

The purpose of serious child safeguarding case reviews, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children. They should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account. Sharing from the learning of these reviews is vital for all practitioners to reflect on to ensure practice is continually evolving in the best interest of children, young people and families.

## Introduction

Child H (Henry) was a 19-week-old non-mobile baby admitted to hospital with seizures and found to have bilateral sub-dural haematomas and retinal haemorrhages, suspected to be non-accidental injuries. Earlier, at 4 weeks, Henry had been admitted with a fractured femur, and at 17 weeks, seen by a GP with a bruise on the temple. Following the incident, both parents were arrested, and interim care orders were put in place for Henry and his siblings.

The review identified substantial learning and led to updates in local safeguarding practice.

## Context

- The family's background was marked by complex health, mental health, and safeguarding needs, requiring coordinated multi-agency involvement.
- There were multiple children in the household, and risks were not confined to Child H.
- The case was subject to a Rapid Review and a Serious Case Review (SCR) due to the complexity and significant multi-agency involvement.
- The case underlined the importance of holistic assessment, robust information sharing, and the need to consider the wider family network in safeguarding planning.

## Areas of Good Practice

- **Prompt multi-agency response:** Ambulance, hospital, and safeguarding referrals were made quickly when Henry presented with injuries. Police and Children's Social Care carried out joint enquiries, including home visits.
- **Appropriate escalation and referral:** Safeguarding referrals were made at key points, and strategy meetings were convened when child protection concerns were identified.
- **Thorough investigation:** Child protection medicals, CT scans, and multi-agency assessments were undertaken following significant incidents.
- **Learning from previous incidents:** Agencies referenced and built upon learning from earlier safeguarding reviews and serious incidents, demonstrating a commitment to continuous improvement.

## Areas for Development

- **Missed opportunities for multi-agency assessment:** After the initial femur fracture, a strategy meeting was not convened, and the paediatrician's opinion that the injury was accidental was accepted without wider multi-agency scrutiny.
- **Incomplete information sharing:** Health professionals did not always have access to the full GP record, and not all relevant information was shared between agencies.
- **Safety plans not robustly multi-agency:** Safety plans focused on practicalities (e.g., father's mobility) rather than wider safeguarding risks and were not always shared with all professionals involved.
- **Over-reliance on single agency opinion:** Paediatrician's opinions were sometimes taken as fact, rather than as one part of a multi-agency assessment.
- **Delayed recognition of non-accidental injury:** Earlier signs (e.g., bruising in a non-mobile baby) were not always escalated as per guidance, missing opportunities for earlier intervention.
- **Siloed working:** Some agencies worked in isolation, and escalation procedures were not always followed when concerns persisted or professionals disagreed.

To make a safeguarding referral about an adult or child call: 0300 121 3 121

Get in touch

If you have any further questions, or requests for additional resources or training please email us at [nyscp@northyorks.gov.uk](mailto:nyscp@northyorks.gov.uk)

## Recommendations (Updates to Actions already completed are in Bold)

- **Second Reporting of CT Scans for Child Protection:** Establish if Royal College of Radiologists (RCR) guidelines recommend second reporting of CT scans for child protection and ensure this is implemented. RCR guidance confirmed; local providers to implement second reporting for both skeletal surveys and CT head scans for child protection cases.
- **Multi-Agency Information Sharing:** Agencies must always seek information from both the GP and Health Visiting service, not assume one health agency has all relevant information. Guidance updated and training provided to ensure minimum information is sought from both sources in safeguarding cases.
- **Paediatrician's Role in Safeguarding:** Paediatricians should provide opinions, not definitive conclusions, on unwitnessed significant injuries and clarify when other causes are possible. Reminders and training for paediatricians to clarify the limits of their opinions in safeguarding contexts.
- **Health Visitor Evidence and Record Sharing:** Health Visitors should clarify the evidence base for their opinions, including records accessed and frequency of contact with the family. Health Visiting services have improved record templates and are providing additional training on holistic assessment and information sharing.
- **Formal Child Protection Medical Reports:** Every Child Protection Medical should result in a formal report, not just when high risk is suspected. Paediatricians across North Yorkshire reminded of this requirement; guidance to be followed as per RCPCH standards.
- **Strategy Meetings for Unwitnessed Injuries:** For unwitnessed significant injuries to non-mobile children, a multi-agency strategy meeting must be convened, regardless of possible accidental explanations. NYSCP Child Protection Procedures to be reviewed and updated; training for all agencies on the importance of strategy meetings.
- **Safeguarding Response to Bruising in Non-Mobile Children:** Maintain a high index of suspicion for safeguarding concerns when bruising is found in non-mobile children; referral to Children & Families Service should be made. Practice guidance reviewed and strengthened; Level 3 safeguarding training for GPs updated.
- **Safety Planning for Suspected Non-Accidental Injury:** Safety plans should include all individuals who could have had access to the child during the period of suspected injury. Children & Families Service to routinely implement comprehensive safety planning.
- **Support for Parental Mental Health and Coping with Crying:** Pregnant women with a history of low mood or post-natal depression should be referred to specialist peri-natal mental health services; all new parents to receive ICON information on coping with infant crying. New peri-natal mental health service launched; ICON information distributed to all new parents in North Yorkshire.
- **Early Help and Information Sharing in Primary Care:** When primary care has concerns about a family, information should be shared with midwifery and health visiting to develop an Early Help plan. Early Help Strategy launched; GP training updated to support information sharing and timely support.

Actions and recommendations will be reviewed as part of the NYSCP Practice & Learning Subgroup meetings

## Questions for Reflection

- Are cumulative risk assessments routinely completed and shared in your service?
- How do you ensure that safety plans are genuinely multi-agency and robustly monitored?
- What mechanisms are in place to challenge or escalate concerns if you disagree with another agency's assessment or plan?
- How do you ensure that the wider family network is considered and engaged in safety planning?
- Are all relevant professionals consistently invited and enabled to contribute to safeguarding meetings?
-

## What to do now

- Consider the questions for reflection in your team meetings and think about how the learning can be embedded into practice.
- Familiarise yourself with the additional resources and information, and promote across your teams.
- Share your learning and the key messages with your colleagues.

Further partnership Audits and Safeguarding Reviews can be accessed [here](#).

NYSCP learning events can be assessed [here](#):

[Pre-recorded learning events can be assessed on the NYSCP YouTube Channel.](#)

## Resources & Further Information

[All NYSCP practice guidance can be accessed here.](#)

- <https://northyorkshirescp.trixonline.co.uk/chapter/children-of-parents-with-mental-health-problems>
- [#AskMe... have the Conversation](#)
- [Managing Different Professional Perspectives and Mutual Challenges \(Including Professional Resolutions\)](#)
- [Professional Curiosity](#)
- [Information Sharing](#)
- <https://www.cafcass.gov.uk/>
- [Children & Families Practice Guidance - Assessments](#)
- [Voice of the Child Practice Guidance & Toolkit](#)

[Learning from other Safeguarding Practice Reviews can be accessed here.](#)

## Get in touch

To make a safeguarding referral about an adult or child call: 0300 121 3 121

If you have any further questions, or requests for additional resources or training please email us at [nyscp@northyorks.gov.uk](mailto:nyscp@northyorks.gov.uk)