Neglect of a Baby - Serious Case Review Briefing

Bristol Safeguarding Children Board **March 2018**

Overview

In 2018 the Bristol Safeguarding Children Board completed a Serious Case Review about the professional response to neglect experienced by a newborn baby in the first few months of its life. The review considers the period from birth until a multi-agency Team Around the Family meeting three months later. Tragically the baby died two weeks after this meeting. The death of the baby was not been found to have been linked to the neglect they experienced and was recorded as a Sudden Unexpected Death in Infancy. The full review has not been published in order to protect the ongoing welfare of other children involved. However the learning and findings of the review are shared here to enable professionals to act on the learning.

Bristol Neglect Strategy

In February 2018 agencies across Bristol adopted the Bristol Neglect Strategy and Guidance for Professionals. This sets out how we plan to work together to reduce Neglect in the city.

Find it here

Relevant Policies

Responding to Abuse and Neglect

BSCB Training

The BSCB run a wide range of inter-agency training which is available to all professionals working in Bristol. This includes training on safeguarding children from Neglect

Details of our training program and course booking can be found at https://bristolsafeguarding.org/children-home/training/

What Happened?

Hospital staff became concerned for the welfare of a baby who was born prematurely. They had identified concerns about the baby's mother's vulnerability in the ante-natal period and had referred to First Response for additional support. First Response recommended she was referred to the Children Centre and the referral was closed.

After birth, midwives remained concerned that the baby's mother may not have the capacity to care for the newborn, particularly with the baby's additional vulnerabilities as a premature baby. The baby's mother was a single mother with a limited support network. She had had a traumatic childhood with a number of adverse childhood experiences which were appropriately explored and documented by health professionals. While she did not have a diagnosed learning disability, she had learning, literacy and processing difficulties linked to her experiences of trauma. The hospital kept the baby on the ward beyond what was medically required because of concerns about mother's parenting capacity, and midwives undertook a home visit before discharge to contribute to their ward-based assessment. Midwives made a further referral to First Response but the review found that this referral lacked the detail First Response required to make an appropriate threshold decision.

Within 24 hours of being discharged home the baby was brought to the hospital having been crying for a significant period of time. The cause of this distress was determined to be hunger. Over the baby's first weeks of life it was regularly left in the care of mother's sister who had a diagnosed learning disability. There had been concerns about domestic abuse incidents between the aunt and her brother, both of whom were adults. Midwives noted concerns about 'filthy' home conditions, exposure of the baby to extreme temperatures, mother's lack of comprehension about the baby's needs (including the need to feed regularly) and 'man-handling' by the baby's aunt. Appropriately a further referral to First Response was made. The referral again lacked detail and analysis of risk and on this basis was triaged to Early Help, which was a new team at the time.

Over the following month concerns escalated. Further domestic abuse incidents occurred between mother's siblings and she reported being bullied by her sister who continued to have regular care of the baby. Whilst concerns were discussed between professionals the term neglect was not used and no changes resulted for the baby. Multi-agency communication was regular and a community paediatrician's advice was sought on failure to thrive however there was a lack of a holistic multi-agency assessment.

A nursery nurse visited the family and shared significant concerns with Early Help. These included; unsafe sleeping arrangements, Mother's lack of awareness of the risks presented to the baby by household hazards, significant nappy rash, the baby being naked and cold to the touch, Aunt's verbal aggression in front of the baby and her rough handling of them, feeding that was described as 'functional' (with no emotional warmth) and Mother's apparent fixation on a constricted feeding regime. The view of the Nursery Nurse was that the baby was exhausted from crying, due to hunger. An urgent GP appointment found that the baby was low weight and that, contrary to advice Mother was feeding the baby water between feeds. A step up to Child Protection was agreed by Early Help with the multi-agency but was not actioned and a multi-agency meeting was arranged for ten days later. The Team Around the Family meeting was held but lacked focus on what was required to safeguard the baby. Sadly the baby died two weeks later.

Things to Consider

Neglect in Infancy

A range of professionals appropriately identified issues which were placing the baby at significant risk. However, they did not use the term neglect between themselves or with the family which limited the multi-agency response. Furthermore the risks and urgency of response required where there is neglect of a newborn premature baby was not fully appreciated. Standard practice such as the time between meetings should have been reviewed and shortened given the baby's additional vulnerabilities. The risk associated with drift is exacerbated when a baby is newborn or premature. The BSCB is launching the use of the Graded Care Profile 2 Neglect Assessment tool in 2018. You will see training advertised in the coming months. This tool will support professionals to make effective referrals and holistic assessments, and have a common framework for discussing risk across partners.

Learning Difficulties/ Disabilities

There is confusion between professionals as to how to work with parents who have learning needs but do not have a diagnosed learning disability. Professionals could have better adapted their interventions for mother's needs so they did not rely so heavily on verbal communication to create change. Professionals should ensure they have access to a range of communication tools and are confident to adapt interventions even when there is not a diagnosed need to provide accessible effective services. Universal services would benefit from linking with specialist services for adults and children with disabilities to share approaches they can embed within their practice. Further, the risks associated with Aunt's learning disability were not recognized when she had regular care of the children. Adult Social Care should have been engaged with and assessments of Aunt's parenting capacity would have supported the holistic assessment of the baby's day to day experience.

Domestic Abuse between non-partners

In Bristol we have found a pattern of professionals lacking confidence in recognizing and assessing the impact of domestic abuse when it occurs between family members who are not partners. It is important to recognise that the impact on the child is just as significant and violence, abuse and coercive control of all forms should form part of the assessment of risk and need for children. BSCB is holding an Annual Conference on Responding to Violence in Families in May. You can book a place here

Tell the BSCB how you have used this briefing to improve practice at:

- Email: bscb@bristol.gov.uk
- Twitter: @BristolLSCB
- Website: www.bristolsafeguarding/children/contact/contact-the-bscb