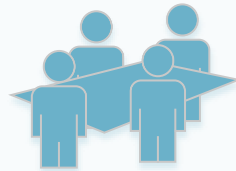
South Gloucestershire Children's Partnership
Practitioner Learning Brief
SCR: Baby E&F March 2020

Background Summary

Towards the end of 2018, a six week old baby was taken to hospital, described as "pale and floppy." Examination of the baby showed that she had suffered serious head trauma considered to have been caused by violent shaking. The brain injuries are likely to have caused permanent damage and lifelong disability. This baby is known as Baby E and is twin to Baby F. During further examination both children were found to have historical healing fractures. There is an older child who was 2½ years old when the twins were born. The sibling had started nursery just before the twins' birth and the nursery staff had no concerns about his well-being or development and had not observed anything unusual in the parent/child relationship.
The family were known to health professionals, the GP, Midwifery and Health Visiting, they had not come to the attention of Children's Social Care or the police.

Learning



7 organisations Involved took part in the review

Baby E&Fs family were invited to take part in the review but chose not to

The Learning:
The learning from this review comes from the detailed analysis of practice with an independent reviewer and focuses on:
- Abusive head trauma (AHT) and how it can be prevented;
- The impact on parenting of multiple births, parental anxiety and additional vulnerabilities which arise from multiple births;
- Working arrangements between Midwifery and Health Visiting, both at a strategic and operational level.

The full SCR has been published and you can read it by clicking this circle

Find the Information Sharing Advice here

Recommendations
- Consider a public health campaign to promote awareness of AHT informed by current research into how AHT can be prevented and what existing resources and strategies are available including those specifically aimed at fathers and male care givers.
- Ensure that commissioners and managers are evaluating the impact of the Health Visiting Transformation Programme and outcomes for children particularly with regard to assessment.
- Consider how to improve professional relationships to enable agencies, particularly Midwifery, Health Visiting and GPs, "to offer help and support in an integrated way."
- Consider the significance of multiple births and whether there should be an enhanced information sharing protocol or service delivery;
- Seek assurances that the introduction of electronic records has a positive impact on safeguarding practice.

What is happening Now?
The findings and recommendations are being considered collaboratively by the relevant health commissioners and providers who will develop an action plan and report to the Children's Partnership Executive. This is happening jointly with the SCR Toby.
The Children's Partnership Executive will monitor the progress of the SCR action plan.