Child T was taken to Hospital in June 2023 by her parents and was diagnosed with a fractured arm. This was unexplained. A further healed fracture seemed to be visible as well .

Brief History of Child T her family and this case.

- An Afghan family, comprising mother, father, two older male siblings (at the time 6 and 10) and another older female sibling. (4 at the time)
- Child T is now two (was one at the time of the incident).
- The Hospital referred the matter to Children's Social Care (CSC), a strategy meeting was held and the child remained in hospital overnight.
- The parents denied they were responsible for the injury(ies)
- The siblings, interviewed alone, did not report any safeguarding concerns.
- Child T was placed with a maternal aunt.
- Harrow Council made a referral to the National Panel and the Harrow Partnership conducted a rapid review , which described additional learning issues.
 - The National Panel agreed with the recommendations as to further learning

Child protection medicals and related issues

- CP medicals were declined for the injured child's siblings by the paediatricians as they believed them not to be justified. There was poor communication concerning this decision between professionals. An audit of CP medicals has been conducted. Better communication will ensue and a new protocol has been agreed.
- The second healed fracture x ray was reviewed by another clinician and his view was that it probably was not a fracture. That issue was not settled, but did impact on the final decision to return the Child T to the family.

Recommendations

- Ask for change the London Child Protection Procedures to explain Police / Crown Prosecution Service Practice
- Ensure that educational establishments have a holiday duty system
- Improve IT connectivity for health visitor /school nurse records.
- Audit MASH cases where early support is refused.
- Paediatricians invited to strategy meetings
- An updated CP medical protocol.

Other safeguarding Issues and the refusal of early support Prior to Child T coming to notice Child T's siblings had been the subject of safeguarding incidents. On each occasion the family had been offered a package of early support. On each occasion it had been refused.

- 1. In 2019 the younger male sibling was seen with a red mark on his face at nursery, which he said variously that his mother and brother had caused.
- 2. In 2021 the three older siblings were reported as playing unsupervised in a road. Further the girl sibling (3 at the time) was reported as behaving in a sexualised way.
- 3. January 22 the younger male sibling reported that his mother had slapped him. His sister said that she has been slapped as well. At the time the mother was pregnant with Child T

Good practice

- 1. The nursery acted quickly and reported the matter
- 1.1 The family received a quick home visit from CSC
- 1.2 The family were offered a package of family support
- 2. The Police attended and gave the family advice
- 2.1 A health visitor followed up with a visit
- 2.2 There was an offer of early support
- 3 The Partners responded effectively to this incident
- 3.1 there was a thorough family support and another offer of early support.

Gaps in service

- MPS did not treat the red mark as an ABH, because of a difference between police investigation and CPS charging thresholds.
- The street play incident happened in the school holidays. Information from the nursery was not available.
- The midwifery service dealing with the Child T pregnancy did not access the siblings' health records; this is due to the complexity of the IT systems for each provider.
- School nurses and health visitors find it hard to access each others' IT records due to a poor IT interface
- The paediatricians did not attend the rapid review.