7Minute Briefing

BABY EVA

Critical Events

This review considers Baby Eva, who was admitted to the A&E with a spiral fracture at four months. Subsequent examination revealed multiple fractures of different ages. Baby Eva was placed in police protection while her parents were investigated, which led to her father being identified as a 'high risk' perpetrator via the MARAC process.

Key Lines of Enquiry

1. Assessment of the impact of previous learning from similar cases.
2. The impact of systems on the quality and response to information sharing / seeking.
3. Responding to information about fathers and their connected children.

The report identified the following themes:

- Ineffective information sharing / seeking
- History of violence and risk not adequately informing assessments
- Missed opportunities for early intervention
- Non-accidental injuries
- Parental engagement and non-compliance
- Professional intimidation

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CROYDON SAFEGUARDING CHILDREN PARTNERSHIP

Good Practice

The following good practice examples show how a thorough and integrated safeguarding process can enhance the quality of care, by highlighting the importance of holistic assessments and multi-agency collaboration.

- **Rapid Response at A&E Department:** The team acted quickly and effectively to protect Eva from a potentially life-threatening situation. They communicated with partners to instigate a strategy meeting, conducted a swift medical examination, with minimal impact on other families. The medical report and other evidence supported the need for legal intervention to ensure Eva's safety. The team's positive efforts deserve recognition and appreciation.

- **Multi-Agency Risk Assessment Conference (MARAC) Involvement:** MARAC assessment of Eva's father as a high-risk individual from a previous relationship, shows a proactive approach to managing domestic violence concerns and ensuring the safety of family members.

- **Historical Context Consideration:** The consideration of both parents' historical involvement with services provides insight into potential risk factors and allows for tailored intervention strategies.

Findings

Key Line of Enquiry 1.

The Impact of previous learning from a similar case. The report highlights systemic failures in safeguarding responses but acknowledges a robust process during Baby Eva's hospital presentation. Effective multi-agency communication and timely medical assessments led to swift safeguarding measures being put in place. However, there's a call for ongoing assurance and improvement in information sharing to ensure earlier intervention. For example, in this case pre and post birth hospital interactions where concerns about Father's presentation were not shared.

Key Line of Enquiry 2.

The Impact of systems on the quality and response to information sharing / seeking. An assessment of the systems found challenges that affect safeguarding, particularly across different boroughs. The lack of integration of electronic records and reliance on manual sharing hinder timely risk assessments. Aggression from Eva's father at the birth hospital, didn't trigger a safeguarding referral, nor was the information shared with the home GP/Health visiting service. Staff turnover and pressures add to difficulties. Improved systems and consistent sharing and seeking information are crucial for effective safeguarding.

Key Line of Enquiry 3.

Responding to information about fathers and other connected children. Professionals had partial information about Eva's father, hindering a comprehensive risk assessment. Despite visibility, he wasn't adequately assessed. Inadequate coding in GP records and lack of protocol for sharing father-related information reduced the visibility of risk. Father's history and its impact on parenting weren't fully considered, impacting risk evaluation. Effective risk assessments requires improved coding, robust assessment practices and, recognition of paternal history, especially where adverse child experiences are apparent.

Improving Practice

- Prioritise learning from past reviews and improve understanding of non-mobile infant vulnerability.
- Develop innovative approaches for information sharing / seeking despite system barriers.
- Include male care-givers in assessments, considering their unique histories.
- Acknowledge the impact of Baby Eva's injuries on professionals and encourage open discussions.
- If a parent shows signs of aggression or threats towards staff, this should be evaluated as a potential risk and addressed accordingly. Staff who are affected by such behaviour should receive adequate support and guidance from the management.

The CSCP will implement and track the suggestions from this review. To access the complete LCSPR Report, please follow this link.

www.croydonlscb.org/LCSPR