Review concerning a baby
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7 POINT BRIEFING

1 SUMMARY

Wakefield Safeguarding Children Partnership (WSCP) undertook a Learning Circle concerning a baby after they attended hospital with an unexplained bruise on their forehead.

The areas the Learning Circle considered included the following:

1. Application of the assessment of non-mobile babies with injuries including bruises, burns and scalds protocol
2. Effectiveness of information sharing between agencies
3. Assessing harm to children where there is no previous historical concern
4. Recognising faltering growth in the context of physical harm

2 WHO WAS THE CHILD AND THEIR FAMILY?

At the time of the incident, the baby lived at home with their parents and elder sibling. There was no history of the family coming into contact with services outside of universal provision. Prior to the incident, the baby was admitted to hospital two months earlier presenting as lethargic, irritable, and not feeding. The baby was treated for septicaemia before being discharged after five days.

3 SUMMARY OF THE INCIDENT

The baby was presented at hospital by their parents, after being advised to attend by the family's health visitor who had noticed a small bruise to their head during a home visit. Parents were unable to explain the bruise and therefore a medical assessment including skeletal survey (full body x-rays), head CT scan and ophthalmology review were undertaken in line with the assessment of non-mobile babies with injuries including bruises, burns and scalds protocol.

The scans confirmed the baby had sustained numerous factures to their ribs, collarbone, arms, legs, along with a potential fracture to their lower back. Upon reviewing the earlier chest X-ray taken when the baby was admitted to hospital prior to this incident, it showed fractures to be present in the baby's ribs.

4 KEY POINTS AND ANALYSIS FROM THE REVIEW

- The ability of the health visitor identifying a small bruise on the baby's head during a routine home visit, and prompt recognition in needing to follow the assessment of non-mobile babies with injuries including bruises, burns and scalds protocol was excellent practice. The availability in being able to discuss and provide information to the on-call paediatrician also enabled a prompt response once the baby arrived at hospital in undertaking a child protection medical

- The health visitor checked the baby's physical appearance after revisiting home due to faltering growth. There was a reflection that this example should be shared with the workforce across the partnership as to the importance in considering faltering growth being due to possible physical injury and/or harm in babies

- There was a reflection when the baby was admitted to hospital prior to the later presentation in how the fractures sustained to their ribs were missed. It was explained that x-ray changes for fractures can be subtle and difficult to see, especially when the reason for the x-ray was to look at the baby's lungs rather than their bones

- There was recognition that there was a level of confirmation bias and an initial sense of dismissiveness that the baby's presentation would have been caused by inflicted injury. It was felt this was potentially influenced by there being no historical safeguarding concerns and the seemingly transparent nature and engagement of the parents. However, the application of the assessment of non-mobile babies with injuries including bruises, burns and scalds protocol ensured all required checks were undertaken and processes adhered to, which led to the identification as to the level and volume of injury the baby had sustained. This incident has demonstrated that the response for a baby who has an unexplained bruise on their head must always be strictly led by the protocol

- There was a delay in the police receiving information indicating the injuries the baby sustained were consistent with inflicted injuries. Albeit the impact for this case in the delay was minimal, due to the swift nature the police officer followed up for information, it is standard practice for the police to be informed immediately so action such as considering powers of protection and securing evidence can be undertaken promptly. Services recognised the communication between them when the results of the scans were discussed could have been more explicit in the analysis as to the severity of the baby's injuries and the need for the police to be notified. This learning has been discussed internally within those service areas

- When the first strategy meeting was held, the paediatrician was not notified of the meeting to attend. This led to discussion as to the need for partner services of health agencies to understand better the different roles and systems they use, as different health providers do not have access to all information which can then impact on the quality of the discussion. In this instance, the strategy meeting was rescheduled for the paediatrician to attend. Prior to Covid-19, strategy meetings concerning children who were admitted to hospital took place on site. There was recognition it may be valuable to consider in the future holding strategy meetings concerning suspected non-accidental injury at hospital given how key the information from a paediatrician is to inform decision making

- Hospital staff were not notified prior to parents being informed they were not to remain on the ward. Usually, hospital staff will be aware and can help support with informing parents and assessment of risk. The safety plan put in place once the injuries to the baby had been confirmed, allowed for grandparents to remain on the ward. The police were not included in the safety plan discussions and given the contact grandparents had with the baby meant they would have been in the pool of potential perpetrators, their involvement in the safety plan would have been valuable

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WHAT WILL WE DO WITH THESE FINDINGS?

- The Learning Circle generated individual, group and system recommendations which are being overseen and implemented by WSCP multi-agency subgroups which are represented by services who work or volunteer with children and families

- WSCP will hold practice review briefings to disseminate the learning and analysis to the children and families workforce

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NEXT STEPS

- The findings of the review has been approved by WSCP and work is underway in implementing the learning from the incident.

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RESOURCES

There are a range of national and local resources, guidance, and training in relation to safeguarding children on the WSCP website.

Wakefield Safeguarding Children Partnership