Cumberland Safeguarding Children Partnership

Local Learning Review Child Lily and Bobby

Cumberland Council

CUMBRIA CONSTABULARY

NHS North East & North Cumbria

What is a Local Learning Review?

A Local Learning Review (LLR) is undertaken when a child or children have suffered abuse or harm, but the circumstances do not meet the full criteria for a Rapid Review or Local Child Safeguarding Practice Review. However, the three safeguarding partners believe there is learning about the way in which local professionals/agencies work together to safeguard children, that could strengthen safeguarding practice locally and improve multi-agency working to better safeguard and promote the welfare of children.

Background

This learning review involved a baby under four months who presented with unexplained bruising and their sibling just over two years old. Both parents had experienced significant Adverse Childhood Experiences (ACEs) and more recent parental vulnerabilities were also identified. For the mother these included the mother's depression, managing a chronic health condition, previously using pain relief to aid sleep and previous separation from the father prior to the baby's birth. For the father it was noted there were previous gambling problems and substance misuse and currently reported low mood and anxiety including poor sleep and being unable to attend work.

These background factors have been noted recurrently in a range of reviews locally and nationally over a significant period of time. "A background of abusive, neglectful or inconsistent parenting ..., where there are histories of poor attachment patterns, can result in poor attachment styles as adults and inappropriate responses to the needs of children, resulting in anger and harm"[1]. They are factors that are often not sufficiently identified or assessed in relation to the potential risk to young babies and children.

An initial Section 47 Child Protection Investigation was commenced but both children were returned home without clearly communicated safety plans. During a subsequent medical review, it was ascertained that the original skeletal survey had not been appropriately reported and healing fractures of both children were discovered.

Learning from the Review

Good Practice

- Initially there was a good pick up on the ACEs and perinatal mental health issues in relation to the mother and support from a commissioned provider to offer support.
- Prompt referral from the Health Visitor to Childrens Social Care with body map and an open and honest conversation with parents about next steps in line with the Bruising in Babies and Children Procedure.
- Immediate identification within the Single Point of Contact that unexplained bruising in a baby should be a joint section 47 investigation.
- Agreeing a more senior health representative to attend the strategy meeting given the lack of clarity in relation to safeguarding actions and a formal escalation of concerns by the 0-19 service.
- Evidence of safe sleep advice and promotion of ICON messages by health professionals, including the GP.

1 The Myth of Invisible Men

Key Areas of Learning

- The need to improve strategy meetings, particularly reinforcing their purpose in relation to sharing and seeking of information, the importance of multi-agency invites and attendance, risk assessment, safety planning, timing and recording.
- The need to improve the robustness of safety planning, especially the communication of plans to all relevant agencies and the need for written safety plans whilst Section 47 investigations are continuing.
- The need to adhere to policies and procedures especially "Bruising in Babies and Children" and "Child Protection Enquiries (Sec 47)" – (Acknowledging these are already under review).
- The need to ensure that children are not discharged from hospital until there have been robust multi-agency and multi-disciplinary strategy discussions that identify risks and ensure detailed safety planning.
- The need to review and communicate the Standard Operating Procedures between radiology and Paediatrics, to ensure effective information sharing and robust child protection medicals.
- The importance of seeking and sharing information with all health professionals, especially with GPs and involving them in multi-agency planning.
- The importance of a Think Family approach, particularly the impact that parental vulnerabilities, medical conditions, feeding issues, parental mental health and anxiety and other parental illness may have on harm to babies and young infants, including the need to consider vulnerability pathways and referrals for Early Help and support.
- The need for all practitioners to understand the complexity of the health "landscape" and be aware of where they need to go to seek specific information.
- The need to reflect on the impact of unconscious bias when assessing risk and the importance of professional curiosity in all work with families.
- The need to review and promote the Partnership's Escalation Policy and the message that all professionals need to professionally challenge when necessary.

Action plans to address key findings and ensure practice improvements have been developed by the Partnership and further communication will be forthcoming from the partnership stemming from this review, as necessary.

Taking the Learning into your Practice:

It is important to take the issues raised in this LLR into your supervision, team meeting and group supervision.

Consider the following:

1. Am I evidencing a Think Family approach in my practice? In particular, recognising the importance of sharing and seeking information about a parent's vulnerabilities, which may have implications for their care of a baby or young child?
2. Where parental vulnerabilities exist, do I always consider the need for Early Help and support/or safeguarding referrals for those children and their families? If consent is not given, am I aware this may be a child protection issue?

3. Are all relevant agencies being invited/information sought/information provided for all Strategy Meetings?
4. Do I always ensure initial safety plans are written and shared with all relevant professionals and do I challenge if this is not forthcoming or I have concerns about any aspect of the plan?
5. Am I aware of my unconscious bias when assessing risk and ensure I remain professionally curious in all my work with families?
6. Do I understand how important it is to speak to a parent's GP when undertaking any investigation/ assessment?
7. Do I challenge where I have any concerns about another agencies practice and do I use the Partnership's Escalation Policy?
8. Do I always access the relevant policies and procedures when working with children and their families?