1. Background

A 4 month old child sustained non-accidental injuries, including a rib fracture.

The child's parents were separated and their had been domestic abuse within their relationship.

It is unknown who caused the injuries as there was a large pool of people who could have caused the injury.

2. Warning signs

During an initial assessment for mental health support during pregnancy, mum disclosed that when dad was frustrated he “would hit things” but never got aggressive with her.

This was shared with mums GP and Midwife however there was no further exploration of this other than routine domestic abuse questioning, which was always denied.

3. Traumatic Birth

The birth was very traumatic, with mum having a major obstetric bleed and being taken to theatre.

Counselling and support was offered to both parents immediately following this.

However on leaving hospital the following day it was clear they were still struggling, a referral was made for mum for further support.

8. Information Sharing with GP’s

The family all shared the same GP practice however it appears that they did not know that mum was due to be discussed at Multi Agency Risk Assessment Conference.

GP records are incongruent of information shared by other agencies in the Rapid Review. There was no mention of the traumatic birth or the impact this had on mum or dad.

Shropshire Safeguarding Community Partnership

4. Unseen Men & Unconscious Bias

Whilst mum was referred for extra support, dad wasn’t even though professionals knew he was also struggling with his emotions.

Dad was present at most of the post-natal visits but he was not spoken to.

When the injuries occurred dad and his parents were spoken to by police before mum.

7. Cross Border Working

The family lived closest to a hospital that was outside of Shropshire and therefore the child was taken there for treatment. The Rapid Review identified:

- Childrens social care had difficulty contacting the ward so contact was made with a safeguarding lead, this was not passed on
- The referral to social care made by the ward was not followed up with a Multi Agency Referral Form

6. Following Procedures

The Regional Child Protection Procedures regarding Injuries in babies and children under 2 is clear about the roles and responsibilities of different agencies.

The incident happened out of hours, however procedures should still have been followed. A strategy discussion did not take place for 36 hours after the initial contact.

5. Delay in Referrals

The referral that was made for mum for support following the traumatic birth was delayed because the referrer did not attend a multi-disciplinary meeting to discuss it.

This left mum with a period of no support and exposed a child to unnecessary risk.

Dad was not offered any support

Injuries in a four-month-old

Learning Briefing

May 2024