7 Minute Briefing: [Practitioner Event/2022/A1]

Date: November 2022

7 MINUTE BRIEFING

1 Background of the case

This case relates to the serious harm of a non-mobile baby, who was noted to have bilateral conjunctival haemorrhage and bruising.
The baby received an early medical diagnosis to account for the injuries. It was later found that this diagnosis was incorrect.

Fifteen days later, the baby was brought to the local ED unable to move their arm. It was found to be fractured. The baby also sustained further bruising whilst under supervised care. The holistic picture was identified during this second presentation.

An explanation provided by the family to account for the fracture did not fit with the injuries seen (mechanism of injury), and alerted practitioners to re-evaluate the original multi-agency plans.

2 How did the SSCP respond?

A notification was received to alert the Surrey Safeguarding Children Partnership (SSCP) of the case and to ask for SSCP consideration for a Local Child Safeguarding Practice Review (LCSPR).

A Rapid Review was undertaken. Detailed discussions and consideration of the nationally set criteria for LCSPR was completed by a multi-agency panel.
Although the case did not meet the criteria for a Local Child Safeguarding Practice Review, it was felt there was learning to be found so a learning event was planned.

A Practitioner Event brought agencies together for reflection and discussion. Their insights and expertise provided an open discussion using a systems theory approach, to consider different agency viewpoints, alongside the benefits and challenges of multi-agency working.

3 Key reflections

Father missing from assessments.
It was felt by the Practitioners involved that very little was known about the father and his history. In respect of the mother there appeared to be detailed knowledge available.

Decision making with limited information.

Practitioners reflected the challenges faced when trying to make decisions when there is only limited information. A pattern of escalating harm can be seen with the benefit of hindsight, but this was not clear at the time.

Policy variation across borders.

Whilst all bruising policies have the same goal, practitioners felt there can be variation between different authorities. This can cause confusion when working across geographical borders. A National protocol would make decision making easier and ensure a consistent approach.

4 Areas of good practice

Following the incident, agencies have completed internal reviews to identify learning. Opportunities for reflection have been undertaken with all involved individually, collectively and within single agencies.

Discussions highlighting safer sleep practices were undertaken with the family in hospital when staff noted baby was laid to sleep on her front.

Hospital staff also recorded many bonding and caring behaviours within their record keeping.

Whilst there were opportunities for intervention at earlier points, ultimately the life of this child was protected from potential escalation of abuse.

5 Opportunities not to be missed

Focus on the presenting issue.
There was delay in activating the bruising protocol. Discussions were focused on finding evidence to prove non-accidental injury and not focusing on the presentation of a non-mobile infant with bruising.

Ensure birth marking is routinely noted at all baby examinations.
Birth marks develop over several days and may not always be seen at birth. Routine assessment will help to differentiate blue grey marking, birth marks and potential new injuries for those who are meeting a baby for the first time.

Raising Awareness of Local Policies for temporary staff
There is often a need for temporary staff such as locum GP's or agency staff, who may not be familiar with the bruising protocol. Policy locations could be included within a practice or organisation 'welcome pack' for easy reference.

6 Thoughts for reflection, supervision or group discussion

- Professional challenges of working with limited information, uncertainty and risk.
- The importance of asking the 'second question'.
- The value of using chronologies for case oversight.
- The value of history taking to form part of holistic assessment (mechanism of injury).
- Assessment of key males present in a child's life.
- Understanding bonding and attachment behaviours.

7 Links for further reading

- 3.3 A Multi-agency Protocol for the Management of Actual or Suspected bruising in Infants who are Not Independently Mobile | Surrey Safeguarding Children Partnership (procedures.org.uk)
- SSCP-Bruising-in-Children-who-are-not-independently-mobile-LEAFLET.pdf (surreyscp.org.uk)
- Bruising in non-mobile infants (publishing.service.gov.uk)
- The Myth of Invisible Men (publishing.service.gov.uk)
- Annual review of LCSPRs and rapid reviews (publishing.service.gov.uk)
- SSCP Safer Sleep 7 Minute Briefing-Feb-23.pdf (surreyscp.org.uk)
- SSCP-7-Minute-Briefing-Professional-Curiosity.pdf (surreyscp.org.uk)