



## Learning Brief Rapid Review – Baby JC September 2023

A multi-agency review was carried out 16<sup>th</sup> February 2022

(The period under review (13/03/21 – 21/01/22))

### Background

JC was a 10 week old baby taken into care following repeated visits to hospital due to concerns over non blanching skin marks and physical presentation which subsequently were suspected to have been sustained non-accidentally.

### Learning Themes

#### 1. Curiosity and Holistic Assessment

There is a picture of professionals offering good support but doing so in response to the specific issues raised at specific times. There is a need to improve professionals' ability and knowledge of the importance of gathering and considering a holistic view of a child/young person's and family's needs. Agencies need to review the capacity, recording systems and practice standards so that all services can be proactive in their support when vulnerabilities are identified.

#### 2. Invisible Fathers

Father's mental health was described as "not so stable". He was still taking anti-depressants for depression and anxiety and although he had tried to stop this medication, he subsequently restarted after seeing his GP in October 2021. He was also known to be accessing counselling. No agencies understood the impact of his anxiety and depression on him, his parenting capacity or his relationship

#### 3. Continuum of Need - A Graduated Response to Need

It was noted within the review that not all agencies are confident or clear on how to support families to access early, preventative support either by an enhanced universal offer such as linking families to their local Children's Centre for groups and parenting support/advice, or through referral to Targeted Early Help, known as Family Wellbeing in North Somerset.

#### Good practice points

- The non-mobile baby protocol is has been updated and is embedded in practice within the Emergency Department at Bristol Royal Hospital for Children. This guidance enables good communication for timely checks between the Emergency Department, Children's Social Care and Police.
- There was a Named Midwife and continuity of care during the pregnancy. Low mood was recognised and enabled conversation about mother's mood through pregnancy. Support with breast feeding led to mother making several contacts to seek support for Joseph's health needs.
- The Health Visitor saw the mother and gave additional advice on feeding. A Patient Health Questionnaire (PHQ) was completed.
- The strategy discussion happened quickly, within hours of the referral, and was well represented, including the GP, and was effective in ensuring Joseph's safety.
- Appropriate discussion occurred between hospital and community paediatric teams regarding his initial presentation and planning of investigations and discussion as to why the skeletal survey was cancelled. The Health Visitor also had this information and contacted Children's Social Care to ascertain if JC was referred or known.
- The Health Visitor saw JC for his 6-week check after the first admission to hospital and recorded that she weighed him naked, and no bruises or marks were noted. She also emailed Children's Social Care to see if he was known or allocated and if there would be any involvement.
- In respect of the first admission, the GP acted swiftly once they had reviewed the images sent by the mother to request the child attend hospital urgently.

#### 4. Suspected Non-Accidental Injury in Non-Mobile Babies

The Review noted clearly that the guidance for managing the presentation of non-mobile babies with suspected NAI is well known and embedded into practice in all agencies. The guidance process to ensure checks are completed worked well.

#### 5. Clinical Decision making and recording rationale and Consultant oversight

The consideration of requirement for a skeletal survey to inform the understanding of JC's non-blanching marks were met with reassurance of a clear rationale based on clinical decision making and proportionality. The impact on a young baby being exposed to radiation unnecessarily is also a very relevant point to consider. However in making this decision it was evident that the hospital records were not as clear as they should be. It is important that there is absolute clarity about such decision making and that this is clearly documented and shared with all agencies where appropriate