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.

07

06

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

team will take to improve practice in line with the findings and recommendations.

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.

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04

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D19

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;

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.

· the MASH and Mental Health Services

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

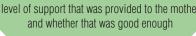
The review looked at the:

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









07 7 Minute 03 Briefing 04 05

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.				



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?



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.