

SERIOUS CASE REVIEW

Executive Summary

for

SUNDERLAND SAFEGUARDING

CHILDREN BOARD

In respect of

Child D

Contents

Page

1.	Introduction	3 - 4
2.	Summary of Information	4 - 6
3.	Lessons to be learned	6 - 7
4.	Recommendations	8 - 9
5.	Recommendations from Single Agency Reports	9 - 12

1. Introduction

- 1.1 The overview report to which this summary relates was commissioned by the Serious Case Review subgroup of the Sunderland Children Safeguarding Board in October 2008. It follows the serious injury of child D, then aged five months, in June 2008.
- 1.2 The circumstances surrounding child D's injury satisfied the criteria for convening a serious case review and Government Office North East (GONE) was notified of the decision to hold a review in June 2008. Some delay has been caused by difficulties in gaining permission for the release of medical records of key individuals.
- 1.3 The sub-group was chaired by a senior detective who was involved in the early investigations surrounding child D's injuries.
- 1.4 The report has been compiled in accordance with Chapter 8 of Working Together to Safeguard Children 2006 which requires the Review to:
 - Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
 - Identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result
 - As a consequence, improve inter-agency working and better safeguard and promote the welfare of children
- 1.5 The Terms of reference for the Review were:
 - To review agency involvement with the family from 22.03.05 to 02.06.08, the latter being the date of the initial contact with the family following the injury to child D which led to the review.
 - To consider family involvement with all key agencies including universal and specialist services
 - To consider the effectiveness of communication between agencies including those with a primary focus on adults and those providing services for children
 - To consider the ability of planned and responsive services to effectively recognise and manage issues of need and risk including the ability to recognise parenting issues
 - To consider the appropriateness of agency responses to a previous injury suffered by child D
 - To consider the effectiveness of agencies in accessing historical information, which may have impacted on parenting ability
 - The report is based on information provided by single agency reports from the following agencies:
 - Health - Lead agency Sunderland Teaching Primary Care Trust (PCT) including Child Health records and GP records
 - A Management Report from Gateshead Health NHS Foundation Trust

- Sunderland City Council Children's Services
- Sunderland City Council Health, Housing and Adult Services
- Northumbria Police-Sunderland Area Command (this included an Appendix produced by National Probation Service Northumbria)

2. Summary of Information

- 2.1 Child D is the only child of his father, (25 years) and mother (26 years), his mother has another child, child D's half brother. At the time of his injury child D was living with his mother, father and half brother.
- 2.2 Child D's mother and father formed a relationship early in 2007 and mother became pregnant shortly afterwards; the pregnancy was unplanned. Both father and mother came from families where domestic violence was a feature of their childhoods.
- 2.3 Mother had a history of depression and had moved house because of complaints from neighbours about noise and poor standards of housekeeping. Prior to the period under review, mother had been referred for counselling after self harming following a miscarriage but attended only once.
- 2.4 Child D's maternal grandmother was well known to health services and the Police because of her alcoholism; several attempts to help her detoxify were noted. The Police were called out on numerous occasions because of disputes between maternal grandmother and her son, child D's uncle. He was known to have anger management problems, worsened by his use of drink and drugs. Both grandmother and uncle stayed with child D's mother from time to time.
- 2.5 Child D's father had been subject to Child Protection Procedures when he was less than a year old after being assaulted by his father. Child D's father has a history of violence and aggression and as a youth, was diagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD). He was known to Sunderland Social Services and the Youth Offending Services intermittently between the ages of 11 and 16 and was also known to the Police prior to the period covered by this review.
- 2.6 Child D's father visited his GP early in June 2007 in an attempt to get help with his irritability, anger and depression. He was referred to the Primary Health Care Team where he was seen by a Community Psychiatric Nurse (CPN), who noted that he had a history of emotional and psychological abuse. No risks were identified and he was discharged. He was referred to a specialist drug and alcohol service because of his chronic dependence on cannabis which he said was causing problems in his relationship.
- 2.7 He returned to the GP practice in December 2007, again asking for help with his temper; on this occasion he told the GP that he was to become a father. He agreed to a further referral to the Primary Health Care Team and an assessment appointment took place in January 2008. Father told the CPN that his anger had worsened since he stopped using cannabis and a treatment plan was agreed. He missed his first two appointments and was finally seen by a CPN in May 2008, mother and both children accompanied him to this appointment. The issue of domestic violence was raised and father was advised to see his GP.

- 2.8 Mother had been treated at Accident and Emergency (A&E) at the hospital in May 2008 for an injury to her nose and wrist saying she had been assaulted by a stranger, this account was unchallenged. She has since said that child D's father caused these injuries.
- 2.9 Mother was known to the health visiting services from the time of the birth of her first child. Shortly after he was born a health visitor was shown two small purple marks on his arm but no investigation was carried out.
- 2.10 From November 2007, a health visitor began to visit the family and put a plan in place to address some of the problems that had been identified. Subsequently mother proved reluctant to accept the health visitor's proposals and their relationship was strained at times. A housing tenancy support worker had also been introduced the previous year to help mother maintain her tenancy. She formed a good relationship with child D's mother and her help was accepted. There is evidence of some good liaison between the two professionals.
- 2.11 No concerns were identified about the care mother provided for her first child care other than the bruising noted above. Mother sought medical care for him when necessary and complied with advice given by health professionals. In November and December 2007, he attended a crèche at a Children's Centre when mother was taking a cookery course. In April 2008 he began attending nursery and had been to six out of a possible eight sessions prior to the injuries to child D which prompted this review. Although no written information was collected during his attendance, it was said that he did not stand out from other children who attended the nursery.
- 2.12 No concerns were identified about mother's care of child D. He was noted to be thriving by both the health visitor and the nursery nurse who carried out his 12-16 week assessment. The health visitor noted both parents showing emotional warmth to child D shortly after his birth and a nursery nurse commented on the positive interaction between the two brothers and their mother. The housing support worker, who was visiting weekly during the early months of 2008, recorded that mother was very tired and struggling to care for her two children and support her mother through a detoxification programme; there were no concerns about the care of child D or his brother.
- 2.13 At the end of February 2008, the health visitor saw father rocking child D vigorously during her visit, she had also noted his animosity to her on her arrival. She discussed her concerns about father's treatment of child D with mother as father was no longer present, mother agreed to share this concern with father.
- 2.14 Child D was brought to the Accident and Emergency (A&E) Department of Hospital 1 by his parents in May 2008, mother having noticed a swelling to the right side of his head earlier in the day. Mother said there had been no trauma and he was said to be well in himself. He was examined by a doctor who noted an impression of a non-specific swelling and questioned whether it was secondary to trauma; he was discharged to the care of his parents without further investigations. Father acknowledged to the Police at a later date, that he had sole care of him at the time the injury occurred.

- 2.15 Child D was again brought to Hospital 1's A&E Department in June 2008 having again sustained head injuries. He was accompanied by his mother and his older half brother. His father and paternal grandmother arrived shortly afterwards.
- 2.16 The circumstances surrounding the injury were that in June 2008 mother had left both children in the care of child D's father while she took the dog for a walk. Prior to this, mother and father had argued and father was said to be in an agitated state. Child D had been well when she left the house but when she returned she found child D injured and in need of hospital treatment. Father said that he had left the baby alone for a short while to visit the toilet and when he returned found child D had fallen off the sofa and was lying on the floor.
- 2.17 Staff in A&E did not accept that the injuries to child D matched the account given by his father. Child D was admitted to the paediatric ward where he was found to have life threatening injuries and was transferred to another hospital the following day. He was found to have skull fractures, bruising to his brain and brain damage. His injuries were subsequently described by a Paediatrician as consistent with being hit by a motor vehicle at 25mph. Later investigations revealed a small sub-dural haemorrhage at the back of his skull, typical of a non-accidental injury, this injury occurred prior to June 2008.
- 2.18 Child D was discharged from hospital, placed with Foster Parents and then returned to the care of his mother with his half sibling. He is likely to suffer lasting physical and mental impairment as the result of his injuries.
- 2.19 Father has been charged with assaults on both child D and child D's mother and was subsequently convicted of these assaults.

3. Lessons to be learned

- 3.1 The review is primarily intended to consider improvements in practice in relation to professional actions or omissions in the delivery of services; its intention is not to apportion blame. Any review process is based on hindsight and mindful of the information available to agencies at the time. This review, as many others, has identified weaknesses in information sharing and a consequent incompleteness of information available to agencies on which to base their judgements.
- 3.2 There is a particular concern about the failure of medical staff to undertake a full assessment of child D when he attended hospital with a head injury a week prior to the admission to hospital that led to this review. Any head injury to a baby who is not yet mobile should have been investigated thoroughly. No information about this injury was passed to child D's health visitor or GP until after child D's second injury.
- 3.3 There are also concerns about the lack of immediate investigation when child D was brought into A&E on the second occasion. Although his significant injuries were suspected to be non-accidental, he was left untreated in the care of his parents for two hours.
- 3.4 There are concerns regarding the failure of both the Community Mental Health Services and GP's to assess father in the context of his social situation and to recognise the impact of his aggression on the children with whom he was living.

Their failure to recognise the harm domestic violence has on children prevented them from sharing the information with any other service, including those working with the family.

- 3.5 Of concern is the way many of the professionals who have been involved in treating members of this family have limited the focus of their assessment to the presenting problem and solely on the individual seeking help. This was true of the medical staff mother consulted about health problems, the staff working to help maternal grandmother overcome her alcoholism and the A&E staff who treated mother's injuries in May.
- 3.6 There is no evidence that the injuries to child D could have been prevented by the actions of any single agency. Although some shortfalls have been identified, good practice was also apparent; support was provided by the housing support worker and the health visitor made appropriate plans following her initial assessment. However, health visiting staff and midwives who undertook assessments failed to include child D's father and focused solely on mother's ability to care for the baby.
- 3.7 The health visitor had recognised stress factors within the family and had drawn up plans to help reduce these stresses. Mother rejected many of the suggestions and their relationship became strained. This led to a failure to implement the whole plan and a delay in implementing those aspects which had been accepted. Although she had noted father's hostility towards her, she had no other information about his volatility; information had not been passed on by either those professionals consulted by father or the housing support worker when she was told the relationship had become turbulent.
- 3.8 The Common Assessment Framework (CAF) was not implemented in Sunderland until after child D was injured. The time scale for implementation was in accordance with Government guidance which stated that implementation should be completed by 1st April 2008. Had it been in place earlier, a multi-agency assessment may have been introduced and the cumulative effect of the stress factors recognised.

4. Recommendations

4.1 Overview Report

- 4.2 The recommendations and the action plans identified in the single agency reports from Health and Children's Services have been taken into account when making these recommendations; where the matters have already been identified in the action plans, no additional recommendations have been made.
1. All A&E staff must undertake a thorough investigation when a non mobile baby presents with a head injury.
 2. Young Children brought to A&E where a non accidental injury is suspected must be treated promptly and not left unsupervised
 3. Sunderland and Gateshead LSCB's must ensure that in guidance and training the significance of domestic violence where there are children in the household is included and emphasised to all constituent members
 4. Staff working in adult medical settings in Primary Care Trust 2, NHS Foundation Trust 1, NHS Foundation Trust 2 and Mental Health NHS Trust 1, must undertake regular, up to date Safeguarding Children multi-disciplinary training. This expectation should be included in their employment contracts
 5. The significance of domestic violence and the importance of keeping child focussed in the face of adult difficulties must be included and emphasised in all child protection training programmes. This training should also raise awareness of the need for a holistic understanding of children and families and the need to be aware of the way separate factors can interact to cause increased harm
 6. Health Visitors and Midwives undertaking assessments must ensure significant male members in the household are included in these assessments
 7. Individual supervision sessions for health visitors must be implemented as a priority
 8. In view of the fact that some residents frequently use health services in both Area 1 and Area 2, protocols must be developed between Teaching Primary Care Trust 2, Hospital NHS Foundation Trust 2 and NHS Foundation Trust 1 to ensure information regarding vulnerable children is shared in a timely manner
 9. When there is a planned withdrawal of support by Housing Tenancy discussions must take place with other professionals involved with the family to identify the need for continuing support and how this will be offered to the family
 10. To avoid any conflict of interest, Sunderland LSCB should ensure that the chair of the Serious Case Review Panel is independent of any ongoing investigation
 11. The Serious Case Review Panel should ensure that the Terms of Reference are clear and unambiguous and agreed in a timely manner
 12. All single agency review authors must follow the agreed format

13. Sunderland Children's Trust must undertake a training needs analysis as to which staff members should receive CAF awareness raising training.
14. Sunderland Adults Safeguarding Board should undertake a training needs analysis with staff who are working with adults who are parents or caring for children to assess whether CAF training is required

5. Recommendations from Single Agency Reports

5.1 Health Management Report Area 2

In terms of lessons learned a number of areas have been identified for improvement including;

1. Ensure improved information sharing between Midwifery, Health Visiting and GP's
2. Ensure improved information sharing between Mental Health Services, GP's and Health Visitors
3. Ensure improved information sharing between CAMHS and school nursing
4. When clients identify anger management issues/domestic violence to any practitioner, that person must assess the wider implications, share information within their own service, with other involved practitioners and refer to other agencies
5. Ensure Health staff working with adults to complete an assessment of the impact of the adults condition on the children in their care
6. Improved clarity of record keeping with regard to Practitioners name and role
7. Ensure Health staff to follow guidelines and procedures when faced with bruising in a non-mobile baby
8. Ensure Health staff make full use of their assessment tools completing all sections or giving a rationale where this is not possible e.g. the assessment framework and the vulnerability assessment tool
9. Ensure Health staff fully complete the demographics for key family members in records
10. Mental Health services to ensure support packages offered to patients on discharge are shared with GPs and other involved professionals
11. Where an adult is vulnerable, health staff must follow the Sunderland's safeguarding adults policy
12. Where a child is vulnerable, health staff must follow all Sunderland's child protection and safeguarding procedures

13. Ensure improved information sharing between Acute services and Primary Care when a child who resides in one area seeks medical attention from a neighbouring area
14. Sunderland Safeguarding Children Board must request the Department of Health to provide clear and consistent guidance to Caldicott Guardians, for them to fulfil their responsibilities to facilitate information sharing in accordance with the principles of Chapter 8 of Working Together

5.2 Health Management Report Area 1

Training Issues

1. Ensure all front line staff especially in A&E receive timely Child Protection training including the recognition of risk factors.
Action: Named Doctor / Nurse for Safeguarding Children
Priority: Medium
2. Ensure all front line staff receive timely training in the recognition and management of domestic abuse.
Action: Named Doctor / Nurse for Safeguarding Children
Priority: Medium

Documentation

1. In suspected Child Protection cases all discussions with team members and senior colleagues must be clearly documented
Action: Trust Clinical Risk Management
Priority: High
2. The reasons for taking action need to be clearly documented e.g. why was the health visitor being sent a letter? Was this routine or because the doctor was concerned?
Action: Trust Clinical Risk Management
Priority: High
3. Who the history is taken from and who is present in the room should be clearly documented.
Action: Trust Clinical Risk Management
Priority: High

Communication

1. If any doubt is left regarding a child's presentation the doctor and/or the nurse should consider direct communication with the primary care worker to share information in a timely manner and an individual responsible for this should be identified.
Action: Named Doctor / Nurse for Safeguarding Children and Senior A+E Nursing and Medical Staff
Priority: High

2. Checks to the list of children subject of a Child Protection Plan should be considered in all cases where there is doubt. Discussion should be held regarding the advantages/disadvantages of doing routine Child Protection Plan checks on babies attending A&E.

Action: Named Doctor / Nurse for Safeguarding Children and Senior A+E Nursing and Medical Staff

Priority: High

Domestic Violence

1. A&E Policies need to be reviewed in line with Area 1 LSCB Policies to ensure children's needs are considered when women attend casualty having possibly experienced domestic violence.

Action: Named Doctor / Nurse for Safeguarding Children and Senior A+E Nursing and Medical Staff

Priority: Medium

The A&E Clinical Pathway

1. Triage of children attending the A&E department should be undertaken by senior nursing staff with experience of working with children either in the A&E or Paediatric domains.

Action: Senior A+E Nursing and Medical Staff

Priority: High

2. A review should be undertaken of the monitoring of children within the A&E department both of the clinical status of the child but also with consideration to the individuals attending with the child in cases where non-accidental injury is suspected.

Action: Senior A+E Nursing and Medical Staff

Priority: High

3. Discharge of a child from the department should involve the triage nurse to ensure issues of concern at admission have been addressed on discharge.

Action: Senior A+E Nursing and Medical Staff

Priority: High

5.3 Children's Services

1. Children's Services to provide Common Assessment Framework, (CAF) and the role of the lead professional training for all professionals working with children
2. Systems in place to ensure that all Childcare provision are accessing Sunderland Safeguarding Children Board procedures and child protection training
3. Ensure that Children's Centre Crèche provision and childcare providers to complete observation records for all children from beginning of involvement
4. Children's Services to ensure that there is improved use of documentation for referral for Children's Centre targeted services, including Childcare to ensure a

holistic assessment of the child's needs

5. Ensure that allocation meetings in Children's Centres follow a formal agenda taking into account assessment, information sharing, reviewing, monitoring of the services and that a full record of the outcome of the meeting is made. Parental participation should be considered as standard practice and reasons for non attendance recorded
6. Improve and standardise systematic case recording systems across Children's Services
7. Ensure that a sample of Child in Need cases, children attending Children's Centres and nurseries are audited