North Yorkshire
Safeguarding Children Partnership

7 point briefing

Learning relating to non-accidental injury in a baby

April 2021

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This seven point briefing focuses on a Baby who was born and discharged home on the same day from hospital. The baby was readmitted to hospital at a very young age, at which point some unusual injuries were noted which were suggestive of non-accidental abuse. The baby's mother had some history of mental health problems and had been referred for ongoing support with this during her pregnancy.

2

What were the tasks / challenges of the case?

- Lack of initial engagement with mental health support services.
- Poor communication between the mental health services and midwifery teams which contributed to a lack of joined up working in the ante-natal period and planning for the birth. (Although there is no suggestion that mother's mental ill health contributed to the injuries sustained by the baby, the lack of robust communication pathways was a feature of practice noted by the North Yorkshire Safeguarding Children Practice Review Panel).
- There was a lack of recognition that additional vulnerabilities during pregnancy meant that a more robust response was required when there was a lack of engagement with mental services in early pregnancy.
- This baby was born during the Covid 19 pandemic lockdown when health services were operating very differently. At this point fathers/birth partners had restricted involvement with ante-natal appointments and during the birth.

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What actions were taken by agencies and professionals?

All health practitioners involved with this family continued to offer support throughout the pregnancy. However, a lack of communication meant that not all practitioners were fully aware of missed appointments and a lack of initial engagement with mental health services.

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What was the response to the actions?

The baby's Mother did eventually access mental health support prior to the birth of the baby. The baby was delivered safely.

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What was the outcome of the case?

Child Protection procedures were instigated and the Police commenced an initial investigation into the circumstances of the injuries.

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Learning points:

- Robust communication channels to be developed to ensure regular liaison between Mental Health Services and Maternity Services.
- Systems to ensure regular liaison takes place between Obstetricians and Community Midwife are to be developed.
- Training to include the importance of obtaining and recording details of father/partner and other household members.
- Mental Health community staff to be reminded about the increasing vulnerability of women when pregnant in relation to lack of engagement.
- Importance of detailed documentation of post-natal examination of the new-born infant.
- Midwives and Health Visitors should undertake a hands on review of the babies physical health.

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Resources that professionals may find useful:

- MBRRACE document, the aim of MBRRACE-UK document is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services. MMBRACE
- Targeted, bespoke training including multi professional learning and supervision
- Regular Safeguarding Supervision, highlighting the importance of information gathering and multi-disciplinary working.
- Local perinatal mental health services to find out more information you can read NYSCP's Perinatal mental Ill health on Children One Minute Guide (OMG)

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