Single Agency Health Safeguarding Review Baby AS February 2022

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1. Introduction

The baby was born in the Spring of 2022 in the Maternity Unit at Salisbury Hospital and is now living in a residential parent and child placement with their parents. The baby's parents lived in Dorset but accessed maternity services from Wiltshire, which is how commissioned services work in that geographical area, it does however add another dimension to working together across boundaries of health and social care.

The baby was discharged from the Maternity Unit 12 hours after birth and was seen by the community midwifery team. At 2 days old the baby was readmitted to hospital due to his jaundice and low temperature.

Neonatal staff raised concern that the baby's parents were struggling to meet their basic care needs, which included changing his nappy and leaving them clean, ensuring that they had adequate feeds and was safe in their environment. Observations highlighted concerns about parenting capacity for the baby, as mother could not always follow clear instructions in relation to feeding times and quantities. Furthermore, she could not show that she could adapt her parenting to meet the baby's needs.

The baby came to the attention of Children's Services in Dorset when they were 4 days old following a referral in from Salisbury Hospital Midwifery Department which raised concerns about the care the baby received from his parents due to mother's physical disabilities and perceived learning difficulties for both parents.

The chronology mentioned that the baby received warmth and love from both parents, but staff were concerned that they would not be able to meet their basic care needs and respond to the changing needs of an infant.

The family of the baby were excited about their arrival and had made plans to help mother in her care of them. Mother had booked early in the pregnancy, and she attended the numerous appointments required for her complex health needs.

2. Purpose

The purpose of this review is to explore the events and outcomes for this family from a health perspective. This review process has strived to be a positive learning opportunity and to help us work together to ensure that the correct processes and pathways are in place.

The review has been led by the Designated Safeguarding Children Professionals from NHS Dorset and Bath and Northeast Somerset, Swindon, and Wiltshire (BSW) ICB. Participants were from Midwifery and Health visiting in BSW, and Dorset and they had been involved or reviewed the records of their teams. Those leading the review promoted a culture of professional support, constructive challenge, and learning, with every voice being heard. Central to the review was the voice of the child and the family. The review took place virtually over MS Teams to look at the information received and to consider what we may do differently in the future should a similar situation arise. The Designates set the Terms of Reference (TOR) and the key lines of enquiry which were sent out to the delegates and the review team then met on 03-09-22 to consider the chronologies and reports submitted by health professionals. This was delayed from earlier dates due to other priorities and one of the Designates being ill with COVID 19.

3. Findings

No.	Key line of enquiry	Finding
1.	Did working between County boundaries impact on the assessment and the decisions made for this family?	Within the discussion it was agreed that BSW and Dorset health partners work well together and that there are good processes in place to ensure robust communication. It is not unusual for women who live in Dorset to birth in Salisbury. This case has highlighted the complexity in the fact that there were 2 addresses, one in Wiltshire and one in Dorset. With the benefit of hindsight, it would have been good practice to ascertain from the beginning, which was the main address for the parents, as this could have ensured that the correct team provided

		consistent care, allowing for an early multi-agency response rather than waiting till Mother was 36/40 pregnant to hand over to Dorset Health Care.
2.	How did the assessments of parenting capacity consider the disabilities of the parents? Is there evidence that Professionals considered the cumulative impact of the parents' disabilities? How was the father assessed in terms of his parenting ability and support for mother?	The review panel decided to group key lines of enquiry together as the impact of disability informed most of the review panels group discussion together. Throughout the chronologies submitted, reference is made to learning disability, yet the focus of care was influenced by the mothers' complex medical needs. On reflection, it became apparent that her medical needs became a smokescreen for her learning disability and her ability to meet the needs of her baby. From this, the panel identified that early intervention, assessment and a team around the family approach would have better highlighted the needs of this family. Had a diagnosis of learning disability been fully understood, this is likely to have influenced the assessment process and care provided. Post-delivery, it was noted by the Consultant Paediatrician that both parents had a learning need, and this emphasises the fact that Father had not been present at many of the previous appointments, as is often the case with working Fathers, and therefore the assessment of the family as a unit was missing a holistic 'Think Family' approach. Think Family is a method of service delivery where consideration of the wider family needs is extended beyond the individual they are supporting. In this case had all the professionals involved in the care met and combined their risk assessments, observations and difficulties shared by the parents with them, a responsive approach to care for the baby and family may have led to early help intervention much sooner. In

		addition, what the maternal grandmother was realistically able to provide in the post- natal period might have been better understood by professionals, leading to a robust risk assessment of parenting capacity.
3.	What resources were available for parents with additional needs, were these considered, or referrals made? These could include statutory, voluntary, or family resources.	Professionals had identified that Maternal Grandmother was Mothers 'carer' and they felt that there was a legal order in place, but they were not sure what this was. Within the discussion it was acknowledged that although Grandmother had said that she would support Mother and Baby after the delivery there were no firm plans in place or understanding of what this care would realistically look like. An assessment was completed appropriately by the Midwife and Health Visitor (HV), but this did not reveal that there were gaps in this provision. There was no evidence of discussion with the Primary Care team about this complex family. It was not clear exactly what the baby's maternal Grandmother's responsibility was within the legal framework to support her daughter, or what benefits she was entitled to. Dorset has a strong, independent advocacy service that works to ensure that the rights and views of those with a learning disability are upheld. It is an excellent resource for people with learning difficulties

		as well as offering support to families and carers. This was not widely known within the group and could have bridged the communication gap between professionals and the family.
4.	What opportunities were there to know more about and assist this family? Were there missed opportunities?	During the discussion, the panel considered two specific occasions where there were missed opportunities. The first being at the initial Midwifery health assessment at 10 weeks of pregnancy. It was acknowledged, at this contact, that the baby's mother had learning needs alongside complex physical needs, and that her mother was her carer. Her physical ability had the potential to become affected by the growing pregnancy, impacting on the appropriateness of living in a flat with stairs. At approximately 22 weeks of pregnancy, housing was identified as a concern for the mother who was struggling with stairs. A multi-agency approach through a team about the person process could have included support from Housing, LD advocacy. Skilled LD input could have shaped the assessment and the care to come. The second opportunity was towards the end of the pregnancy where a joint visit between the HV and MW identified that there were concerns about both parents' ability to safely care for the baby alone. There was a plan for referral for early support assessment but the baby required induction and was born close to this time and the referral was not made.

		There was good evidence of cross boundary care between the geographical area and the HV / MW teams caring for the family. Due to the complexity of Mothers' health needs, the authors reflected that there were multiple health workers involved in the care. Inviting a wider group of health professionals to include: - Obstetrician, Paediatricians, Anaesthetist, Sonographer, GP etc would have allowed for a deeper understanding of the situation and enriched the review process and learning. This would also enable a breadth of learning for those professionals, all of whom played a significant part in the care of Mother and Baby and are accountable for safeguarding the family.
5.	What other agencies were this family accessing and how did agencies communicate with each other, including the GP?	During the pregnancy, the family were in receipt of universal services and only became open to Children's Social Care when the baby was re-admitted to NICU. There were some communication challenges experienced between Children's Social Care, the family and healthcare professionals within NICU. The panel members discussed how issues with communication flow meant that staff felt under pressure from the parents to answer their questions about the future of their lives with the baby and whether they would be removed from their care. The outcome of this

		was that parents felt mistrustful and frustrated with health professionals which in turn led to distress of those caring for the baby. Examples of this were: a poor response to requests for information and for there to be direct contact between social workers and the family and not receiving minutes from the strategy discussion. Reflections from participants have highlighted the importance of effective communication between professionals and families. Their experience has demonstrated how a breakdown in relationships can occur as a result of poor communication, especially when parents are vulnerable and in this case have learning difficulties.
6.	Did the COVID Pandemic impact on the assessment/ care received by the family?	It was very clear in conversation that the impact of COVID was still being felt at this time with staff sickness, shortage, and low morale in teams. The baby was born at a time when staff and patients were becoming unwell with the Omicron variant. The conversation highlighted how staff shortages had the potential to affect care, but COVID 19 was not raised specifically in either of the chronologies submitted.
Good Practice Findings		
1.	There were many examples of good practice throughout the review. Panel members signed up to the process and sent chronologies within the time frame agreed.	

2.	Open and reflective conversations between participants enabled recognition of actions, and consideration of what impacted on this case.
3.	Teams from both areas have already used learning from the case to put changes into place.
4.	Processes generally work well between Wiltshire Maternity and Dorset HV and Primary Care services.
5.	Professionals had considered the needs of Mother and completed assessments in relation to the additional needs of the family.

4. Recommendations

No.	Recommendations
1.	Professionals need to be aware that terms such as learning need, learning difficulty, and learning disability are incorrectly used interchangeably and they should seek clarity and record carefully as to which of these applies to each individual.
2.	Professionals should consider the significance of a learning needs and what this means in real terms for parenting capacity/ability.
3a.	Assessing Learning disability needs to be completed by those with the appropriate skills to do so, and the use of an advocacy service should be a priority for all families with a learning disability.
3b.	We need to seek assurance that all parts of the Health system are aware of their responsibility to safeguard women and children where a parent has a learning disability/difficulty
4.	Where possible, joint visits should be completed in the mid-trimester to allow for time for assessment and intervention pre-birth.

5a.	Minutes from multi-agency meetings should be shared with all involved professionals to ensure that there is a full understanding of concerns and actions to reduce the risk to the children. In this case, the strategy meeting minutes were not shared with all health professionals.
5b.	Develop a plan, template, or pathway to ensure best way of communicating with women with a learning disability/need
6a.	An agreed means for personalised communication between all agencies at a level that the service users understand when being discharged to either home or another service. Discharge planning meetings must occur upon discharge from NICU
6b.	Discharge planning meetings must occur upon discharge from NICU
7.	Ensure parents understand the literature that is provided to them, for example ICON and the different roles of practitioners and what to expect from the service

5. Review Process

This single agency review was requested by Dorset's Multi-Agency Quality of Practice and Actions Group (MAQPAG) to understand Health processes in relation to safeguarding the baby during the anti-natal period and the immediate post-natal period. The Designated Nurse for Wiltshire and Dorset met to agree the review process and terms of reference prior to inviting managers to participate and contribute to this review. The Designated nurses had formulated a hypothesis before the agency chronologies were collated and key themes identified. These being communication and the interchangeable use of the term's disability, learning disability and learning difficulty. This review was delayed due to annual leave in the summer period and a period of sickness. There were 3 Panel meetings; the first to discuss and agree key lines of enquiry and the terms of reference, the second for the Panel to meet to discuss the chronologies and learning and the third to agree the first draft report. All participants – Midwifery, Public Health Nursing and Designates – participated fully with the process and all actions and recommendations have been agreed. Despite this being a single agency review, the report has found that there is some learning for Children's Social Care and wider Health partners.

6. Summary of key learning

- Professionals are not always clear about the specifics of a learning need, a learning difficulty, or a learning disability (see the PDSCP Policy on Parents with Learning Disabilities here Safeguarding Children where a Parent has a Learning Disability (proceduresonline.com)
- It is important to establish exactly what this means for the individual and their capacity to parent.
  Professionals should ascertain:
  - Is there a diagnosis for their patient and are they accessing support?
  - If not, what support /assessment from disability services are available?
  - Professionals must know and understand the implications of interchangeable language and the impact on individuals as highlighted in this case.
  - Professionals should use a 'Think Family' approach and remember to include all Professionals involved in every aspect of their care and not assume that another professional is responding to this. Think Family must be embedded in all aspects of care provided by professionals to pregnant women, assumptions about who will escalate concerns should not be made.

- Assessments need to be person centred and to look at the detail of the plan in order to ensure safety for children.
- Advocacy services should be used to ensure that that the rights and needs of individuals with a learning disability are respected.
- Primary care should be involved in discussions and plans in these complex cases, they often hold additional information about families that aid in a holistic assessment.
- Joint visits need to be done early enough in pregnancy so that there is time for multi-agency assessments, processes, planning and implementation to be effective.
  Reviews should consider all professionals who may have insight and can gain learning from case reflection.

- When a learning disability is identified, it is important that the plan of care includes an agreed, clear line of communication between the family and agencies, to minimise anxiety and distress. In this case, the mother had been described as the carer, but it was not clear in what capacity.
- Safeguarding is everyone's business, and we need to seek assurance across all Health providers that this is embedded and that there is evidence in records to reflect this where there is a concern.

7. Next steps

Meeting together as health professionals allowed for the deep and honest reflection into the complexities of this case and those present embraced the opportunity with an open mind. All participants engaged with the learning and agreed there were some considerations to take forward relating to future similar cases. There is learning for other health partners and their responsibility to safeguard children and families. This case has highlighted that there were numerous health specialists providing care to the woman, who could have shared any identified concerns with Children's Social Care, midwifery or health visiting services which may have resulted in an earlier awareness of concerns.

Opportunities were there to seek assessment for the family from 'Early Help' processes, but these were not taken. It was well documented that the parents showed warmth and love towards their baby, but the parents did not demonstrate the skills or understanding to meet the basic care needs of the baby, resulting in the need for a residential placement to assess their parenting capacity.

A better understanding of what family members can realistically provide in such cases should form part of the assessment process. This case has highlighted that there were unidentified risks associated with the maternal grandmother and her ability to be present for the time needed to ensure the care needs of the baby could be met. More detailed assessment would have helped professionals to understand how much time and care Maternal Grandmother could realistically offer. It would also have allowed for a clear understanding of any legal responsibilities as perceived/ assumed by Professionals. This would then have allowed for time to put a clear, appropriate, and supportive plan in place, including Maternal Grandmothers role and responsibilities in the care of the baby.

Finally, effective communication is key for all professionals providing care, developing an agreed means of communication ensures understanding and strengthens professional relationships especially at a time when parents are fearful that their child may be removed from their care.

List of Appendices

1. **Terms of Reference**

Health Review into Baby AS

The purpose of this review is to explore the events and outcomes for this family from a health perspective as a positive learning opportunity and to help us work together to ensure that the correct processes and pathways are in place.

The review will be hosted by Designated Safeguarding Children Professionals from Dorset and BSW CCG. There will be a culture of professional support, constructive challenge and learning as a foundation of this event and we will meet to look at the information received, considering the best ways forward. Every voice will be heard and central to this will be the voice of the child and the family.

Summary of Case

Baby was born in Salisbury Hospital and is now living in a residential parent and child placement with his parents.

The baby was seen by the community midwifery team and on the 20th of February 2022 readmitted to hospital due to jaundice, high sodium, low sugar, low temperature. Once readmitted, Neonatal staff raised concern that his parents were struggling to meet basic care needs which included changing his nappy and leaving him clean. They struggled to administer feeds to a level which meant the baby was satiated. Observations highlighted concerns about parenting capacity for the baby as his mother was unable to follow clear instructions in relation to feeding times and quantities. Furthermore, she could not adapt her parenting to meet the baby's needs.

The baby came to the attention of Children's Services in Dorset on 22 February 2022 following a referral in from Salisbury Hospital Midwifery Department which raised concerns about the care the baby received from his parents due to his mother's physical disabilities and perceived learning difficulties for both parents.

Key Lines of Enquiry

- Did working between County boundaries impact on the assessment and the decisions made for this family?
- How did the assessments of parenting capacity consider the disabilities of the parents?
- Is there evidence that Professionals considered the cumulative impact of the parents' disabilities?
- How was the father assessed in terms of his parenting ability and support for mother?
- What resources were available for parents with additional needs, were these considered, or referrals made? These could include statutory, voluntary, or family resources.
- What opportunities were there to know more about and assist this family? Were there missed opportunities?
- What other agencies were this family accessing and how did agencies communicate with each other including the GP.
- What reviews have already been done within your service, if any and what can these bring to the table?
- Did the COVID Pandemic impact on the assessment/ care received by the family?
- What were the aspects of good practice to share?

Timeline for Review.

24.5.22: Send out chronology to participants of the review.

1.7.22: Return information and Chronology to shiela.willoughby@dorsetccg.nhs.uk

11.7.22: Group to meet to review findings and discuss learning and agree any actions.

Final report to be written by end of August (Date to be confirmed)

Jane Murray (She / her)

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8 Web: www.dorsetccg.nhs.uk

https://nhsdorsetgp.sharepoint.com/sites/Safeguarding https://nhsdorsetccg.sharepoint.com/sites/safeguard

2. Chronology template

Agency:					
Chronology Author (name and role):					
TIMELINE: Start of Pregnancy to current situation					
Incident: See TOR					
Completing the chronology: Please outline briefly <u>all</u> the contacts with the child/adult.					
Please briefly summarise your agencies involvement with the child/adult(s), including any relevant information outside the timeline:					
Date and time, if available	**Contact with which adult/s Please use full names**	**Which professional – please use full name and role**	**What was this event (e.g. meeting, phone call, virtual meeting, home visit etc); what was discussed, and actions/decisions recorded**	**Documents reviewed:**	**Appraisal of Practice**

Please return SECURELY to Shiela.willoughby@dorsetccg.nhs.uk

Please PASSWORD PROTECT.

Any information provided will be used for the purposes of the review only.