Babies under one year: reducing avoidable harm by recognising risk and protective factors

Introduction

This briefing has been prepared to help practitioners in all agencies better understand and respond to the needs of vulnerable unborn children, infants and their parents. It is based on the learning from a number of Serious Case Reviews involving death or significant harm to infants in Northamptonshire in recent years, and on additional learning nationally.

Potential risks and vulnerability factors will be considered under the headings of **parent and family factors, child factors and wider environmental factors.**

We often make assumptions about the ability of a partner, or the wider family network, to be supportive or protective. Protective factors will generally be apparent from the discussion below. In general, babies born to parents who have experienced stable, happy childhoods, in a stable relationship with a supportive partner, and positive and supportive wider family networks, will thrive.

Where there is vulnerability, risk is reduced where the parent can engage with support services and show capacity for change where needed.

Where a parent has difficulties such as mental health problems or learning difficulties, the presence of a supportive partner or other significant adult, e.g. a grandparent, living within the household or otherwise involved in the daily care of the child, and also able to engage well with agencies, is particularly vital.

Specialist assessments of risk and parenting capacity may be required in some cases, but all practitioners who come into contact with babies, or expectant or new parents, have a duty to ensure that vulnerable infants are safeguarded, and this document outlines a broader approach to roles and responsibilities, next steps when vulnerability is recognised, information sharing, support services, and safeguarding referrals.

Summary of local and national learning

Ages of concern: learning lessons from serious case reviews (Ofsted, 2011) summarises some key findings from the 482 SCR's evaluated between April 2007 and March 2011. 35% of children considered by these reviews were under the age of one year, and the report has a particular focus on learning from these cases (and those involving older adolescents, not covered in this briefing)

The most common causes of avoidable harm analysed through serious case reviews were non-accidental injuries, and sudden unexpected deaths in infancy where there was strong evidence of avoidable risk factors (for example, co sleeping). Such risks had often not been recognised or addressed effectively even where children had been subject to child protection plans. Cases of both types have occurred in Northamptonshire.

National learning has identified some less common situations, e.g. where deaths have been caused by gross neglect leading to severe malnourishment and dehydration, or inflicted (e.g. suffocation) by a parent with mental illness.

Key findings overall were that information sharing was often inadequate, that parents' own needs and the fragility and vulnerability of very young infants were underestimated, and that pre-birth assessments were sometimes undertaken too late, or were insufficiently detailed or analytical to identify risk and plan support for parents.

Parent and family vulnerability factors

Teenage or young first time parents: – Many young mums and dads, including teenagers, will be parents, can care very well for a baby, but it is particularly important to consider wider vulnerability factors for this group. Where young people have neglectful or abusive backgrounds or other additional difficulties, and then become parents themselves at a young age, they may find it particularly hard to cope with the stresses of new parenthood.

The role of fathers: – Services for prospective and new parents must ensure that they **engage with fathers as well as mothers** and that the needs and vulnerabilities of fathers are considered, to build an understanding of the father's role in the parental relationship, whether supportive, disengaged or posing a risk. The **dynamics of the relationship** must also be explored and understood – is there a significant **age differential**? Is one partner dominant or controlling?

In some cases a new partner rather than the birth father is living with or regularly caring for a child (or will be a carer for an unborn child) and the nature of any such relationship must also be understood. Occasionally the birth father rather than the mother becomes the main carer for a child. The role of partners as carers where a parent is in a same sex relationship must also be considered.

The role of partners should be **regularly reviewed** – we often ask about partners only at the antenatal booking visit or first contact with the health visiting service. A relationship with an abuse partner may be described as over, only for the abuse to return later into the life and household of the parent and child. Occasionally a parent may try to conceal relationships they know will be considered risky.

Parents' own experience of being parented: – Parents who have experienced adverse circumstances in childhood, such as **abuse or neglect** may find it harder to cope with the stresses of parenthood themselves. Childhood abuse may have resulted in periods on a **child protection plan**, or as a **Looked After Child**. There is evidence of adverse childhood experiences in the past for one or both parents in all recent Northamptonshire serious case reviews involving infants, and this reflects national learning.

Parents who have experienced abusive parenting themselves may **lack a supportive family network.** Where grandparents of a new baby are still involved, they may still be unable to provide safe care themselves, or support to parents may be controlling or critical. They may also have a history of **exclusion from education** or **poor educational attainment,** which in turn further reduces resilience.

Parental **mental health difficulties**, **drug or alcohol use**, or **learning difficulties** may impact on parenting capacity and this impact must be assessed. Specialist assessments may be required in such

cases, but any practitioner who is aware of such issues should consider whether there is evidence that the parent is able to provide a safe and caring environment for their child.

Domestic abuse may pose a particularly high risk to unborn/young infants, and a **history of violence** in broader contexts, e.g. violent offending behaviour or A&E attendances linked to violence, may also indicate underlying risk. Domestic abuse risks are known to increase in pregnancy and after the arrival of a new baby.

Previous parenting experience – parents who have **harmed a child in the past**, or from who a child has been removed, may still pose a risk to a new baby.

Late presentation to antenatal services, and in particular **concealed pregnancy**, can prevent effective early assessment of needs and risks, and may indicate ambivalence or fear about the pregnancy and parenthood, difficulty in prioritising the needs of an unborn child, and difficulties in engaging with agencies

Child Factors

A number of factors can increase the vulnerability of young infants particularly in combination with parental and environmental risk factors.

Prematurity may mean that pre-birth assessments, and thus risk assessment and planning for the new baby, may not be completed, particularly where there has also been a late antenatal booking. Very preterm infants will need weeks or months of hospital care, while discharge planning can progress. However, **prematurity,** low **birth weight** and **complex health problems** or **disability** increase the physical vulnerability of the baby. Parents may experience more difficulty with bonding where there is a prolonged hospital admission or where the baby is harder to care for than usual.

Vulnerable parents may have a **limited understanding** of typical childhood care needs and development, and **unrealistic expectations** of the child's own emotional needs and responses, understanding and behaviour. They may particularly struggle with and resent a child who **cries frequently** or is **difficult to feed.**

Environmental Factors

Risk assessment and support planning for infants and their parents is made harder where parents lack **good quality, stable accommodation** or are **homeless**. Frequent changes of address may result in loss of contact with professionals as the child and parents move between teams. Parents will also find it hared to ensure that the home environment is safe, warm, hygienic and adequately equipped with bedding and feeding equipment for a young infant.

Safe sleeping arrangements are critical and are required throughout the **night and day** for very young infants. **Co-sleeping** has been identified as a preventable risk factor in many serious case reviews nationally, and has been a factor in a number of child deaths in Northamptonshire. The safest sleeping arrangement for a young infant is in a cot beside the parent's bed. Advice is given to all prospective parents about the potential risks of co-sleeping, and some parents may then make an informed decision to co-sleep; The risk of co-sleeping is increased where a parent or carer smokes within the house or where a co-sleeping adult has consumed alcohol.

Roles, responsibilities and next steps:

All practitioners who come into contact with babies, or expectant or new parents, have a duty to ensure that families are supported and that vulnerable infants are safeguarded. Young infants are often known only to health agencies. Midwives and health visitors will always be involved with new parents and young infants, but responsibility for the initial recognition and assessment of risk must however be acknowledged and acted on much more widely.

Young infants may also come into contact with GP's and with hospital or other specialist health services. Very young parents will come into contact with a range of agencies and police, social care and education services will often hold extensive current and historical information on particularly vulnerably young parents.

Police, GP's, A&E staff, housing services, adult mental health staff and all other services working with adults must always **consider whether an adult presenting to services is a parent or prospective parent**.

Next steps will depend on the practitioner's role and involvement with the parent or child and cannot be covered comprehensively – practitioners should follow their own agency procedures - but any practitioner working directly with parents and children, who has a concern for an unborn child, infant or new parent should consider the following questions:

- What do I know about this parent's current wellbeing? Do they have difficulties which might affect their ability to care for a child?
- What do I know about their own childhood, and experiences of being parented? Did they experience problems such as school exclusion, offending behaviour, self harm?
- What do I know about the father/partner? Is he/she involved in the day to day care of the child? Do parents have a positive and supportive relationship? Who else cares for this baby and what do I know about them?
- What are the broader support networks for these parents? Do they have extended family who can offer practical and emotional support?
- Does the child have a stable, good quality home environment? Do I need to see the sleeping arrangements for this child? Who is living in the household? Have I noticed evidence of other resident adults in a single parent household? Are there any contact access problems with this family?
- Does the child have additional vulnerabilities such as health problems? Is this baby harder than average to care for? Do parents enjoy and respond sensitively to this baby?

Concerns should normally be discussed with parents, unless this would increase the risk to the child or highly vulnerable parent. In such cases it is essential that concerns are discussed promptly with a **safeguarding lead.**

Consent should be sought from parents to seek further information to clarify the answers to the questions above, and to share information with relevant agencies. In particular, the GP is likely to hold information about issues such as parental mental health and will usually have information on significant childhood difficulties.

Where vulnerabilities have been recognised it is particularly important that practitioners working with the family seek to understand the day to day lived experience of the child. This will likely require an increased number of home visits and direct observation of the care and interaction provided by the parents.

Families should be supported to access relevant support services. Where families have multiple needs or vulnerabilities, a Common assessment (CAF) will usually be appropriate.

Where there are concerns about actual or potential significant harm, LSCBN and agency safeguarding procedures should be followed. Concerns should always be discussed with the agency **safeguarding lead**, but this should not delay an urgent safeguarding referral where this is required.

Children's Social Care is the lead agency when child protection enquiries and assessments are undertaken, but these are multiagency processes and the questions to be answered are essentially those outlined above. Where vulnerability or risk is being managed, whether through a CAF, child in need plan or child protection plan, focus must remain on:

- **The day to day experiences of the child**
- **Evidence - rather than assumptions - that parents or alternative carers are able to provide consistent, safe and responsive care.**