Hartlepool & Stockton-on-Tees SAFEGUARDING CHILDREN PARTNERSHIP

1 Context

Three month old Alex was taken to hospital twice in the same day; firstly following a reported choking episode and secondly with seizures. The baby was later diagnosed with a subdural haematoma (bleed on the brain) and a healing rib fracture, which were concluded to be non-accidental injuries.

2 Background

•The parents and older sibling were already known to a number of agencies, having received early help support for financial difficulties and risk of homelessness. A further social work assessment had been completed following a domestic abuse incident.

•During the single assessment, Mother disclosed that there had been unreported domestic abuse in their relationship in the past when Father had on one occasion pushed her and on another kicked her. She stated that he also sometimes struggled as Sibling could be difficult to feed, and that he had once 'force fed' Sibling.

•Following assessment, the case was closed to CSC, with the parents stating that they did not wish for further support via child in need but with the agreement that Father would attend counselling sessions. Once completed, work would be undertaken with Harbour. (This did not happen).

•Sibling had been previously taken to either the Urgent Care Centre (UCC) or Accident and Emergency (A & E) on 17 separate occasions. On five of these occasions, when Sibling was between 6 months and 11 months old, a head injury or a report that he had bumped his head was either the primary reason for the visit or spoken about during the visit. None of the attendances were considered a safeguarding concern, either due to physical abuse or lack of supervision.

•When Alex was born, the support being received by the family was largely universal and those involved had no concerns.

3 Findings

1) Information sharing and communication between agencies – seeking, clarifying, verifying and analysing.

The parents in this case were likable and plausible. They came across as open and honest and as having a loving relationship with each other and with the children. Regardless of what is being seen, professionals need to ensure they triangulate what parents are saying by establishing the facts, gathering evidence, and communicating well with all involved. There is a need for all professionals to have a conscious and healthy scepticism. It is important that professionals share information and communicate to ensure that they do not solely rely on parental self-report.

2) When a case is closed to Social Care, clarity is needed regarding what should happen if any concerns emerge or if the family do not continue to cooperate with any agreement made at closure. This should include the midwifery service if there is a pregnancy.

In this case, it was agreed that the couple needed to complete individual counselling before they attended domestic abuse support. There was no agreement at the end of Social Care involvement regarding if and how attendance should be monitored and what should happen if the parents did not attend.

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3) The cumulative impact of parental risks and vulnerabilities should be considered in assessments and when working with a family.

There are factors in a parent's background which can potentially present a risk to a child. These include issues that were evident in this case, such as domestic abuse, parental mental health, adverse childhood experiences, young motherhood, and estrangement from the new mother's own parents. All of the cumulative vulnerabilities were not considered alongside the current concerns to form a working hypothesis of risk.

4) The cumulative impact of any incidents or concerns should be considered. This requires information sharing and peer discussion, effective systems for reviewing any notifications, and reflective supervision.

The review has found that while none of the injuries which prompted sibling's attendances at A & E appeared to be suspicious, ACHILD was not completed following all of the presentations and therefore there was no opportunity for them to be considered for any pattern. When there are a number of issues over time it is important to a child to consider whether there is a safeguarding issue emerging, for example rough handling or lack of supervision. While none of the injuries in themselves were likely to have met the threshold for a child protection intervention, consideration of the wider picture would have been helpful, along with looking at the incidents together to consider if there were cumulative concerns. This will not always be possible in an acute setting, so there is the need to ensure that those in community health services are aware of the attendances.

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5) At the point of closure, Information should be shared with those continuing to work with the family, including midwives, if there is a pregnancy. Any new information that emerges, including further anonymous allegations, should also be shared.

Two anonymous referrals were received which were said by Mother to be malicious in nature. The information shared and decision made was not communicated with those who were continuing their involvement with the family however, such as the health visitor, the midwife or the GP. A new baby was due, and research shows that domestic abuse can increase when a woman is pregnant. This means that the midwife was particularly key. She would be seeing Mother through her pregnancy. As the midwifery service had not been involved at the time the safety plan was drawn up at closure, they may not have been aware of the plan, and they were not informed that a new referral had been made. They were therefore potentially working with the family without the benefit of knowing the history and vulnerabilities. If the case is not yet allocated to a midwife, information should be shared with the safeguarding nurse for the midwifery service if a pregnancy is known or suspected.

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6) GP information should be considered as part of a strategy discussion and additional information sought as part of the assessment.

The GP was not spoken to during the S47 investigation following the domestic abuse incident, despite Mother and Father having lived elsewhere and the GP records being the only likely place where relevant background information was available. GPs should always be consulted to inform a strategy discussion and subsequent investigation/assessment.

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7)Strategy discussions should always include consideration of whether siblings require a Child Protection Medical as per the Tees Child Protection Medical Procedure.

While there were no concerns for Sibling's health at the time of the serious incident, it was important to the investigation and their wellbeing to see if Sibling had any injuries.