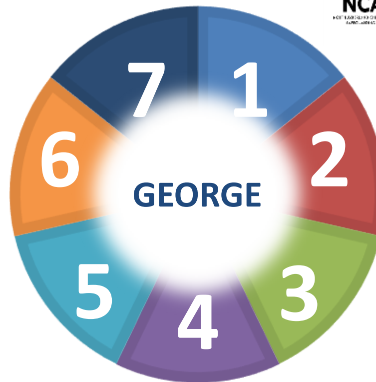
1. George – Background

- *George and his sibling aged 2 ½ had been subject of child in need plans since July 2020. Signs of neglect.*
- *April 2021, George presented at Paediatric Emergency* Department with severe oral thrush; so serious he was admitted to hospital. He was observed to have four potential bruises on his face, two of which (one either side of his head) were later determined to be non-accidental injuries. First Skeletal survey identified no initial remarkable findings.
- Second skeletal survey was undertaken two weeks after the first as per local protocol. Survey indicated George had a healing fracture to his left tibia and four healing fractures to his ribs. Assessment of these injuries by clinical experts was that they were indicative of non-accidental injury.

2.Family context

- Family known to multiple agencies over an extended period of time.
- Mother – concerns around mental health and excessive alcohol misuse. Diagnosis of emotionally unstable personality disorder. History of sexual abuse as a child and spent some time in care.
- Father - known to adult social care relating to domestic abuse - including incidents as an alleged victim of financial abuse (perpetrator his mother) and a threat of violence by him (with a knife) to a younger sibling. He also had mental health issues, autism and ADHD.
- George's older sibling had previously been noted during a hospital appointment to have had a higher than usual number of bruises that were mostly explained but indicated inadequate supervision; there remained three bruises which were unexplained.



3. Areas of concern

- **Brusing noticed by hospital staff but not acted upon immediately until anonymous call received by social worker alleging bruising to George and sibling.**
- **Similar patterns of previous concerns around sibling that did not lead to a pre-birth plan for George.**
- Concerns around sibling led to a delayed 'on-line' strategy meeting that police were not able to gain access to, in order to share information.
- S47 enquiries did not lead to an Initial Child Protection Conference (ICPC) or CP plan.
- Newly qualified staff had limited supervision and staff changes led to a lack of continuity and oversight.
- Accumulation of concerns relating to the parents' historical and recent behaviours were not collated or analysed sufficiently in the care planning.

4.Areas of concern

- Potential gap in the Mental Health Trust's clinical and safeguarding supervision, ongoing monitoring and safeguarding review of mother.
- Categorising a case as a Child in Need has implications for how it is viewed and managed by other agencies.
- Vulnerabilities of the father were not necessarily shared with the children's social worker.
- Sibling's nursery raised concerns over sibling's behaviour and presentation, social work visits to speak to child were unsuccessful.
- Provision of safeguarding supervision to staff working with the family appears to have been inconsistent, with gaps evident across some of the agencies.

5.. Themes

- Bruising in immobile baby
- Parenting ability (both) and "The Myth of Invisible Men"
- Decision making, risk assessment and management oversight
- Multi-agency working
- Neglect
- Information sharing
- Voice of the child
- Provision of professional supervision for safeguarding
- Child in Need versus Child
- Protection?

6. Good Practice

- Acute Hospital Safeguarding Team responded to an anonymous tip off regarding concerns that George had bruising which had not been initially picked up. As a result, bruises were then identified. Mother was overheard saying to father on 'FaceTime' that the bruises were there from birth (birthmark) but father said they were there only the day before. This conflicting information provided evidence to support the non-accidental injury explanation for the bruises.
- GP practice ensured appropriate coding was placed on father's file after a MARAC (domestic abuse) case in 2018 as well as sharing information regarding father as part of a 'Sharing Information Regarding Safeguarding' (SIRS) request – a process in place to ensure appropriate information is shared regarding a father when his partner is pregnant.

7. Key Learning

- Where there is any suspicion of bruising in an immobile baby action should be taken immediately, and a referral made to CSC .
- When a section 47 (child protection) investigation does not lead to an ICPC being held, those agencies involved in the original strategy meeting should be consulted to ensure they are in agreement with this decision.
- Information should be shared across agencies so the wider family context can be considered.
- The child's voice should be reflected in all agencies' documentation about them, and included in wider assessments of risk
- Strategy meetings, should be held within timescales and all agencies should attend, particularly Police where a crime may have been committed.
- Good quality supervision should be in place to ensure the right cases receive safeguarding supervision, contain challenge where required, and cases are appropriately risk assessed.
- Where there are concerns and evidence of childhood neglect, this should be clearly identified in records using the word 'neglect' and discussed accordingly at relevant meetings.