Seven Minute Guide Panel Case

01 Background

Mother and her son moved into CE with the son being on a child protection plan due to domestic abuse concerns regarding mother and a previous partner. Transfer in CP Conference outcome - a child protection plan was not required as the move had increased the child's safety, and a period of child in need planning was put in place with case closure a year later.
Social work assessment due to concerns about domestic abuse, alcohol misuse and mother's deteriorating mental health

02 Safeguarding Concerns

Health visitor concerned that the baby's head appeared enlarged.

Initial GP examination didn't identify signs of trauma

15 days latter child seen at A&E and admitted after ultrasound scan

07 Implementing Change

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

03 The Incident

Subdural haemorrhage and retinal haemorrhages is abusive head trauma, although there is evidence of two bleeds of different ages, this is not necessarily indicative or two incidents.
During this period AL had been cared for by both of her parents and also by extended family members as the relationship between the parents became more problematic

06 The Recommendations

- Develop and implement a process for the sharing of all anti-natal information between Cheshire East Health Services and Hospitals in the surrounding areas where mothers opt for delivery elsewhere.
- Assurance is sought that the process for Midwifes accessing EMIS has been fully implemented and is effective.
- Standard information sharing protocol is developed for accessing GP records by health partners and implemented.
- A process is devised and implemented that ensures information discussed at GP safeguarding meetings is shared with midwives and health visitors.
- GPs are informed when a child is subject to a S47 assessment.
- Practitioners should be briefed on the relevance of the Toxic Trio to their ongoing assessments and interventions.
- Self-reporting of the involvement of other services should be followed up to understand the implications for the current situation.
- Seek assurance that the development to improve multi-agency contributions to strategy meetings is having a positive impact.
- Ensure there is Health provision at CHECS that can access health records and provide that information to the strategy meeting process.

05 The Findings

Good practice was identified –
There was child protection planning at the earliest point for the child concerns were identified and weight was given to relevant history
Decision making around the medical – the GP spoke to grandmother on her own to test potential child protection concerns
The health visitor pursued concerns and outcomes for the child
The Social Worker was proactive in having a conversation with paediatrician.

04 The Review

A Case Panel Meeting was conducted by Cheshire East Safeguarding Children Board. The review focused on the

1. Cross border working in multi agencies
2. Information sharing
3. Interrogation of your own case notes
4. Are we over reliant of self-reporting?
5. Strategy meetings

Cheshire East Local Safeguarding Children Board

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