City of York
Safeguarding Children Partnership

7 POINT BRIEFING:
Baby James - Learning from Practice

Baby James Local Safeguarding Child Practice Review (LSCPR)

1. Who was Baby James?

James is a 4-week-old baby who sustained multiple non-accidental injuries including a fractured femur (thigh bone), fractured clavicle (collar bone), and fractures to his lower legs and ribs whilst in the care of his parents and maternal grandparents. It was also noted that James was failing to thrive.

James is the first-born child to mother and the fifth child of father (he has four other children living in two other households). James was not known to Children's Social Care however, his four half-siblings from his father's two previous relationships had been known to services due to concerns of Domestic Abuse between the parents.

James' father had been previously reported as the perpetrator of domestic abuse against his mother and two of his partners. One of these incidents relating to a previous partner led to the case being discussed at Multi Agency Risk Assessment Conference (MARAC) for high risk Domestic Abuse and the two children from Relationship 2 were made subject of Child Protection Plans for Neglect. The Child Protection Plans ended when the mother of the two children ended the relationship with the father.

2. What key practice areas were identified as part of the LSCPR?

Key Practice Episode 1: Booking Appointment

This was an unplanned pregnancy in a new relationship of 3 months. At booking the Father disclosed Domestic Abuse in his previous relationships which had led to Children's Social Care (CSC) involvement and him having no access to his children. He also disclosed previous drug and cannabis use. James' mother disclosed previous substance misuse and a history of depression and suicide attempts between 2015 and 2017.

The Midwife did not contact either the Trust's Safeguarding Team or Children's Social Care (CSC) at the time of booking but did subsequently contact CSC to ask if there were any concerns/involvement with the family. The Midwife was informed that Children's Social Care had no current involvement or concerns.

Key Practice Episode 2: Community Rehabilitation Company (CRC) involvement

James' father was known to CRC due to his offender history and CRC undertook a risk assessment to evaluate his risk of harm to others and how likely he was to re-offend. As part of this CRC contacted the Police and CSC and both agencies reported that there were no current concerns. During this time CRC became aware that his partner was pregnant.

Following supervision of the case, the CRC Officer was asked to complete a safeguarding referral. The referral was not made on the basis that CSC had withdrawn their services, father had no contact with his children from previous relationships, and there was no evidence of abuse in the current relationship.

Key Practice Episode 3: Delivery

The midwife on the labour ward contacted the community midwife due to the information that was recorded on the maternal wellbeing form specifically regarding father's restricted contact with his older children due to domestic abuse. The community midwife informed the midwife on the labour ward that there were no concerns for James and he could go home with parents.

The labour ward midwife then subsequently contacted the Safeguarding Children's team for the Trust, who advised that she contact CSC in respect of James. The midwife did ring CSC who reported that they have no current concerns regarding James' father or his children. Domestic abuse routine enquiry questions were asked again by midwifery services and mother reported that she felt safe at home.

Key Practice Episode 4: New Birth Visit

The Health Visitor undertook a thorough and extensive new birth visit seeing James with his mother and maternal grandfather and advised on safe sleeping, ICON and feeding. James' father was reported to be upstairs during the visit. The Mother shared that she 'had got pregnant early into the relationship but it was going well' and that James' father had no contact with his other children but no reason for this was given.

Following the new birth visit the Health Visitor contacted the community midwife regarding mother's presentation being 'twitchy/gittery' and that she was unsure whether this was substance misuse or nerves. The community midwife advised that she felt that the mother's presentation was due to nerves around professionals. The Health Visitor also contacted CSC about father as it was unclear why he has no contact with his children. CSC reported that there had been allegations made in August 2019 that father had been released from prison regarding drug related offences and also informed the Health Visitor that two of the children were open to CSC and had an allocated Social Worker. The Health Visitor contacted the Social Worker on three separate occasions and left messages for call back. The Social Worker did not contact the Health Visitor.

Key Practice Episode 5: GP visit

James' mother contacted the GP to say that James was unsettled. The GP saw James the same day, he was fully examined, the GP observed James feeding and no concerns were noted. Advice was given regarding feeding and for mother to seek further help if required. No bruising was noted on physical examination at the time of the presentation to the GP.

Key Practice Episode 6: Hospital Attendance

On the 14th August James was brought by mother to York Hospital as mother noticed he had a swollen leg. A safeguarding assessment was completed and concluded that the injury is not consistent with history given and that an inflicted injury is suspected. James was admitted to York Hospital that evening for further investigations and child protection medical. The hospital's safeguarding procedures were followed, and arrangements were made by the hospital for one-to-one supervision overnight as per safeguarding procedures. A referral was made to CSC Emergency Duty Team due to suspected non accidental injury as per CYSCP Injury to Non Mobile Infants Practice Guidance.

3. What areas of good practice were highlighted?

Key Practice Episode 1: Booking Appointment

- Routine Domestic Abuse enquiry was undertaken by the midwife with mother was on her own
- An Antenatal liaison summary detailing mother's previous mental health concerns was sent to the GP as per expected practice enabling the GP to be aware of the pregnancy and initiate information sharing as required to safeguard maternal and the unborn child's wellbeing.
- The midwife shared IAPT details to support mother with her mental health.
- The maternal wellbeing form was completed so that the hospital was aware of mother's previous mental health and this could be monitored, and appropriate support given.
- Mother had the same midwife enabling continuity of care.
- Mother was seen regularly by maternity services during her pregnancy. All ante-natal appointments were completed face to face and there was no evidence of any impact or disruption to maternity care delivered to mother due to Covid-19.

Key Practice Episode 2: CRC involvement

- CRC did complete safeguarding enquires with Police and CSC.
- Father told CRC that his current partner was pregnant, and the CRC undertook a risk assessment.

Key Practice Episode 3: Delivery

- The labour ward midwife explored the history of the family with CSC to ensure that baby was safe to go home.
- The labour ward midwife liaised with the community midwife to explore her concerns.
- The labour ward midwife asked routine Domestic Abuse enquiry questions.

Key Practice Episode 4: New Birth Visit

- James was seen by the Health Visitor with mother.
- Health Visitor undertook all routine health checks.
- Thorough advice was given to mother about feeding, and about not leaving James longer than 3-4 hours between his feeds.
- ICON was discussed and safe sleeping advice given.
- The Health Visitor was professionally curious as to mother's presentation and father's lack of contact with his previous children.

Key Practice Episode 5: GP visit

- Telephone triage due to covid-19 and following this James was seen by the GP fully examined and advice given to mother with regards to feeding and what to do if she was concerned.

Key Practice Episode 6: Hospital Attendance

- The CYSCP multi-agency safeguarding procedures were followed by staff and Professionals were effective in ensuring that James was safeguarded.
- A strategy meeting was held by EDT and a further strategy meeting was convened.
- The hospital's safeguarding procedures were followed.

4. What were the key learning points?

Learning Point 1:

When issues are disclosed about expectant parent(s) history of substance misuse, domestic violence in previous relationships, or other matters for potential concern, services across CYSCP should ensure referrals are made to Children's Social Care services, at the earliest opportunity to allow CSC to consider the need for and where appropriate initiate a pre-birth assessment.

Learning Point 2:

The processes for sharing midwifery services or other health professionals concerns about the safety of, and/or any potential risks to, the unborn child should ensure information shared between healthcare and other agencies in a timely manner.

Learning Point 3:

Training and ongoing professional development should include reference to the routine transfer of observations from work diaries into patient records, so that a wider staff group can appropriately access relevant information and if necessary, act on it.

Learning Point 4:

Where knowledge about a parent/parents is held across separate GP practices because each parent is registered with a different one, relevant information should be shared, and systems should proactively enable this. Any issues of concern regarding parent(s) can then be added to risk assessment(s,) including where these trigger CSC referrals.

Learning Point 5:

The Police Service should ensure that "look back" practice is routine when a person about whom other agencies have concerns is the subject of an enquiry to the Police, to enable all services to be aware "no current concerns" may not mean there are no concerns at all. This case shows the relevance of historical information, particularly relating to the role of James' father.

Learning Point 6:

The CRC should ensure the robustness of practice that will follow through on referrals to CSC services. This case highlights that CRC should have made such referrals at several points regarding James' father who was under CRC supervision both because of crimes leading to a custodial sentence, and his history of domestic and other violence, whilst also being a father of four children and stepfather to a fifth.

Learning Point 7:

If an agency contacts CSC services regarding potential concerns about either established or expectant parent(s,) in particular a history disclosed by one or both about domestic violence, substance misuse, or potential risks to any child, CSC should ensure its systems support the consistent creation of a full, clear picture of the parent(s) as risk factors, including using the same "look back" approaches.

Learning Point 8:

This case highlights some misunderstanding about what constitutes a referral. CSC and partners should agree the means to ensure that if an agency enquires whether a parent causing concern is known, this is automatically considered a referral so a complete and consistent "audit trail" can be created. Ensuring regular reviews of referral trends will be necessary, to avoid over-referral becoming a regular event.

Learning Point 9:

This case identifies missed opportunities to ensure timely and effective information sharing seeking to ensure the safeguarding of James. Agreements to share information already exist across CYSCP. Implementation of them should be reinforced on a regular basis with staff in services across the Partnership. CYSCP, and individual agencies, should ensure they continue to address gaps in how services, including those referring cases in, practise information sharing that actively enables timely interventions.

Learning Point 10:

Fathers, including expectant fathers, should be considered as central as mothers to the development, life experiences and safety of York's children and young people. Ensuring all fathers are dealt with as if they are as vital as mothers will be key to continuing to improve safeguarding responses across CYSCP.

Learning Point 11:

Professionals should display a necessary degree of professional scepticism and curiosity when considering what adults say about their own and a child's situation. Regularly reminding all staff about apparent but false compliance should be routine across all agencies in the CYCSP, reinforced in clinical and professional supervision as well as through CPD and audits of practice.

Covid Specific Learning:

Due to COVID 19 restrictions in place following NHS guidelines Antenatal contacts were at that time of this case only offered by telephone as face-to-face contacts were restricted. Observation of family would have been carried out during a face-to-face antenatal visit and had this been able to happen earlier there may have been an opportunity to identify concerns with regards to the Mothers presentation per birth.

The ICON message was delivered at variant points. It was not clear if this was discussed with father at the point of James being discharged from hospital due to visiting being very limited on the post-natal ward due to covid.

Due to Covid-19 almost all contact with father by CRC were remote, which prevented the monitoring of body language and expression, which would ordinarily give rise to challenging information provided by service users.

5. The Voice of the Child

Although James was only 4 weeks old when he sustained significant injuries it remains important for professionals to ask themselves what the child would say if they were able? What would it like to be a baby living in this household? What would the baby say needs to change to improve his safety and wellbeing? James would have no doubt wanted to be cared for in a safe and loving environment.

6. Next steps for City of York Safeguarding Children Partnership:

The specific actions arising from this LSCPR will be taken forward by the CYSCP

Additional Learning relating to themes from this case can be found in the Child Safeguarding Practice Review Panel Annual Report 2020 particularly in relation to;

- Theme 1 - child's lived experience (Pg 27)
- Theme 3 - critical thinking / challenge (Pg 29)

7. Useful Resources:

The CYSCP Website Babies and Pregnancy page has lots of useful information including:

- ICON – Babies cry, you can cope programme and ICON leaflet
- North Yorkshire and City of York Managing Injuries to Non-Independently Mobile Children

Additionally the following information is available on the CYSCP website:

- Safeguarding Unborn Babies – Practice Guidance
- Engaging with Fathers – Principal Social Worker Blog
- Information regarding the Multi-Agency Safeguarding Hub (MASH) and accompanying forms
- North Yorkshire and City of York Council Information Sharing Form.

Where do I go for further information?

Please visit the CYSCP website for up to date information and latest news.

Please also sign up to the CYSCP Newsletter and follow us on Twitter @YorkSCP