Lessons Learned and practice pointers

- A strategy meeting should always be convened where a child is injured as a result of a domestic violence incident.
- GP checks must be carried out in all cases where a S47 is initiated. This should include asking the GP for information regarding the parents or caregivers.
- All professionals must challenge decisions made and escalate concerns if they believe a child may be at risk of significant harm – a copy of the escalation procedure can be accessed via the web http://northumberlandlscb.proceduresonline.com (Chapter 2.7)
- It is important that all those present at appointments are recorded in order to monitor potential issues of coercion and and control that can be factors in domestic abuse.
- All agencies should follow up contact with children's services within 24 hours for Child Concern Notifications (CCN) / Domestic Violence Notifications (DVN)and any other type of contact/referral submitted for injuries to immobile babies, where there has been no subsequent contact from children's services.
- An Initial Child Protection Conference must be held when any child, particulaly an immobile baby, suffers an injury as a result of being caught up in domestic incident between his/her parents or caregivers. This will enable a formal multi-agency Child in Need or Child Protection Plan to be put in place to help keep the child safe from future harm.
- Where there is a written agreement in place this must be reviewed and included in the review must be the extent to which the parents are engaged. Where possible, a joint visit should be carried out by social worker and health visitor to reaffirm concerns and to draw up or revise a written agreement.
- All self-harm incidents require urgent referral to mental health services – http://northumberlandlscb.proceduresonline.com (Chapter 1.4.33)
- All teenage pregnancies should be discussed in a 'supporting families' meeting within a GP practice setting. These meetings should include GP, midwife, school nurse and health visitor. The aim of this meeting is to share information and to form a supportive team around young, vulnerable families. This may highlight issues not shared previously at maternity appointments and may also address the issues of unnoticed fathers.
- GP practices should ensure good communication and information sharing with midwives and school nurses
- Maternity assessments and Health Visitor assessments should be complete and include information regarding both parents, including background/history. Where it is not possible to receive all of the information, this should be revisited before 28 weeks gestation. If father is not able to attend the antenatal appointment, written consent should be obtained for his information to be recorded and shared with professionals when required.
- Where 'corporate booking' clinics are the practice, a copy of the level 1 form should be available for review by the midwife conducting the clinic
- Where safeguarding concerns are are highlighted by nursery nurses/staff nurses when carrying out home visits, these concerns should be discussed with Health Visitor and a plan of action agreed.
- Midwives should inform parents of the dangers of shaking a baby and rough handling, prior to discharge from the postnatal ward. This should include strategies for dealing with crying babies – a leaflet has been produced and will be given out to parents

Details have been changed to protect the identity and privacy of family members and professionals involved in this case.

For more Information contact: Steve Day, Safeguarding Standards & Quality Assurance Manager. Email: steve.day@northumberland.gov.uk
Telephone: 01670 623980

Keeping Children and Young People Safe from Harm, Abuse and Neglect

Northumberland Safeguarding Children Board

Highlighting Lessons from Management Review

Local

Date of Review: November 2013
Local Authority: Northumberland
Name: John

Outline

John is the first child to his young mother. The identity of his biological father was unknown at the time of the incident but mother has since shared the name of the man whom she says is the baby's biological father. During the pregnancy mother began a relationship with a new partner. At the time that John's injuries were sustained, John and his mother were living at the home of maternal grandmother. It is unclear whether mother's partner was also resident there, as he had an alternative address in a neighbouring authority.

John was 3½ months old when an incident of domestic violence occurred within the family home between mother and her partner that resulted in John sustaining an injury to his head. Mother's account of the incident, to the ambulance service, was that John was cradled in her arms when the violence occurred. John was not transferred to hospital by the ambulance service, but a referral was made to children's services and police were contacted and attended the scene.

Children's services became involved following the referral and the (Acting) Designated Doctor examined John the following day, a CT scan was taken of his head and a skeletal survey undertaken, both of which were normal. A Section 47 enquiry was undertaken. There was no Strategy Meeting convened during this process and the case was opened as a 'Child in Need'.

Two weeks later John was admitted to hospital with serious head injuries, bilateral retinal haemorrhages and seizures. Mother and her partner provided two explanations for these injuries; however the opinion of the Consultant Paediatrician involved is that John's injuries are more likely to have been caused by excessive shaking.

Summary of Findings

The services made available to mother and her partner should have been much more robustly informed by earlier multi agency information sharing; for mother's partner from his childhood history and for mother from her much more recent involvement with GP, EWO and mental health services. The recognition of John's vulnerability was therefore inadequate. When the first incident occurred the safeguarding investigation was not timely, did not put proper safeguards in place nor seek the information necessary to conduct a meaningful assessment of risk. Multi agency liaison with GP's is absent from this case, where critical information was held on mother and her partner. An injury to an immobile baby was not sufficient to ensure that all relevant information was shared, in order to safeguard effectively.

Lessons for this management review are highlighted within the Ofsted thematic report (Ages of Concern 2011) under 'recurring messages' (for babies under the age of 1). Some of the lessons are relevant to this case:

- the risks resulting from the parents own needs were underestimated, particularly given the vulnerability of babies
- there had been insufficient support for young parents
- the role of the fathers had been marginalised
- practitioners underestimated the fragility of the babies

Social workers and other practitioners need to understand the significance of family history and the impact has on parenting capability. Workers should be informed of the dangers of 'start again syndrome' and should read and understand the themes and messages from the Ofsted report 'Ages of Concern' – http://www.ofsted.gov.uk/resources/ages-of-concern-learning-lessons-serious-case-reviews