Safeguarding Children in Stockport

7MB – Baby S

7-minute briefings (7MB) are intended to be simple and quick to read, teams can use them within meetings as a team-based learning exercise.

How did we Review?

A rapid review panel meeting was held with key partners and agencies. Whilst this case did not meet the criteria for a Child Safeguarding Practice Review, learning needed to be shared. A second panel meeting was held to include more agencies and information from another Local Authority to identify the learning. Following the panel meetings learning circles will be held to disseminate learning and this briefing will share learning more widely in the partnership.

Background

Baby S was known to Children's services prior to her birth. Her mother fled domestic abuse perpetrated by Baby S's father early in the pregnancy, initially moving into a women's refuge within Stockport from another area.

Baby S's mother had experienced childhood trauma, finding her own mother after she had completed suicide, and later being subjected to physical abuse and sexual abuse. She has a condition which causes chronic pain for which she takes medication. She told her health visitor that she may be addicted to the pain medication. She also had depression.

Baby S's father had a history of violence, substance abuse, and was on the sex offender's register. He had experienced childhood trauma. He was released on license at the time Baby S was born. His licence expired a month prior to the incident.

Incident

When Baby S was 6 months old her mother asked Children's social care to assess the father. This was to check he was safe to see Baby S. Shortly after this she stopped working with services, failed to attend appointments for herself and Baby S, stopped taking her medication and attending the Freedom Programme. At 9 months old Baby S was taken to hospital with a significant fracture to her arm, health professionals then identified she had a further injury - a healing rib fracture thought to have been caused up to 6 weeks prior. Both injuries were deemed to have been inflicted upon baby S. Baby S was removed from her parents' care and lived with foster carers during the investigation.

Findings - Childhood trauma and the impact on parenting

It is important to recognise that having a new baby is difficult under typical circumstances and with lots of good support, however when a new mother is isolated and vulnerable with additional medical and mental health needs, then this requires increased attention and support. In Baby S's case support was provided within the Team Around the Child process. The mother was accessing mental health support; however, the case was stepped down at the time the incident happened. It was optimistic given the release of the father from prison. Shortly after stepdown, appointments were missed and there was attendance at hospital by the mother for pain along with other warning signs. A multi-agency professionals meeting at this point would have brought the information together. There is learning on how services support traumatised, vulnerable, and isolated young parents.

Findings - Transfers between areas

In this case the mother moved between areas fleeing domestic abuse. This led to gaps in knowledge about the mother's history. For example, although the triage report noted she had been a looked after child, this was as a brief line and was not explored further. We need to consider how we seek historical information that would be pertinent to the current situation, assessment and to consider how this may affect mental wellbeing and/or parenting capacity. Additionally, in this case we may have been less optimistic of the risk the father posed to the mother and that he would see her and his child out upon his release. Had agencies been aware of the history and rape allegations, understood the background and history of those involved in Baby s's life, the intervention may have been different. It should be noted that on transfer within hospitals the responsibility lies with the receiving hospital to contact the previous provider and request any pertinent information when high risk safeguarding issues have been identified.

Findings - Communicating the role of the Father

Adult facing services had knowledge of the father and his history. The way information is communicated between Adults and Children's services should be considered. In this case there were issues related to not accessing information of the father and the risk he posed.

Additional Learning

Additional learning from the case included the importance of accurate recording processes, in this case there was a delay between information being gathered from visits and it being recorded on to systems.