D19

01

Background

D19s older sibling was living with their maternal grandparents on a voluntary child arrangement order. The mother was struggling to cope due to her mental health. At the time of the order being made she was pregnant with D19.

02

Safeguarding concerns

A referral was made to Children's Social Care advising that D19s sibling was living with his grandparents due to his mother's poor mental health impacting upon her ability to care for him. Concerns were shared regarding her ability to care for the unborn child. The referral suggested that a pre-birth assessment be considered.

03

The incident

D19 was taken by his Mother to the GP for his immunisations and the medical practitioner noticed a haemorrhage on their eye. The mother could not give any suitable explanation as to how it occurred. A Child Protection Medical revealed 3 broken ribs and also a fracture to the top of right leg as a result of non-accidental injuries.

04

The review

The review looked at the;

reasons why a pre-birth assessment was not completed

quality of recording and information sharing by partner agencies

level of support that was provided to the mother and whether that was good enough

05

The findings

The triggers to initiate the pre-birth protocol are not clearly understood and are not consistently applied.
Important safeguarding information was not always shared from one partner agency to another.
A lack of connectivity between different parts of the safeguarding system meant that the mother did not receive the support that she needed. Specifically this was between;

- the MASH and Mental Health Services
- Early Help Services and MASH (due to I.T. systems)
- The Early Help Panel (due to a process gap and error)

regular safeguarding updates help practitioners to stay up to date with current issues and alert to the signs of abuse and safeguarding procedures to follow.

06

Recommendations

- All partners would benefit from a refresh on the triggers for a pre-birth assessment so that they can initiate their own early help assessment, make a referral to Children Social Care and/or be in a better position to professionally challenge decisions.
- The 7 minute briefing on Information Sharing should be revised and re-circulated to all partner agencies so that information that can help partner agencies safeguard children is shared in accordance with good practice principles.
- Any agency that identifies that parental mental health needs are impacting on parenting capacity needs to share that with other partner agencies working with the family so that information can be triangulated and an appropriate response agreed.

07

Implementing Change

Reflect on the findings and discuss the implications for your service/practice. Identify and outline the steps you and your team will take to improve practice in line with the findings and recommendations.

Tameside Safeguarding Children Partnership

D19 - Action Plan

Name of Organisation .....

Team Manager .....

Name of Section & Team .....

Contact Details .....

Identify the learning or recommendations that are relevant to your team and summarise your teams' discussion on those points

1.

2.

3.

Tameside Safeguarding Children Partnership

Please ensure you keep a copy of this discussion and plan for your records. Tameside Safeguarding Children Partnership will ask teams to provide evidence of the discussion, agreed actions and for evidence of improvements to practice.

D19 - Action Plan

What actions have been agreed to improve practice?

What needs to happen?	Who will do it?	By When?	How will you know when it has been done?	How will you know if it has worked?

Tameside Safeguarding Children Partnership

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