Learning Lessons from Serious Cases

Briefing Note for Team Meetings

Unexplained Bruising....

October 2021

Background

This independent review focuses on the tragic death of a 21-month-old child in November 2017 as a result of catastrophic brain injuries following a violent assault. The child's mother suffered from drug addiction before and throughout the pregnancy, and the baby was born prematurely. There was a long history of agency intervention with the family, with the child's tThis independent review focuses on the tragic death of a 21-month-old child in November 2017 as a result of catastrophic brain injuries following a violent assault. The child's mother suffered from drug addiction before and throughout the pregnancy, and the baby was born prematurely. There was a long history of agency intervention with the family, with the child's two older siblings living with their maternal grandmother since 2015 under a Special Guardianship Order (SGO). In March 2016, the child was placed with a relative under an SGO, following a positive assessment and endorsement by the Family Court. Children's services continued to offer support to the Special Guardian for a further 6 months.

In April 2017, the Special Guardian rekindled her relationship with the perpetrator who is now known to have a history of mental health problems and violence, which includes domestic abuse. At the time he was attending a domestic abuse perpetrators group work programme and disclosed that he had started a relationship with a woman with children. This important information was not shared by the Probation Service, with partner agencies.

During October and November 2017, the Special Guardian expressed concerns to nursery and healthcare professionals about the number of bruises sustained by the child. A medical review at hospital was undertaken a month prior to the fatal assault, but at that time no safeguarding concerns were identified. In November 2017, the child was admitted to hospital having been found unresponsive at her home address and sadly died three days later. In March 2021, the perpetrator was found guilty of the child's murder and sentenced to a minimum term of 20 years in prison. The review identifies important learning for front-line practitioners.

Improving Practice

- If you become aware of a new relationship and have concerns about the risk the individual poses to their new partner and/or children, share this information with other professionals working with the family in order for any risks to be identified and assessed, as set out in '*Right Help Right Time Delivering effective support for children and families in Birmingham'* guidance. If there are no professionals working with the family, refer your concerns to the Children's Advice and Support Service (CASS).

- When a parent/carer presents with a child with an unexplained bruise or bruising, be curious and seek a detailed explanation, particularly in non-mobile babies. Always be mindful that disguised compliance could be a factor. Following your discussion with the parent/carer, consult with your agency's senior safeguarding lead for advice and support on what action is required.

Good Practice and Learning

1. In this case, the post-placement support network was not clear and a multi-agency pathway with a named lead agency and clear expectations would have been helpful. All carers who now have an SGO granted in Birmingham are offered support via the SGO Support Team for a minimum of six months post Order with an allocated Social Worker. The SGO Support Plan is then reviewed on an annual basis. Special Guardians have also been provided with access to advice and guidance as and when required. They have access to continued training, support groups and dedicated support to assist with the child's education.
2. Enough time should always be given to assess the integration of the child within the family, the care of that child and the impact this has on all members of the family before the final SGO is made. Now nationally, Family Courts work in close collaboration with safeguarding agencies to ensure that children who achieve permanence through special guardianship receive appropriate levels of support and supervision following the Order.
3. The nursery and GP were unsure of what action to take when the child presented with significant bruising. In the intervening period regional guidance on the management of injuries in babies and children under two years of age was updated in August 2020, and training for health professionals around bruising in infants and children has been, and will continue to be, delivered.

Next steps – What can you do

a) Circulate this Briefing Note to all members of your team and discuss the case at your next team meeting or supervision session. Use the PowerPoint presentation to ensure everyone understands and is able to apply the learning.

b) Familiarise yourself with regional guidance about the management and referral of babies and children under the age of two years, particularly those who are not yet independently mobile, who have presented with an injury – click here

c) NSPCC provides useful guidance for professionals on how to identify bruises that may be the result of non-accidental injuries. To access the guidance, **click here**

d) Make sure your team are aware that the Right Help, Right Time (RHRT) guidance is currently being refreshed and will be available to download from the BSCP website. For a copy of the current RHRT guidance **click here**

e) Encourage your team to attend 'Learning Lessons from Serious Cases'. For more information on this training course and for future delivery dates **click here**