Summary

Suspected non-accidental injury in pre-mobile baby aged 7 weeks.

Learning: There was not sufficient professional curiosity regarding the father of Baby G. Partner agencies did not escalate concerns regarding poor communication, and/or contact, and/or attendance at the strategy discussion immediately after Baby G was admitted to hospital.

Summary recommendations: To review with partner agencies the effectiveness of escalation policies and their application locally. Children’s social care to develop clear practice guidance on how to respond to non-accidental injuries in pre-mobile babies.

Keywords: Mental health, Professional Curiosity, involvement of fathers, escalation process, strategy discussions.
What happened for this child and family?

Baby G was the first child of her parents and there had been no previous involvement with child protection agencies. As a result of an accident, the father had a long term disability and suffered from chronic pain. He was on antidepressant medication. Baby G was 7 weeks old when she was admitted to hospital in February 2017 with injuries which were suspected to be non-accidental. These included fractured ribs, fractured hand, a break to her thigh bone, a suspected head bleed on her brain and a potential fractured arm.

Baby G’s mother experienced anxiety during the pregnancy. The health professionals involved recognised the mother’s vulnerabilities such as anxiety and the risk of post-natal depression and provided support through additional midwifery contact following the birth of Baby G. This evidenced good practice, and health professionals responded proportionately.

The health visiting service provided additional support to the family following Baby G’s birth due to the knowledge that the mother was experiencing anxiety.

It was later decided as part of a ‘Fact Finding’ hearing that Baby G’s father was deemed to be culpable for the injury caused to Baby G. The father is no longer the primary carer to Baby G and Baby G has been able to return to her mother’s care and is doing well.

A number of Serious Incident Meetings were held with the key agencies who supported the family to determine whether a Serious Case Review should be initiated or if another review mechanism would be most helpful in understanding the practice learning.

The conclusion was that, although there had not been any missed opportunities or issues of concern in relation to multi-agency working prior to the serious incident occurring, there were multi-agency issues around process after the incident and therefore a Multi-agency local learning review was recommended. The learning from this review is also linked to learning from the following: SCR’s (Child E 2014, Emergency and Duty Team (EDT) arrangements) and (Child John, 2018, Professional decision making in response to non-accidental injury, direct communication with families when possible, EDT when non-accidental injury has occurred, professional attendance at strategy discussions and compliance with Working Together 2018.
Key Learning from the Review

- Emergency Duty Team (EDT) arrangements were not at the time effective and staff practice was not sufficiently thorough. At the time of referral from hospital staff there was only telephone discussions with the family. The emergency duty team staff now attend safeguarding training and regular supervision to ensure practice is consistent with mainstream colleagues, and that the principles of relationship based practice is adopted.

- The EDT team has since been reviewed and recommissioned ensuring out of hours staff are available for face to face meetings and discussions with professionals and families in cases of non-accidental injury at the earliest opportunity. This also ensures there can be adequate liaison and safety planning at the early stages of involvement.

- How individual agencies respond to unexplained injury when there is uncertainty or differential diagnoses for a child’s medical condition. The importance of strategy discussions in determining what safety planning is required and to consider any other potential risks posed during periods of uncertainty, and while assessments are being undertaken.

- The hospital staff involved at the time did not challenge other professionals in relation to the limited contact which took place following Baby G’s admission, and children social care did not challenge the police regarding non-attendance at strategy discussions. This underlined the importance of professionals knowing when to escalate and understanding the processes in placed to support this action.

- The father’s mental health was not explored in depth and there was limited professional curiosity about the father’s depression and the potential impact of his depression on the couple’s relationship and the family as a whole.

- An unexplained injury may be indicative of violence and there was insufficient exploration of domestic abuse.
Key Learning for Practitioners

- Parents and caregivers need to fully understand the processes within safeguarding and how we achieve 'safe uncertainty' while assessments are ongoing. When working alongside parents and families, we should communicate clearly our worries, and ensure they have support in participating where possible in formulating assessments and safety planning.

- Safety planning is essential during periods of uncertainty, and strategy discussions need to consider contact and supervision arrangements during periods of assessment, and/or while the child remains in hospital. Safety planning cannot wait until the conclusion of assessments. Professionals need to maintain curiosity and healthy scepticism in cases of possible non-accidental injury.

- Any unexplained injury, for example bruising on non-mobile babies should be dealt with in accordance with the statutory guidance set out in *Working Together 2018*.

- Professionals need to understand and be aware of escalation processes and feel supported when deciding on this course of action.

Next Steps

- To review with partner agencies, the effectiveness of escalation policies and their application locally.

- Children’s social care to develop clear practice guidance on how to respond to non-accidental injuries in pre-mobile babies.

- Professional Standards and Quality Assurance, Children’s Social Care to continue to monitor compliance with *Working Together 2018*, with specific reference to the timeliness of strategy discussions and ensuring the correct personnel are in attendance. Police, health and children social care to complete an audit on strategy discussions to confirm sustained improvements. Assurances to be provided to the Bexley Safeguarding Partnership for Children and Young People.

- Training on ensuring involvement of and work with fathers in child and family assessments including parenting assessments.

- Staff briefings for safeguarding champions and multi-agency training events to include the importance of knowing and understanding escalation processes. Encouraging professionals to challenge and to adopt a willingness to challenge.

- Briefings for families and professionals to be completed, on how to respond in cases where there are issues of differential diagnoses and/or uncertainty regarding possible non-accidental injuries in pre-mobile babies.