

1 Background and Concerns

Child 10 and 11 were siblings, both under the age of two. The case spanned across two local authority areas. Mother had involvement with CSC in another area as a child, both parents were very young. Father had a history of physical violence. The younger child sustained a bite to the cheek at 4 weeks old and the older child three separate injuries including a fall and to pulled elbows.

2 Purpose of the Review

- Rapid review undertaken following the submission of a serious incident notification to the national practice review panel by Children's services.
- Purpose to identify immediate action needed to ensure children's safety, consider potential for identifying improvements to safeguard and promote the welfare of children.
- Decide next steps including whether or not to undertake a child safeguarding practice review.

3 Key Lines of Enquiry

- Were parental vulnerabilities/ history known or taken into account by agencies
- The differences between the use and recording of medical information in respect of childhood injuries between CSC and NLAG
- Whether the children's lived experience was known or understood to agencies
- Were all S47 strategy discussions in line with Working Together 2018

7 Further information

- ❖ [Bruising in children who are not independently mobile](#)
- ❖ [Graded Care Profile 2](#)
- ❖ [SCP Training](#)
- ❖ [Line of Sight process](#)
- ❖ [Threshold of Need](#)
- ❖ [Referral Process](#)
- ❖ [SCP Policies & Procedures](#)



4 Key Practice Episodes

Expected good practice

- Police protection taken appropriately.
- Interim Care Orders sought by Children's Services within 72 hours of the Police protection being made.
- Clear planning of how best to safeguard the children is recorded and was executed in a timely manner to safeguard the children

Areas for improvement

- Late transfer in to NEL health visiting services by other area
- The hospital records of the injuries lacked detail and context
- Deficiencies in communication and information sharing between NLAG and Children's Services in respect of the consistency and terminology of medical information in respect of injuries.
- Child's lived experience not understood by involved agencies

5 Learning

- Assurance needed there is a clear process for notification of pregnancies from NLAG to Health visiting services and records to ensure ante natal visits take place
- Supervision to A&E staff to include clarity and the need for professional curiosity, query diagnosis of injuries and clear recorded detail of the mechanics of the injury
- Following referral to CSC, police where potential non accidental injuries, a strategy discussion needs to be reconvened after the medical examination and for the paediatrician who undertook the medical assessment/ to attend.
- The Transfer processes for Health Visiting services to ensure young people who are parents are identified and includes assessment of additional vulnerability and required support

6 Progress/Impact

- An action plan has been developed and implemented.
- The health visiting and school nurse transfer process has been reviewed in ensuring historic risk factors are conveyed to the receiving area
- The Hospital safeguarding medical guidance has been revised to ensure the paediatrician that undertook the safeguarding medical or their deputy attend the strategy discussion
- A standard operating system has been developed to resolve any blockages in information in respect of pregnancies between the midwifery and health visiting services
- The need to capture the context and mechanics of childhood injuries has been reinforced through hospital training and supervision