**Learning from Rapid Review on physical harm and neglect:**

This summary highlights the key learning points from the rapid review for a non-mobile baby who was taken to hospital with multiple fractures, indicating the baby had been harmed on at least three separate occasions over several weeks.

This baby was under child protection planning for neglect pre and post birth and several services were supporting the family at the time. Prior to these serious injuries, there were no known medical concerns, and the baby was reported as healthy and meeting all developmental milestones.

**Key findings:**

## In summary the main findings of this review were:

* Mother’s additional needs and experience of trauma were not considered when planning and assessing her ability to parent, both before and after baby was born
* Mother repeatedly sought attention from emergency services whilst self-reporting that all was well to others. This behaviour was not understood as a means of communication by the partnership
* Concerns were shared by the housing provider regarding baby’s home environment, parenting and the male carer in his life. An anonymous referral was also made to the NSPCC, but did not appear to impact on decisions made in the child protection planning process
* There was a need to thoroughly assess and clearly understand the roles of the three men who were influencing the lives of the mother and baby, which did not occur
* Practitioners were too optimistic within the safeguarding partnership about mother’s ability to live on her own and take care of her child
* The COVID-19 pandemic measures impacted on working and decision making for the baby and mother, i.e. assessment undertaken online, limited direct content

**Themes in common with other Oxfordshire case reviews:**

* The importance of thorough and detailed planning and assessment before and after birth
* Understanding how trauma affects behaviour and seeing behaviour as a way of communicating
* Acting upon information being shared and received by the partners involved to inform and manage risk
* Being aware of and assessing the roles of fathers and other men in the family
* Being professionally curious

**Themes in common with national reviews**

* Assessing risks and providing support for the whole family
* Ensuring professionals working with children, especially those under 1 year old, involve and assess fathers and male carers meaningfully
* Recognising and addressing the vulnerabilities of babies
* Considering parents’ mentalhealth and their ability to care for their children

**Strengths in practice**

* The social worker advised that baby must be seen by medical professionals due to his vulnerabilities, as part of the child protection response

**Learning Points for practitioners and managers**

* It’s important to plan thoroughly for birth to consider the needs, risks, and potential harm to an unborn baby, especially if there are concerns about the parents, partner or family
* Assessments should consider any known additional needs, risks, protection factors, and personal history to help with current safeguarding plans
* Understanding behaviour as a way of communicating that something is wrong, being curious and working together across the partnership to understand what was happening for mother at this time
* Using a trauma-informed approach: Mother had additional needs and experience of trauma, which wasn’t fully recognised in planning and decision-making
* Being cautious about being too optimistic, even if one risk decreases, other risks might still be present
* A multi-agency chronology could have helped understand baby’s life, showing patterns and important events, and sharing information among involved agencies
* More attention should have been given to assessing mother’s partner and understanding the roles, responsibilities and impact of the men in baby’s life to consider any risks to baby
* Considering community-based support when discharged from CAMHS so that mother had consistency in the support being provided
* Whilst many meetings have moved online since COVID-19, some meetings are more supportive in person and should have been considered in this case

**Key messages for the safeguarding system**

* The importance of multi-agency core group ensuring that ongoing actions to carry out parenting assessments are completed and used to inform and evidence decisions made

**If you do one thing……**

Make sure assessments and safeguarding plans consider each family member’s needs, who is involved in the child’s life, protective and risk factors, and personal history. Give equal importance to all information/concerns shared

**Did you know? The following links offer useful further information and guidance:**

* [Pre-birth assessment practice guidance](https://www.oscb.org.uk/documents/pre-birth-assessment-guidance/)
* [Single and Multi-Agency Chronology Practice Guidance 2021](https://www.oscb.org.uk/wp-content/uploads/2021/02/Single-and-Multi-Agency-Chronology-Practice-Guidance-Final-2021-1.pdf)/[MAC 7-minute guide 2021](https://www.oscb.org.uk/wp-content/uploads/2021/02/7-minute-guide-MAC-Feb-2021.pdf)
* [The Seven Golden Rules for Info Sharing](https://www.oscb.org.uk/wp-content/uploads/2019/07/The-Seven-Golden-Rules-for-Info-Sharing.pdf)
* [Protocol for management of bruising in pre-mobile babies/children](https://www.oscb.org.uk/documents/protocol-for-management-of-bruising-in-pre-mobile-babies-children/)
* [Understanding and working with CAMHS – digital copy](https://www.oscb.org.uk/wp-content/uploads/2022/11/Understanding-and-working-with-CAMHS-Digital-version.pdf)

**Please share the learning from this summary in your teams, discuss in your team meetings and supervision, and make sure you are familiar with the relevant tools and guidance.**