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Reason for the review

Daniel died at the age of 7 weeks. Whilst to date the cause of Daniel's death remains unascertained, a forensic post-mortem identified multiple rib fractures of varying ages. The strategic partners from the Pan-Dorset Safeguarding Children Partnership (PDSCP) met to discuss this case under the Rapid Review process and it was agreed the criteria for a Child Safeguarding Practice Review (CSPR) were met. Daniel's death was also reviewed under the statutory Child Death Review Process.

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Background

Daniel lived at home with his older sibling, Sarah, and both parents. Little was known about extended family and friends and the family were only known to universal services. When mum was pregnant with Daniel and Sarah was 5-months old, she was taken to A&E with a minor head injury. The parents confirmed that Sarah had fallen on a concrete floor whilst being held by her half-sibling (age 5 years). This incident was shared with Children's Social Care and the Health Visitor, however, no further medical treatment was required.

Following Daniel's death, the identified rib fractures triggered a strategy meeting and an Initial Child Protection Conference (ICPC) to consider Sarah's safety was agreed. The result of the ICPC was for Sarah to be the subject of a Child in Need (CIN) Plan which was later closed 4-months later before the forensic post-mortem results for Daniel were known.

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Key Learning

- The impact of covid on service provision.
- Responding appropriately to injuries to non-mobile babies.
- Promoting safe sleeping, coping with crying and preventing non-accidental head injuries in babies..
- Effective information sharing, assessment and analysis
- Lack of professional curiosity
- Assessing and responding to neglect
- Ensuring effective assessments of parenting
- The visibility and voice of the child
- Delays in reporting forensic post-mortem report

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Useful Links

[PDSCP Protocol for Non-Mobile Infants and Children Presenting with Actual or Suspected Injuries.](#)

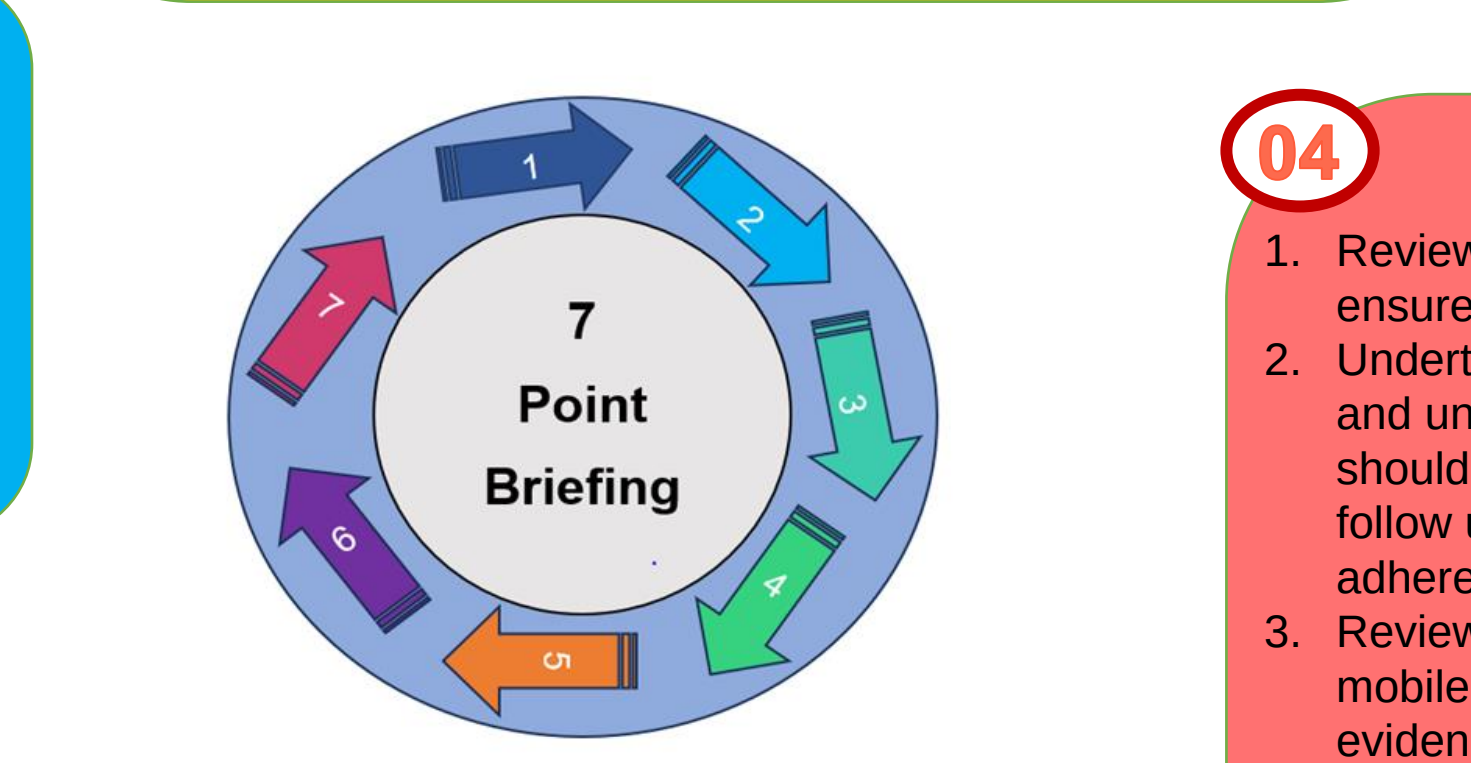
[ICON](#) is about helping people who care for baby's cope with crying. The website has resources for parents and professionals.

[PDSCP Multi-agency Neglect Assessment Tool kit.](#)

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Implementing Change

- Circulate this briefing to agencies and services about the learning from this review.
- An action plan with actions assigned to agencies sits alongside each recommendation and is monitored through the safeguarding partnership and includes quality assurance activity to see if changes have made impact on practice.



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Recommendations

1. Review the Pan-Dorset Non-Mobile Infants Protocol to ensure clear terminology and the actions required.
2. Undertake a multi-agency audit of babies 6-months and under attending A&E with any injury. The audit should include agency response, risk assessment, follow up, appropriate codes/alerts added and adherence to Pan-Dorset Non-Mobile Infants Protocol.
3. Review the Pan-Dorset training offer in relation to non-mobile babies and include how learning can be evidenced.
4. Produce and circulate a briefing to practitioners for non-accidental injuries in babies.
5. UHD to consider implementing a standardised risk assessment tool for triaging children attending A&E.
6. Review ICON (Parenting programmes to cope with infant crying) across maternity, health visiting, primary care and Children's Social Care.
7. Undertaken an audit on decision making and outcomes in strategy meetings, child protection conferences and child in need cases.
8. UHD should review their current systems in order to promote attendance of Paediatricians at child protection conferences.
9. A multi-agency response to identifying neglect through the use and understanding of shared assessment tools.

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Recommendations (cont)

9. Multi-agency Task and Finish Group to review the current knowledge and practice of tools used then establish an agreed approach to effectively identify neglect.
10. The Child Death Overview Panel (CDOP) to raise the delays in forensic post-mortem results as part of the national reporting system and within the annual report to include perceived lack of experts used for these reports.
11. Local Police and Pathologists should agree a protocol to prioritise the processing of post-mortem results, especially when there is an element of risk known such as another child in the household.