BIRMINGHAM
Safeguarding
Children
PARTNERSHIP

‘Never, Ever Shake a Baby’

Webinar Programme

15:00	Welcome & Introduction – Jane Armstrong, Co-Chair Serious Cases Sub-Group
15:10	Case Overview and Key Learning – Bev McConnell, Lead Reviewer
15:40	Comfort Break
15:45	Invisible men in safeguarding – Adam Birchall, Principal Social Worker, Birmingham Children's Trust
16:15	'Never, Ever Shake a Baby' Campaign – Simon Cross, BSCP Business Manager
16:30	Q&A Session
16:55	Closing Remarks

Case Overview and Key Learning

Bev McConnell, Lead Reviewer

What is the review about?

- This review focuses on the inherent risks to infants, especially where domestic abuse is known or suspected and how incorrect information in the referral shifted the focus of the multi-agency response.
- Appropriate referrals were made after domestic abuse, through physical and coercive control, was witnessed outside the hospital during Covid restrictions.
- The incorrect information, once discounted, led staff to step down their response to early help and a strategy discussion was not held. Important information about the father's history had been shared but was also not considered and the mother's denial of the witnessed abuse was accepted.
- Attempts by the referring agencies to escalate the concerns took too long. The baby later suffered serious head and other injuries that were found to be non-accidental. Both parents were found guilty of child cruelty.

Case history

- Soon after the baby's birth there was a witnessed episode of domestic abuse outside the hospital and referrals were made to children's social care.
- At just one month old the baby suffered serious head injuries and bruising to the body. The medical view was that these injuries were likely to be non-accidental, and possibly because of a shaking incident.
- West Midlands Police (WMP) undertook a criminal investigation into how the injuries to the baby were sustained, and both parents were convicted of harming the baby.

Lived experience of the baby

- The baby lived in the maternal grandmother's home with their mother, maternal great-grandfather and maternal aunt
- Their home was said to be cramped and 'cluttered' and needing repair. With lots of items in the hall and bare concrete blocks
- The mother shared a room with maternal aunt and the baby. The father would also stay in the same room as them.
- The baby had a crib in the lounge (which was untidy but satisfactory) for sleeping in the day and slept upstairs with them at night
- The baby was a good birth weight and gained weight as expected, he appeared well and was woken up gently when seen two days before he was admitted with a life-threatening head injury.

Parental history - mother

- The mother had a history of anxiety and self-harm in the context of anxiety about her college work and a history of domestic abuse in a previous relationship. She was five years younger than the father and was pregnant early into their relationship aged 19.
- She presented for booking with maternity services at 9 weeks 4 days gestation. Mother admitted self-harm but denied domestic abuse and advised staff of father's neurodiversity.
- Mother's pregnancy was during Covid, the usual universal services such as maternity, hospital and GP services were involved with her.
- The father attended maternity appointments with her and was noted to possibly be controlling and having her phone. Their relationship was described as hostile and that "both can be to blame".
- Mother was described as apologetic and trying to placate the father when she had to stay in the hospital when both she and the baby were unwell after the birth.

Parental history - father

- The father was said to have diagnosed ADHD, autism and a learning disability, he struggled with his medication but had not accessed any specialist services since 2018.
- He had a history of dysregulation and anger as well as relationship difficulties and concerns re coercive control in a previous relationship.
- His anger had caused him difficulty and he attended hospital with hand injuries, he was detained under Mental Health Act Section 136 in 2017 after punching a wall and saying he wanting to take his own life.
- The father only saw universal services such as smoking cessation at his GP surgery during the period under review
- The father was present at the birth, but due to Covid arrangements he was not allowed back in the hospital, he was said to be sending 100s of texts
- Following the baby's birth there were concerns about his controlling behaviour and witnessed physical aggression towards the mother.

Key aspects in this case

- The incident was referred to the Multi-Agency Safeguarding Hub (MASH) by both the hospital and WMP. The referrals were clear that physical domestic abuse and coercive control had been seen by hospital staff postnatally.
- There were different scorings on the DASH forms with one standard, (reflecting mother's denial of DA) the other correctly scored medium risk based on what was known and seen. This should have alerted triage staff to the high risk to the baby and mother.
- The referral from WMP included information regarding father's history of neurodiversity and previous violent incidents but also included incorrect information regarding mother previously having 4 children removed.
- The incorrect information became the focus of the referral and staff sought to find evidence around this, when mother was spoken to, she said it was a malicious referral, staff were then reassured and stepped the case down for HV to complete Early Help Assessment. Father was not interviewed regarding the witnessed assault on mother.
- There was correct escalation of the referral outcome from the MASH Nurse/WMP as a s47 enquiry was required under Right Help Right Time due to the witnessed domestic abuse and father's history. This escalation outcome remained unresolved over the next 4 weeks.

Key aspects in this case

- Information sharing between CSC, maternity, the health visitor (HV) and the GP was delayed at key points in the case.
- The HV did not know about the CASS outcome until after the new birth contact, so changed the Health Visiting dependency level from Universal to Universal Plus Medium.
- During the new birth consultation, mother did not disclose any information regarding domestic abuse and HV was unable to ask the routine domestic abuse question as family members were present.
- The baby had a ‘clicky arm’ during a midwife's home visit, the mother called the GP who advised her to go to A&E. Mother attended and said he was crying more and not moving his arm. No concerns identified, so he was discharged
- The HV undertook a planned home visit and the baby’s head circumference had increased 2 centiles, the HV planned to contact the GP, but the baby was admitted into hospital with a head injury before the contact was made.

Areas of good practice

- The Community Midwifery Team took a detailed booking history from the mother and had regular face to face contact throughout pregnancy and after the baby's birth, despite Covid restrictions.
- Referrals to the Children's Advice and Support Service (CASS) from Birmingham Women's Hospital (BWH) and West Midland Police (WMP) regarding domestic abuse following birth were timely and clear regarding the perceived risks and inherent vulnerability of the baby as a new-born infant.
- The Police referral was screened within 24 hours by a CASS practice supervisor who recognised the domestic abuse and determined the concerns were 'complex and significant' and that further social work oversight was required in line with expected practice.
- There was evidence of some professional challenge around the risks of domestic abuse by BWH and WMP who sought to progress the referral to the Multi-Agency Safeguarding Hub (MASH) through the escalation protocol.
- The MASH Safeguarding nurse recognised incorrect information had been included in the referral and this was appropriately escalated.
- The Health Visitor quickly identified the need to prioritise a new birth visit for the baby on receipt of the outcome form from CASS.

How to improve practice?

- Practitioners' screening referrals need to ensure they consider all factors within referrals, including parental factors, to identify the level of risk and vulnerability.
- Strategy discussions need to take place where policy and guidance indicate it is required.
- Practitioners need to be alert to '*confirmation bias*', which hindered the judgements made and actions taken in this case, so that they do not become distracted by a 'dominant' factor in a case.
- Peer and management reflection is helpful in avoiding this practice error.
- Practitioners need to ensure they work in a 'Think Family' approach and that assessments consider the needs of parents with identified learning disability and neurodiversity.
- Practitioners need to reflect that parental denials and explanations of malicious information need to be balanced against practitioner reports of witnessed abuse.

How to improve practice?

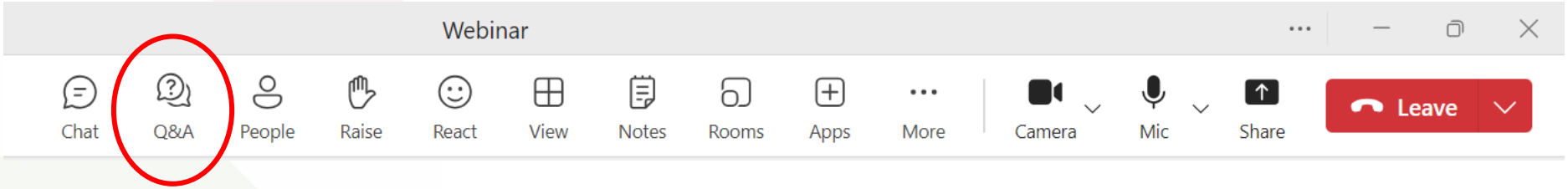
- Health practitioners need to utilise the Shared Care Records to review relevant information in both the mother's and father's GP records in decision making.
- Practitioners need to ensure that parents are seen in person when indicated by policy and procedure.
- Where domestic violence and coercive control are witnessed by practitioners, the perpetrator should be interviewed by Police and action considered.
- The escalation protocol supports robust approaches to professional disputes and practitioners need to ensure they follow each stage in a timely way.
- Practitioners need to be alert to practice guides such as the **Never, Ever Shake a Baby Campaign** and share it with new parents they are working with.
- Practitioners should read and share the resources on working with domestic abuse and **ICON.**

Comfort Break - Back in 5 minutes!

If you have a question for the Q&A session

You can submit a question by clicking on the Q&A button on the top toolbar and typing your question.

We will then answer your question during the Q&A session after the second presentation.



Invisible men in safeguarding

Adam Birchall, Principal Social Worker
Birmingham Children's Trust

January 2025

Invisible Men

The roles of invisible men

There are two main types of ‘invisible’ men (sometimes referred to as ‘hidden’ men or ‘unseen’ men) that have been identified in case reviews.

- Men who posed a risk to a child, which resulted in the child suffering serious harm or death.

- Men who could have protected and nurtured the child in their life but were overlooked by professionals.

Prevalence data

8 Convictions per year on average

2:1 Ratio – fathers: mothers

5:1 – 26:1 Ratio fathers: stepfathers

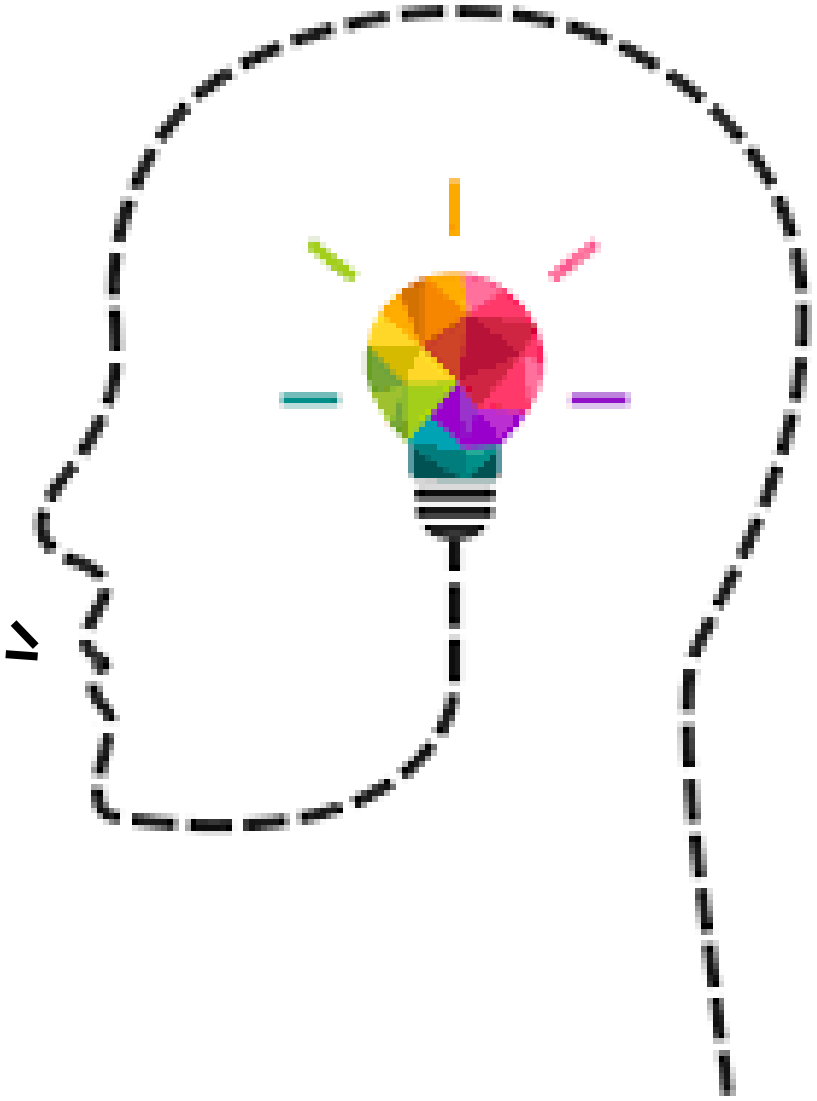
Research Evidence

- High prevalence of substance misuse
- Unmanaged mental health needs
- Often difficult childhood experiences
- Impulsive behaviour
- Poor emotional and behavioural regulation
- Low frustration/ heightened anger responses
- Shame preventing help being sought

Dickens, Tara (2018) An Exploration of the Psychological Characteristics of Men Who Cause Severe Physical Harm to Children Under the Age of Five. Doctor of Philosophy (PhD) thesis, University of Kent,.

Professional Curiosity

We're all familiar with the term 'Professional Curiosity'. In the context of invisible men, what do you think this means for our roles?



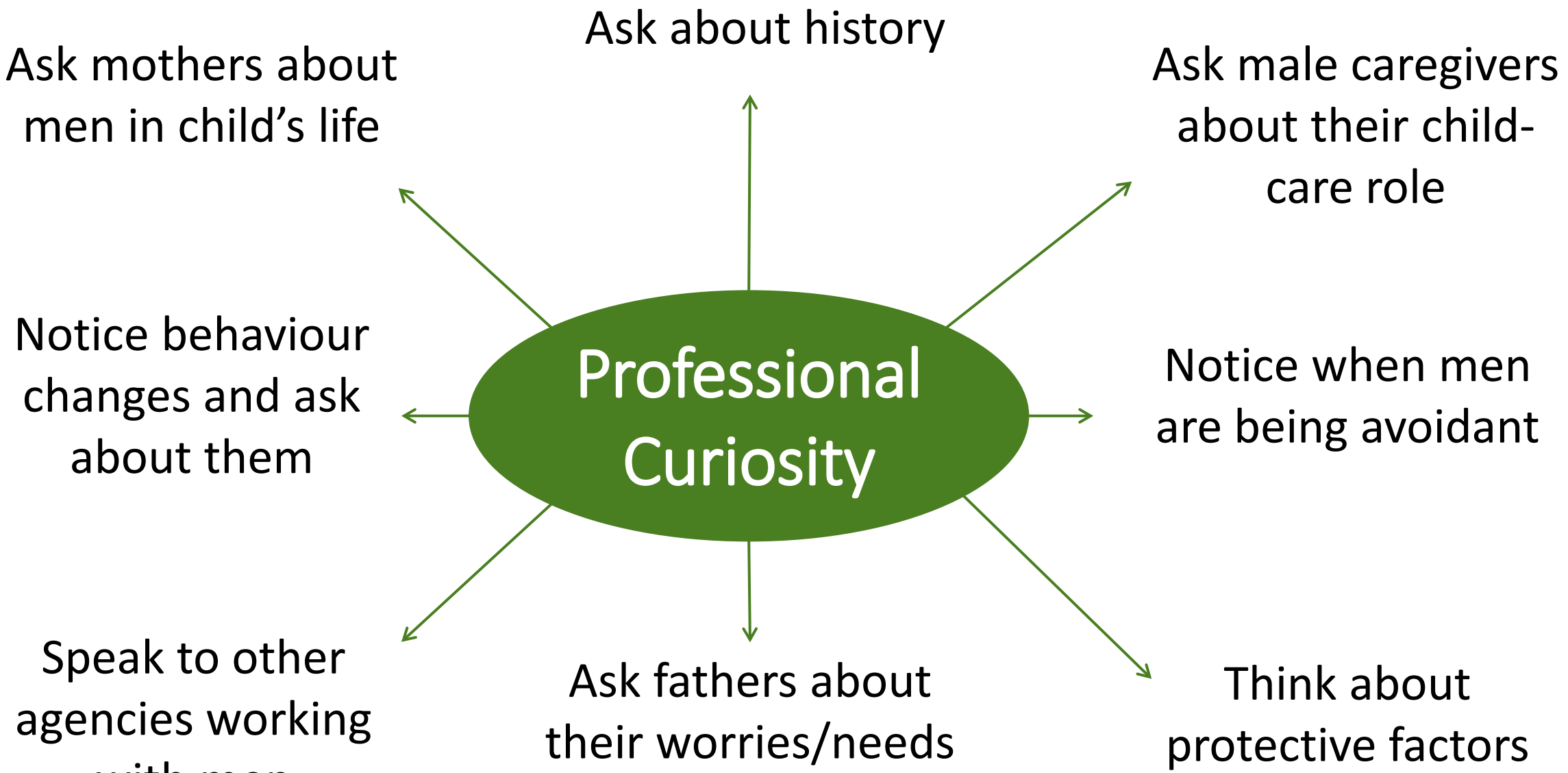
Reflective Exercise

Join the discussion on Slido!

Go to
www.slido.com
and enter code
3086200

OR

Scan with your phone camera


Ask about history
Ask mothers about men in child's life
Ask male caregivers about their child-care role
Professional Curiosity
Notice behaviour changes and ask about them
Notice when men are being avoidant
Speak to other agencies working with men
Ask fathers about their worries/needs
Think about protective factors

"You are the first person who has ever wanted to know what actually happened, what I went through. No one has ever asked me before....no one has ever bothered with me – you are the first person that has ever sat down and asked me my story."

Quote from a man convicted of killing a baby, interviewed as part of the Child Safeguarding Practice Review Panel's review of non-accidental injury of infants by male caregivers, 'The Myth of Invisible Men' September 2021

Questions?

NEVER, EVER SHAKE A BABY

Birmingham Safeguarding Children Partnership

NHS Birmingham Community Healthcare NHS Foundation Trust

NHS Birmingham and Solihull

The Campaign

The campaign arose out of concerns surrounding shaken baby cases in Birmingham. Recent statistics have shown that shaken babies and Abusive Head Trauma (AHT) feature year on year in West Midlands' infant hospital admissions and Serious Incident Notifications. It launched in June 2022.

The campaign is primarily aimed at male parents/carers. Research carried out by ICON (an organisation which aims to help parents/carers cope with crying) has also shown that men are responsible for 70% of AHT/shaken baby. Men are also more likely to miss out on the vital support and guidance offered at appointments such as health visits or parent support groups.

The core campaign material focused on two short films designed to raise awareness of the issue and demonstrate how stress can build when looking after a crying baby – a significant trigger in shaken baby cases.

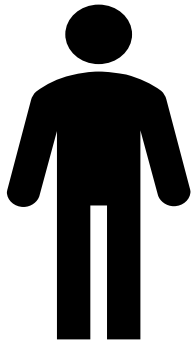
Watch ‘Morning at Home’

Social Media

"Feeling overwhelmed? You're not alone, all babies cry. Here's how to stay in control. #NeverEverShakeABaby"

SHARED ON TWITTER AND FACEBOOK

ADVERT TARGETED AT MEN AGED 18-35



REACHED 320k IMPRESSIONS

CAMPAIGN OUTCOMES

Successful digital campaign

Endorsed by a wide range of organisations and safeguarding partnerships

Shared with multi-agency partners and practitioners

Resonated with target audience

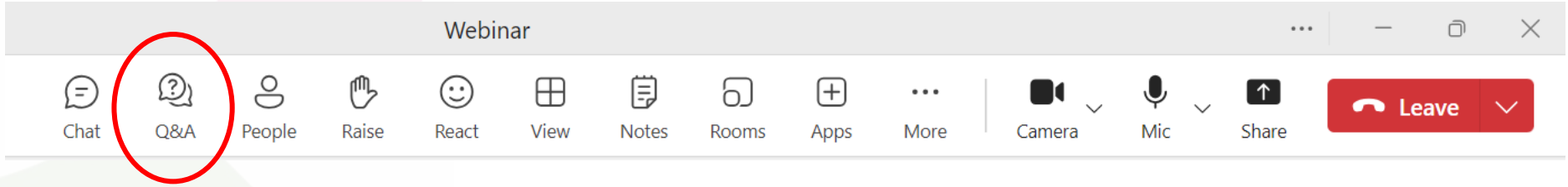
Q&A session

You can ask a question by either:

Raising your hand and unmuting your microphone when prompted.

OR

Click on the Q&A button on the top toolbar and type your question.



Contact BSCP

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Tel: 0121 464 2612

BIRMINGHAM Safeguarding Children PARTNERSHIP

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