LEARNING BRIEF

# Rapid Review—Alfie*

January 2022

## Background

Alfie* (*name changed for anonymity) was a 10 week old baby taken to hospital unresponsive and having seizures and was subsequently found to have suffered from abusive head trauma likely to have been sustained non-accidentally.

**A single agency health review was carried out in 2020 followed by a multi-agency rapid review in 2021.**

## Theme 1—Safeguarding Referrals

Although there were several points where safeguarding concerns arose, no safeguarding referrals were made. The professionals considered the safeguarding issue 'below the threshold'. This suggests that the Local Offer for safeguarding concerns, particularly for those issues below the safeguarding threshold are not understood by multi-agency partners.

The Early Help offer can be viewed **HERE**.

NS Threshold Guidance is currently under review .

## Theme 2—Terminology/professional language

There was more than one term used to describe Alfie's mother's mental health condition. All professionals should share an understanding of the terminology used. Awareness that the term 'carer' is used differently between professionals.

## Theme 3—Learning for Primary Care

Alfie's mother's mental health diagnosis wasn't coded in her GP record historically. Her record codes did not reflect the scale and severity of her history nor did her record show she had a carer.

There was no routine documentation or prompt to discuss parent's health including mental health during routine 6 week baby checks. In response the Named GPs have created a more extensive template for the baby and maternal postnatal checks, with prompts to take a more detailed social history and explore safeguarding concerns.

## Theme 4—Communication

Communication between different services was not as effective as it could have been. A multi agency meeting could have been arranged when the pregnancy was first recognised. The GP was not aware that Alfie's mother's engagement with mental health services was intermittent. A multi agency meeting would have provided opportunity for information sharing and triangulation of strengths and worries. The GP was not invited to the 32-week meeting although the health visitor was and did attend. The ED notification that was intended for the Health Visitor was sent to the GP.

ICON Babies Cry, You Can Cope!

Health practitioners have implemented the **ICON programme** which provides information on infant crying and how to cope.

## Positive Practice Points

- ☑ At the first children's ED attendance there was recognition of the concern for maternal support, with the intention of alerting the health visitor to this.
- ☑ Alfie's parents engaged well with Early Help through phone contact and seemed open about their parenting
- ☑ The GP practice had offered timely appointments in response to concerns raised by Alfie's mother, including a 6 week baby check offered on time despite the Covid pandemic
- ☑ There was some good communication between health services, such as between mental health services and the community midwife.
- ☑ The health visitor attended the perinatal care planning meeting and received a written handover from the midwife following Alfie's birth. She also completed a mental health and wellbeing review of Alfie's mother which reflected the same concerns beginning to be discussed elsewhere.

NSSCP NORTH SOMERSET Safeguarding Children Partnership