01

Background

Child H was a twin who lived at home with mum, dad and sibling.

Mum had previously had four children removed.

Mum met new partner and had a child who following pre-birth assessment was living with mum and dad.

Mum became pregnant with twins when sibling was 2 years old.

Midwife contacted children's social care who said had no concerns at present and did not do another pre-birth assessment. Twins went home with mum and dad after 8 weeks on the neonatal ward.

02

Safeguarding Concerns

The threshold for a pre-birth assessment was not adhered too.

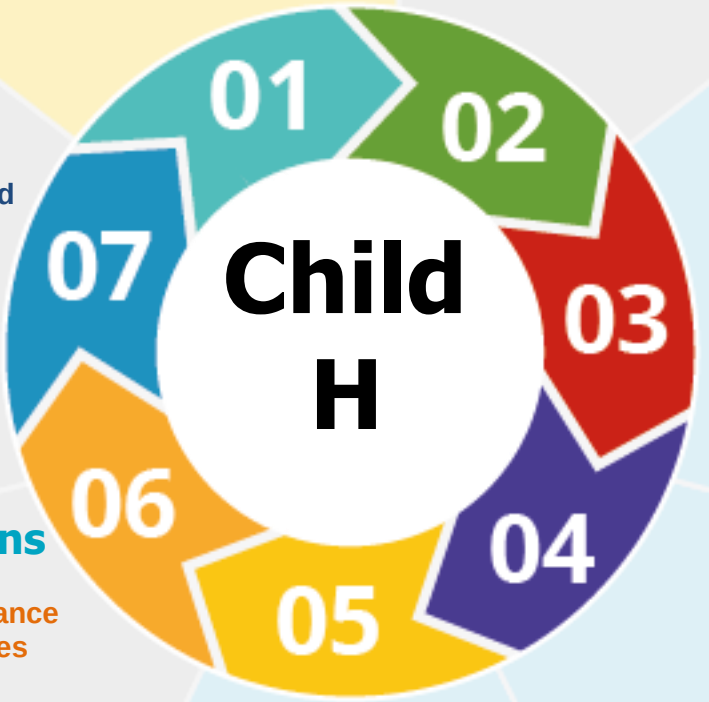
A lack of understanding regarding the impact of having premature babies in an already stressful household

A lack of knowledge regarding the stressors that can increase the risk of parents shaking babies.

03

The Incident

Child H was a twin born, prematurely, in September 2014.
Child H was admitted to hospital age 11 weeks, following a 999 call made by the baby's father.
MRI and CT scans indicated that the injuries to Child H were consistent with abusive head trauma (possibly caused by shaking).
Child H and siblings were placed under Police Powers of Protection,
Child H was left with disabilities following the incident.



07

Implementing Change

Reflect on the findings and discuss the implications for your service/practice

Outline the steps you and your team will take to improve practice in your area.

Recommendations

LSCB should seek assurance that when partner agencies undergo organisational change, the risks to safeguarding practices and processes have been considered and fully assessed.
Pre-birth assessments are understood.
Ensure all information is shared about families where there are risks identified.
LSCB should consider whether it is confident that the criteria and procedures for instigating pre-discharge meetings are robust and well understood.

06

The Findings

No record of the contact with children's Social Care on record.
Partner agencies unaware of the detail in the pre-birth assessment procedures.
All partner agencies unaware of the risk factors that are associated with abusive head trauma.
Professionals are more likely to consult with other staff members than look at procedures if they are unsure what to do.
Discharge meetings should always consider potential safeguarding risks in line with abusive head trauma.

The Review

A Serious Case Review was held, the aim of which was to 'identify any lessons to be learn that could improve practice and systems.

The review made recommendations to the LSCB to be shared with staff and an action plan was developed.

Oldham Local Safeguarding Children Board

05

04