BRISTOL SAFEGUARDING CHILDREN BOARD BRIEFING

Issue Date: 4th October 2017

CHILD PROTECTION INCIDENT REVIEW BRIEFING – BABY R

What is a CPIR?

A CPIR (Child Protection Incident Review) is undertaken by BSCB when a case is referred that does not meet the criteria for a Serious Case Review, but can still provide learning at a local level in respect of:

- How agencies are working together
- Improvements that might be required in local services

In Bristol the decision to undertake a CPIR is made by the Serious Case Review Sub-group. A CPIR is completed by local reviewers appointed by the Serious Case Review Sub-group, using the same 'systems' based approach that is used for Serious Case Reviews.

CPIR's are not published, but their learning needs to be shared within the professional community, both what to do differently, and where best practice is identified.

To help embed this learning with all professionals involved in safeguarding children we have decided to issue briefing notes for Bristol CPIR's that can be used to inform practice, and for training purposes across the city.

WHAT WE KNOW ABOUT THE FAMILY AND WHAT HAPPENED

Baby R was born in January 2015, to a family made up of Mother, Father and one other child that was 19 months old. The family had worked with children's services Mother was pregnant with their first child and the social worker closed the case in July 2014.

When Baby R was 6 days old a midwife noticed a bruise on the baby's face. She followed guidance which included a referral to social care. A S47 child protection assessment was completed and the case was closed.

Nine weeks later a health visitor noticed Baby R had injuries to the hips and was in pain. Baby R was found to have a fracture to the left femur, skull fractures, rib fractures and multiple fractures across both left and right lower legs and to the right arm. These injuries were of varying ages, up to 3-4 weeks old at the time of discovery. The children were removed from the parents, who faced criminal charges regarding the injuries.

OUR FOCUS IN THIS REVIEW: THE SHARING OF INFORMATION AND ENSURING THAT ASSESSMENTS ANALYSE RISK

The review identified times when professionals acted quickly and demonstrated best practice to protect Baby R from harm. They also involved the Father in assessments, something that historically Bristol has struggled to do.

The assessment regarding Baby R's initial bruise took 6 days to complete, and was finished by the time the notes from the child protection medical were received 14 days after they were dictated. Those medical notes included actions for the social worker but there isn't evidence that they were completed.

The S47 Assessment recorded that the bruise at 6 days had a reasonable explanation and was from the birth – this was not accurate. The medical had concluded that it could not determine whether the injury was from the birth, or another cause. This is the difference between saying we don't know how the bruise happened, and saying the bruise definitely wasn't caused by the parents.

Health records show Father living with Mother and the children continuously; the S47 assessment recorded him as living at a separate address. The assessment didn't show analysis possible risk from Father due to previously recorded concerns about his anger issues, and a known incident of domestic abuse between Mother and Father.

None of the records showed evidence that practitioners involved in this case received effective supervision. Reflective practice might have ensured that all risks were fully explored and analysed.

THE GOOD PRACTICE THAT WE IDENTIFIED

- When the bruise was first seen at 6 days old all agencies responded promptly and appropriately.
- The Health Visitor notified the Social Worker regarding a black eye seen on the elder child 6 months before Baby R's injury.
- The Child Protection medical was conducted promptly, and dictated within 24 hours
- The Health Visitor independently assessed the family and considered the need for enhanced Health Visiting support.
- The Health Visitor recognised Baby R's distress and took all appropriate actions – acting professionally, supporting the family but always having safety of Baby R as the priority.
- The Father was involved in assessments by both Social Workers and Health Visitors.
- All professionals saw the family promptly.

WHAT WE HAVE LEARNT

- We need to be certain that we record findings accurately.
- The level of analysis in S47 assessments should be clearly documented to ensure that assessments are not descriptive.
- All agencies having contact with a family undergoing S47 assessments should be contacted and have information included in the process.
- Communication systems are really important between agencies. If there are delays in sharing information it can impact on keeping children safe.
- Information and actions from Child Protection processes must be communicated promptly with everyone who is part of the action plan, or has contact with the family.
- Health and social care should be demonstrating through their records that effective supervision takes place when starting or ending cases where child protection concerns exist.

WHAT WE CAN DO DIFFERENTLY IN THE FUTURE

- Share records in relation to child protection promptly – if professionals don't know about actions they can't complete them.
- Check even the basic information about a family with each other – different addresses, contact details, or

dates of birth can be important.

- Make sure everyone involved with the family is communicated with during S47 processes – if you know about other people involved tell the social worker.
- Record facts accurately – "we don't know" is exactly that and is less likely to be influenced by the 'rule of optimism'.
- Request supervision for all child protection cases when they open and before closing. If you're a manager, provide it – reflective practice is important for all practitioners to ensure objective analysis has been completed and that risk has been robustly assessed.

GOOD PRACTICE GUIDANCE RELATED TO THIS REVIEW

- Multi agency guidance for the management of strategy discussions: https://bristolsafeguarding.org/media/1185/strategy-discussions-2017.pdf
- Multi agency guidance for injuries in non mobile babies: https://bristolsafeguarding.org/media/1173/ma-guidance-to-injury-to-non-mobile-babies.pdf
- Supervision good practice guide and tools: https://bristolsafeguarding.org/media/1279/joint-bscb-and-bsab-integrated-supervision-good-practice-guide-and-tools-for-web.pdf

FEEDBACK, SUGGESTIONS AND IDEAS

Tell the BSCB how you have used this briefing to improve practice at:

- Email: bscb@bristol.gov.uk
- Twitter: @BristolLSCB
- Website: www.bristolsafeguarding/children/contact/contact-the-bscb

Let us know if you identify work that the BSCB could complete to support professionals learning and development in relation the findings from this review.