Norfolk Safeguarding Children Partnership

The Norfolk Safeguarding Children Partnership Strategy to Protect Babies From Harm

Refreshed Autumn 2022

1. Introduction

1.2 The Norfolk Safeguarding Children Partnership (NSCP) agreed to make protecting babies a priority in the summer of 2020. This was partly in response to the national increase in cases of non accidental injury (NAI) to infants as well as in the context of local Serious Case Reviews and Safeguarding Practice Reviews (SCRs/SPRs). This strategy was originally published in autumn of 2020 and this revision is intended to set out the progress made as well as the ongoing actions to further improve practice.

1.2 The Protecting Babies from Harm strategy has a dedicated multi-agency steering group chaired by Health (Cambridgeshire Community Services, Norfolk's 0 – 19 Healthy Child Programme Provider) who over see the underpinning action plan. The steering group benefits from the NSCP's Senior Data Analyst who has supported the group by developing a comprehensive data profile on this cohort.

1.3 The original strategy covered four main areas: non-accidental injuries to babies; assessing risk to unborn babies, including concealed or denied pregnancy; the capacity of parent/carer to manage crying; and safer sleeping. In this iteration, the actions against all babies cry have been completed and are embedded in practice so no longer included in this iteration of the strategy.

1.4 The successful implementation of the strategy so far can be summarised by five C's:

- Creativity
- Connectivity
- Communication
- Community
- Consultation

1.5 There have been numerous achievements over the past two years which can be ascribed to small changes having big impact. These achievements are summarised in the table below:

Creativity	• Developing innovative tools to engage with families, such as Safer Sleeping videos • Ensuring tools and policy development are more accessible and easier to follow • Establishing dedicated resource for how we work with fathers in response to the National Child Safeguarding Practice Review *The Myth of Invisible Men* • Using data and performance intelligence to establish better grip on the risks and presenting issues for vulnerable babies and families
Connectivity	• Strengthened partnership working involving professionals from across health, social care and other sectors • Bringing people together through All Babies Cry briefings • Reporting to the NSCP Partnership Group and three statutory partners to ensure strong links between strategy implementation, leadership and the frontline
Communication	• Ongoing development of the award winning Just One Norfolk (JON) platform to support parents, families and professionals • Promoting Joint Agency Group Supervisions where the professional network working on cases involving babies can reflect together in a safe space
Community	• Engagement and communications planned and monitored with relevant aspects of communication and resource development noted above • Recognition of the strengths and resources within families to support parents with newborns through DIY Family Networking tools available on JON
Consultation	• Policies developed – medical examinations and concealed/denied pregnancy - and road tested with professionals prior to launching to incorporate feedback and ensure buy-in • Workshops with frontline professionals: feedback from practitioners of the energising focus of the strategy • Gaining feedback from families and communities on assets developed to ensure they are part of the solution

1.6 There is also evidence that the learning from SCRs/SPRs and this strategy is being applied in practice. For example, while there are still incidents of NAI, these are dealt with swiftly and pre-emptively resulting in a reduction of cases of serious harm requiring a referral to the SPR Group. There is also evidence of cases that occur out of hours having a better, more timely response in terms of moving to strategy discussions and actions to protect the infant. Finally, there have been cases of best practice around early intervention to protect babies from harm logged, although there is more to do in terms of disseminating learning from/showcasing cases where the processes worked well.

1.7 This strategy refresh recognises that while much has been achieved there is no room for complacency. The action plan underpinning this strategy is

reviewed regularly and where appropriate recommendations from audit and SPRs are marked as complete or new recommendations added. These are included as Appendix 1

2. Strategic Aims and Objectives

The NSCP's aspiration would be to eradicate harm to babies in whatever form it manifests itself. In acknowledging that some of the variables involved are beyond the Partnership's ability to control or alter, the strategic aim seeks to:

Minimise the risk of babies, including unborn children, suffering from harm in all forms, and ensuring that their first two years enable their development so that they safely reach their early years milestones.

Learning from local and national Safeguarding Practice Reviews, we recognise that we need to be trauma informed to enable the frontline to safeguard effectively and fully understand the experience of the service users, including vulnerable parents and the impact of parenting on unborn, non-mobile and pre-verbal babies. This strategy sets out some parameters to make our objectives achievable with three overarching aims. The objectives/ high level actions we will take to achieve the strategic aim are listed against each strategic statement below.

2.1 Preventing Non Accidental Injuries: We will work with professionals from all disciplines to implement the learning from Norfolk's thematic Serious Case Review on NAI, Case AF[1]. Building on a trauma informed approach, we will support staff to have safe and challenging conversations with families and each other to ensure practice is baby focused and risk sensible. There will be specific focus on: respectful scepticism ("thinking the unthinkable"); professional challenge and deference; and giving voice to the baby's lived experience of care.

Objectives and high level actions:

- Review of pathways into services, including barriers and promote these through professional drop in/awareness raising sessions as part of the Protecting Babies communication plan
- Improved communication with Primary Care
- Building stronger links with the Neglect Strategy Implementation Group and promoting the use of Norfolk's Graded Care Profile, particularly where the baby is born into a large (4+) sibling group
- Developing robust and dynamic risk assessment to include professional curiosity about parental experience of adversity and the impact of

[1] Case AF was published in January 2020. Its findings remain relevant today and go beyond NAI. The key findings are included as Appendix 2 for easy reference.

Adverse Childhood Experience (ACEs) on parents' ability to care for vulnerable babies
- Improved understanding and inclusion of fathers/male partners and other carers.

2.2 Unborn babies: We will develop practice to better safeguard unborn children and address risks posed by concealed or denied pregnancy. The definition of neglect incorporates risks posed in utero and we will have transparent and challenging conversations with parents and each other to address reasons why a pregnancy may be concealed/denied, including the impact that this could have on unborn children.

We also need to consider how we manage 'flight risk' at the point of birth and ensure that we draw in learning from best practice in risk assessment and prevention in these cases.

Objectives and high level actions:
- Promote and seek feedback on the recently developed policy and procedure on concealed/denied pregnancies
- Review of pre-birth assessment policy in response to a multi-agency audit undertaken in spring/summer 2022
- Guidance on flight risk to be written and disseminated throughout the partnership in line with NHS national guidance

2.3 Safer Sleeping: We will provide the training, tools and resources to families and staff from across the partnership to ensure that safer sleeping messages are delivered to and understood by families with newborn babies. We will communicate effectively with parents of newborn babies to ensure that they understand the risks posed by inappropriate sleeping arrangements and can provide a safe place for their babies to sleep. Partners from all agencies will reinforce the messages and contribute to robust risk assessments and safety planning for changes in routine to address any underlying issues, including overcrowding, substance and alcohol misuse and parental mental health.

Objectives and high level actions:
- Refine the monitoring process to understand the reach and impact of communication assets developed to date with the support of the NSCP's Senior Data Analyst
- Continue to promote and gain feedback from families via the Just One Norfolk platform

2.4 Data and communication are common threads across the strategic aims. The data profile developed in the first iteration of this strategy will be used to measure progress and identify any key areas of learning or practice improvement, e.g links to neglect and how well we involve fathers. The

NSCP's Communication Officer supports with a dedicated communication plan to ensure that all assets and tools are shared and promoted effectively.

2.5 In addition, training needs will be assessed both in terms of specific learning around this age group as well as linking to workforce development to ensure a shared understanding of trauma and resilience in all families. From 2022 a dedicated Trauma Informed workstream is taking the lead on developing appropriate training for different ages and stages; that workstream is closely tied into all of the NSCP's priorities and will ensure that particular risks to unborns and newborns are considered in context.

3 Definitions and Terminology

There are a number of definitions and terms that apply to this strategy.

3.1 **Non Accidental Injury (NAI):** Collins dictionary defines NAI as: *damage, such as a bruise, burn, or fracture, deliberately inflicted on a child or an old person*.

3.2 **A concealed pregnancy** or **denied pregnancy** is defined locally as:

- *a woman is unaware of or unable to accept the existence of her pregnancy.*
- *physical changes to the body may not be present or misinterpreted.*
- *a woman may be intellectually aware of the pregnancy but continue to think, feel, and behave as though she is not pregnant.*
- *a woman knows she is pregnant but does not tell any health professional.*
- *when a woman tells a professional but conceals the fact that she is not accessing antenatal care.*
- *when a pregnant woman tells another person or persons, and they conceal/do not disclose the fact to professionals.*

3.3 **Neglect:** *The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse.*
(Working Together 2018)

3.4 **Terminology linked to Safer Sleeping:** The terms below have been taken from the National Panel's Thematic Safeguarding Practice Review: ***'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm'*** (July 2020). See also Lullaby Trust safer sleep advice.

Bed sharing: *Where the parent or parents sleep in the same bed with their infant. It is often done by mothers or caregivers to extend breastfeeding, to employ easy access to breast for night feeding, and to foster bonding or physical closeness with infants.*

Co-sleeping: *The practice of sharing a bed, sofa, armchair or other surface with an infant for sleep, which can take place intentionally or unintentionally*.

Families with children at risk: *Families whose circumstances indicate high risk of significant harm. The range of circumstances indicating high risk of significant harm included:*

- *current or previous child protection or children in need plan*
- *cumulative neglect*
- *known misuse of alcohol or drugs*
- *domestic violence or criminal behaviours*
- *mental health problems deemed to present a risk to children's wellbeing*
- *unsuitable housing or frequent moves of home*
- *parents who were care leavers*
- *parents who were care leavers*
- *other children removed from care or courts involvement*
- *young parents*

Out-of-routine incidents: *Unexpected changes in family circumstances immediately before the Sudden Unexpected Death in Infancy (SUDI), in which an infant is placed in an unsafe sleep environment. These situations occur across the full continuum of risk. In high-risk families they may be associated with situations where there is escalating safeguarding risk.*

Pre-disposing risks: *Factors that are strongly associated with the incidence of SUDI. Local interventions by partner agencies focus on modification of the risk through universal and targeted services.*

Situational risks: *Where an infant is at risk of significant harm as a result of neglect, domestic violence, parental mental health concerns or substance misuse. In high risk families, these factors are present in combination with factors such as deprivation, worklessness and poor housing conditions. Work by partner agencies to reduce the risk of SUDI in these families often takes place within a framework of statutory intervention.*

4. Principles:

4.1 The NSCP adheres to the following principles in the development and implementation of this strategy:

- We will maintain a clear focus on the unborn child/baby and focus on their lived experience of care and acting as their advocates
- We will have whole system leadership in awareness raising and tackling the risks posed to babies with all partner agencies taking responsibility for professional standards within their organisations.
- We will have clear lines of accountability, roles and responsibility in cases of unborn children/babies

- We will have a shared, multi-agency approach to identification of risks posed to babies and agreed interventions and pathways
- We will demonstrate commitment to equalities and diversity acknowledging that some unborn children/babies are at more risk due to their diverse needs
- We will be culturally competent in this area of work, recognising that parenting is learned and has cultural influences
- We will adhere to the NSCP Practice Guidance for Safeguarding Diverse Ethnic Minority Children Young People & Families
- We will be competent and confident in recognising and managing the complexity and emotional impact of safeguarding babies, with a focus on 'thinking the unthinkable'

5. Measuring Impact

5.1 Impact will be measured against outcomes defined in the *Best Start for Life: A Vision for 1001 Critical Days*, namely:

- **Seamless Support for Families** – Norfolk pathways
- **A Welcoming Hub for Families** – Norfolk Family Hubs and Community & Partnerships
- **Information that Families Need When They Need It** – Just One Norfolk resources and Public Health messaging
- **Empowered Start for Life Workforce** – training, policy and procedure
- **Continually Improving Start for Life Offer** – data, evaluation, outcomes and inspection
- **Leadership for Change** – NSCP working together to meet the needs of unborns, babies and their families

5.2 Quantitative and qualitative measures to assess and monitor progress have been agreed by each individual workstream. Data is provided by partner agencies, including NHS providers and Public Health, and is brought together by the NSCP Senior Data Analyst for assessing progress and measuring impact.

5.3 The action plan is regularly reviewed and RAG rated. It is anticipated that this strategy will be completed during 2023 – 24 and any outstanding actions or areas for practice improvement will be allocated appropriately to other workstreams.

6. Leadership and Governance

6.1 As a priority area, Norfolk's Strategy to Protect Babies From Harm will be governed by a discrete multi-agency NSCP subgroup, chaired by Cambridgeshire Community Services, Head of Service for the 0 – 19 Healthy Child Programme Provider.

6.2 The Protecting Babies Steering Group has clear Terms of Reference and representation from strategic leaders from across the partnership. The Chair reports regularly to the NSCP Partnership Group.

6.3 The Protecting Babies Steering Group is strategic and is supported by two subgroups with identified leads to deliver against the strategic statements set out under Section 4 (NAI and concealed/denied pregnancy are joined to minimise duplication). The Steering Group is responsible for improving multi-agency practice and the subgroup leads will support specific developments against their areas of responsibility, as detailed in the action plan.

Appendix 1

SCR/Scrutiny/Audit recommendations cross referenced with Protecting Babies Strategic Aims –
NB completed actions have been greyed out in the refreshed strategy

Recommendation **Source:** National Child Safeguarding Practice Review: SUDI (summarised)	**Cross Ref**
Robust commissioning to promote safer sleeping within a local strategy for improving child health outcomes	2.2
Multi-agency action to address pre- disposing risks of SUDI for all families, with targeted support for families with identified additional needs	2.2
Differentiated and responsive multi-agency practice with families to promote safer sleeping in the context of safeguarding concerns and other situational risks	2.2
Under pinning systems and processes with relevant policies, procedures and practice tools that support effective multi- agency practice across the continuum of risk of SUDI.	2.2
Source: National Child Safeguarding Practice Review: The Myth of Invisible Men	
Develop ante- and post-natal health provision to fully include fathers and to include extra support to those who need it and increase their ability to early identify risk factors.	2.1
Ensure a greater integration of children's and adult service provision, especially adult mental health and substance misuse services	2.1
Integrate response to the Domestic Abuse Act 2021, how they will ensure a focus on the risks to babies and children and how they will work with perpetrators	2.1
Ensure that children's social care lead on the development of practice that improves the engagement and assessment of men involved in children in need, child protection and children in care services	2.1
Develop leaving care services to ensure they address the need for preparation and support for parenthood	2.1

Source: Norfolk Serious Case Reviews	**SCR Ref**	**Cross Ref**
The NSCP must develop better understanding of the impact of concealed/denied pregnancy and the impact on bonding and parenting capacity*. All concealed or denied pregnancies must be referred to Children's Advice and Duty Service and Social Work assessment; cases should be monitored to assess the extent of the issue, types of interventions and outcomes, including what services are put in place if cases close following the assessment. ** Research shows that when the baby is born there may be poor attachment and bonding, with the mother being psychologically unprepared to look after a new baby. This should lead to psychological or psychiatric input being considered as part of any assessment or discharge plan.*	AJ	2.1
There needs to be ringfenced reflective time for more junior practitioners to explore safeguarding issues in relation to diagnosis/decisions directly with senior Paediatric Consultant colleagues, particularly if they have not been fully involved in the decision-making process.	AJ	2.1
Safeguarding concerns in infants under 12 months, documented in the clinical record, should prompt practitioners to consider more thorough clinical examinations, including monitoring of weight and plotting on centile chart. An action plan to embed the learning across relevant practitioners will be formulated following this review.	AJ	2.1
There needs to be effective and explicit communication between Social Care and partners involved with family when a case is closed. The decision to close a case by Social Care should be informed by the views of Health Visitors, GPs and other relevant professionals; the case closure process needs to be reviewed by Children's Services to ensure everyone is aware and in agreement. Children's Services also to review standard closure letters to parents to ensure they are more explicit about ongoing involvement with the child via other agencies e.g. Community Care.	AJ	2.1
Children's Services to review the terminology describing different types of Family Network or Rapid Review meeting to make them distinct and linked to the purpose of the meeting. The outcome of that review and any guidance developed to be shared with all partners.	AJ	2.1
The use of cultural genograms should form an integral part in Family Network Planning.	AJ	2.1
A multi-agency task force should be urgently formed in Norfolk, including representatives from the front line, to collate data on serious injuries in similar circumstances to pre-mobile pre- verbal children. Task force to oversee practice and better understand the extent of this critical safeguarding issue. The learning identified in this review should inform the work of this group.	AF	2.1

NSCP are encouraged to build on the work that has been completed during this review and adopt a whole systems approach to the key learning (summarized in Section 10 above.) NSCB are invited to apply the Appreciative Inquiry model to plan how the learning will be implemented.	AF	2.1
NSCP should review and re-launch the 'Safer Sleeping Guidelines for Professionals'. • Relevant partner agencies should ensure that appropriate staff are familiar with the 'Safer Sleeping Guidelines for Professionals' and are adhering to these when working with families where there is a pregnancy or a baby under 12 months of age. • Relevant partner agencies should ensure that agency policies and procedures are consistent with the revised 'Safer Sleeping Guidelines for Professionals'.	AB	2.3
NSCP and partner agencies should continue to evaluate the impact of the film regarding safer sleeping to inform decisions as to how it should be used in the future.	AB	2.3
NSCP and partner agencies should evidence how they will promote a culture change regarding the importance of agencies engaging with all significant carers when working with families	AB	2.3
Cambridgeshire Community Services should ensure that fathers/partners are specifically invited to be present at the antenatal visit and new birth visit and evaluate the outcomes.	AB	2.3
NSCP should seek reassurance that the partner agencies with roles and responsibilities in respect of unborn children are effectively implementing the Norfolk Pre-Birth Protocol when working with women and girls who are pregnant.	AB	2.2 & 2.3
Children's Social Care should ensure that assessments are suitably robust, comprehensive and analytical with high quality managerial oversight. They should be conducted in accordance with all aspects of the Norfolk Local Assessment Protocol, using the Framework for the Assessment of Children in Need and their Families (as set out in Working Together 2018), underpinned by the Signs of Safety Approach. Assessments should include contributions from partner agencies and where the family contains a child under five years of age a joint visit by the social worker and health visitor should be undertaken	AB	2.3
Children's Social Care should ensure that the Child in Need process replicates that of any other statutory process and that equitable regard is paid to children subject to Child in Need planning. This must be evidenced in supervision and management overview records. Additionally, there must be clear evidence of who was invited to Child in Need meetings, who attended, clear actions and timely minutes of the meeting	AB	2.3
Agencies who work with children and families should ensure that when practitioners are working with a family who lives in social housing and their housing situation is a source of concern, contact is made with the housing provider at an early stage.	AB	2.3

NSCP should develop links with CGL to ensure that: • The learning from this review is shared with CGL; • Working relationships are developed between CGL and agencies working with children and families.	AB	2.3
The revised Norfolk GCP must be used in cases of neglect with strong multi-agency leadership to ensure effective implementation. This should include agreeing clear roles and responsibilities for completing the Norfolk GCP in any safeguarding/care plan. Audit of neglect cases from across the child's journey to test effective implementation and assess how it impacts on planning and interventions within 12 months of publication.	AK	2.2
Babies born into large (4+) sibling groups receiving interventions should be recognised as increasingly at risk; this should cover Early Help Assessments, Family Support, Child in Need and Child Protection Plans. This specific risk should be written into the Norfolk Threshold Guide. Risks should be made clear in records and tested through a dip sample audit within 12 months of publication.	AK	2.2
The NSCP should produce and promote sector specific good practice guides on working with fathers and father figures and good practice in working with them, highlighting the expectations of all partner organisations around professional curiosity, engaging, assessing, recording and information sharing when working with all families.	AK	ALL
Professionals working with pregnant mothers and fathers-to-be should be mindful of the extent of current and historic substance misuse and the impact on the unborn child as well as any existing sibling groups. This should include financial impact, parental ability to regulate mood and neglectful and/or emotionally abusive parenting. The Norfolk GCP should be used in response to these cases to measure impact over time and should be incorporated into the GCP audit. The NSCP should consider what communication campaigns and or training is required to raise awareness of the impact of substance misuse.	AK	ALL
Source: Multi-Agency Audit on Pre-Birth Assessments		
Wider sharing of pre-birth toolkit to encourage joint visits and outcome focussed planning between SW/HV/Midwives.	PBA audit	2.2
Social workers and multi-agency partners, to be clear about the purpose and the terminology used for pre-birth visits. This will ensure that they are not missed by Health Visitors and Midwives if they are labelled Social	PBA audit	2.2

Work assessments, rather than Pre-Birth Assessments. This would result in joint, outcome focussed assessments.		
A mechanism for more structured thinking about non-resident/ non coupled fathers and how we engage with them. This will ensure that the fathers voice is heard and contributes to the pre-birth assessment	PBA audit	2.1 & 2.2
Use of genograms when completing the Pre-birth assessment, particularly with large sibling groups or complex family networks. This will ensure that the child's lived experience, risks and protective factors and considered as part of the planning.	PBA audit	2.2

Appendix 2: Case AF – Thematic SCR on NAI Summary of Key Learning

- **Early involvement of trusted adults in the lives of children and adults builds a platform on which future trusted relationships can be built.** Windows of opportunity should be harnessed, and services (such as those provided through the voluntary sector, FNP and the Eden Team) should be strengthened to increase capacity and gaps identified.

- **Dynamic multi-agency risk assessments and risk sensible practice must be strengthened,** the family and the multi-agency network should be fully engaged and the SOS model comprehensively embedded.

- **Respectful relationships** should be promoted and facilitated across organisational hierarchies and the ownership of risk/decision making and collective problem-solving should be improved by routinely promoting information exchange, active dialogue,[2] debate and challenge and through specific multi-agency forums, supervision and training.

- **Breaking the trauma cycle - the cyclical nature of family patterns and difficulties needs to be understood. Awareness of ACEs and impact should be strengthened** (about children and parenting capacity) and a shared multi-agency response delivered.

- **Safeguarding children is a human service, the emotional content of the work has a bearing on how children are safeguarded.** The psychodynamic aspects (including how defences are constructed against the inherent anxiety) need greater attention and ways found to acknowledge the impact and mitigate the risks to enable the workforce to think and act.

- **The multi-agency safeguarding workforce protects children from harm every day and improves their outcomes.** This workforce is the system's most precious resource, opportunities to demonstrate their value should be harnessed. **Celebrate and promote good practice and what works well.**

- **A just learning culture needs to be established** to support the work force in identifying strengths and vulnerabilities so that learning and development can be strengthened.

- **A trauma informed approach is needed** in order to respond to the needs of children and their parents, and the needs of staff**.**

[2] Active dialogue is a conversation, participants are neither passive nor dominant. It features an exchange of information and knowledge, respectful challenge, curiosity and debate.

- **Know your children – know your hot spots and prioritise – know your vulnerabilities. Courageous conversations are needed,** this includes conversations with families, the front line, commissioners, inspectorates and political leaders.

- **Be conscious about the impact of organisational flux**, inspections and SCRs and take steps to mitigate these risks.

- Find ways to **increase energy and commitment to build partnership working** both at the front line and at a strategic level - be creative and take a long-term view. Develop joint priorities and a shared understanding/language and vision when responding to the learning from this review.