Thematic Review – Executive Summary

Child N, Child R and Child S

Reviewers:

Karen Hedgley and Elaine Wyllie

Designated Nurses for Safeguarding Children and Children in Care, Humber and North Yorkshire ICB

1. Introduction

1.1 This thematic review was commissioned by the NYSCP Executive in January 2023 to identify learning from three similar cases of non-accidental injury to non-mobile infants. All three of the cases considered were the subject of Rapid Reviews which included recommendations for practice which were taken forward by the Partnership.

1.2 It was recognised that the occurrence of three such similar cases in a relatively short time period was unusual for this Partnership. One of the most notable similarities between the cases was that on this basis, it was agreed by the NYSCP Executive that the most appropriate authors for a thematic review would be the two Designated Nurses for Safeguarding Children from Humber and North Yorkshire ICB (North Yorkshire place). Neither Designated Nurse had direct or indirect involvement with any of the cases under consideration and, therefore, were considered sufficiently independent of decision-making to author the review.

1.3 In order to ensure appropriate oversight and scrutiny of this review, strategic leads from both the local authority and police were involved in agreeing the methodology, in NYSCP panel meetings and in review of the final report.

2. Summary of cases relating to Child N, Child R and Child

2.1 Case Summary: Child N

2.1.1 Child N was a three-month old infant who was initially admitted to hospital with a presentation of unexplained seizures. Subsequent investigations showed extensive subdural haematoma (bleeding/fluid around the brain) of different ages, together with retinal haemorrhages. The conclusion was that these injuries were a result of a non-accidental head injury.

2.1.2 Child N was the second child in the family. There were no safeguarding concerns identified in the family prior to the incident of concern.

2.1.3 Features identified as part of the Rapid Review into this case included child N being viewed as 'unsettled' due to perceived feeding difficulties, maternal mental ill health and challenges around information sharing between health professionals.

2.2 Case Summary: Child R

2.2.1 Child R was a four-week-old infant. She was brought to the Emergency Department (ED) with a swelling to the right thigh. An X-ray showed a fracture to the mid-shaft of the right femur. A child protection medical assessment was completed which showed additional

fractures to both sides of the ribs, a second fracture to the right femur which showed signs of healing, and a fracture to the right upper arm. No organic reason was identified for these fractures, and they were deemed to be non-accidental.

2.2.2 Features identified as part of the Rapid Review into this case included a paternal history of adverse childhood experiences and parental mental ill health.

2.3 Case Summary: Child S

2.3.1 Child S was a seven-week infant who was taken to hospital by ambulance with reported breathing difficulties.

2.3.2 Further investigations showed that Child S had a bleed to the right side of the brain and that both sides of the brain were significantly damaged. Child S also had a fractured but healing right collar bone which could have been sustained during birth. Several ribs were also fractured but healing. The consultant advised that the fractures and head trauma are most likely to be inflicted injuries, as Child S was a non-mobile infant.

2.3.3 Features identified as part of the Rapid Review into this case included parental mental ill health, potential neurodiversity in one parent;, Child S also being seen as experiencing feeding difficulties.

2.4 The NYSCP panel received an update that Child N, Child R and Child S are now in placements which are meeting their needs. Their developmental progress is being regularly monitored in light of the injuries they sustained – for one infant, those injuries have led to life-long disabilities.

3. Methodology

3.1 The authors worked with stakeholder agencies represented on the Review Panel to identify Key Lines of Enquiry. These were explored extensively through two Panel meetings when feedback from front-line practitioners was also presented and considered.

3.2 The final report was agreed by the NYSCP Executive in January 2024 and submitted to the national Child Safeguarding Practice Review Panel as per requirements in Working Together (2023).

3.3 The learning and recommendations from this Review are being taken forward by the Partnership.

4. Key lines of enquiry

4.1 The agreed lines of enquiry were as follows:

1. How do health professionals explore with prospective and new parents the impact of a new-born infant on their mental health and emotional wellbeing?
2. How do health professionals work with families to ensure they receive coordinated post-natal support and guidance on infant feeding specific to the needs of that family? How do health professionals recognise when additional support is required and how are they able to respond to this within current commissioning arrangements?
3. How do health professionals reach a shared understanding of any potential vulnerabilities in a family, and then work collaboratively to ensure targeted and effective support?
4. In the first few months after the birth of an infant, how are the ICON messages explored with parents such that they are supported to cope with normal infant crying and how do professionals gain an understanding of individual family's experience of crying?
5. What areas of good practice are seen in these 3 cases and how can we support practitioners to adopt these more widely?

4.2 It must be noted that the factors identified through the lines of enquiry were *not* known to be directly related to the injuries sustained by the babies considered in this review. However, they were common factors in the three cases and could lead to increased vulnerability.

4.3 In reviews such as this, it is good practice to seek and reflect the views of parents and carers. However, due to ongoing police investigations, the authors were unable to directly talk to the parents involved and to seek their views on how these factors impacted on them and their ability to safely parent their infant.

5. Summary of key areas of learning

5.1 Developing professional skills:

5.1.1 Working collaboratively with families requires practitioners to seek information from various sources, synthesise that information to formulate a holistic assessment which includes assessment of vulnerability, and to develop in conjunction with the family and relevant colleagues, a package of support tailored to individual need. To deliver this complex

task, practitioners need robust pre-registration education, effective preceptorship arrangements and ongoing professional development through access to training programmes. Much of this work is already in place, but the findings from this review suggest that additional work could be undertaken to strengthen practitioner knowledge and skills around the importance of individualised care, bespoke to the identified needs of each family.

5.1.2 Access to expert, reflective safeguarding supervision is critical in terms of supporting professional development and resilience and promoting safe outcomes for children. It is recognised that there is ongoing work within health provider organisations to ensure that regular supervision receives appropriate prioritisation.

5.1.3 NHS providers of midwifery and health visiting services across North Yorkshire should consider how the learning from this review can be incorporated in all programmes of training and preceptorship. They should also continue to promote access to and prioritisation of reflective safeguarding supervision in line with existing organisational policies.

5.2 Management of the 'unsettled infant':

5.2.1 Management of the 'unsettled infant' can be a clinically challenging task and requires practitioners to quickly rule out any underlying significant health issues which could lead to deterioration in the infant's condition. Once these potential physical causes are ruled out, the NYSCP panel felt that practitioners would benefit from some clear guidelines to help them support parents to manage their infant's presentation.

5.2.2 These guidelines should include exploration of infant feeding practices and perceived feeding difficulties, recognising that parents may often attribute infant crying and unsettled behaviour to a feeding issue – which may not always be the case.

5.2.3 Where no organic causation for the crying is identified, the importance of individualised conversations with parents to help them understand normal infant crying patterns is vital. Such conversations need to explore parents experience of crying, their understanding of normal infant crying patterns as described in the ICON message (https://iconcope.org), and their response. The conversations also need to be sensitive to any identified vulnerabilities or potential barriers to understanding – such as neurodiversity, previous experience, parental health issues, etc.

5.2.4 NYSCP should consider the following actions in relation to this learning:

- Reinvigoration of the ICON work to encourage practitioners to not only deliver the message, but to tailor this to individual need.
- The development of some guidelines for the management of the 'unsettled infant' which would need to reflect both potential feeding problems, as well as normal infant crying patterns, and sources of help and support for practitioners and families. This guidance should be accessible to all practitioners working with families with small infants.

5.3 Pathways to support parents with mental health difficulties:

5.3.1 Parental mental health was a key feature in the cases reviewed by the NYSCP panel. The panel reflected that as well as practitioners being able to identify when a parent has an ongoing mental health problem, they also need to recognise the potential impact of this on parents' ability to provide safe and nurturing care to their infant, and to have confidence to explore this with parents. Furthermore, they also need to be aware of all the various sources of support, avenues for referral and when to seek further expert advice.

5.3.2 The NYSCP panel advised that NHS health providers of midwifery and health visiting services in North Yorkshire in conjunction with NYSCP should consider development and dissemination of a resource which describes:

- How to assess the impact of parental mental health on parenting.
- Resources available to support parents who are experiencing emotional or mental health problems.

5.3.3 When developing this resource, particular consideration should be given to available sources of support for men in the different geographical locations across North Yorkshire.

5.4 Sharing good practice:

5.4.1 The review identified a number of areas of good practice evidenced in these cases. These included:

- Once non accidental injury was identified, there was a robust multi-agency response to ensure the safety of the infants and other siblings.
- The ICON message was delivered in all three cases on multiple occasions in line with agreed protocols.
- There was flexibility of approach demonstrated in one case where a practitioner elected to undertake a face-to-face contact rather than the mandated virtual contact.
- Maternal mental health was assessed repeatedly in both ante-and post-natal periods, and onward referral appropriately considered.

6. Next Steps

6.1 Relevant agencies across North Yorkshire are required to:

- consider the findings of this review.
- contribute to the NYSCP action plan which will take forward the learning.
- disseminate learning from this review across their own organisation.