more reflective and achieve changes to practice that are consistent with the priorities arising from the two reviews.

1.5. See appendix 1 for the full terms of reference for the review.

2. Methodology

2.1. Dr Liz Adamson has been commissioned as the independent author for the review. See appendix 2 for the author's CV.

2.2. Practitioner events were held to consider key questions developed by the author and the DDSCP Child Safeguarding Practice Review and Partnership managers in line with the terms of reference for both Infant 1 and 2. (See Appendix 3 for the list of questions)

2.3. A manager's event for both Infant 1 and 2 was held at which the key points from the practitioners' learning events were discussed.

2.4. These minuted events were chaired by the author and supported by the DDSCP Manager and Child Safeguarding Practice Review Manager.

2.5. Subsequently, catch-up meetings were held with key practitioners and managers who were not able to attend the events.
2.6. The author has seen the collated reports for the Rapid Reviews of these cases and has noted the actions identified by services to address specific areas of service improvement. Detailed chronologies have not been reviewed and the focus has been on extracting broad learning in respect of reducing risk to infants.

3. Format of the report

3.1. Part 4 summarises the key learning themes that emerged from the review.
3.2. Part 5 outlines these key learning themes in respect of what emerged from reviewing each case.
3.3. Part 6 highlights the joint themes that emerged from the case reviews.
3.4. Part 7 draws an overall conclusion.
3.5. Part 8 considers actions are already being taken.
3.6. Part 9 makes further recommendations.

4. Summary of the key learning themes that emerged from the review:

4.1. Infants are intrinsically at risk because of their immature anatomy and physiology and their rapid development.
4.2. The introduction of any infant into a household will result in stress to some degree.
4.3. It is of vital importance to quickly identify and assess any additional risks an infant will face, such as:

- Any intrinsic additional needs of the infant, such as ongoing health, growth, or developmental impairment problems.
- Challenges in the home environment already resulting in increased stress, such as poverty, large family size**,** poor health and/or additional needs of carers or siblings**,** multiagency input to family and unresolved practical challenges to daily living, amongst others.
- Carer response to stress:
    - Lowered resilience to and/or capacity to deal with stress as evidenced by a carer's history.
    - History of a known response to stress by a carer that could increase risk to an infant, such as anger, aggression or reliance on substances.
    - Lack of engagement by key carers with practitioners, thus limiting assessment of stress within the household.
- Current/history of any mental health problems of carers:
    - The importance of fully exploring and understanding the nature of any problems and the extent to which they are under control.
    - Concerns if carers resist engaging in assessment of their mental health problems or minimise them.

- Current/history of substance misuse by carers:
    - The importance of fully exploring and understanding the nature of any problems and the extent to which they are under control.
    - Not relying on a carer's account of the amount and frequency of alcohol or drug use.
    - Recognition that chaotic alcohol and substance misuse is, by definition, less predictable and can therefore present a greater risk than stable use.
    - The importance of knowing what might precipitate unsafe alcohol or substance use in a carer with a chaotic pattern of usage.

4.4. The importance of good multiagency communication and relationships built on understanding, valuing, and trusting each other's roles.

4.5. The importance of recognising and having ways of addressing hidden risk when carers are not accessible to assessment or there is a lack of openness by carers about potentially harmful behaviours.

5. Review of cases

5.1. **Infant 1** was born to a mother with a history of chaotic alcohol abuse which she linked to times of stress, including a time when she was undergoing the fertility treatment which resulted in her first pregnancy. She also had a history of an eating disorder.

5.2. Between pregnancies, she was treated for depression and anxiety. She discontinued this treatment when she discovered she was pregnant.

5.3. The mother was seen, and fully assessed, by an experienced specialist substance misuse midwife during the pregnancy with Infant 1 and denied using alcohol. She has subsequently admitted that this was not the case and that she drank (and smoked) during the pregnancy.

5.4. After Infant 1's birth, she saw her GP and resumed medication for anxiety and low mood. She continued to deny alcohol abuse, indicating occasional use only.

5.5. Services involved with the family during Infant 1's life were midwifery, health visiting, GP, Early Help services, Talking Mental Health, police, Every Child A Talker programme (for the older sibling) and Drug and Alcohol services.

5.6. At various times, and to various of the professionals involved, Infant 1's mother denied having an alcohol problem or admitted using alcohol heavily sometimes, expressed difficulty coping with a toddler and an infant, showed great anxiety about her older child's speech development (to the extent of being "tearful" about it) and what she described as faecal "smearing" when the child was 15 months old.

5.7. She was observed by one professional to be drinking wine whilst making tea with no other adult in the house, she was reported missing with the children to the police by her sister because of the concerns about alcohol usage and she was reported to the police by her husband for driving with

the children when she appeared to him to be obviously under the influence of alcohol.

5.8. The concerns about alcohol use were recognised and confronted by all the professionals involved but the outcome was an acceptance of mother's script that her alcohol usage was under control.

5.9. There was also a professional conclusion that Infant 1's father was a protective factor although it was not clearly outlined in what way he could effect this protection when he was out of the house at work.

5.10. Safety issues were addressed with mother in accordance with protocol but there was no clear risk assessment as to whether her need for alcohol overcame her ability to provide safe care for her children at times, or what the triggers were for her chaotic, and therefore potentially risky, alcohol use.

5.11. When Infant 1 was six months old, father returned home from work to find mother asleep in a chair with Infant 1 between her and the arm of the chair and apparently lifeless. Resuscitation attempts were partially successful but Infant 1 died two days later.

5.12. Infant 1's mother admitted having drunk either two or three bottles of wine before passing out in the chair.

5.13. Infant 1's father and maternal family subsequently presented a picture of persistent, heavy drinking for many years, which was very different from that presented by Infant 1's mother herself.

5.14. At the professional's meeting to discuss Infant 1, there was general agreement that professionals had accepted mother's own script about her drinking, that some information which could have challenged that view was not shared fully across all agencies and that the wider family had information about mother's alcohol use that practitioners had not accessed. Had the information that emerged after Infant 1's death been fully shared beforehand it could well have shaken the confidence of professionals that this baby was safe and led to more assertive safeguarding action.

5.15. There was discussion about the need for professionals to be not only professionally curious but also professionally sceptical when dealing with a carer who had alcohol problems and to develop the confidence and skills to be able to engage not only with all immediate carers but with the wider family, or to recognise that blocking this engagement could be a reason to consider escalation.

5.16. There was discussion about the additional challenges of controlling chaotic alcohol misuse. In the case of Infant 1's mother, she was seen as someone who used alcohol to cope with stress rather than someone with an addiction and this seems to have been regarded as a lower level of concern. However, there was no clear assessment as to what the stressor points were that could trigger mother's excessive alcohol consumption and risk to her infant.

5.17. The family of Infant 1 was invited to contribute to the review.

5.18. **Infant 2** was born prematurely, with a chromosome abnormality causing significant and enduring health problems, into a family with five older siblings, one of whom had a congenital health problem, and parents who both had ongoing physical and mental health problems.

5.19. Infant 2's condition was one that had an impact on feeding, growth, and development as well as other health problems. Infant 2 spent six weeks in the neonatal intensive care unit (NICU) before being discharged home with a feeding tube in place. During the time Infant 2 spent in the NICU, the parents were noted not to visit very frequently. No concerns emerged about their direct care of Infant 2 when they did visit, however, although there was one instance of father being verbally abusive to mother and/or an older sibling. A multiagency discharge planning meeting was held prior to Infant 2 leaving hospital.

5.20. The family had been known to children's social care services for 18 months and had been escalated from an Early Help level to Child in Need because of poor engagement by the parents and no improvement in what were considered unsatisfactory home conditions for the children. Following the escalation, engagement by mother improved significantly and home conditions improved. Father's engagement with social care services, however, remained very poor and it is unclear as to the degree to which this was affected by his mental health condition.

5.21. There was a history of lack of engagement with health care by parents for their own care and for that of the older children. They did, however, engage well with medical and other secondary care health appointments for Infant 2.

5.22. Home visits by health practitioners were undertaken weekly, alternating between the Health Visitor and the Family Care Sister from NICU. These professionals attended the regular multiagency planning meetings and gave updates on Infant 2's health condition and health needs, which they felt were being met, largely by the mother.

5.23. Infant 2 had an eight day stay in hospital at three months old with feeding problems and difficulty with weight gain. This was felt to be intrinsic to the underlying health condition and not to reflect poor parental care. Hospital staff failed to inform the allocated social worker when Infant 2 was discharged from hospital on this occasion.

5.24. 19 days after this discharge, Infant 2 was seen for a routine Xray examination of the spine and was found to have six fractured ribs. At a full medical examination following the discovery of these fractures, bruising was noted to the bottoms of both feet and to the back. Specialist opinion, sought by the local medical staff, was that there was no link between the occurrence of the fractures or the bruising and Infant 2's

chromosomal abnormality and the initial medical conclusion was that these injuries were most likely caused non-accidentally.

5.25. Based on the initial medical conclusions, Infant 2 was taken into the care of the local authority, along with the younger two of the siblings, and had no further fractures or unexplained bruising whilst in care.

5.26. Legal processes to determine the likelihood of Infant 2's injuries being non-accidental were started and independent medical opinion from a number of different specialists was sought. A comprehensive Finding of Fact judgment concluded that injuries had been caused on three separate occasions, were caused by robust handling, were linked to reduced bone density and vulnerability to easy bruising resulting from Infant 2's underlying medical condition and identified both parental handling and professional handling during medical procedures as being causal. The judgment concluded that although these injuries were caused by Infant 2 being handled more robustly or zealously than would be considered normal for a baby of that age, they occurred when Infant 2 was already distressed and the handler would not have realised that harm was being caused.

5.27. The Finding of Fact noted that the initial medical conclusion and consequent action by social care services was reasonable based on the information available at the time.

5.28. The judgment also concluded that practitioner concerns about the care of Infant 2's siblings did not amount to neglect and all the children could be returned to the care of their parents.

5.29. At the professionals' meetings to discuss Infant 2, held prior to the Finding of Fact judgment, contrasting pictures of the family emerged from the perspectives of some health professionals and those from children's social care and education, which reflected the family situation presented in court and the legal analysis iterated in the Finding of Fact judgment.

5.30. Health professionals, particularly those involved in Infant 2's secondary level of health care, expressed a positive view of the parents, whom they felt were engaged in managing Infant 2's care well. They acknowledged that some concerns had been raised about parents' infrequent attendance during Infant 2's stay in NICU but felt that this was justified by the pressures of a large family. The NICU staff had recorded the verbal abuse issue and reported it to the social worker but did not appear to have reflected on it and knowledge of this did not appear to be considered more widely as part of any broad assessment.

5.31. All professionals recognised mother as the main carer for Infant 2 and visitors to the home from all professions felt that mother was the practical mainstay of the family. The home visits by health professionals were focussed on Infant 2's health needs and how these were being met by mother. There is no evidence of consideration of the additional stress the

family was under and the impact Infant 2's health needs could have had on the whole family.

5.32. Encompassed within the overall positive attitude to the family situation by many health practitioners, it is, however, recorded in the Rapid Review for Infant 2 that the following factors, which could have given rise to concern about stress within the family, were identified in the health records:

- Both father and mother had mental health concerns.
- Parents were coping with the loss of a previous child by stillbirth.
- Father reported allegations that one of his children had been sexually assaulted.
- Concerns that could have indicated possible neglect were recorded, including poor home conditions, poor school attendance, poor presentation of the children and poor parental engagement.
- Parents were already coping with a child with disability and health needs and a child who was being educated at home.

5.33. In contrast, social care and education professionals expressed significant frustration in their involvement with the family and concerns about the children. Lack of engagement with the Early Help worker frustrated her efforts to ensure the children attended school regularly, received appropriate health care, were kept clean and suitably dressed and lived in a house with acceptable standards of cleanliness. This eventually led to an escalation to Child in Need and the allocation of a social worker. The social worker had more success as mother recognised that this was a serious situation that needed addressing. Her level of engagement improved, and home conditions became acceptable. School attendance by the children continued to be erratic, however, and the oldest child refused to attend school and was educated at home. There was also continuing failure to take some of the children to health appointments.

5.34. The social worker was able to observe father on her visits, including observing him handling Infant 2, but he did not engage in any conversation that would have enabled her to assess his parenting capability or capacity or overall contribution to family functioning.

5.35. Social work focus was on improving the care of the children as many elements of this were felt to be neglectful. Although engagement and management of the house had improved, there were other aspects of care that continued to raise concerns. The social worker sought regular supervision and expressed her view that the case was "stuck" and that when progress was made in one area another caused concern so overall progress was extremely limited. The discussion of possible escalation to a higher-level Child in Need with independent chairing of meetings or to

Child Protection level, both before and after the birth of Infant 2, indicates the level of her concern.

5.36. The social worker clearly did consider possible risk to a vulnerable infant in this situation but was reassured by her observations of how both parents handled Infant 2.

5.37. Education staff were also frustrated by the lack of parental engagement, the erratic and poor school attendance and the children sometimes attending school unkempt and unclean. A particular concern arose when two “EpiPens” for one of Infant 2’s siblings, kept in school under the agreed protocol for dealing with children with a severe allergy, ran out of date and no replacements were provided by parents despite many reminders. The Finding of Fact judgment concluded that there was no evidence of risk to the sibling of a severe allergic reaction as a result of this. However, it was reasonable for the school to be concerned based on them initially being informed that the EpiPen was needed and not receiving any subsequent information to the contrary.

5.38. It was also noted that the parents did not access the online nursery account through which important information was shared with parents, again despite many reminders.

5.39. The parents expressed to health professionals their dissatisfaction with the input from children’s social care, which they felt was adding stress to their lives by expecting what they regarded as unreasonably high standards within the home and attendance at multiagency meetings, whilst not addressing practical issues of everyday living such as a washing machine and vacuum cleaner that were not working and which they did not have the material resource to replace.

5.40. Many health professionals appear to have accepted a narrative for this family of parents in difficult circumstances dealing stoically and caringly with the additional burden of a child with significant additional needs. Whilst this narrative had validity for Infant 2, it did not facilitate a more objective assessment of how the family was functioning.

5.41. Many of the health professionals also appear to have accepted the parents’ view of social care input and whilst there was health engagement with the multiagency planning processes for the family in respect of Infant 2, this was mainly focussed on the health needs. Opportunities were missed to work more collaboratively and effectively with other agencies to contribute to a broader assessment of family functioning and risk.

5.42. The discussions at the professionals’ meetings highlighted the need for greater understanding of different professional roles to engender a more integrated approach based on mutual understanding and trust.

5.43. Given Infant 2’s medical problems, it is difficult to assess whether the injuries suffered were preventable. However, it is reasonable to consider that a more comprehensive and coordinated assessment addressing the issues of vulnerability and risk, which were subsequently subjected to

comprehensive scrutiny during the Finding of Fact hearing, could have resulted in Infant 2's handling being safer in all contexts.

5.44. The family of Infant 2 was invited to contribute to the review.

5.45. **Infant 3** was born into a reconstituted family of mother, natural father, and a maternal half sibling.

5.46. There was a history of conflict and violence in mother's relationship with the father of Infant 3's half-sibling, with three incidents of mother involving the police in respect of her ex-partner's behaviour, and one incident when her ex-partner involved the police in respect of her behaviour. The risk was categorised as medium.

5.47. Social care services had been involved in carrying out a single assessment and there had been Early Help assessment because of the parental conflict and challenging behaviour of the sibling, which was reported to be worse after contact with the father.

5.48. The Early Help and health visiting service input resulted in identification of the sibling's speech and language problems, which were thought to be a significant factor in the behaviour problems. Appropriate referrals were made to address this.

5.49. There were no concerns about Infant 3's care and no history of alcohol or substance misuse.

5.50. Infant 3's parents were said to have attended the GP frequently with concerns about feeding problems and weight gain. A referral for paediatric opinion was made.

5.51. At the age of three and a half months, Infant 3 was taken to hospital with a raised temperature and, on examination, was noted to have a swollen leg. X-ray examination showed fractures at both ends of the femur and further investigation identified rib fractures. In total, Infant 3 was found to have 16 fractures, which were diagnosed as being non-accidental.

5.52. Parents have denied injuring Infant 3 and have offered no explanation as to how these fractures have occurred.

5.53. Infant 3 has been taken into foster care and no further fractures have occurred.

5.54. A practitioners' meeting was not held for Infant 3. Reports for the Rapid Review into the case, however, highlight that no contact was made with mother's ex-partner about the domestic violence, that insufficient consideration was given to mother's contribution to the conflict and violence and that the sibling's behaviour was not followed up in a systematic way. There was also consideration during the Rapid Review as to appropriate response to medium risk domestic abuse that is on the cusp of high risk.

5.55. On reviewing the case for this report, it is clear that the needs of Infant 3 and the sibling were being identified by professionals and being

addressed, but risk to them, and in particular to Infant 3, was not being assessed.

5.56. It is apparent that there was little if any recognition of the possible impact of the stress of the ongoing conflict between mother and her ex-partner or of the feeding difficulties being assessed either as a significant additional stress or as possibly being externally mediated rather than resulting from an intrinsic health problem.

6. Joint themes from professionals' and managers' meetings

6.1. The intrinsic vulnerability of infants needs to be better integrated into professional thinking. It is vital that professionals are focussed on identifying additional vulnerabilities of an infant or stresses within the family that could escalate that risk to a level requiring some preventative and protective intervention.

6.2. During the review, it was generally recognised that the development of a tool focussed on infancy (an "Infant Care Profile") which could be used universally would be helpful in prompting professional consideration of risk factors and providing structure to inform possible escalation, facilitate honesty and clarity with carers and to enable wider family members to be engaged when needed.

6.3. One key element of such a tool would be consideration of the stresses faced by carers and their known response to such stress, and the possible risk that could pose.

6.4. It was recognised that the confidence and skill to probe and challenge by the "respectful and authoritative, relationship-based safeguarding practice" identified as best practice for an effective prevent and protect model in the Child Safeguarding Practice Review Panel report *Out of routine: A review of Sudden Unexpected Death in Infancy (SUDI) in families where the children are considered at risk of serious harm* requires development and nurturing by:

- Inclusion in both basic and child safeguarding training.
- Opportunities to learn from experienced professionals within and across agencies.
- Supervision and support from team leaders/supervisors that is reflective as well as task-based, provides overview and objectivity to avoid practitioners becoming enmeshed in a family script or dominant narrative and, when needed, facilitates "thinking the unthinkable".
- Multiagency team working was acknowledged as being essential and the following points were made in this respect:
    - Understanding and valuing professional roles across agencies should be improved by including in all levels of safeguarding training.
    - Co-location remains a sound basis for good interagency working.

- Emailing can improve and speed up communication if used properly but can be at the expense of relationship building so attention should be given to other opportunities for direct interaction, such as learning events.
- Creating safe space in which professional effectiveness can be discussed enables creative learning from each other's skills as well as enabling challenge. Professionals' meetings and peer review can offer such space.
- The overview provided by meetings chaired by an independent and experienced senior practitioner was seen as valuable in facilitating good multiagency working as well as reflection and challenge.
- Strong leadership and culture were both seen as vital to effective safeguarding and there was discussion at the managers' meeting about "developing managers to make a difference" which featured the following elements:
    - Knowing their staff and being able to recognise and manage both strengths and weaknesses.
    - Developing their staff by providing or ensuring provision of good supervision and support.
    - Addressing quality assurance by auditing and using data to improve outcomes. An example given was whether it can be demonstrated that using the resilience and vulnerability supervision model for health visiting and school nursing in Derby City has improved outcomes for children.
    - Promoting multiagency team relationships in the ways discussed above.

7. Conclusion

7.1. Between January 2018 and 25 Dec 2020 across Derby and Derbyshire, five infants died where abuse or neglect was a causal factor, and six infants were subject to a life-threatening non-accidental injury. These cases have been subject to reviews and constitute 69% of all the cases reviewed by the DDCSP during this time. These data highlight that infants locally do face risks and that it is important to learn how to reduce them.

7.2. National data also demonstrate the vulnerability of infants and highlight the need for focussed attention on the risks they face and the urgency of addressing them. The Department of Education report *Complexity & challenge: a triennial analysis of serious case reviews 2014-2017* identified 154 reviews of infants in that period, which was 42% of the total. Of these 154, 84% were in infants less than six months old. The NSPCC Learning publication 2020, *Statistics briefing on child deaths due to abuse and neglect,* quotes homicide rate data of 45/million population for infants, 2.5 times the rate of the next highest group (16-24 years).

7.3. The importance of alertness to injuries in infants and of practitioners being fully aware of the possibility that they may be harmed by their carers, has been shown in many studies. For example, data presented at a conference on Abusive Health Trauma (AHT) in Australia in 2020 showed that infants presenting with AHT were nearly six times more likely to have presented with previous injuries than those presenting with non-abusive head trauma.

7.4. About half of cases in Serious Case Reviews have not had any social care input, which emphasises the need for earlier alertness and assessment at universal, single agency level.

7.5. The link with difficult socioeconomic factors and domestic circumstances is demonstrated in national data. The annual review of child deaths for the year ending 31.03.19, for example, identified 195 Sudden Unexpected Deaths in Infancy in 60% of which modifiable factors were found. The Child Safeguarding Practice Review Panel report *Out of routine: A review of Sudden Unexpected Death in Infancy (SUDI) in families where the children are considered at risk of serious harm,* published in July 2020, highlighted the increasing link of SUDI with families in adverse circumstances and the need to develop "supportive yet challenging relationships that facilitate more effective safer sleep conversations".

7.6. All three infants featured in this review were born into families facing challenges in their lives to a varying extent and they received input from a variety of practitioners who addressed the assessment and provision of services to meet their <u>needs</u>, largely with a high level of care and expertise.

7.7. However, there was less attention to the assessment of <u>risk</u> to these infants and although there were examples of good communication this was not universal, with the result that some key areas of risk were unrecognised or underestimated.

7.8. In particular, the levels of and triggers for stress experienced by the carers of all three infants, and what was known about how carers had responded to stress in the past, were not factored into professional assessments.

7.9. Some practitioner assessments made assumptions that were based on limited contact and information.

7.10. In the case of Infants 1, there was knowledge within the wider family that would have strengthened the assessment of risk had this been pursued with a more authoritative professional approach and which could have resulted in agency partners becoming more engaged in a coordinated protective response.

7.11. The significant sense of shock experienced by practitioners when these infants suffered preventable harm, whether intentional or unintentional, reinforces the fact that risk had been largely unrecognised and unassessed. Some health practitioners involved in the care of Infant 2, in particular, found it difficult to accept the possibility that harm can be

caused intentionally by a carer. Whilst the Finding of Fact judgment was clear in stating that this was not the case with Infant 2, it is important for practitioners to retain sufficient objectivity to allow for the possibility of abuse. Infant 2's case should also serve as a salutary reminder of how easily unintentional harm can be caused to very vulnerable infants and the importance of constantly reviewing and improving handling techniques with practitioners and carers.

7.12. Acceptance of the principle of assumption of risk to an infant, because of their intrinsically very immature physiology and high development needs, and the requirement, therefore, to systematically exclude any additional risk could enable a safer professional approach. This would be facilitated by a universal tool to continually assess and re-assess any ongoing or new risk.

7.13. Practitioners need to be supported in their work with infants by:

- Having a raised awareness of the intrinsic vulnerability of infants and the high risks they face.
- Working in teams with strong leadership that enable professional skills, knowledge and confidence to be developed, supported and shared.
- Having good supervision that is not only task based but enables reflection.
- Working within organisations with strong leadership and a culture focussed on child safeguarding.
- Developing a strong relationship with other agencies engaged in child safeguarding based on knowledge and valuing of each other's roles and learning from each other's skills and attributes.

8. Actions

8.1. There has already been considerable learning from the Rapid Reviews into Infants 1 and 2 and the key actions identified here have been and continue to be supported by the Chief Officers of the DDSCP partner agencies. Strengthening of safeguarding arrangements to improve the safety and welfare of infants will continue to be a priority across the partnership

8.2. A Keeping Babies Safe Strategic Lead has been established and has overseen the delivery of a multi-agency action plan to improve safeguarding arrangements to keep babies safe, including the key actions summarised below:

- Derby City Council and Derbyshire County Council reviewed all open cases of children aged under one during January and February 2021 to assure themselves that appropriate action was being taken to keep the children safe including appropriate levels of face to face visiting. This assurance was reported to and endorsed by the DDSCP.

- The DDSCP carried out a multi-agency audit during 2021 to obtain assurance of the quality of services provided to families to keep babies safe, including the assessment of risk and needs of babies.

- Children's Services in both Derby and Derbyshire have undertaken a series of briefings with front line staff and managers to ensure that the pre-birth protocol is widely understood to identify vulnerabilities for babies at the earliest opportunity. Audit programmes are in place to evaluate the impact of the revised protocol. Further sampling was captured in reflective case discussion sessions with front line staff which took place in 2021, with the focus being the safety of babies.

- The Derby and Derbyshire Safeguarding Children Partnership has published the *Keeping Babies Safe Strategy: Three Steps for Baby Safety.* This has been widely distributed amongst the partnership and launched at the *Keeping Babies Safe Conference* held in June 2021. The conference provided professionals and frontline practitioners, from a wide range of sectors, with the opportunity to hear insights about the latest strategies, local reviews, and national learning to protect babies from harm.

- A *Keeping Babies Safe* briefing was published to capture and promote learning identified at the conference. The briefing and associated training includes explicit reference to parental substance misuse, the risk of neglect to babies and early identification of risk through the effective use of the Early Help Assessment.

- The *Keeping Babies Safe Steering Group* is coordinating and driving forward how practitioners across Derby and Derbyshire work effectively together with families.

- Across the partnership over 100 Keeping Babies Safe Champions have been trained in Safe Sleep, Safe Handling and Safe Space The champions promote awareness of the vulnerabilities of babies and provide a source of advice to their colleagues to promote best practice.

- Specific feedback has been received from practitioners and KBS Champions to demonstrate the impact of the developments upon practice and outcomes for children.

- The Derby and Derbyshire Safeguarding Children Partnership has an e-learning course *Protecting Babies from Harm* and a more in-depth virtual course *Keeping Babies Safe (Level 3)* for practitioners from all agencies. Evidence is being submitted by practitioners who have completed the courses, demonstrating the positive impact the learning is having on their practice and the safety of babies.

- A new assessment tool for practitioners to use in partnership with parents to discuss the risks associated with co-sleeping and bed sharing is being introduced. Early versions of the assessment tool were shared with some families to see how helpful they found the information. Their comments have helped improve the assessment tool and the final version is being

prepared for publication and will be available for practitioners to use with families very soon.

- A sample of parents/carers has provided some assurance that the messages of how to keep babies safe are being understood and used by parents/care givers. Safer sleep messages appear to be well established and understood by most parents/carers. Respondents were able to give examples of what they do in practice with their baby.

- The Derby and Derbyshire Safeguarding Children Partnership has policies and procedures which help keep babies safe. These have all been reviewed and updated following both a serious case review and a child safeguarding practice review which focussed on learning arising from harm to babies. Organisations provided feedback in November 2021 about the positive impact these documents had made.

9. Recommendations

9.1. A universal risk assessment tool to guide professional practice in safeguarding infants should be developed. Practitioners must clearly understand that an infant has no resilience and is inherently therefore at greater risk. The tool must reflect this and should emphasise a basic assumption of risk factors which are to be assessed so that they can either be excluded or early concerns recognised. It must identify what is happening in the household, what pressures and stressors exist, how carers are responding or likely to respond to these, be clear about what constitute the risk factors that must be excluded and consider both intentional and unintentional risk.

9.2. The importance of supervision in supporting implementation of all actions aimed at keeping infants safe must be recognised. Whatever model of supervision is used, its aim across all services should be to:

- Develop and support professionals in respectful, assertive practice to challenge and explore concerns, including ways of engaging with the wider family when potential risk factors may be hidden by carers being deceptive or not engaging.
- Support early decision making about the need for intervention or escalation into and within multiagency processes so that more are brought into the partnership arena.
- Enable the impact of the supervision in improving the wellbeing of children to be assessed.

9.3. Child safeguarding learning programmes across all agencies should address the need for practitioners to be knowledgeable about the roles of all professionals involved in child safeguarding and to have more of an insight into the concerns of each agency.

9.4. Current practice for partnership working at all levels in cases involving infants should be reviewed and the following elements considered:

- Wider, possibly universal use of senior professionals to chair children in need multiagency meetings for all infants, irrespective of the perceived complexity.
- Senior level leadership at all levels, from targeted single agency through all levels of formal partnership working, to provide challenge and overview and to facilitate partnership working.
- Clarity about multiagency plans so that practitioners from all agencies who are visiting the family home or/and in contact with any members of the family are clear about what risk factors, stress points and vulnerabilities need to be reviewed and assessed at each interaction and share the information.
- Ensuring that the due attention given to stress points within a family that could trigger a harmful response can incorporate an objective, absolute and non-judgemental assessment of material resources available to families, and to finding solutions to practical, daily living problems that could trigger a stress response, such as lack of or non-functioning essential domestic appliances.

Dr Liz Adamson
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