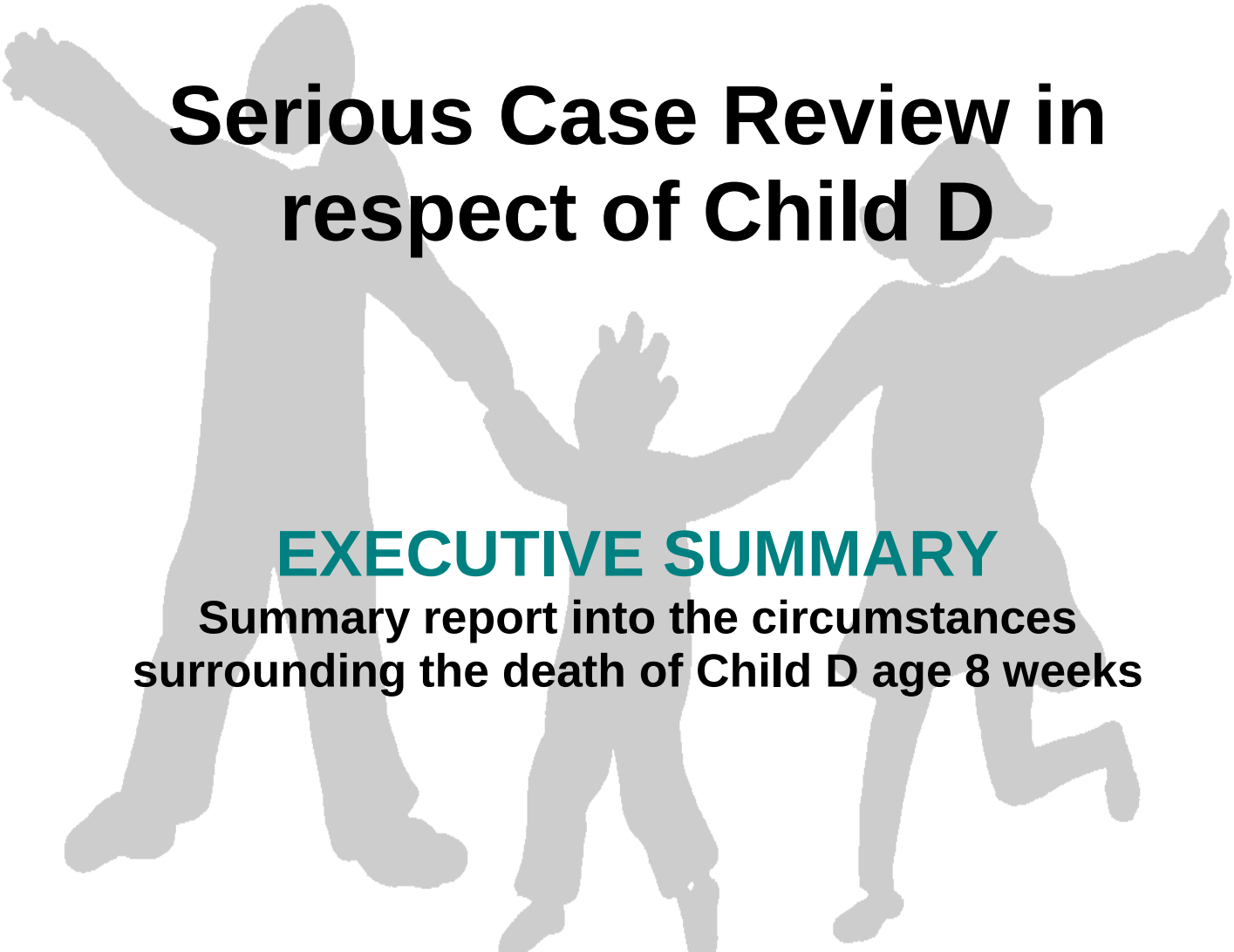
DUDLEY SAFEGUARDING CHILDREN BOARD

'Working Together to Keep Children & Young People Safe'

Serious Case Review in respect of Child D



EXECUTIVE SUMMARY

Summary report into the circumstances surrounding the death of Child D age 8 weeks

Commissioned and published by Dudley Safeguarding Children Board

December 2010

1.0 INTRODUCTION

1.1 This is a brief and anonymised summary into the circumstances surrounding the death of Child D, aged 8 weeks.

1.2 The Serious Case Review was commissioned by Dudley Safeguarding Children Board in accordance with statutory guidance – *'Working Together to Safeguard Children',* which sets out expectations of organisations and individuals who have particular responsibilities for safeguarding and promoting the welfare of children.

1.3 The review was undertaken by an independent author, supported by a panel of local professionals. Both parents contributed directly to the review, although it should be acknowledged that at the time Child D's father was subject to a criminal charge in respect of his death.

1.4 Chapter 8 of *'Working Together'* guidelines sets out the circumstances when a child's death should prompt a review of the involvement of organisations and professionals with the child and family. The purpose of a Serious Case Review is 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 children and promote their welfare
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result; *and*
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

1.5 Serious case reviews are not enquiries into how a child dies or who is to blame. These are matters for coroners and for criminal courts, as appropriate.

2.0 BACKGROUND

2.1 Child D died as a result of trauma to the brain. The precise cause and circumstances remain unexplained.

2.2 The child was in his father's care when the ambulance services were called, with reports that he was not breathing.

2.3 When the ambulance services arrived the child was already in cardiac arrest. He was rushed to a local hospital where he was immediately resuscitated, but remained very poorly. Initial indications were that he may have a serious blood disorder whereupon he was quickly transferred to a specialist unit within the region.

2.4 The parents presented a history that Child D had been very unsettled for several days previously and had 'spontaneous' bruising to various parts of his body. The second hospital later identified additional bruising, some of which might have been caused by resuscitation attempts. Further tests ruled out more obvious or serious forms of blood disorder. The possibility of non-accidental injury was also raised.

2.5 A child protection strategy meeting was quickly convened. At this point, Child D was considered to be 'brain dead' and surviving only with the aid of a life support machine. The family agreed for this to be switched off.

2.6 Further more sophisticated tests were commissioned, the results of which were reported 10 months after Child D's death. Although falling short of a conclusive cause of death, the possibility of 'shaken baby' was confirmed and prompted the arrest of both parents and the initiation of a Serious Case Review.

2.7 Criminal proceedings in respect of Child D's father were not proceeded with by the Crown Prosecution Service following a 'finding of fact' within civil proceedings relating to his admission to having shaken the child in response to him not breathing.

3.0 HISTORY

3.1 Child D was not the subject of any formal orders, protection plans or previous interventions by statutory agencies in Dudley, nor had there been any previous concerns or allegations reported in respect of his safety.

3.2 Child D's father had been known to various local agencies as a child and adolescent, with some concerns relating to his own safety, behaviour, school attendance and family relationships. The involvement by more specialist agencies ended when Child D's father was 14 years of age.

3.3 Child D's mother was not originally from the West Midlands and was not previously known to statutory agencies. Information subsequently was brought to the attention of the police that she had been dismissed as a nursery nurse following concerns about her treatment of young children. She disputes these accounts and claims she was witness to poor practice by other staff and therefore victimised due to 'whistle-blowing.'

3.4 There were no concerns expressed by any professionals during ante-natal care. Post-natal, she continued to co-operate and presented as a confident and competent 'young mum'. She was bonding well with Child D who was making good progress according to health assessments.

3.5 Three weeks after the birth of Child D, his father was seen by local GPs on several occasions with reports of stress, anxiety, anger and fears of self-harm, although he subsequently disputed the latter. He was not considered to present a risk of harm to others.

3.6 During this period, Child D was also presented to the GP with concerns about his health and parents also claim that they had alerted key professionals to 'spontaneous bruising', although there is no record by the professionals within these agencies.

4.0 ANALYSIS OF KEY ISSUES

4.1 There were no risk factors identified during pregnancy and involvement with Child D and his parents following his birth. He was making good progress and was being monitored by universal health services.

4.2 The individual management and overview reports have recognised several examples of good practice, including support and advice during pregnancy and following Child D's birth. In their contribution, the parents spoke positively of support from hospitals, midwives and the ambulance service. They were satisfied with the level of support they received from community health services, but feel that their later concerns with regards to their son's health were not 'heard'.

4.3 There were issues in respect of recording practices for some agencies and communication, notably between the GPs, midwives and health visitors.

4.4 The review also highlights the importance of balancing support to parents in circumstances where a child has died unexpectedly with prompt investigations when 'suspicions' of non-accidental injury are raised. This also had an impact on the timeliness of the serious case review.

4.5 The views of the parents were sought as part of this review. They specifically highlighted the importance of health professionals making time for, and listening to parents' as they 'know their babies', especially when their 'demeanour' suddenly changes. They also stress the importance of record keeping, particularly within the child's 'red book' and the need for health visitors to be available if they need urgent advice or assistance.

4.6 Whilst recommendations for improvement have been made, the review has not identified any opportunities for any agency to have anticipated or prevented Child D's death.

5.0 RECOMMENDATIONS

Dudley Health Services should address the following:

5.1 Review guidelines for completing 'initial assessments of new parents, and how best to research and include parental histories

5.2 Consider how best to improve information sharing between GPs and other professionals supporting parents and babies; and to address specifically if and when parental histories can be shared

5.3 Review and reinforce the importance of good record keeping

5.4 Highlight to staff the importance and benefits of early and frequent contacts with new parents, and to consider the particular value of 'home visits' alongside invitations to clinics

5.5 Highlight the importance of actively engaging fathers in initial assessments and to explore the possibilities of 'father specific sessions' in ante and post natal care programmes

5.6 Consider how larger GP practices can best provide continuity of services to individual patients

Dudley Children's Social Care should address the following:

5.7 Practice and guidance when strategy meetings consider 'other children' in the family

5.8 Practice and guidance in relation to continuing or completing Section 47 assessments when children die in the course of initial enquiries and key links to Sudden Unexpected Death in Infancy (SUDI) protocols

West Midlands Police should address the following:

5.9 Review practice in relation to completing child protection investigations, responding to appropriate thresholds and ensuring appropriate timing for key interviews

Leicestershire NHS Trust should address the following:

5.10 Review their policies and practice for the storage of medical records

Dudley Safeguarding Children Board should address the following:

5.11 Thresholds for instigating serious case reviews and recognising early lessons that can be applied whilst other investigations continue

5.12 Consider how all agencies, specifically West Midlands Ambulance Trust, can make a full contribution and an informed analysis to any Serious Case Review they engage in

5.13 The contribution from Dudley Group of Hospitals to ensure that an appropriate degree of independence and analysis is reflected in the robust approach expected of Serious Case Reviews

5.14 Clarify the expectations of GPs who are asked to contribute to Serious Case Reviews and if necessary to ask Ofsted to address the matter and advise accordingly.

Dudley Safeguarding Children Board agreed an action plan in February 2009. Its implementation has been monitored and progressed under the guidance of its Serious Cases Review Sub-Committee and all relevant actions have now been completed.