



Case Review executive summary

March 2004

Introduction

This is a summary of a serious case review by the Area Child Protection Committee (ACPC). It was undertaken following concerns that an eight-week-old child had suffered life-threatening injuries, to the extent that it was originally feared she might not survive. The purpose of the review is to examine ways that child welfare agencies worked together in the management of the case and to identify lessons that might be learned in improving inter-agency arrangements locally for safeguarding children's welfare.

Review

Serious case reviews have become one of the key aspects of ACPCs' activity nationally in improving inter-agency collaboration in this area of work and in promoting better-informed practice.

This is the 30th case that Staffordshire ACPC has reviewed in these circumstances over the past ten years. It is the fourth such case involving twins or triplets.

The scope and detail of conducting serious case reviews is set out in chapter 8 of "Working Together to Safeguard Children" (1999), published by the Dept of Health and others: www.tso-online.co.uk

Case Summary

This eight-week-old child had been admitted to hospital in 2002 because of injuries that were originally thought to be the result of poor parenting. On the following day, however, the child's condition deteriorated. She was admitted to a paediatric intensive care unit where further assessment revealed severe shaking injuries to the brain.

A subsequent skeletal survey undertaken on the twin sister revealed healing rib fractures that were thought to be at least six to eight weeks old. There had not however been any previous concerns for either of the children. Though born prematurely, they had made good progress in neonatal care and they were discharged relatively early to their parents' care. The family was not previously known to Social Services.

The children's father was subsequently charged with serious offences relating to the child (ren)'s injuries. Both children became the subject of care proceedings by the local authority. Parents then separated. Though initially placed with foster carers, the children were subsequently returned upon directions of the court to their mother's care.

Lessons Learned

1. Detailed “history-taking” by clinicians and by social workers remains an important feature of assessing parenting capacity and in diagnosing serious head injuries in young children.
2. Research evidence shows that serious head injuries (including shaking injuries) in children under two years of age are often preceded by the child sustaining minor episodes of bruising, especially to the face or trunk.
3. The association between child maltreatment and multiple births is also well established in contemporary literature. Problems are often associated with premature birth and with practical difficulties that parents have with bonding.
4. This has implications for all agencies in providing supportive services to families following a multiple birth.
5. Diagnosing serious head injuries in young children remains a challenge for doctors - given the evolving pattern of symptoms - though the association with hypothermia should not be overlooked.
6. Re-evaluating risk is a continuous process in safeguarding a child’s welfare particularly in establishing that a child is “safe”.
7. Determining that extended family members necessarily provide the best alternative option in caring for a child should always be the product of an informed assessment and of any appropriate review.
8. In making and taking referrals about safeguarding children’s welfare, staff should be clear about the scope and findings of any initial assessment(s) that might have already taken place and of any other action that may need to be considered.

Recommendations

- That ACPC explores the scope for developing a better understanding of the association between hypothermia and shaken baby syndrome. This is being progressed by ACPC’s health sub-committee.
- That ACPC progresses work already under way concerning
 - a) the use of Police Protection Powers. Staff’s Police intend to report to ACPC by May 2004.
 - b) auditing local arrangements for the discharge of vulnerable children from hospital in the wake of the Laming Inquiry. All acute hospital Trusts who treat Staffordshire Children are contributing to this work.
 - c) better-informed assessment and management of risk. ACPC will be generating further initiatives.
- That local hospital Trusts should record parent-child interactions where there are concerns for the health or needs of a child, or following an “at risk” pregnancy.
- That education and training initiatives reinforce:
 - a) making and taking effective referrals
 - b) the routine assessment of siblings in safeguarding children’s welfare.
 - c) the need for clarity in invoking child protection procedures, particularly via strategy discussions/meetings.

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