**Non-Accidental Injury in Under 1’s**

**Positive Practice Review**

**May 2022**

**Context**

In September 2021, the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) Business Team undertook a deep-dive analysis into Non-Accidental Injury (NAI) in under 1’s in response to an unprecedented number of referrals to the national Child Safeguarding Practice Review Panel (CSPRP) during that summer. The deep-dive report was presented to the Executive Board, who endorsed the recommendation to pursue a positive practice review of cases sharing similar risk characteristics, that had ended with positive outcomes[[1]](#footnote-1). The aim of this review is to identify what has worked well to enable effective safeguarding so the learning can be shared across the partnership, building on what is already working well.

**Case identification**

In January 2022, the KSCMP Business Team presented to DivMT in Kent’s Integrated Children’s Services (ICS), requesting the identification of cases matching the risk profile of the original 6 in the NAI deep dive as closely as possible. These characteristics included:

* Parental mental health issues
* Parental substance misuse issues, including during pregnancy
* Cannabis use in the household
* Premature birth

And of significant interest but less importance:

* Family history of ICS involvement
* Deprivation/financial issues
* Housing issues
* Parental Adverse Childhood Experience’s (ACE’s)
* Older sibling in care or living elsewhere

Each of the 4 districts were tasked with identifying 3 cases and forwarding their Liberi ID numbers to the KSCMP Business Team, with a view to the 6 most closely matched being selected for the positive practice review. The 6 selected demonstrated 6 or more of the 9 identified characteristics at the time a Children and Families assessment (C&F) was undertaken in respect of the unborn (therefore ‘premature birth’ was removed as a characteristic and substance misuse concerns/maternal use during pregnancy were separated). The final 6 were represented by the districts as follows:

|  |  |
| --- | --- |
| **ICS District** | **No. of cases in report** |
| North | 2 |
| South | 1 |
| East | 1 |
| West | 2 |

These cases were then reviewed in a desk-top exercise using records available on Liberi.

**Positive Practice - key themes**

From the desk-top review of Liberi records, the following key themes were noted in relation to these cases:

**Agency checks**

These cases demonstrated clear evidence of multi-agency checks for the purpose of informing the Children and Families (C&F) assessments. It was evident that the checks were used to establish a picture of the families’ circumstances over time and to corroborate details shared by the families themselves. This enabled a more holistic assessment of risk, and reduced reliance on ‘face value’ parental accounts.

**C&F Assessment (pre-birth)**

As noted above, assessments evidenced the gathering and corroboration of information from multi-agency partners. They also analysed this information in the context of what was already known about the families and whether current circumstances resembled previously observed patterns or indicated new risks.

Assessments tended to explore family and wider support networks, as well as associated risks. They thought beyond immediate family and/or the household, to consider others who were likely to be relevant to the babies’ lives.

Some assessments drew links between current circumstances and behaviours, and the risk of Sudden Unexplained Death in Infancy (SUDI). The Child Safeguarding Practice Review’s thematic review into SUDI can be found [here](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf). This demonstrates foresight and an understanding of safeguarding issues relevant to the local and national landscape.

**Referrals to Family Group Conferencing Service**

In all 6 cases, a referral had been made to the Family Group Conferencing (FGC) service. Whilst the impact of FGC support on safeguarding is less easy to gauge as part of this review, what can be assumed is that the professionals in these cases were mindful to consider and explore existing and sustainable support networks to help safeguard the subject children. Information on Kent’s FGC service can be found [here.](https://www.kent.gov.uk/education-and-children/protecting-children/family-group-conferences)

This resonates with the ‘Think Family’ approach in Health and the AWARE principle adopted by Kent Police. For further information and relevance to Kent Local Child Safeguarding Practice Reviews, KSCMP’s Family Context and Professional Curiosity 5-minute factsheet can be found [here](https://www.kscmp.org.uk/__data/assets/pdf_file/0016/134116/Family-context-and-professional-curiosity-final.pdf).

**Case notes**

Some excellent practice in relation to case recording was observed, with particular case notes modelling how it is possible to capture the lived experience and voice of a child. Some offered insight into the relationship between the social worker and the children in the families. For example, in one case note, the social worker described how the baby became unsettled and was handed to her by the mother as she went to prepare a feed. The social worker described her interaction with the baby, including how the baby looked, how she may have been feeling, and the behaviours that led her to believe that. An absence of this type of relationship being reflected in case notes has been highlighted as an issue of concern in historic case reviews locally and nationally, such as that of Peter Connelly (see [here](https://www.gov.uk/government/publications/haringey-local-safeguarding-children-board-first-serious-case-review-child-a)).

**Supervision**

Each of the Liberi profiles evidenced supervision and oversight by senior managers. This enabled progression to be tracked and support for the social workers to plan next steps.

One social worker commented “supervision enabled me to reflect. It was always open and non-judgemental and helped me to recognise what my own limitations might be in relation to the case.” The views of the social workers are explored in more detail in the next section.

**Positive Practice – feedback from professionals**

Alongside the desk-top review of available records, efforts were made to contact the allocated social workers who completed the C&F assessments for the unborn babies[[2]](#footnote-2). They were invited to engage in semi-structured discussions over MS Teams to share their views on what worked well to ensure the effective safeguarding of these children. KSCMP are very grateful to these social workers who willingly offered their time and valuable insight to assist with this report. The key themes arising from these discussions are detailed below:

**Early Request for Support via the Front Door**

Several of the social workers commented that the Request for Support (RFS) submitted via Kent’s Front Door service occurred at the very early stages of pregnancy. This enabled the time required to establish a relationship with the families, gather relevant information for assessment, complete chronologies, initiate any relevant proceedings well in advance of birth, and front-load support so there was adequate time to measure impact prior to birth.

**Exploring the family support network**

Social workers commented that from the outset they wanted to understand who was going to be relevant in the lives of these babies. This may have been in a supportive role that provided practical and emotional help for the parents, or more directly as potential care-givers for the babies themselves. Also noted was the importance of understanding who was relevant to the lifestyle of the parents, and if these individuals would likely pose risk if in contact with the babies.

**Relationship building**

It was felt that some of the most important and meaningful visits were for ‘a cup of tea and a catch up’ rather than a targeted intervention. It was noted that capacity does not always allow for this, however, when it does, it helps establish a positive and trusting working relationship that can subsequently support better safeguarding. It was commented that this helped to break-down some parents’ preconceptions about working with professionals and made them feel more comfortable about engaging in subsequent processes.

**Multi-agency responsibility for co-owned and created support plans**

Those interviewed commented on the support provided by wider colleagues (namely Health, Education, Housing, Probation and Substance Misuse services) in assessing risk, creating plans and communicating effectively in relation to any observed changes in the family’s presentation or circumstances. One social worker described a multi-agency exercise involving ICS, the school and Health Visitor, where Mother’s history was discussed and triggers for increased risk of harm identified. Behaviours that might indicate Mother was struggling were noted, meaning that when her presentation did in fact change, it was quickly picked up and communicated to the wider professional network, leading to an immediate multi-agency response.

Several commented they felt those in the professional network took equal responsibility and accountability for safeguarding, which meant that concerns were responded to quickly and proactively across the board and were not left solely for Children’s Social Care to address.

**Creative and practical support**

Two of the social workers commented they created visual aids and timetables for parents who might otherwise have struggled to structure their time or remember and keep to appointments. Although quite a basic task, they were confident this facilitated positive engagement and could be used as a tool to measure what parents were proactively engaging with (e.g. by crossing off days on the calendar or adding their own images to the timetable).

**Observations and analysis**

In all the cases considered for this positive practice review, the family had a history of involvement with ICS. This is significant for 2 reasons: firstly, when a RFS was submitted to the Front Door the history of involvement would have indicated the significance of current concerns, lending to appropriate triage. Secondly, once allocated to a social worker, the historical records helped to establish patterns of behaviour over time, avoiding current concerns being considered in isolation, and lending to effective forward planning.

It is important to contrast this with breadth of NAI cases the KSCMP is currently reviewing, which includes several where the family had not had a history of ICS involvement, having only been supported under a universal offer. With this in mind, consideration should be given to how the positive practice identified in this report can be shared and embedded in universal services, such as midwifery and health visiting, to facilitate the identification of safeguarding concerns that require a RFS at an early stage.

What has been noted to have worked well in these cases will come as no surprise to safeguarding professionals. Multi-agency collaboration, good quality assessment and case-recording, management supervision, building meaningful relationships with families and offering creative and practical support are basic requirements that most would likely highlight as essential for effective safeguarding. What it might indicate for the Partnership, is a need to ‘get back to basics’ following the interruption the pandemic caused to ‘business as usual.’

1. ‘Positive outcomes’ meaning the children were appropriately safeguarded, with no direction regarding how that may have been achieved e.g. accommodated by the Local Authority, or family supported and case stepped down to Early Help services due to decreased risk. [↑](#footnote-ref-1)
2. 5 of the 6 identified social workers contributed to this report, with the 6th being on maternity leave. [↑](#footnote-ref-2)