EXECUTIVE SUMMARY: SERIOUS CASE REVIEW March 2007

INTRODUCTION

This is the Executive Summary of a Serious Case Review undertaken by Somerset Local Safeguarding Children Board (LSCB). The review considered the circumstances of a number of unexplained injuries to the child Child C, who was born on the 1st June 2005. These injuries were judged to be non-accidental. Currently Child C is subject to an interim care order and is placed with foster carers. Legal proceedings are ongoing to decide his future care.

The review looked into circumstances dating from the antenatal period to the time when Child C was 9 months old.

This summary provides:

- A description of the Review process, including contributors to the review.
- A summary of the circumstances leading to the review.
- Key themes and lessons for the future.
- Recommendations for further action.

REVIEW PROCESS

- As required in Chapter 8 of the Working Together to Safeguard Children (2006) guidance issued by the by HM Government, a case review was undertaken to establish a multi-agency overview, incorporating a factual chronology of all the events, to understand whether child protection guidance was followed by individual agencies, what lessons could be learned from the case, and whether there were any ways in which all agencies might be better able to protect vulnerable children.
- The Serious Case Review Panel comprised Senior Officers from key statutory agencies, where that officer had no previous involvement in the case.
- Agencies that had been involved in the care of Child C were asked to undertake Internal Management Reviews and to provide a chronology of their involvement with the family.

CONTRIBUTIONS TO THE REVIEW

The following agencies provided individual agency management reports and chronologies:

- East Somerset NHS Trust – who provided ante and post natal care for Child C and his mother.

- South Somerset Primary Care Trust - who provided Primary care for Child C and his mother.

- Somerset Children and Young People's Directorate - who provided social work services to Child C and his family

- Avon and Somerset Constabulary – who investigated unexplained injuries to Child C

- Avon and Somerset Probation Service – who provided services to one of Child C's parents.

- Bristol North Primary Care Trust – who provided Primary care for Child C when he was temporarily resident in their area.

- United Bristol Healthcare NHS Trust – who provided medical care for Child C when he was unwell.

- Children and Family Court Advisory and Support Service - who represented Child C's interests in family law proceedings

- Foster Care Associates (Western) - who provided a foster placement for Child C and his parents

BRIEF SUMMARY OF THE REVIEW

Child C is the only child of his parents' relationship. The antenatal period was uneventful.

Child C was born prematurely, on 1st June 2005, at 28 weeks gestation, in a local district hospital. He remained in Special Care for a further 8 weeks, latterly for 5 weeks at a District Hospital closer to his home address. He was discharged home on 25 July 2005 in the care of his mother to the maternal grandmother's home. Two weeks later, they moved with Child C's father, to independent accommodation.

Child C was admitted to the Accident and Emergency Department of the District Hospital on the 27th August 2005 with vomiting and decreased movement of his left leg. Child protection concerns were raised at this time, and the emergency duty team social worker was informed the following day that the parents had agreed to Child C remaining on the ward whilst further investigations were made.

Medical investigations at that time concluded that there were no fractures to the leg. This combined with a credible explanation from mother and information from the health visitor that she considered the mother to be very caring, led to Child C being discharged home. An outpatient date for 2 weeks hence was made, for a repeat skeletal survey to be taken.

On 12th of September 2005 Child C was seen for an orthopaedic follow-up appointment. The repeat skeletal survey revealed a hairline greenstick fracture to

his left femur. The parental explanation given previously was accepted and Child C returned to his parents' care.

On 23rd September 2005, during a home visit, the health visitor was shown non-blanching marks (can be a sign of bleeding into the skin or bruising) on Child C's left forearm and a small mark on his chin. The health visitor took no action other than to advise his mother to monitor the marks, and see the GP if there was any deterioration.

On 25th September 2005 Child C was admitted to hospital with bruising to wrists/fingers and other parts of his body, including a torn frenulum. The parents could offer no explanation for the injuries.

On 30th September Child C was discharged from hospital to the care of the Local Authority.

He moved with his parents to a specialist parent/Child Assessment foster placement on 7th November 2005.

On 7th December 2005 Child C vomited twice during the evening with some streaks of blood, while at the foster placement with his parents. He was taken to a Bristol hospital where the doctor could find no obvious cause. The incident was said to be a possible torn blood vessel whilst vomiting.

On 8th December 05 the foster carer saw two red marks on Child C's forehead whilst in his father's care. Child C's parents could offer no explanation. Child C was seen by a G.P. the following day - no concerns were raised.

On 19th December 2005 Child C was seen by a Specialist in Paediatrics in Somerset - a weight gain was recorded.

On 6th January 2006, whilst in his father's care, Child C started coughing up a large amount of blood and the foster carer heard a distressed scream from Child C. Child C was taken to a Bristol A & E hospital and transferred to another Bristol hospital because non-accidental injury was suspected. He was discharged the same day to the foster placement he shared with his parents – bleeding from the nose was considered by the ENT consultant to have been spontaneous.

During January 2006 three overnight visits took place to independent accommodation, as the Family Law court had agreed that Child C could return to his parents' sole care at the end of January 2006.

On 7th February 2006, at an Initial Child Protection Conference Child C's name was placed on the Child Protection register in the category of physical abuse

On 16th February 2006 Child C was seen by the local GP, who diagnosed a viral illness

On 21st February 2006 Child C was seen again by the GP. An ongoing viral infection was diagnosed and a bruise on his face noted. Child C's mother reported that he had

had a nosebleed the previous night - the GP believed that this might be due to previous nasal trauma when Child C was instrumented (nasal gastric tubes) in hospital. The GP noted a small amount of blood in his nose and brownish marks on his face to the left side of his mouth. This was thought to be long-standing. The information was shared with the social worker.

On 22nd February 2006 the social worker and health visitor liaised and the social worker arranged for Child C to be seen by a Paediatrician in relation to the marks on his face. However, the Paediatrician was concerned for his general health and admitted Child C to hospital with suspected meningitis, which was later confirmed.

On 2nd March 2006 Child C was clinically improving but became blue after being fed by his father and was transferred to a Bristol hospital. Information was transferred regarding social issues and several relevant letters were copied and taken to Bristol, including information which showed that Child C was on the Child Protection Register in Somerset.

On 7th March 2006 the Bristol hospital social work department was notified of Child C's admission and a social worker was allocated who liaised with the Somerset social worker to arrange a discharge-planning meeting.

On 10th March 2006 X-rays were performed because, although Child C was still recovering from his illness, he appeared to be in pain and disliked being handled. The X-rays revealed fractures. A strategy meeting was held where it was agreed that Child C was to be cared for by two nurses and all parental visits were to be supervised.

On 12th March 2006 Child C's mother told a nurse that she and Child C's father had split up, and that she thought he was responsible for hurting Child C. In the presence of maternal grandparents she repeated this to a paediatrician and also disclosed previous domestic abuse. She also implied that Child C's father was responsible for incidents of bruising and red marks to him, whilst in foster care.

On 13th March 2006 a full skeletal survey revealed further old injuries and it was agreed that the Local Authority would apply for an Interim Care Order. It was also agreed that hospital staff were no longer under suspicion and that a normal staff ratio could be resumed.

KEY THEMES AND LESSONS FOR THE FUTURE

There are a number of lessons to be learned from this case.

- All agency professionals need to establish a common language to explain concerns and planned action

- Children who are the subject of legal proceedings require multi-agency coordinated planning to ensure their safety, particularly when they remain in their parents' care.

- Without a chronology of the child's medical history, single incidents viewed in isolation did not trigger concerns which an overall picture would have indicated

MAIN RECOMMENDATIONS FOR FUTURE ACTIONS

- All hospitals must have available in A and E departments and paediatric wards a list of the contact details for Named/Designated Doctors across the region so that information can be transferred quickly when a child who is subject to a Child Protection Plan moves from one hospital to another.

- Named Doctors in Hospital Trusts should clarify and raise awareness with relevant colleagues of procedures for Serious Untoward Incident Investigations, relating to when a child is injured in hospital.

- The Somerset Health community should consider developing a system, whereby one medical professional collates medical information, for children who are subject to family law proceedings or a child protection plan.

- When the lead professional for Child Protection is unavailable [on leave, sick etc.] there must be a replacement professional in every organisation, available to manage the lead professional responsibilities.

- When the Local Authority instigates care proceedings, whether an interim order is granted or not, if the child remains at significant risk, a multi-agency meeting should be called, to identify lead professionals for the case within each agency, who coordinate ongoing information/concerns and act as the interagency interface.

- The LSCB should provide written definitions of different types of meetings held between agencies to be used in interagency and single agency training in relation to managing Child Protection concerns.