North Yorkshire
Safeguarding Children Partnership

7 point briefing

Child R - The importance of follow up when parents of young babies request advice about potential injuries

December 2023

1 Context

Child R was a young baby who was only a few weeks old when they were presented to the Emergency Department (ED) with a swollen limb. Child R was found to have multiple fracture to the limbs and the ribs. It was not possible to age these fractures, some were showing signs of healing and others were not. These are significant injuries in a young baby. It is thought that these were the result of non-accidental injury. The mother had had contact with services a week before this presentation reporting that Child R had a swollen limb. She was advised to take Child R to be examined by either the GP or ED. If Child R had been seen at this stage there may have been an opportunity to recognize the injuries sooner or prevent further injury. At the time this briefing was prepared it was not known who had caused the injuries.

2 Background

- Child R was born by planned caesarean section to parents who had engaged well with both antenatal and post natal care. All the routine contacts were offered and attended.
- Child R's father was recognised to have experienced some Adverse Childhood Experiences as a young person and reported suffering from low mood at times. Child R's father had not had a consistent positive male role model in his own childhood. This information was not known to Health at the time of Child R's birth.
- A week prior to the presentation to ED Child R's mother contacted the midwifery helpline with the call being taken by a Midwifery Support Worker. Child R's mother reported noticing swelling to one of Child R's limbs. Advice was sought from one of the midwives and Child R's mother was asked to seek medical help by contacting her General Practitioner (GP) or attending the ED. The review group could not however find any record of Child R's mother following this advice

3 Tasks/Challenges

- **Safety netting and information sharing -** consideration needs to be given regarding how to 'safety net' to ensure that when parents of young babies are asked to seek medical advice that this advice is followed, and that the information is recorded and shared with relevant professionals. The midwifery service is reviewing the procedures around its helpline and the 0-19 service is reviewing its procedures around the use of text messaging.
- **Socioeconomic status** - The father is a working class white man – one of the at risk groups in "The Myth of Invisible Men" Report
- **National Perinatal Institute documentation** – this documentation does not prompt midwives to ask about fathers' histories. This is something that would need addressing at a national level so has been raised with the National Child Safeguarding Practice Review Panel.

- **Understanding the lived experience of fathers** – the rapid review identified that the father had suffered significant Adverse Childhood Experiences (ACES) and had not had a consistent male role model in his childhood. Despite the fact that the father had been present at most of the appointments and it had been recorded that he had a history of low mood, this information was not known to those providing antenatal and postnatal care.
  There needs to be greater curiosity of the lived experience of fathers and how this may impact on their ability to parent. The findings of this rapid review of Child R align with the findings in the document: The Myth of the Invisible Men: Safeguarding children under 1 from non-accidental injury caused by male carers; September 2021. Even though the father had been present at appointments he had not been (to use the wording from the Myth of the Invisible Men) "significantly and substantially" involved. His own history and how this would impact on his parenting, had not been explored. When his low mood was mentioned, it could have prompted an exploration of the underlying causes and whether additional support was needed.
- **Proportionate information about fathers** - there needs to be mechanisms that allow relevant and proportionate information in fathers' primary care records to be available to the midwifery and health visiting services. The information about the father history was in the primary care records but was not shared with other professionals.

4 Good Practice

- The ICON information (a programme to reduce abusive head injuries) was shared with both parents face to face on three occasions and twice by electronic push notifications. Routine enquiries about domestic abuse were made by both midwifery and health visiting and it was documented in the records that opportunities were found to ask the mother these questions when no other adults were present
- When Child R was presented to ED the child protection concerns were recognised and acted upon quickly by all 3 agencies. The needs of both Child R and the sibling were both considered within these processes.

5 Update

Practitioners directly involved with Child R have received feedback as part of the Rapid Review process.

6 Actions

- Work is ongoing across agencies to consider how best to engage with fathers/male carers.
- Developing a system where the midwifery can request that primary care share any information relevant to safeguarding present in a father's record even if the father is registered at a different practice to the mother.
- Work is in place to look at safety netting when 111 recommends children with injuries attend the emergency department.

7 Resources professionals may find useful:

The Myth of Invisible Men (publishing.service.gov.uk)