Sunderland Safeguarding Children Board

Serious Case Review Learning Bulletin
Baby G

This learning bulletin outlines the learning from the Serious Case Review for Baby G that will be published by the SSCB in due course. The SSCB expects that this bulletin will be used by every team in every setting to review the team's practice against the learning, identify what the team needs to do and engage actively in transforming practice.

Serious Case Review (SCR) Learning Bulletin
Baby G

Theme of SCR	Poor assessments/sporadic single incident interventions/incoherent early help/limited risk assessments/failure to escalate concerns/neglect/concealed pregnancy/non-accidental injuries in baby (spiral fracture to arm)
Date Published	06.09.2016

Case details :

Family History

- The family is White British with English being their first language
- Baby G is the second child to Mother and Father
- Father has had involvement with Police resulting in 18 month suspended custodial sentence for Wounding, with requirement for Probation Supervision
- Father regularly used Cannabis
- Mother and Father in long-term relationship since teenagers
- Mother's first pregnancy was terminated when she was 15
- History of domestic violence between Mother's parents
- Baby G had 1 older sibling
- Family lived with Paternal Grandparents until just before birth of Baby G

Baby G

- Second child of Mother and Father
- Born in early 2015
- Baby G's Mother did not reveal her pregnancy to professionals for several months, booking into antenatal care late at 26 weeks of pregnancy
- In May 2015 - Baby G's parents brought him to hospital saying that he was having problems moving his left arm. An x-ray confirmed a spiral fracture to his arm as well as evidence of a calcified, older fracture, to his left clavicle and a further old fracture of his left femur. These injuries were considered likely to have been non-accidental and a referral was made to Children's Services
- Care Proceedings followed and both Baby G and his sibling have not been returned to the care of their Parents

Family Involvement with SCR

- Mother and Father met the Business Manager during the review to have the purpose of the review explained to them, but no further discussion was possible, as there are possible pending criminal proceedings

Key Points of Learning:

Indicators of risk and vulnerability – emerging themes included:

- Lack of professional curiosity and probing about the history of each Parent
- The implications for an offender like Father, who had committed several violent offences, of becoming a parent, should have been explored and contact should have been made with other agencies
- Mother was nearly always seen in the company of Father and professionals seemed to have been unable to provide opportunities for her to be seen alone; this meant that it was very difficult to assess their relationship and to what extent Mother may have deferred to Father
- Insufficient regard was given to the view of an experienced Midwife
- Professionals operating too independently rather than together and without good and

timely liaison and communication with each other

Good Practice Identified

- There was some timely and consistent practice by those professionals who sought to support the family. There are many examples of both the Health Visitor and the Midwife engaging well with the family. Baby G was examined by them and they gave Mother clear advice about his care
- When Baby G came to hospital again, swift action was taken to protect him once evidence of non-accidental injury had been identified

Recommendations from Serious Case Review

- Joint working / professional collaboration and sharing views and information. This should include:
  - The importance of respecting the opinions and assessments of other professionals, whatever their status, to ensure that practice is child centred
  - The vulnerability of immobile infants to Non-Accidental Injury (NAI). The procedure for the Assessment of Bruising/marks and possible NAI in a non-mobile baby or child should continue to be promoted across agencies using this case to demonstrate the issues
- The significance of parental history and particularly of violent offending should be included in the SSCB's procedures for Section 47 enquiries and risk assessments
- The SSCB's Learning and Improvement Workshops on the findings of SCRs in Sunderland should be reviewed to ensure that they:
  - Reinforce the essential requirements for joint professional practice
  - Promote the significance of parental history, particularly issues of parental violent offending when undertaking Section 47's and risk assessments
- The SSCB should seek assurance from Sunderland Children's Services and Northumbria Police that there is a clear and agreed protocol in place for the conduct of joint investigations of child abuse or neglect. This should include the work of the MASH

Learning and Improvement Workshops are being held on learning from SCR's and information can be accessed at http://www.sunderlandscb.com/pr_training_cms.html

The Overview Report will be published by the SSCB in due course. This SCR was referred to in a thematic report published on 6 September 2016 which pulled together the learning from four baby SCRs in Sunderland. The report and accompanying documents can be accessed at http://www.sunderlandscb.com/pr_scr_cms.html