Norfolk Safeguarding Children Partnership

Learning Events and Strategic Management Response to Protecting Babies From Non-Accidental Injury

Learning from Child Safeguarding Practice Reviews, Rapid Reviews, Practitioners and Families

V3

18/10/21

Introduction

This report was commissioned by Norfolk Safeguarding Children Partnership (NSCP) with the intention of learning more about how children are safeguarded from non-accidental injury (NAI)[1], particularly within the context of the global Covid -19 pandemic.

Sadly, there was a national increase in non- accidental injuries (NAIs) of over 20% during the first lockdown, many of these families were not previously known to services. The British Medical Journal reported 10 cases of babies with suspected abusive head trauma in one month, compared with an average of 0.67 cases a month pre Covid-19. Between the 1st of January 2020 and the 31st of December 2020, the National Safeguarding Panel[2] received 482 "serious incident notifications" of injury and death involving children. Of these 482 notifications, 206 were in relation to child deaths and 267 related to serious harm, of which 191 related to children under the age of one.[3]

As discussed later in this report, the impact of inequality is an important consideration: *The concentration of serious safeguarding incidents was greatest (39% of all notified incidents) for children living in the 20% most deprived areas of England (based on the Index of Multiple Deprivation). Just 5% of all notified incidents were for children living in the 20% least deprived areas.*[4]

During the initial onset of the pandemic, the Safeguarding Practice Review Group (SPRG) in Norfolk received several referrals in relation to non-accidental injuries (NAI) to babies. Many of these babies had no previous contact with Children's Services and seemed very much hidden until they were presented at hospital. It was concluded that it was important to understand the impact of Covid-19 on children, families and services and to understand whether services to children and families were informed by previous learning about non- accidental injuries. This was in the context of recent Serious Case Reviews (SCRs) on pre-verbal/non-mobile babies published in Norfolk in the last two years[5] and a national Child Safeguarding Practice Review on Sudden Unexpected Death in Infancy (SUDI).[6]

Impact of Covid -19

On the 23rd of March 2020, the country was put into 'lockdown' as a response to the pandemic caused by the Covid-19 virus. Overnight, many services were stopped - schools closed, people were confined to their homes. Only essential services were provided with only key workers allowed to leave their homes for work purposes. Schools, voluntary organisations and some health and care providers closed or moved to

[1] (NAI) is defined as any abuse inflicted on a person or knowingly not prevented by a care giver
[2] www.gov.uk/government/publications
[3] Annual Report 2020.Patterns in Practice, key messages and 2021 work programme. The Child Safeguarding Practice Review Panel. HMG 2021
[4] https://www.health.org.uk>news-and-comment
[5] Thematic Serious Case Review AF. Norfolk Safeguarding Children Board 2020. Serious Case Review AB. Norfolk Safeguarding Children Board 2019
[6] Safeguarding children at risk from sudden unexpected infant death - GOV.UK (www.gov.uk) July 2020

remote provision. This had an immediate impact on families with young children, vulnerable families, pregnant women and their partners.

Agencies working together to safeguard children faced major challenges during the pandemic and needed to respond and adapt practice quickly in order to maintain support and protection for vulnerable children and families. The Covid-19 pandemic has demonstrated even more clearly the importance of human connection, acts of human kindness and trauma informed approaches.

Impact on families

Parenting and family stressors are strong factors in incidents involving non- accidental injury (NAI), neglect and sudden unexpected death in infancy (SUDI).

During lockdown, there was a lack of involvement by extended family for all and in some families new partners joined the household to avoid restrictions. For some there was a rise in domestic violence[7], a decline in mental health and wellbeing[8] and financial hardship.

The impact of school closures and restrictions on multi-agency service provision meant that the identification and support for children and families was either limited or lost. It is important to acknowledge that the experiences of children and families of the lockdown varied considerably. The impact of the pandemic revealed that existing inequalities deepened and the divide between the rich and the poor widened.[9]

Methodology & Context

Rapid Reviews (RRs) were completed on the three cases referred to the SPRG. The purpose of these RRs was to understand what had happened in these cases and to take forward immediate learning. In addition, the RRs sought to understand whether the impact of the pandemic on service provision and on families had influenced the outcome and what needed to happen to better protect babies in these circumstances.

At the time, the NSCP had adopted 'Protecting Babies' as one of its priorities alongside Neglect and Child Exploitation. The 'Protecting Babies from Harm Strategy' was written during the Spring and Summer of 2020 in response to local and national findings about risks to babies and unborn babies. The four key objectives contained within the strategy are**:**

- **Non- accidental injury**
- **Concealed/ Denied pregnancy**
- **Safe Sleeping**
- **All Babies Cry**

[7] Domestic abuse during the coronavirus (COVID-19) pandemic, England and Wales ons.gov.uk
[8] https://www.mentalhealth.org.uk
[9] https://www.sheffield.ac.uk/news/covid-19 pandemic has widened gap between rich and poor and-its-not-finished-yet (University of Sheffield August 2021)

In this context, it was decided not to proceed to commissioning formal Child Safeguarding Practice Reviews (CSPRs). Instead an innovative approach to consulting and learning from multi-agency frontline staff and managers and families was designed. The purpose was to:

- learn from practitioners' experience of safeguarding babies
- learn from parents
- understand the impact on services and families of lockdown
- understand how previous learning from SCRs had made a difference.
- inform the NSCP strategy.

Several research questions were agreed and a series of three learning events were designed. Due to the ongoing impact of the pandemic, these events were conducted virtually. Participants were drawn from all the agencies working together to safeguard children in Norfolk. A virtual platform was used, which included breakout rooms where participants were able to engage and discuss their experiences in providing services during the pandemic and to answer the research questions in a safe space. The process was supported by two independent reviewers[10] who had previous experiences of conducting SCRs, including a Thematic Review, in Norfolk.

Multi-agency participation

Delegates attended from across the multi-agency partnership including the private and voluntary sector. A total of 73 delegates attended: 54 delegates attended at least one session (74%) and 29 delegates attended all three sessions (48%).

Aims and Outcomes. The following aims and outcomes were agreed at the start:

- Review the effectiveness of local multi-agency systems in relation to NAI.
- Respond to research questions.
- Reflect on challenges and opportunities posed by Covid19 in relation to working with babies and their families.
- Consider how learning from SCRs is applied in practice.
- Produce an operational action plan.

Structure of learning events

Session 1: Strategy introduction/consultation & response to Covid-19

Session 2: Universal experiences and identifying risk factors, including parental vulnerabilities.

[10] Ann Duncan and Bridget Griffin

Session 3: The legal framework, evidencing NAI and exploring professional deference.

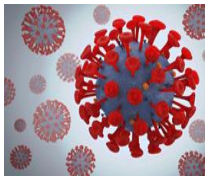
Involvement of families

..... *raising a child without a village is doable but miserable and so very lonely.*[11]

Covid brought back memories of when I had no-one – I felt isolated and suicidal – I did not want to wake up.[12]

Virtual conversations were undertaken with a total of 7 families including 3 fathers. Statutory safeguarding services were involved with 3 of these families. NAI was a feature in only one case: one father was coming to terms with harming his baby. Parents spoke about their experiences of services and the impact of the lockdown on pregnancy and parenthood.

It is important to acknowledge that this was not a large group therefore the views of these parents cannot be concluded as representative of all families in Norfolk. It is also important to say that the views of practitioners, about working with families, are not necessarily directly related to these families. That said, the information provided by families represent important anecdotal insights about parenting during lockdown and about their experiences of services over this time. Grateful thanks are extended to these families for their time and for their courage in speaking out.



Session 1: Covid-19: impact on families & services

National and local landscape – Data emerging from across the world is demonstrating that existing inequalities have deepened. The experience of children and families during the pandemic has been very different.

'*Children are not the face of this pandemic. But they risk being amongst its biggest victims'*[13]

The 'stay at home' guidance issued by the Government on 23 March 2020 was necessary to protect the NHS and save lives by flattening the curve of coronavirus infection. But for some, home is not a safe place to be.

Domestic Abuse (DA): *An epidemic beneath a pandemic.*[14] A global surge in domestic abuse has been reported during the coronavirus pandemic, as lockdown

[11] Guardian May 2021: 'Pain and joy of parenthood'
[12] Quote from a single mother, caring for her child alone, who was engaged in this review
[13] United Nations (2020) Policy brief The impact of Covid-19 on children.
[14] BBC report 23rd March 2021

rules unintentionally brought about an increase in risks faced by those living with domestic violence[15]. The UK has followed this global pattern. While domestic abuse was already a significant concern, calls and contacts to the national domestic abuse helpline run by the charity 'Refuge' were 49% higher in the week prior to 15th April 2020 than the average prior to the pandemic. On the 6th of April, traffic to the helpline website increased by 700% compared to the previous day.[16]

In a report published by ISOS[17], the authors recognise the dependency of babies on their care givers and acknowledge that: *At the same time new parents are susceptible to feelings of isolation, anxiety and perinatal mental health issues, all of which were likely to be heightened during lockdown, impacting parental capacity for responsive caregiving, attachment and brain development.* The dependency on a range of universal and specialist health services in pregnancy, during birth and over the first months of life, is also recognised*:*

There is a higher likelihood, especially for first babies, of families being previously unknown to services and not easily identifiable as needing targeted or specialist support. When services are delivered remotely/digitally babies are less likely to be seen and heard by professionals compared to older children.

It is important to recognise that practitioners providing the care and support were also living through the pandemic and possibly experiencing their own stress and anxiety. The pandemic has had an impact on the emotional resilience of all staff working across the multi-agency network.

The Norfolk Response to Covid-19/lockdown

Just One Norfolk (JON)[18] is an innovative service that provides a single point of access (a phone line and digital platform) for children and young people 0-19 and their parents and carers to discuss health and wellbeing. It provides a wide range of accessible information to the community, and it was clear that this was a valuable resource for practitioners and families alike. JON was created by Norfolk Children and Young People's Services and provided by Cambridge Community Services (CCS) in the context of delivering The Healthy Child Programme (HCP). It was co-produced with Norfolk parents and in consultation with partners working in the multi-agency network.[19]

[15] Lockdowns around the world bring rise in domestic violence, The Guardian, 28th March 2020
[16] In the year ending March 2019, an estimated 2.4 million adults aged 16 to 74 years in England and Wales experienced domestic abuse (1.6 million women and 786,000 men). The police recorded 1,316,800 domestic abuse-related incidents and crimes in the same period: 746,219 (57%) of these were crimes, an increase of 24% from the previous year. Of the 366 domestic homicides recorded by the police between April 2016 and March 2018, 270 of the victims were women. (Office for National Statistics, 'Domestic abuse in England and Wales overview: November 2019', 25 November 2019; Explanatory notes to the Domestic Abuse Bill 2020
[17] Isos Partnership for the First 1001 Days Movement. Jodie Reed (Lead Author) with Natalie Parish: January 2021
[18] https://www.justonenorfolk.nhs.uk
[19] The JON initiative had the potential to improve confidence and ability to self-care by parents, which could enable the wider system capacity to deploy more resources to those families in greatest need.

As a system Norfolk adapted quickly to provide a good multi- agency response:

- Agreement was given that no health visitors or wider Health Care Programme staff would be redeployed and by the 8th of April 2020, the 'Healthy Child Programme' were rolling out video calling.
- All vulnerable families were prioritised by most services for face-to-face contacts
- An increase in engagement with fathers through use of virtual platforms was reported by Children's Services and GPs.
- The wider children's system responded to requests by parents for digital access to support by signposting to relevant websites that provided guidance /support such as Just One Norfolk.

Before the pandemic and lockdown, the journey through pregnancy and the first year of a child's life would generate a number of interactions by professionals that allowed the family to be observed in a number of different settings.

In Norfolk there are approximately **9000** babies born a year - of those about 80% are assessed as requiring universal support. This equates to **7200** babies leaving **1800 babies in** targeted care. The number of contacts for this cohort have been estimated as the following:

- Midwives – average 6 contacts (8 for first babies) which is more than **54000 contacts**
- Ultrasound Scans x 2 = **18000**
- Healthy Child Programme. In first year, families receiving universal services receive four contacts and eight for targeted families = over **43200 contacts**
- Seen by GPs - at 8 weeks – another **9000 contacts**
- Immunisation programme - 4 contacts = **36,000 contacts**
- Average contact with Just One Norfolk by parents with children under 1 = approx. around **41, 600**

This equates to over **201, 000 contacts by professionals per annum**. During lockdown, the number of routine contacts was scaled back by each service and as a consequence the number of opportunities for interactions with the family were reduced.

It was noted that in the first few weeks of lockdown parents accessing support dropped dramatically and, at some points, there was almost zero contact with health and support agencies. This generated a level of concern for professionals who were anxious about the loss of early warning systems that in usual circumstances would alert them to the need for support and intervention.

The views and experiences of multi-agency practitioners.

Research Question 1.
How well do services understand the impact of remote working during Covid-19 on the services provided to babies? What are the risks and what can be/is being done to mitigate against them?

Impact on services: There was a strongly held view that virtual working constrained personalised communication, robust assessment and visibility of more vulnerable children, families and environments in which they live. There were fears about what was being missed in virtual meetings/calls especially in relation to domestic violence/coercive control. Practitioners spoke of there being a danger that they were *working at the edge of their competence* in a virtual world. There was a concern that some families may present a 'staged' view of family life. The importance of sensory perceptions was emphasised – *being able to feel, see and smell the home* was felt to enhance assessments. There was a consistently held view that tools were needed to enhance virtual assessments and that bespoke training was needed to build skills in conducting virtual visits and assessments. It was felt important that the limitations of assessments completed during lockdown were recognised by organisations with an explicit acceptance that it was just not possible to be as robust as they would like in their assessments.

There were also positives in working remotely. Practitioners spoke about an increase in the attendance of varied professionals in multi-agency meetings and greater integration between services: *There is no point going back to how we were pre-Covid, we need to build on what we have achieved and find safe ways to deal with 'the new normal.'*

Impact on practitioners: There were both positives and negatives about changes in working practices. The benefits of working from home, and the use of virtual platforms, were recognised as an efficient way to work which cut out unnecessary travel time and allowed for wider multi- agency involvement. However, staff felt pressure to respond to the endless emails long after the normal hours of a working day, and experienced difficulties in leaving work behind. Boundary activity is the space between work and leisure time which is particularly important for people working in stressful jobs. Individuals use their daily commute to process their working day in order to start their personal space and time. For some it has felt like *working from home - living at work*. In the stressful world of safeguarding, it was clear that this impacted on the ability of practitioners to find space away from work: *to reflect and recharge.* Practitioners talked about a lack of support and a feeling of isolation within the working day. Casual opportunities of informal sharing/reflection of complexities/problems in face-to face interaction with colleagues *by the water cooler or boiling a kettle* were missed. However, senior managers across the multi-agency partnership spoke of strong partnership working at a strategic level within the multi-agency safeguarding network in Norfolk during the pandemic. This included collaboration, mutual aid, and offers of support across agencies.[20]

[20] Multi Agency Safeguarding Task Group and COVID operational Safeguarding Group.

Impact on parents: Building relationships with families during face-to-face contact was clearly important and this seemed of particular importance for parents who had experienced past difficulties in relationships. For some parents it seemed that they needed to feel a sense of the other person 1:1 before they could risk forming a trusted relationship with a practitioner. On the other hand, other parents also spoke about the benefits of virtual meetings which were felt to be less intrusive and enabled fathers of new-borns, who were working, to attend these meetings.

Responding to Covid-19: Adapting and responding to the 'new normal'

It was impressive to hear how practitioners and services quickly adapted and responded to 'the new normal' and to changes in working practices. There were many examples of this such as: virtual case conferences, Child in Need meetings, meeting children and families in outside spaces, extended use of social media, making the most of technology and capitalising on the opportunities presented by existing websites.

There were also examples of how services have reflected and adapted their response to the pandemic. An example of which was a GP practice. In line with other practices at the start of the pandemic a list of vulnerable people had been drawn up and flagged – but this list only included the elderly. In the future, a list of vulnerable families/parents will be included: *We now have alerts on the medical system which marks those as being vulnerable as well as escalation systems for parents missing their baby check-up appointments.*

Research Question 2.
Do we fully understand the impact of Covid-19 on family units, particularly if they were not previously known to services? How can we better support them in this period of uncertainty? What are the indicators, e.g. police callouts for domestic abuse/substance misuse, which may better inform risk assessment?

The challenges and resultant risk and impact on children and families of the Covid-19 pandemic was a prevalent concern within all the learning events. Practitioners spoke about how services had to quickly adapt and described an understandable focus on those regarded as most vulnerable and these families continued to receive services during lockdown. However, there was a universal fear that children who had not yet been born and/or children who were previously not known to services could have been at greatest risk: *The priority became responding to the pandemic; known families were responded to and we adapted to meet need. But new-born babies were not a priority if the families were not known…. they were lost from view and had to go it alone with minimal support*.

The multi-agency workforce knew the risk indicators such as police call outs for domestic abuse and histories of substance misuse but much of the overall impact of the pandemic was not known, certainly in the first lock down. Therefore, the impact was not fully understood at the time and there was not a universal understanding of how the pandemic may have presented new risks and/or compounded existing

vulnerabilities. There were strong views that the urgency of dealing with the threat of the pandemic meant that other issues had to be acute/urgent before they were dealt with; there was an understandable focus on saving lives.

Unless families came forward and asked for support, identifying those families who were struggling was felt to be very difficult. Families who gave their views about reaching out for support spoke about feeling that they could not do so because of the global crisis – *I felt my needs were not important - I started to withdraw into my own bubble –it was just me and [the baby] - and as time went on, it started to feel too difficult to reach out.*

Practitioners spoke about the importance of having an active publicity campaign during any future lockdowns *to debunk some of the national media stories that gave a picture of everything closing down – and seemed to be invested in creating alarm and spreading fear,* when in reality many services continued to be provided including the Early Childhood and Family Service, GP practices, statutory social work intervention, midwifery and The Healthy Child Programme. A '*# We're Still Here NSCP'* communications campaign was mentioned as a good initiative that maintained contact with families in one service area and Just One Norfolk was felt to be a very helpful resource for families and, when speaking to families, they agreed.

It was felt that there was a need to better coordinate information gathering and sharing about families during lockdown. It was suggested there was a need to consider new ways of communicating with each other and with families as traditional routes of contact (such as face to face meetings and direct contact with services) were not available. There was a suggestion that potential vulnerabilities/risks could be identified through: A&E attendance (however, the number of visits made to A&E fell dramatically)[21]; mental health services for adults and children; housing services; and through the private and voluntary sector (such as food banks).

Practitioners spoke about an increased engagement by fathers in various ways including antenatal care: 'Father's Online'[22] reported a 20% increase in people accessing Just One Norfolk, there was an increase in GP virtual consultations with fathers and increased attendance at (virtual) case conferences. This increased attendance at case conferences of both parents was acknowledged as sometimes difficult to manage in situations where there is acrimony but the value of hearing the perspectives of fathers, *which can provide a balance to maternal self – reporting,* was valued.

GPs acknowledged the increase in pressures for new mothers and fathers and spoke about the importance of acknowledging the impact on mothers - *but also dads – some of whom had been made redundant/lost their jobs.* Several GPs said that:

[21]The total number of attendances in March 2020 was 1,531,100, a decrease of 29.4% on the same month last year. These are the lowest number of attendances reported since this collection began and are likely to be a result of the COVID-19 response. NHS England

[22] https://www.familymattersuk.org

some *fathers felt the pressure of becoming new parents and wanted to provide for the family but were unable to do so.*

In conversations with fathers, they spoke about the restrictions during lockdown meant that they could not go to scans and could not stay in the ward after their baby was born. This was important to them as full engagement in this early time was felt to strengthen bonding and attachment. Parents also spoke about the impact of all the rules and regulations and there were different views about this. For some, the rules and regulations provided a clear framework about what they and others should and shouldn't be doing and this seemed to provide a measure of containment in an anxious world. However, there were also views that some of the rules in hospitals seemed to *squeeze out common sense*- such as fathers being allowed in the ward only for visiting time (meaning that they came and went) which was felt to increase, rather than decrease, the risk of coronavirus infection.

Three of the mothers (who were interviewed) who spent periods of time on the maternity wards after the birth of their baby, felt that some staff were *uncaring;* it was almost as if the human element of care had been squeezed out of some staff with the pressures on them to abide by multiple rules and procedures and the ever-present threat of infection. Birth and new parenthood can be a time of uncertainty and the uncertainty about Covid-19 undoubtedly compounded existing anxieties. The importance of human kindness seemed to become even more significant during this period. The independent reviewers wondered about the impact of relentless work, anxiety and secondary trauma on medical staff resulting from the pandemic and how this was being contained/how staff were supported with this.

Conversations with parents of babies born during lockdown revealed that the birth experience was important to consider and the quality of the relationship between parents, at the time of pregnancy/ at birth and during the first few weeks and months of life, could be an indicator of potential vulnerability – this is discussed later.

Session 2: Stress and anxiety - identifying risk factors, including parental vulnerabilities.

Introduction: Much has been written about the level of stress and anxiety experienced during the pandemic. The ability to cope with stress depends on the controllability of the stressor and the measures to contain and delay the spread of Covid-19 presented major stressors for families which could not be controlled. The loss of income, restricted social and leisure activities, isolation and loss of loved ones, all compounded the stress of living in an uncertain world.

Nationally, reports have emerged showing that for some there has been a negative impact on maternal mental health/anxiety which increased with poverty and young

age: 43% parents with income under £16,000 reported an increase in crying and 70% of all parents said Covid-19 impacted upon their ability to cope.[23]

Research Question 3. How explicit are we in asking parents how they respond to and manage stress and anxiety, particularly in the context of lockdown? What language do we use? What tools and resources are available and what needs to be developed?

Emotional wellbeing of parents was acknowledged as critical to how they are able to manage stress and anxiety and provide care to babies/children. It was said by the parents in the sample, that explicit questions about responding to stress and anxiety were not routinely asked during lockdown. The reason for this was put down to the difficulties in virtual meetings where it can be challenging to establish trust and difficulties in reading body language (which would normally be a way of communication and would prompt greater curiosity).

Screening tools were felt to be helpful and various tools were discussed. The PHQ9[24] is a tool used by GPs, the Healthy Child Programme (HCP) and hospitals to screen for anxiety and depression. It was felt that these are a helpful way to prompt questions and establish next steps/further enquiry. Other useful tools were mentioned such as 'ECFS Outcome star'[25] which looks at the holistic needs of a family and includes prompts to instigate wider conversations – *when a parent feels safe and understood - we will get different responses.* It was felt that '5 ways to wellbeing' could be something that the Norfolk Network could adopt when working with each other and with parents.[26]

There were also good examples of the kind of empathetic questioning that opened up the conversation and enabled mothers to speak about their emotional wellbeing: *introduce the word 'anxiety' – make it normal so there is no stigma attached*. Ask mothers about their journey into parenthood and their experience of the birth: *What has your journey been like? Make talking about feelings normal - What does it feels like when ….?* A key point was made about the need for practitioners to think about the stages of grief: *What has been lost? What might someone be grieving?* Such as: *the loss celebrating the birth of a child, the loss of a loved one, the loss of human connection and affirmation.* The importance of brave open conversations was stressed and the need to make this kind of gentle questioning *part of what we all do.* The importance of including fathers in this approach to conversations was also stressed.

During conversations with mothers, all reported they were not asked how they were in the routine 8 - week check completed by GPs. They said that the focus was entirely on their baby. The fathers said they were not included in this check, even when they were present in the room/during the virtual meeting. They said they were

[23] *Maternal mental health and coping during the COVID-19 lockdown in the UK*: Data from the COVID-19 New Mum Study. Sarah Dib, Emeline Rougeaux, Adriana Vázquez-Vázquez, Jonathan C K Wells, Mary Fewtrell. UCL Great Ormond Street Institute of Child Health London UK. October 2020.

[24] https://patient.info/doctor/patient-health-questionnaire-phq-9

[25] https://www.outcomesstar.org.uk

[26] Evidence suggest that there are 5 steps you can take to improve your mental health and wellbeing: connect with other people.be physically active, learn new skills, give to others and pay attention to the present moment (mindfulness). https://www.mind.org.uk

often not asked about how they were, or about their baby, during virtual visits and this seemed to indicate to them that their importance as a care giver was not valued. For the father who went on to harm his child, he said he was emotionally struggling at the time and his partner was also struggling with anxiety. It had been a traumatic birth, the images and feelings associated with this had stayed with him; he said no-one asked how he was, and he did not feel able to say that he was struggling: *I was (rightly) not the focus. I had not given birth. I had not gone through what [his partner] had gone through. I felt helpless to help – I felt like a passenger*. For this father, there was also a powerful sense of not being entitled/not worthy of help and support. When statutory child protection services became involved, after he had harmed his child, he praised the social workers involved: *They are amazing - they care about how we get through this as a family.* When he was asked about what message he would want to give to other fathers who are feeling stressed he said*: Talk to people about how you feel and see how they react – learn about who you can trust and talk to them – prioritise your feelings.*

Approaches to engagement, to interviewing and to listening should be the same for both women and men. Exploring their histories, where they draw their support from, how they see their futures – again, this is common ground for those working in the field and applies to both men and women. The evidence from this review suggests that there is insufficient evidence that practice with men has these characteristics[27].

Responding to Covid -19: Adapting and responding to the new normal

It was clear that some practitioners had adapted their approach in exercising professional curiosity online. They gave examples of; framing open ended questions, watching out for eye contact and the circumstances when this changed, specifically asking about how the pandemic was uniquely affecting families, and using observation and listening skills: *I have learnt to listen more.* The 'All Babies Cry' campaign was felt to offer valuable information and resources for both practitioners and families and was particularly important during lockdown. Practitioners said that they spent more time online which meant that they searched other helpful resources/tools which they learnt from and could signpost parents to: *For Babies Sake – break the cycle - is a really good visual tool with a strengths-based approach to support recovery for parents with unresolved trauma.*

It was felt it would be helpful for networking opportunities to be in place with peers to learn from each other about what works well with families and *to test out/practice how to have difficult conversations/ create opportunities to speak about feelings.*

[27] "The Myth of Invisible Men" Safeguarding children under 1 from non-accidental injury caused by male carers. The Child Safeguarding Practice Review Panel. HMG: September 2021

Research Question 4.
How is the impact of parental vulnerabilities understood and assessed in relation to current and potential parental capacity? Do we understand or ask about the parents' experience of trauma (e.g. Adverse Childhood Experiences) in order to assess their ability to regulate their stress responses to their babies? Focus on fathers.

Introduction: Research[28] on Adverse Childhood Experiences (ACEs) offers an important perspective on childhood experiences which are associated with risks to health and wellbeing in childhood and adulthood. It is not known how far the pandemic may have exacerbated existing adversity for children (such as living in households that feature conflict and/or domestic abuse) or increased children's exposure to ACEs (such as bereavement).

During lockdown, surveys conducted with children by MIND[29] have shown a significant increase in anxiety, and a decrease in mental wellbeing. Almost half (47.5%) of women with babies aged six months or younger met the threshold for postnatal depression during the first Covid-19 lockdown, more than double the average rates for Europe before the pandemic (23%)[30]. Women described feelings of isolation, exhaustion, worry, inadequacy, guilt, and increased stress. Many grieved for what they felt were lost opportunities for them and their baby and worried about the developmental impact of social isolation on their child.

GPs in Norfolk reported a rise in prescribing anti depressant medication for new mothers during lockdown. In part, this seemed to be due to the limitations of social interaction/availability of services at that time. It was felt important to acknowledge that a new mother experiences a range of emotions which may include sadness, anxiety, low mood and some mothers just require reassurance that this is 'normal'*: I was feeling low, and the GP prescribed anti-depressants. I did not take them, and the feelings passed. Looking back, I feel I just needed reassurance that I was not alone in what I was going through. I feel guilty that I felt like that, I should have been happy.* Consultations with GPs were mostly virtual; time pressures did not seem to allow for mother's emotions, and expectations of parenthood, to be explored. In response, some GPs are now routinely asking about how lockdown is affecting parents and asking specific questions about how they respond to crying babies.

Lockdown Fathers: The untold story[31] is a recent study based on a nationally representative sample of more than 2,000 fathers. This study found that most spent more time with their children, built stronger relationships with them, and improved their parenting skills during the first Covid-19 lockdown. They grew in confidence as parents, gained greater insights into their partners' caring roles, and did more housework. However, there is another side to this story for fathers who lost work, felt unable to financially provide for their new-born and who needed support in adapting

[28] This research should not be considered in isolation from the much broader body of research on vulnerability and the wider social determinants of health Asmussen K, Fischer F, Drayton E, McBride T. Adverse childhood experiences: what we know, what we don't know and what should happen next: Early Intervention Foundation 2020
[29] https://www.mind.org.uk
[30] *New mothers twice as likely to have post-natal depression in lockdown*. UCL Great Ormond Street Institute of Child Health London UK. May 2021 (https://www.ucl.ac.uk/news/2021/may/new-mothers-twice-likely-have-post-natal-depression-lockdown).
[31] The Fatherhood Institute survey was conducted by Britain Thinks and funded by the Nuffield Foundation.

to their new role in a time when services were not readily available (and when services were available they were lost from view). It seemed that some fathers may have struggled to find a sense of value in what they brought as a parent of a new-born, and in contending with their own emotional wellbeing (that may have been overlooked or supressed) in a world where the emotional needs of men remain obscured from full view/societal acceptance.[32]

A recently published report by the Child Safeguarding Review Panel (CSRP)[33] makes an important observation:

Many of the issues explored reflect deeply engrained roles, stereotypes and expectations about men, women and parenthood in our society. Notwithstanding major social changes, women continue to be regarded as the prime and sometimes only protective carer for their children. Some men struggle to articulate their fears and anxieties about fatherhood, may be poorly prepared for its demands and resort too quickly to violence, creating very significant risks to children in the situations considered here.

The views and experiences of multi-agency practitioners and families

The views of practitioners in Children's Services was that the importance of parental vulnerabilities was understood in understanding and assessing risk. The Signs of Safety[34] model was said to prompt this approach to risk assessments. However, exploring past trauma and the impact of childhood experiences on current wellbeing and parenting capacity was said only to be possible once a trusted relationship was formed and this took time to establish: *These kind of in-depth assessments and curiosity about past trauma cannot be achieved online. Intuition, gut feeling and communication through body language is key.*

The impact of trauma and adverse life experiences was known well by practitioners in the learning events. However, if families were not known to services it was felt that this is more difficult to determine in early contact/universal provision and that more needed to be done to engage fathers in these discussions.

It was felt that understanding parental vulnerabilities, and what might be triggered under stress such as a crying baby/a baby who is unwell/difficult to settle/difficult to feed, needed to be understood at the earliest possible point – *if possible, during ante natal care.* Therefore, it was felt important to explore emotional wellbeing and the origins of anxiety/low mood etc with both parents, particularly fathers, during this antenatal period. It was felt that parents could be supported to learn not just about practical tasks such as feeding/weening etc but also about the emotional impact of parental anxiety/mood on a baby and the emotional fallout/triggering of childhood trauma/adversities. For Babies Sake[35] was mentioned as a helpful organisation

[32] https://www.fathersdirect.com
[33] "The Myth of Invisible Men" Safeguarding children under 1 from non-accidental injury caused by male carers. The Child Safeguarding Practice Review Panel. HMG: September 2021.
[34] https://www.signsofsafety.net
[35] https://www.forbabyssake.org.uk

providing advice, guidance and tools in addressing relevant issues which they refer to as: *ghosts in the nursey*

Ghosts in the nursery: Case example from speaking with parents as part of this review

Rosie had her first baby during lockdown, Mia was a happy baby who was no trouble. Rosie found caring for Mia easy – it felt natural to her as she had been the eldest sister in a large group of siblings. When she was growing up her parents had not been able to look after them and were dependent on Rosie to be a substitute parent. Being a second mum (and dad) to her siblings had been part of growing up. She cooked the meals, took her siblings to school and looked after them. Rosie moved out of the family home before lockdown to live with her boyfriend and Mia was born. Just before Mia's birth, her siblings were removed from her parents as there were concerns about the care they were receiving. Rosie was desperate to see her siblings, but this proved impossible. Just after Mia was born, Mia was admitted to hospital with a minor health condition and Rosie stayed in the hospital with Mia. At this point, Rosie broke down – she was very low in mood and attempted to take her own life. Statutory services became involved.

Rosie had not told her story to anyone before meeting with the independent reviewers. The reviewers wondered whether it might have been possible for professionals to have understood this story before and considered whether her fears about losing Mia (and being separated from her) may have triggered 'ghosts in the nursey' to appear – her childhood and her feelings about the recent separation from her beloved siblings may have been triggered and felt overwhelming.

Whilst it is accepted that building trust with parents can take time, and that forming these trusted relationships can be more difficult in a virtual world, this case example illustrates that holding in mind the concept of '*ghosts in the nursery'* can open up the possibility of being respectfully curious about emotional triggers, or echoes from the past, that influence our response in present time.

Research Question 5.
How do current systems and processes support dynamic risk assessments that place the experience of young pre-verbal/pre-mobile child at the centre of the assessment process? What opportunities and/or requirement is there to be innovative and adapt to changing circumstances?

Introduction: Risks must be assessed from the perspective of the child in a dynamic and ongoing cycle; *Assessments are a continuing process and not an event*. [36] A safe child protection system needs to deal proficiently with risk and probability; it is not enough to respond reactively after an incident of harm has been caused to a child. Good risk assessments construct a coherent story about the child's circumstances; they appreciate that there will be ambiguity and uncertainty about some matters; they have been constructed through the testing of hypotheses and a curiosity that sees people in their contexts; they are considered and thoughtful; and

[36] Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children. HMG 2018

finally, they allow for and enable change whilst having an awareness of key times when risks may escalate: *Critical thinking (is needed) about the contribution of the pandemic to changing risk and need, and its impact on the daily life of children and families.*[37]

The views and experiences of multi-agency practitioners.

There was a strong view that the joint visits between SWs and health professionals (health visitors and midwives) enhance dynamic risk assessment.[38] During lockdown although home visits took place, joint visits were not possible.[39]

Remote child protection case conferences were felt to have significantly improved multi-agency sharing of information, dialogue and collaboration. Remote working was said to have increased the speed at which assessments are completed (which is particularly relevant for Norfolk practitioners who may need to travel across county - consuming much professional time). It was said that families have benefitted from quicker assessments as plans are put in place at an earlier stage. On the downside, it was felt that the lack of interaction with parents by a range of practitioners in assorted services meant that there are fewer opportunities to establish trusted relationships/see the various aspects of a child and family.

GPs spoke about a change in the way patterns of non- attendance are recorded and reviewed. For children, this equates to: 'was not brought'[40] and this highlights patterns in families that need to be addressed.

Several practitioners demonstrated that they understood the stresses/risks posed for vulnerable families during the pandemic and adapted assessments to take account of these things (although this was more on a case-by-case basis/dependant on whether the practitioners were aware of the potential risks). It was felt that many of these stressors only came into focus during the second lockdown and over the recent past, and that the guidance and formats for risk assessments and interventions should guide practitioners in asking specific questions about these stressors/the experience of parents/families.

Practitioners recognised the importance for families in *feeling held – feeling contained – feeling held in mind* in difficult/uncertain times. This was described as the message given to families about the 'team around the child/family' approach in early years *which comes from a place of care and compassion, from one human to another – the importance of one human being connecting to another*. This was felt to be particularly important when working with families where consent for service involvement is required.

[37] Supporting vulnerable children and families during COVID-19. Practice Briefing. The Child Safeguarding Practice Review Panel. HMG: December 2020

[38] http://cdn.communitycare.co.uk

[39] Visits took place separately and the assessments were shared between the HV and SW.

[40] When referring to children, reframing 'did not attend' to 'was not brought' is a change in perspective about the reasons a child does not attend an appointment. It originated from a SCR published by Nottingham Safeguarding Children Board- this helpful reframe has been adopted in Norfolk.

Helpful tools for practitioners and parents were mentioned such as Read My Mind[41]. Read My Mind is a library project which encourages men who are either experiencing depression or low mood levels to take part in social reading activities. Funded by Norfolk County Council Public Health, the project is for men aged 18+ and explores whether there is a link between reading and improving men's mental health and well-being.

Practitioners from the Family Nurse Partnership (FNP)[42] and early years spoke about *seeing the world through the eyes of a child* and supporting parents to tune in to how their baby is communicating/what they are communicating and equally to find space/time out for themselves (especially when a baby is frequently crying/crying excessively). Parents agreed that this advice was helpful and spoke highly of the information contained in Just One Norfolk regarding these issues. However, it was also said that some practitioners continue to write in assessments/conference reports about babies that they are: *too young to have a voice.*

Some practitioners spoke about how they bring the focus on the child by always using the child's name, being curious about everyday life, recognising developmental stages: A*hh he is gurgling. Wow she is watching you intently. She is so curious. He is trying to walk.* They also spoke about sharing their experiences of motherhood/fatherhood: *Sharing stories of parenthood – sharing the highs and lows. Sharing feelings that arose* (although clearly not to excess and only with the intention of introducing a conversation about feelings).

For families that were not already known, there was less of an opportunity to complete assessments as they were largely out of view during the pandemic. The 8-week check completed by GPs was felt to be an important opportunity to get a sense of family life/the child's experiences. As stated previously, the experience of families during this check was that their wellbeing was not important/asked about.

The recent thematic Serious Case Review in Norfolk[43] suggested that traumatic births posed a potential risk for babies and, if this was coupled with caring for a baby who was unwell/ who struggled to feed/who was difficult to settle, this increased the risk of harm. In the Rapid Reviews undertaken by NSCP the three cases involved young mothers who had difficult relationships with the father of the baby, or where the father was no longer involved. In two cases there was a new partner who very quickly moved into the family home to avoid the lockdown restrictions. Two had past experiences of anxiety and all had experienced some postnatal difficulties including feeding problems. One mother told the GP at the 8-week check that the baby cried all the time, but little was done in response.

[41] Read My Mind - Collections of books with advice and information to support and help people manage their wellbeing. www.norfolk.gov.uk/libraries-local-history-and-archives/libraries/library-services/health-and-wellbeing/online-resources/read-my-mind

[42] FNP has three aims: to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency. FNP is a voluntary, preventive programme for vulnerable young first-time mothers. https://fnp.nhs.uk

[43] Norfolk Safeguarding Children Board: Thematic Serious Case Review September 2019

Most of the families seen as part of this review, described a traumatic birth such as: an emergency caesarean *which was frightening;* use of forceps, *which was brutal;* excessive loss of blood *which was shocking;* lengthy labour and the baby being in distress. Most of the babies were unwell such as tongue tie, high palate, difficulty feeding, cow's milk protein allergy. Several were described as fretful, clingy babies, some rarely slept and some persistently cried. Most of the mothers suffered from low mood/anxiety. With one exception, the families had managed to effectively deal with these challenges without baby being harmed but hearing the families describe what they went through over these early months it seemed incredible that they had the resilience to cope. Some of their stories felt tortuous and some were candid about what feelings this time brought up for them. These feelings seemed perfectly understandable under the circumstances.

Therefore, it seems important that these factors are considered as critical indicators of risk. However, when talking about dynamic risk assessment in the learning events these factors were not mentioned. Learning from previous SCRs, and from families as part of this review, suggests that a dynamic risk assessment must consider factors such as resilience and vulnerability in these circumstances and how they change over time and in response to different stressors. Questions such as: Are the feelings that emerge dispositional (a recurrent behavioural, cognitive, or affective tendency) or situational (influence on behaviour from an environmental source)? are important to assess and understand. For one father his resilience was low because he felt unworthy and helpless, he felt powerless to affect change and an existing vulnerability which was dispositional (of unresolved anger from the past) was triggered.

Session 3: The legal framework, evidencing NAI and exploring professional deference.

Research Question 6. Do we understand enough about specific injuries and where they are positioned in order to better assess potential risks? What inhibits professional curiosity? What may prevent professionals from following relevant policies, protocols and procedures? What part, if any, does professional deference play?

Introduction

Non-Accidental Injury (NAI): Non-mobile infants rarely bruise, there is limited scope for them to bruise themselves and it is more likely to be indicative of NAI. Risk of death is highest, in fact 3 times greater, in the first year of life. The positioning of the bruising and whether the explanation is plausible and developmentally appropriate is important to establish. Small injuries can be predictors of more serious abuse and must be investigated.

Bruises that are on the soft parts of the body are a cause for concern, such as:

- Ear, neck trunk and buttocks and areas of the face (excluding the T-zone)
- Clusters of bruising
- Bruises of uniform shape
- Bruises that carry an imprint of an implement
- Bruising with petechiae (a small red or purple spot caused by bleeding into the skin)[44]

Professional curiosity is the capacity to thoroughly explore the information received/gathered and to be respectfully uncertain and curious about this information, rather than making assumptions or accepting versions of events at face value. The lack of professional curiosity is commonly sighted in SCRs although, as identified by the National Panel [45], it is not clear why professional curiosity was absent. *Reviews frequently highlight a lack of 'professional curiosity' and 'over optimism.' Assessments and plans for support are framed by underlying assumptions that remain unchanged in spite of continuing or spiralling risk. This is particularly so where there has been intervention over a number of years. These circumstances are often combined with a lack of challenge between professionals and a reluctance to escalate concerns.*

To have the capacity to be 'professionally curious' requires practitioners to be adequately equipped with relevant knowledge and skills and to have the confidence to exercise authoritative practice[46] in their work with families, and within the wider multi-agency network. In the absence of authoritative practice there is a risk that deference, instead of challenge, becomes a feature of inter-agency and multi-agency work.

Research has shown that this needs to be underpinned by a culture of supportive and reflective supervision which gives the time and support necessary to seek to understand what may lie beneath the surface of how a child/adult may present, and/or seek an alternative explanation to the one that is being presented. This curiosity should not be limited to what might be happening to a child or within a family but also what might be happening within a multi-agency group of professionals. These circumstances typically require practitioners to be confident enough to ask questions from a position of not knowing/not assuming. It is linked to 'thinking the unthinkable' and 'the rule of optimism.' All three concepts are core features of safeguarding work and share similar factors that may inhibit our capacity to be curious/uncertain. These factors can be grouped into key areas which include volume of work, skills, and the quality of support provided. If these things are not available, human biases (such as confirmation bias) can colour our vision: *we are influenced by what we expect to see.*[47]

[44] https://www.adc.bmj.com prevalence and distribution of petechiae in well babies
[45] Annual report 2020. Patterns in practice, key messages and 2021 work programme. The Child National Safeguarding Practice review. HMG 2021.
[46] In summary: Authoritative Practice is characterised by a focus on the needs/voice of a child, includes respectful challenge and uncertainty, considers the needs of parents and sees these needs from their point of view, without collusion, and recognises that *there is no single professional who has a monopoly of knowledge or skills to bring to the case*. Authoritative Child Protection Child Abuse Review Vol. 22: 1–4 (2013) Ed. P. Sidebottom.
[47] Protecting Children: The Central Role of Knowledge. J. Akister. 2011

The views and experiences of multi-agency practitioners and families

Do we understand enough about specific injuries and where they are positioned in order to better assess potential risks? Practitioners from across the network, particularly non-medical professionals, found the presentation delivered during the learning event very helpful in understanding more about this. It was felt that this knowledge tends to be known well amongst police and medical colleagues but not across the wider network.

What inhibits professional curiosity? There were views that difficult conversations/being probing/curious about explanations for injuries was an area that required attention across the multi-agency group. It was felt this was not something that all practitioners felt comfortable with: *don't be too 'British' – parents expect us to ask probing/difficult questions.* Whilst it was accepted that a fear of alienating a family may influence/inhibit these conversations, and lead to a greater risk to the child, it was felt that there were some key skills that could be taught to facilitate practitioners having difficult conversations with parents and with each other.

NAI was a feature in only one family who were engaged in this review. When the father was asked about what the most important message he wanted practitioners to hear was that he needed practitioners to be curious about him and about his emotional wellbeing. He needed practitioners to probe about his ways of dealing with stress/his response to feelings of being out of control/angry/sad/helpless. For all other families there was a consistent message that they would have welcomed greater curiosity about; how they were feeling/how they were feeling about being a parent, about their baby's health and wellbeing.

What part, if any, does professional deference play? Discussions about the part played by deference in safeguarding work brought up several issues. One of which related to the influence of organisational culture and hierarchies; be it the chain of command or the unspoken hierarchy of how knowledge and skills were rated/valued across the multi-agency network. It was accepted that hierarchy was an inherent, and necessary, part of an organisation and that 'the chain of command' was a core feature of safeguarding policies and procedures. However, it was felt that a culture of openness, challenge and debate should be nurtured and strengthened within teams/services/organisations and within multi-agency work. This echoes with the principles of authoritative practice: *…there is no single professional who has a monopoly of knowledge or skills to bring to the case.*[48]

This was demonstrated in an example given by two GPs who spoke about the importance of practitioners entering into collaborative decision making and action in relation to injuries which may have been observed. *Sometimes it feels like it is passed to us – there is nothing special we can do in these situations.*

Passing decision making to clinicians about injuries has been a feature of SCRs. Whilst it was completely accepted that clinical judgement is a necessity, it was emphasised that safeguarding decision making cannot be left to a single professional; it requires full information sharing, collective thinking and collaboration.

[48] Authoritative Child Protection: Child Abuse Review. Vol 22. Ed: P. Sidebottom. Wiley Online Library 2013

It was felt that single agency working can be influenced in part by deference but also by siloed working - where decisions opinions and judgements are not always actively promoted and owned as a shared responsibility. Another key area was how the multi-agency system deals with challenge and the need for this challenge to be part and parcel of safeguarding work: *It should be welcomed - not dealt with defensively.* An example was given where a challenge became categorised as a complaint that involved *a lengthy paperwork exercise of dotting the i's and crossing the t's.*

Practitioners spoke of feelings of isolation when dealing with NAI/critical incidents and the need for there to be structured support within the system when dealing with incidents, and after the emergency has passed. They spoke about the need for space to be created in a system for a debrief with practitioners immediately after a critical event to enable joint reflection, immediate learning and support, rather than, in a worse case scenario, waiting for the SCR/CSPR to start.

What may prevent professionals from following relevant policies, protocols and procedures? Practitioners said that for some staff in the workforce access to policies & procedures was difficult/not readily available, particularly for those in community settings such as nurseries/early years provisions or in the private and voluntary sector. It was felt that more needed to be done to create flow charts; easy to follow steps and *more bite sized training* and awareness raising tools. It was felt important to receive clear communication about amendments to policies/procedures and for there to be improved consultation with staff about amendments.

Research Question 7.
What is your experience of training in identifying and responding to non-accidental injuries? How do you translate learning into practice and what support do you get to do this? After attending these sessions, can you identify what further training you might need? Are there any examples of good practice?

There were very different experiences of identifying and responding to NAI. Various levels of training were identified which were dependant on a specific role and area of responsibility. There was a general sense that, apart from clinical staff, other practitioners felt ill equipped/lacked confidence to be more curious about injuries/the position of injuries on children. As mentioned above, there was a view that the presentation delivered during the learning event was an example of good practice and should be available to staff across the workforce (in particular for nurseries/child minders/schools/pre-school settings/playgroups etc). It was suggested this training could be in the form of an online seminar/lunch time briefing.

Other areas that were felt to require training was how to manage anxiety in demanding situations (such as NAI) and how staff can be supported at these times. More training on court skills, child protection conferences training and having difficult conversations with parents and with each other, were all felt to be important.

Hearing from families

What does Norfolk do well? - celebrating success

Face-to face visits. It was clear that the face-to-face visits usually undertaken provide opportunities to build trusted relationships and that these relationships are valued.

The importance of relationships: The power of empathy and compassion. Kindness and genuine concern provided a feeling of being seen and heard in times of anxiety and when this was provided- even virtually/over the phone - it was memorable.

The importance of knowing our child. *Knowing our child like we do, a focus on our baby and our journey of parenthood* - knowing and understanding - *the good and the not so good.*

The importance of celebrating birth and hearing it said: *What a beautiful child – you have done so well.*

The importance of showing you care creating safe moments when parents can be vulnerable and say they are struggling *I am sad, I feel useless, I feel helpless.*

The importance of knowing we are not alone: *there is someone holding me/us in mind – Knowing who I can speak to and being available.*

The importance of sharing professional wisdom & advise *telling us about services we can access in the local area – telling us not to worry – its normal – it will pass (or not).*

What does Norfolk need to do better?

Imagine you are in the situation.

Listen to the detail – *we know our babies best.*

Listen out for clues – "I *used to be anxious" - ask us about this and how we are now.*

Ask parents how they are without judgement: *How was the birth – how are you feeling*? **Show** – *by your tone of voice – your facial expressions - that you care.*

***If we are worried** about something to do with our baby or ourselves: Ask us to show you*

***Be clear** about steps we should take – signpost.*

Hearing the voice of families - emerging themes

Inequality: Emerging evidence on health inequalities and Covid-19 is showing that people's experiences of the pandemic have been shaped by their health and existing inequalities[49]. This was mirrored by the backgrounds of the families spoken to whereby those who were in employment and had no financial pressure were able to access private scans and private outdoor spaces. For other family's social isolation and financial pressure increased during the pandemic and impacted on their mental health well-being. In addition, having pre-existing knowledge which included: knowing how the system should work, knowing/having the ability and resources to access information about services/symptoms and feeling entitled to make requests seemed to influence how, and at what speed, resources/services were accessed.

Traumatic births & impact: The impact of trauma is a subjective experience. In the case of a new baby, the impact of complicated births was not explored/understood but had a profound impact on mothers and fathers and has potential implications for attachment/bonding.

Post-natal complications included wound infections, mastitis, difficulty with feeding due to tongue tie. There was an acceptance that all babies cry but it was felt important to acknowledge that some cry more than others, and the reasons need to be explored.

Maternal emotional wellbeing: Mothers spoke about their emotional wellbeing during pregnancy and birth and in being a parent. All spoke about impact in various ways: anxiety and depression featured and 3 out of 7 were prescribed anti-depressants. Families were unaware of the normal physiology of the immediate post-natal period particularly the 'baby blues' and this seemed to increase their anxiety and feelings of helplessness. It was understood that GPs were encouraged to ask the mother/ father about how they were coping at the 8-week check, but the families involved in this review said they were not asked and said the sole focus was on their baby.

Fathers were out of sight: The pandemic offered an opportunity to engage with fathers with many of them spending time at home/ working from home. Fathers spoke about feeling left out of the pregnancy; they were not allowed to attend the scans and felt that they missed out on the opportunity to share the experience of preparing for birth/pre-birth activity with their partner. During the post-natal period the fathers said they felt ignored by practitioners and never asked how they were coping as a new parent or about their relationship with their baby.

Taking the Learning Forward

The Learning Events provided a safe platform for staff to reflect and share experiences of working at a time of uncertainty. The research questions stimulated discussion and debate and an opportunity to

[49] https://www.health.org.uk>news-and-comment

capture what has worked well, what can be improved, and what more may be needed.

A wealth of information has emerged for consideration by the Protecting Babies Steering Group (PBSG) including: the impact of trauma on parents and staff, the importance of support and reflection after a critical incident, and the good and bad of virtual working. The importance of exercising curiosity and of gut feelings in assessments was felt to be particularly noteworthy learning.

Paying attention to gut feelings

The ability to receive sensory input through various psychological processed in the body translates the stimulus or data into meaningful information, intuitive reasoning plays a key role – acting as a starting point for assessments of risk: *immediate emotional response or gut feelings during a visit draws attention to potentially salient information before it was rationally accessible.*[50] The learning in this review about the importance of sensory perception or gut feelings when visiting, while remaining alert to avoidable biases, should be built upon in safeguarding practice.

Next Steps

Moving forward, the PBSG should consider how to disseminate the learning to the wider multi-agency network and think about key questions that have emerged.

Suggestions include:

- **Your workforce is your strength**: Practitioners in the workforce are deeply committed to safeguarding children. The compassion that they demonstrate and the care and human connection they provide is possibly the greatest safeguard. Consider: How is your workforce celebrated and supported in the way they support and protect children and families every day of their working lives?
- **Provide webinars*/ Bite sized training*** on legal and medical perspectives/knowledge about NAI
- **There are many tools in use – develop a shared repository of tools**
- **The importance of times to pause together** - these learning events allowed this to happen and strengthens knowledge, relationships and multi-agency working - what might this look like in the future?
- **All babies cry – but some cry more than others.** This needs to be acknowledged and there needs to be greater curiosity about this – whilst the message all babies cry is helpful – it also risks normalising circumstances when a baby is crying more than normal and may inhibit curiosity about what might be wrong/whether baby has an underlying medical condition/whether maternal anxiety is contributing/ what may be happening in the home
- **The importance of the 8 - week check** – ask about maternal & parental wellbeing and making attempts to include fathers in this appointment

[50] *Making Sense of the Initial Home visit: The Role of Intuition in Child and Family Social Workers' Assessments of Risk.* L Cook. Journal of Social Work Practice. October 2017

- **Focus on ante natal care and these very early weeks and months of birth**. This is well known to be a of attachment & bonding and is regarded as 'a blueprint for life': What may inhibit bonding? What ACEs may be present that may trigger an emotional response that could present a risk to a baby in certain circumstances?
- **Learning from each other – to have difficult conversations** – to have conversations about feelings – learn from each other about the tools and resources that work well
- **Be on the *front foot* – prepare for another lockdown –** *need a project plan on the shelf* – what have we learnt? Develop a bank of resources – tools.

Putting Learning into Practice - Learning from SCRs

1. The importance of fathers: *I felt like a passenger.*[51]

Fatherhood is not an option. It's not about parents' rights, it's about making sure that we offer children the best opportunities in life and that means including fathers in all aspects of their lives.[52]

It is the prime contention of this review that the way safeguarding, and related services operate makes it far too easy for them to remain 'invisible' and 'not engaged.' [53]

It seems to be well known that fathers are often lost from view. The thematic SCR in Norfolk highlights the lack of attention given to the relationship between the father and the child: *The relationship between the father/male care giver received very little attention, as a result this relationship was unknown.*[54] and the Child Safeguarding Practice Review recently published[55] identifies:

Mothers are more likely to be seen in a more rounded, holistic way, with their strengths identified and built on, areas of concern addressed, and attention given to enhancing their support systems. In short, greater proportionate effort and attention is given to enable mothers to be the best parents they can be. This more nuanced approach does not generally underpin practice when engaging fathers. This has a catastrophic impact on some babies and was a key driver behind our decision to conduct this review.

There are promising early indicators of increased involvement by fathers in antenatal care, accessing bespoke websites and conference attendance but these need to be built on. Fathers need to be kept in view; by asking for their perspectives; building trusted relationships; normalising and encouraging father's to talk about emotions/emotional impact of witnessing a traumatic birth/contending with a crying baby and supporting partners; and by supporting father's to be the best they can be:

[51] Quote from father who was engaged in this review
[52] Adrienne Burgess, Chief Executive of The Fatherhood Institute,.
[53] The Myth of Invisible Men" Safeguarding children under 1 from non-accidental injury caused by male carers. The Child Safeguarding Practice Review Panel. HMG: Sept' 2021
[54] Norfolk Safeguarding Children Partnership. NAI Thematic Review. AF 2020
[55] "The Myth of Invisible Men" Safeguarding children under 1 from non-accidental injury caused by male carers. The Child Safeguarding Practice Review Panel. HMG: Sept' 2021

A cultural shift is needed: Culture change is never easy to achieve. It means taking an organisation-wide approach to including fathers and working with other agencies and joining up principles; it means starting with a belief that fathers matter too, and engaging them in the early years sector, schools, social services and health services.[56]

Many of the issues identified in this review echo the findings in the report by the Child Safeguarding Practice Review Panel. NSCP are encouraged to build on the learning in this review by considering how the recommendations outlined in this national report will be taken forward.

2. Continue to promote trauma informed approaches and strengthen a generative culture[57] within and across the multi-agency network

A generative culture is able to make use of information, observations wherever they exist in the system without regard to location or status, whistle blowers and other messengers are trained, encouraged and rewarded - a just culture where people feel they will be judged by reasonable standards, and what was known at the time not by hindsight.[58]

It remains important for trauma informed approaches to staff and families alike to be promoted and supported within organisations and that organisational cultures need ongoing attention and review. The thematic SCR in Norfolk highlighted the benefits of a generative culture within and across the multi-agency system and that if a positive learning culture is not present, this means that *errors may not recognised as part and parcel of the work and practitioners feel worried they may be blamed, rather than understood, if a mistake is made. A practitioner commented - It is not safe to be wrong and the sentiment of this statement was repeated in the focus groups across the multi-agency system.*[59]

- **A trauma – informed approach**

Practitioners spoke about feeling bombarded by stories of children who have suffered/are suffering pain.
• Were overwhelmed by the emotional impact of the work
• Recognised that this has eroded their thinking and inhibited curiosity.
• Understood that without the right support it might be tempting to opt for what may seem to be a plausible explanation for a child's injury (that it was caused accidentally.[60]

It remains important that this emotional context is thought about and responded to within safeguarding work and it seems important for organisations to reflect on how well staff were supported during lockdown and consider what has been learnt about how a trauma informed approach can be enacted in exceptional circumstances. It

[56] www.fatherhoodinstitute.org- *The risks of excluding fathers.*
[57] Three Cultures Model. Professor Westurn (2004) BMJ Quality and Safety Journal V.13
[58] Norfolk Safeguarding Children Partnership. NAI Thematic Review. AF 2020
[59] Norfolk Safeguarding Children Partnership. NAI Thematic Review. AF 2020
[60] Norfolk Safeguarding Children Partnership. NAI Thematic Review. AF 2020

also remains important to pay attention to the birth experience and appreciate the impact of traumatic births on parents - to focus on this and the dynamic between parents and ask: What more might be needed in Norfolk?

- **Continue to promote an understanding of ACEs**

The Thematic Review highlighted the importance of practitioners having a good understanding of ACEs and how these may impact on adult mental health and wellbeing. During the learning events, this seemed to be understood. However, understanding that ACEs are concealed and embodied overtime, and can be tiggered by specific life events (especially in response to the feelings that can arise when caring for a child in stressful circumstances), did not seem to be fully understood. It seemed difficult for some practitioners to move from a position of having the knowledge about ACE's, to creating opportunities to ask about childhood experiences and how they may impact in present time. It remains important for practitioners to be supported in being curious and to find ways of opening these conversations with parents, particularly in a virtual world. 'For Babies Sake' speaks about *ghosts in the nursey* and provide guidance and tools to assist practitioners in working with parents about these issues. NSCP are invited to consider what more is needed to support practitioners in this vital area of safeguarding work.