Learning Review Report

Amelia

Amelia lived with her mother and older half-brother. As an unborn baby, Amelia and her brother were previously subject to Child Protection and Child in Need Planning due to concerns related to domestic abuse, poor home conditions and neglect. The children's Child in Need Plan ended three months prior to Amelia's birth in October and no issues or concerns were raised by any agencies working with the family. However, there were incidents of Amelia not being brought to routine health appointments, and one minor incident of Amelia's father harassing her mother's previous partner but neither raised safeguarding concerns nor required onward referral to Children's Services.

The relationship between Amelia's mother and father had ended before her birth.

The relationship between Amelia's mother and her previous partner had resumed prior to Amelia's birth. In the following January they separated but both remained living in the family home.

A male family member was also living in the home at this time and was reported to be sleeping on the sofa and helping with jobs in the home.

Following the separation of Amelia's mother and her previous partner, concerns were raised regarding verbal arguments and escalating aggressive behaviour between the adults in the presence of both children. A referral was made into the Multi-Agency Safeguarding Hub and the Police were requested to visit the family home.

During this visit, Amelia's brother disclosed that his mother's previous partner had previously hit him on the face which had left a red mark. This was witnessed by Amelia's mother and both children were placed on a Child in Need Plan.

From January to March, the previous partner of Amelia's mother was thought to be providing the majority of care to both children until he moved out.

Amelia's mother was reported to be in a new relationship, following her previous partner moving out of the family home. Amelia's mother was engaging with professionals as part of the Child in Need Plan.

In late March, during a routine health visitor appointment, Amelia's mother reported low mood and that she was pregnant, and her new partner was the father.

A scheduled Child in Need Review meeting took place in April, and this was extended to include the unborn baby.

In late May 2019, Amelia was presented to the Emergency Department with an arm injury. Following further examination, Amelia was found to have multiple injuries. No explanation was given by the adults for the injuries. Amelia's injuries were considered to be non-accidental, and a Section 47 investigation was commenced.

Amelia's mother was latterly charged for child cruelty. The supporting investigation highlighted that the adult family member who had been living in the family home had continued to reside at the home in exchange for him undertaking most of the care for Amelia and her older brother.

Learning Point One:

HSCP has previously published and promoted online practitioner-based toolkits to support working with unidentified adults and adopting a family approach. HSCP to consider the re-promotion of these and other toolkits as part of its work to improve communication with agencies.

Hampshire Children's Services and Southern Health Foundation Trust to re-share both toolkits directly with front line staff and ensure both are included in training for newly recruited staff and trainees.

Children's Services to continue with their existing work under their transformation programme to seek internal assurance on the implementation of agreed tools and policies.

Learning Point Two:

HSCP to include a reference in future audits of multi-agency practice to review agency record keeping and ensure that records are clear what information has been shared by service users, and what information has been passed to other agencies for further action.

Learning Point Three:

The understanding and use of agreed escalation routes have featured in other learning reviews and audits of practice undertaken by HSCP.

HSCP to:

- Develop a short briefing guide that partner agencies can share with staff in staff training and briefing sessions.

- Include information on escalation in either of the 2020 rounds of Regional Practitioner Briefings

- Request that all external trainers reference the agreed escalation protocol in all HSCP training.

Learning Point Four:

As part of existing audits of practice and peer review programmes, HSCP to continue to seek assurance that the voice or perspective of the child is included in case files and safety plans.

Learning Point Five:

HSCP to share the learning from this case with all its external trainers to inform its ongoing multi-agency training programme.

HSCP to share the learning of this case in its next round of Learning Lessons sessions.

HSCP to publish this case in both the 'Understanding Unidentified Adults' and 'Adopting a Family Approach' toolkits.

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