

**WREXHAM
LOCAL SAFEGUARDING
CHILDREN BOARD**

SERIOUS CASE REVIEW ON CHILD 2

EXECUTIVE SUMMARY

MAY 2009

FOREWORD

This report is published by the Wrexham Local Safeguarding Children Board. This is a multi-agency group that has responsibility to oversee how services and professionals within Wrexham cooperate and work together to safeguard children and to make sure that the inter-agency arrangements in place within the county bring about positive outcomes for children.

The Local Safeguarding Children Board in Wrexham operates under Government Regulations that came into force in 2005. These Regulations require all Local Safeguarding Children Boards to set up a serious case review when abuse or neglect of a child is known or suspected and a child dies or sustains a potentially life-threatening injury or serious and permanent impairment of health or development.

This review was set up as a result of injuries sustained by an 18-day old infant. The main objective of the review was to identify steps that might be taken to prevent similar harm occurring in future. In doing this, the review set out to:

- establish whether there were lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children;
- identify clearly what those lessons were, how they would be acted upon, and what was expected to change as a result; and as a consequence:
 - identify issues in inter-agency working in order to better safeguard children; and
 - identify examples of good practice.

The review was conducted under the guidelines set out in the Welsh Assembly Government document *Safeguarding Children – Working Together under the Children Act 2004*.

BRIEF OUTLINE OF THE CASE

This serious case review looked into the case of an 18 day old infant who had sustained a head injury reported to be caused accidentally while being fed by his father. The child was initially seen in the Accident & Emergency Department of the District General Hospital and was discharged after examination. The child's parents returned the child to the hospital later the same day because his condition had not improved. At this stage, the child was admitted to hospital and subsequent medical investigations at the District General Hospital and at a Specialist Children's Hospital revealed that the child had acute bilateral subdural haematomas and retinal haemorrhage that were considered to be the result of a non-accidental injury. The child remained in hospital for 4 days, after which he was discharged into the care of local authority foster carers.

HOW THE CASE REVIEW WAS CARRIED OUT

Following the injuries to the child, the Local Safeguarding Children Board met and agreed that a serious case review should be carried out to examine the involvement of agencies with the child and his family, starting from the first antenatal contact with the child's mother and ending when the child was discharged from hospital and accommodated with local authority foster carers.

The serious case review panel was made up of representatives from the National Public Health Service; the North Wales Trust, Eastern Division (formerly North East Wales Trust); Wrexham Safeguarding & Support Department within Children & Young People Services; North Wales Police; Wrexham County Borough Council Legal Department; and North Wales Probation Service, Eastern Division. The panel was initially chaired by the Chief Safeguarding & Support Officer from Wrexham County Borough Council and, from February 2009, by the Assistant Director of Children's Services, Barnardo's Cymru. The reason for the change of chair was to bring more independence to the review process, in line with one of the recommendations from the Baby P enquiry.

Each agency that had been involved with the child and his family was required to produce a chronology of their involvement, together with a report identifying key aspects of that involvement. The chronologies and reports were then used as a basis for an

overview report that was compiled by an independent author appointed by the Local Safeguarding Children Board. The full report, which contained 4 recommendations and an action plan, was sent to the Welsh Assembly Government on 25th May 2009.

ISSUES ARISING FROM THE CASE REVIEW

Prior to the injuries that resulted in the child being admitted to hospital, there was nothing known to the Health professionals involved with the family to indicate that there was any need for concern about the child's health, development or welfare.

Although there was information on record to indicate that the background of the child's father could compromise his parenting, that information was not available to Health staff at the time when the child was examined at both the District General Hospital and the Specialist Children's Hospital.

One of the interesting features of this case is that Health professionals were the only ones to have contact with the child and his parents from the point of the first antenatal visit to the time when the child was admitted to hospital with a suspected head injury. As a result, in this case, there were none of the communication difficulties between agencies that are frequently identified in serious case reviews. Nor were there any obvious communication gaps between Health professionals involved with the child and his parents.

The one area of concern in this case was that, when the child was first examined in the Accident & Emergency Department of the District General Hospital, no consideration was given to the possibility that his injuries could have been caused non-accidentally. As a result, the child was discharged from hospital without seeing a paediatrician and, had a paediatrician been consulted at that point, the likelihood is that the child would not have been discharged. Given the subsequent diagnosis of non-accidental injury, the child's discharge following the examination in the Accident & Emergency Department placed him at further risk of harm.

Following the child's discharge from hospital, he was returned to hospital later that same day by his parents because they were concerned that his condition was not improving. At that point, the child was admitted to hospital and was under close observation until he was discharged into the care of local authority foster carers 4 days later.

Although non-accidental injury was considered when the child was seen by a consultant paediatrician at the District General Hospital, there was sufficient doubt about the cause of the child's injuries to justify further tests and it was only after referral to the Specialist Children's Hospital that non-accidental injury was confirmed. This is the point at which the child protection procedures were invoked and, whilst they could have been invoked earlier in the process, there was never any risk that the child would be removed from the hospital by his parents while medical investigations were being undertaken.

Alongside the concerns in this case, there were also examples of good practice, as follows:

1. following the birth of the child, the midwifery service and health visiting service were of a high standard;
2. the Ambulance Service demonstrated safe and best practice in taking the child to the Accident and Emergency Department following the emergency call from the parents;
3. when the Consultant Paediatrician was informed that the CT scan identified bilateral subdural haemorrhage, he arranged transfer to the Specialist Children's Hospital for further investigation;
4. the standard of record keeping within Health observed in the review was generally of a high standard and caused no concern;
5. from the point at which a child protection referral was made, this matter was dealt with in a timely and appropriate manner;

6. all relevant checks were made and documentation was completed promptly, accurately and thoroughly on both electronic and paper files;
7. once child protection concerns were confirmed, there is good evidence of agencies working together, sharing information and agreeing what action to take to protect the child.

RECOMMENDATIONS

The review made 4 recommendations, all of which have implications for practice. The Local Safeguarding Children Board has accepted these recommendations and incorporated them within an action plan for implementation over the next 3 months.

The recommendations made are as follows:

1. the Child Protection Flowchart used by the Accident and Emergency Department should be reviewed and a copy given to all health staff and trainees when commencing work on the Accident and Emergency Department;
2. the Paediatric Department of the District General Hospital should implement the new Standards for Radiological Investigations of Suspected Non-accidental Injury (The Royal College of Radiologists & the Royal College of Paediatric and Child Health, March 2008);
3. the content of holistic assessments should be reviewed to ensure that they provide opportunities to identify historical factors that might compromise parenting;
4. all health visiting/midwifery staff should be reminded of the requirement to carry out holistic health assessments in the antenatal period.