Rapid Review Learning Briefing

Baby D

This rapid review looked at significant events leading up to an incident involving a 12-month-old-baby being admitted to hospital with significant injuries. A rapid review learning event took place in July 2022 and involved professionals from 10 organisations. The review focused on the 6 months prior to the incident and investigated how the safeguarding system worked together to keep the child safe and whether there were any key areas of learning for the safeguarding partnership.

D (pseudonym) lived with mum and two-and-a-half-year-old sibling. Mum brought D to the emergency department (ED) reporting he had fallen from the bed and had been crying, irritable, and not able to use one arm. The neuroradiology report showed findings consistent with a traumatic injury which may have been caused by shaking. In the two years prior both baby and older sibling had sustained injuries or required urgent care treatment. The multi-agency partnership was unable to be conclude if the traumatic injuries were deliberately inflicted, however, due to the nature and volume, plus the context of a chronology of other historic injuries sustained whilst not being supervised there were concerns about neglect and physical abuse.

ICON stands for:

Infant crying is normal

Comforting methods can help

It's **O**K to walk away

Never, ever shake a baby.

Rapid Review Findings

What Went Well

The review found areas of **good practice** around the **universal services offered**.

Health and safety advice provided **was appropriate** and in line with guidance.

Good safeguarding practice was evidenced in **response to non-accidental injuries in the ED**, unfortunately baby had already been seriously injured at this time.

Click here for information to support families

What Could Have Been Better

Notifications of a child's attendance at an unscheduled care setting are triaged by the Public Health Nurse Response Team (PHNRT) to identify children/families that may benefit from PHN intervention. Due to the volume of notifications received and limited resource within the team this led to delays in the triaging process.

Due to resource constraints, there **was missed opportunities for additional input** from the health visiting team to undertake a home visit, provide support and advice, and liaise with the nursery provision in the week after the incident.

A holistic, Think Whole Family, approach to the child's presentation was needed. Considering previous injuries of baby and sibling within a six-month period should have initiated professional curiosity, triggered a home visit, and would have supported the professional's assessment of whether there was a need to be concerned for the child(ren)'s safety and welfare. This may be an indicator of parental stress, supervision issues or parenting support needs whereby consideration should be given to either refer to early help or submit a safeguarding referral.

Click here for KBSP multi-agency guidance for injuries in Non-Mobile babies

Click here to find out more about ICON

What Needs Improvement

As a result of this review, **all Emergency Department information for under 1s will go directly to the local health visiting team.**

Further review and auditing of ED to PHNRT information sharing and timeliness of health visiting contact will be undertaken

A policy reflecting the process for managing ED notifications and a graduated response to presentations will be established in Bristol.