



# Case Review Executive Summary

October 2008

## INTRODUCTION

This is a summary of a Serious Case Review undertaken by Staffordshire Safeguarding Children Board (SSCB) following the presentation of a baby in May 2008, aged six weeks old, to an Accident and Emergency Department in the county with potentially life threatening injuries. Four days earlier the baby had been taken to the same hospital department by it's parents with a head injury.

The baby had, according to available evidence, suffered a potentially life threatening injury, potentially as a result of abuse or neglect and, therefore, in accordance with Working Together to Safeguard Children, 2006, Para 8.2, it was agreed that a Serious Case Review would be undertaken in order to examine interagency practice and information sharing and learn lessons.

This Executive Summary provides an overview of:

- the Case Review process
- the circumstances of the baby and it's family
- lessons learnt from the Case Review
- recommendations for action by the Staffordshire Safeguarding Children Board.

Findings of the review have been reported to the Office for Standards in Education (OFSTED) as is required. The review was completed within statutory timescales.

Information in this report has been anonymised including references to the gender of the children.

## **CASE REVIEW PROCESS**

The process of the Review was managed by the Serious Case Review Panel which is made up of members from the SSCB. The SSCB is made up of all public agencies working with children and families in the county and some voluntary organisations. This includes, for example, Children and Lifelong Learning Services, Staffordshire Police, Health Agencies and Education.

Each agency who provided a service to the baby and it's family were asked to undertake a review of their involvement called an Individual Management Review (IMR). This involves producing a report and chronology of involvement. Independent Overview Report Authors were appointed by the Panel to produce an Overview Report pulling together all information from the IMRs. The baby's parents were involved in the process and met with the Authors of the report. The Overview Report analysed all the information including information from the parents and produced lessons to be learnt and recommendations for action. A clear focus on the needs of the baby and it's sibling was maintained throughout the process.

## **FAMILY BACKGROUND**

The baby's parents are married and also have a pre-school child. The family live in privately rented accommodation and have moved a number of times.

The baby's father has received a variety of psychological and counselling services including medication, for mental health problems over many years. He had at one point expressed concerns about the impact of his mental health on his wife and child to a mental health professional. His medical history was not known to practitioners providing maternity and health visiting services to the family.

## **OUTLINE OF EVENTS LEADING TO THE SERIOUS CASE REVIEW**

The baby was taken by it's parents to an Accident and Emergency department with a bruised eye. The parents reported that the baby had banged heads with it's father's head. This was recorded as a minor injury. A doctor examined the baby's face and head and provided a leaflet on head injuries. The family and the baby were then sent home. There is no record that advice was sought from a paediatrician or consultant on call prior to discharge home.

The Health Visitor made a routine home visit three days later where the parents explained about the visit to the Accident and Emergency department and the Health Visitor recorded bruising around the left eye. The Health Visitor recorded the injury as consistent with the explanation and also recorded that the baby was reported to be unsettled.

The baby was re-admitted to the same Accident and Emergency department after a 999 call to the Ambulance Service by the father the following day. Subsequent examinations indicated haemorrhaging behind the eyes and also indicated two or three fractured ribs. The opinion was expressed that these injuries may be non accidental and a referral was made to the Vulnerable Children's Division of the Children and Lifelong Learning Directorate.

The baby was discharged from hospital 16 days later and placed with foster carers while enquiries and assessment were ongoing. The baby's sibling was placed with extended family to ensure that their welfare was safeguarded while enquiries were taking place.

## **ISSUES ARISING FROM THE REVIEW PROCESS**

The issues that stand out as areas of concern in relation to interagency working and safeguarding children are:

- That a full examination did not take place at the first hospital visit and procedures relating to bruising in infants under six months old were not followed.
- That previous Serious Case Reviews had already made recommendations about the response of health professionals in relation to injuries in children under six months old.
- That there was no system of communication from the hospital to the Health Visiting service or vice versa to share information. (A Paediatric Liaison Service to address this has now been implemented).
- That checks made by the Vulnerable Children's Division to find out the involvement of other agencies with the family were not as thorough as they should have been which meant that they did not identify the father's medical history.
- That the sharing of information between adult mental health services and services that work with children and families did not take place.
- That the joint police and social work enquiries did not receive a consistent medical opinion to assist decision making about the risks to the baby and their sibling.
- That the parents found most professionals supportive but felt let down by discussions about them, by professionals, taking place on an open ward.
- That the Review found some examples of good practice such as the West Midlands Ambulance Services' system to follow up call outs to children.

## LESSONS TO BE LEARNT

In the research report *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn?* (Brandon et al, 2008)<sup>1</sup>, an analysis of Serious Case Reviews between 2003 – 2005, it states in the Findings in the Executive Summary:

*In two thirds of the reviews the children died and in a third the children were seriously injured. As in other studies of serious case reviews, almost half of the children were under the age of one year. Many of these babies had non fatal injuries (often head injuries).*

**Practice note:**

*Staff working with young babies and their families, particularly midwives, health visitors and GP's have a key role in safeguarding children.*

**The learning point** for the Staffordshire Safeguarding Children Board in relation to injuries to young babies and for medical staff is that policies and procedures must be adhered to.

Another Key Finding of the research report states (page 7):

*The families of very young children who were physically assaulted (including those with head injuries) tended to be in contact with universal services and adult services rather than children's social care.*

The related learning point is the need for effective information sharing and communication between Adult Mental Health services in health agencies and social care agencies across the county where services are being provided to an adult caring for a child or children. Additionally practitioners undertaking checks as part of a Section 47 (Children Act 1989) enquiry should understand the need to establish the involvement of mental health services with parents, and any other key adult service providers, as such information could be of significant importance to the decision making assessment, and safeguarding of children.

The challenge for the Staffordshire Safeguarding Children Board will be to implement the lessons learnt at the local county level in line with the recommendations and the Action Plan, as it is a key lesson that previous Serious Case Review recommendations had not effectively been implemented at all levels within agencies in the delivery of training, in the implementation of procedures and, therefore, in practice.

The outcome of this Serious Case Review as with all Serious Case Reviews nationally, as noted in the research, must include a regular effective audit of

<sup>1</sup> Brandon, M., Balderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J. and Black, J. (2008): *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn? A Biennial Analysis of Serious Case Reviews 2003 -2005*, University of East Anglia

the Action Plans and recommendations of all past Serious Case Reviews to ensure that no areas are overlooked or forgotten in the training of staff in all agencies or in the practice and services delivered in all agencies.

### **KEY RECOMMENDATIONS FROM THE REVIEW**

- That all staff in constituent Health agencies, and in this case, the specific hospital Trust, should regard any bruising in a child who is non mobile or under six months of age, as suspicious of being non accidental until proven otherwise. This would generally be by carrying out a multi-agency child protection investigation.
- That all training programmes for health and interagency courses, and specifically the training programme delivered to Accident and Emergency staff, reinforce the implication of bruising in non mobile babies or those under the age of six months.
- That all Vulnerable Children's Division staff who undertake lateral checks (checks to other agencies) are briefed that it is essential to check with all agencies who provide services to adults as well as children. Additionally that the Assistant Directors of the Vulnerable Children's Division put in place a programme of regular audit to monitor that this is incorporated into practice, supervision and case decision making.
- That all member agencies of Staffordshire Safeguarding Children Board and Staffordshire and Stoke-on-Trent Safeguarding Vulnerable Adults Board have a point of reference to the guidance on information sharing from their internal agency procedures to the Safeguarding Children Board Procedures regarding Information Sharing.
- That Staffordshire and Stoke-on-Trent Safeguarding Vulnerable Adults Board receive a copy of the Executive Summary and a briefing on this Serious Case Review in order to share the lessons learnt. Additionally that a request be made to them to review their constituent agencies training needs and strategies in relation to practitioners who provide services to adults who are parents or carers of children, in relation to identifying safeguarding concerns.
- That Staffordshire Safeguarding Children Board provide training in relation to information sharing to be targeted to managers in member agencies of Staffordshire Safeguarding Children Board and Staffordshire and Stoke-on-Trent Safeguarding Vulnerable Adults Board.
- That the representatives on Staffordshire Safeguarding Children Board for Staffordshire Police, Children and Lifelong Learning Directorate and Designated Doctors develop a mechanism and protocol to facilitate communication in relation to medical opinions requested in relation to a

Section 47 enquiry. The Designated and Named doctors should provide a point of contact which co-ordinates medical opinions and medical reports within clear timescales in all cases.

- That the Staffordshire Safeguarding Children Board undertake a review of all recommendations of Serious Case Reviews which have taken place four years prior to the establishment of the Staffordshire Safeguarding Children Board Serious Case Review Sub Group to ensure that appropriate actions have been taken to implement the recommendations.

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