CYSUR 5 2017

Concise Child Practice Review

1 Background

The MAWWSB undertook a Concise Child Practice Review which looked at agency learning following the discovery of multiple life threatening injuries to a 4-week old baby. These included a fracture to the skull and other multiple fractures, bi-frontal haemorrhage contusions, bruising, scratches and a torn frenulum. A Concise CPR must be undertaken where abuse or neglect of a child is known or suspected and the child has died or sustained potentially life threatening injuries, or sustained serious and permanent impairment of health and development and was neither looked after or on the CPR during the 6 months preceding the incident.

2 Context

The family were known to the GP, HV, Midwife, Paediatric Services and Nursery There was no previous involvement from Children's Services. The baby's injuries were found by a New Born Hearing Screener during a routine visit. The baby was seen to be extremely overwrapped in a pram with noticeable facial injuries. The family court process identified the children's mother had a significant learning disability and very limited parenting capacity and the father was found to have borderline capabilities.

The parent's ability to parent independently was untested as following birth of the older siblings they had lived with and were supported by maternal grandparents.

3 Identified Themes

Communication and Information Sharing: If health professionals involved with the family had shared information with each other, it is possible the level of the family's vulnerabilities could have been identified sooner and specialist support obtained. There were missed opportunities to seek support for the family when the baby was observed to be overwrapped by health professionals on 3 separate occasions.

Discharge Procedures: The mother and child were inappropriately discharged from Midwifery Services on a Friday despite identified safeguarding concerns

4 Identified Themes

Professional Curiosity: A little more professional curiosity at the time could have identified the mother's learning difficulties and specialist support sought at an earlier stage. Enhanced support was offered from the HV due to a previous history of post-natal depression, a focus on this potentially missed the wider context of the parent's limitations.

5 Identified Themes

Professional Understanding of Parental Learning Disabilities and its Potential Impact on Parenting Capacity: It is not always immediately obvious someone has a Learning Disability. The children's mother developed life skills and coping strategies that enabled her to mask her level of understanding, this meant her disability was missed by professionals. Staff reported a lack of knowledge and training opportunities in this area.

The Importance of Prompt and Appropriate Referral Making. Medical and Social Care Professionals collectively concluded that by making the referral when she did the New Born Hearing Screener saved the child's life.

6 Learning and Actions

Training and awareness raising on Learning Disabilities and its potential effect on parenting capacity is provided for Midwifes and Health Visitors

All agencies to promote safeguarding training to ensure all staff are confident and know how to make a safeguarding referral.

Midwifery Discharge procedures are reviewed to consider good practice standards for discharge when there is an ongoing safeguarding concern.

7 Learning and Actions

Communication Systems are reviewed and developed to support and improve the communication between GP's, Midwifes and Health Visitors, to enable prompt information sharing for vulnerable children and adults

A Regional Protocol for Injuries to Non-Mobile Babies to support best practice is developed by the MAWWSB

Timely Internal Reviews of Critical Incidents take place and all agencies to ensure that they have systems and procedures in place to review any critical incidents/near miss episodes and identify any immediate learning in a timely manner.

For full report please click here