Derbyshire Safeguarding Children Board
Child Practice Review Report

Derbyshire Safeguarding Children Board

Child Practice Review ADS13

Review Process

In June 2013[1], despite the efforts of the medical and nursing staff caring for her, the child in this case died in hospital of a head injury aged 9 weeks old. At the time this report was initially prepared the circumstances in which the injury occurred was still under investigation. The death of a child in these circumstances is always a tragedy. Formal and effective systems are required to review what has happened and to learn from the experience so that inter-agency child protection arrangements or services can be further improved where this is thought to be necessary.

Legal Context:
A Serious Case Review was commissioned utilising the Child Practice Review Model by Derbyshire Safeguarding Children Board, in accordance with Working Together to Safeguard Children (Department of Education 2013).

Regulation 5 of the Local Safeguarding Children Boards Regulation 2006 sets out the functions for LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5. (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
   (2) For the purposes of paragraph (1)(e) a serious case is one where:
   (a) abuse or neglect of a child is known or suspected; and
   (b) either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

This review was undertaken in line with the principles of learning and improvement set out in Section 9 of Working Together to Safeguard Children (Department of Education March 2013). The methodology used was the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).

[1] **(Date has not been specified to preserve the anonymity of the child concerned)**

The Child Practice Review process was introduced in Wales in January 2013 to replace the Serious Case Review Process. This is an innovative formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead it is an effective learning tool for Local Safeguarding Children Boards to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken of the case is not the focus of the reports which are succinct and centre on learning and improving practice. However, because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of Safeguarding Boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Board may identify additional learning issues or actions of strategic importance. These may be included in the final child practice report or in the action plan as appropriate.

Circumstances Resulting in the Review

This review was commissioned following the death of a child, aged 9 weeks who was the only child within the family. Prior to the time of the incident the child and the parents only had involvement with the usual universal services. The parents were viewed as being competent and caring and the review did not indicate that additional services should have been offered or put in place. The parents had planned for the father to be the primary carer of their child following the mothers return to work and he had the support of the paternal grandmother who lived nearby.

The child was admitted to hospital after a call was received by the ambulance service from the father stating that the child was in a serious condition. The father, who was at this time providing sole care, had consulted with the GP earlier that same day. When the child's condition further deteriorated, he contacted his mother for advice and summoned the emergency services.

The child was admitted to the local hospital. Following medical examination and an abnormal CT brain scan, the child's condition was medically managed and advice sought from the regional Children's Hospital. The child was subsequently transferred to this hospital where further assessment and review indicated that the child had sustained a haemorrhage in the brain. Traumatic head injury was suspected and child protection procedures were invoked. Sadly, the child died of the injury sustained 3 days following admission**.** The cause of the brain injury and the circumstances in which it occurred is a matter of ongoing investigation at the time of this report.

Methodology

Following notification of the tragic death of the child in this case and agreement by the chair of the Derbyshire Safeguarding Children Board to undertake a Child Practice Review, a Review Panel was established in accordance with guidance. This was Chaired by Dr Patricia Field, Consultant Paediatrician and member of Derbyshire Safeguarding Children Board and included representation from relevant organisations within Health, Police and Social Care. Lin Slater, Designated Nurse, Safeguarding Children Service, was commissioned from Public Health Wales to work with the panel and to undertake the review. The time period for this review is between August 2012 and June 2013. This covers the antenatal period, the birth and up to the point of death. Full Terms of reference are included in Annex 1.

All agencies reviewed all their records and provided timelines of significant events and a brief analysis of their involvement. These were considered by the panel and provided opportunity

for panel members to raise questions and clarify understanding of the circumstances of the case and of the separate services provided. The agency timelines were merged and used to produce an interagency timeline. This was carefully analysed by the reviewing officer with the Panel and informed of the areas of interest that required further exploration and consideration. The process also allowed for the identification of the key practitioners required to attend a learning event in order to understand the detail of the single and interagency practice in this case. The summary timeline is attached as Annex 2.

The Chair of the Panel and reviewing officer met with the family to gain an understanding of their experiences of the services offered. This was shared with the Panel and with practitioners attending the learning event held on January 30th 2014, facilitated by the Reviewer and attended by the Chair of the Panel and Board Manager of the LSCB. The learning event was organised in line with Welsh Government guidance (Child practice Reviews Organising and Facilitating Learning Events, December 2012) and a record of the event was made.

Following the learning event, the reviewer collated and synthesised the learning to date for discussion with the panel. Practice issues originally identified by the Panel were re-examined in the light of the findings of the review. This also provided opportunity to identify issues requiring further clarification with practitioners or managers. In reviewing the findings, the Panel gave consideration to what could be done differently to further improve future practice. A draft report was provided to the Panel on March 21st 2014

The Reviewing officers will meet again with the family to provide them with a copy of the review when completed and agreed by the Derbyshire Safeguarding Children Board. The full report will be made publically available by the Board.

Practice & Organisational Issues Identified

This family were engaged with routine universal services. The scrutiny of this case gave no indication that additional services should have been offered or that alternative actions should have been taken by practitioners. Areas of good practice were noted by the reviewing panel and by the parents. However, the process of detailed examination of interagency working and facilitated reflection by practitioners provides an opportunity for wider learning to emerge about the ways in which services work together and are offered. These are:

The importance of joint working and reciprocal information sharing between members of the primary health care team.

Whilst there is no evidence to suggest that this impacted on the management of this case, it was acknowledged by health services, that good working relationships formed through joint working by members of the primary health care team are necessary to inform assessments, coordinate care and enhance interventions to support family members. In this situation practitioners noted that changes to working practices meant that the patient's GP was not always informed of pregnancy, it was recognised that this significantly reduces the opportunity for reciprocal information sharing and in obtaining a fuller picture. While there is nothing to suggest that relevant information was not shared in this case, this process issue should be addressed.

Health visitor antenatal contact was recognised as good practice and welcomed by these parents who were expecting their first child. In order to inform the health visitor care plan, the assessment made at this contact needs to be recorded in ways that allows retrieval at the primary birth visit but at the time of this case, the record was kept separately. Although the record made at the antenatal contact would not have impacted on the subsequent care plan

this may be relevant for other cases. Changes that have been made to practice now ensures that the record is available to the health visitor following the birth.

The importance of delivering child health services in ways to maximise engagement and provide support for families.

The personal circumstances of this family led to their decision for the mother to return to work shortly after the birth and for the father to remain at home as the primary carer. Universal services provided in respect of childbirth and child rearing are generally targeted at women, with fathers accessing these services through their partners. Classes and 'groups' are not always accessible or an effective way of supporting men unless designed specifically for this purpose. Ways in which new fathers may be better engaged and supported could be explored by all family services. For those who are primary carers as in this case, an enhanced service could be explored by maternity and health visiting services.

The provision of both universal and targeted services for children and families through a single point of contact at a community children's centre is noted to be an effective and helpful way to deliver services for families. This provides further opportunity to engage with men who are in a parenting or caring role.

The importance of providing health protection messages.

The nature and circumstances of the head injury that resulted in the death of the infant in this case are a matter of ongoing post mortem and police investigation and should not be subject to speculation. Nonetheless the panel agreed that the importance of careful handling and protecting babies' heads is an important public health message. Derbyshire Safeguarding Children Board has in place a strategy for informing new parents about coping with early infancy that includes the strong message that it is never safe to shake a baby. A short film is used to convey this information and all parents who deliver their babies (within county) are shown this film before discharge from hospital. In this case the film was not shown as the baby was delivered in a local hospital that was out of the Safeguarding Children Board area. It would be helpful to review and explore how this strategy can be expanded geographically and in ways that allow this message to be heard by other potential carers of young children and the general public.

To support the local arrangements, a protocol should be developed by health services in Derbyshire to describe how the film is used by statutory universal health services to ensure that if both parents are not shown the film in hospital then this is made available in the community, particularly so when the baby is delivered out of county. This will help to maximise coverage and ensure that fathers and other members of the household with a potential caring role are included.

Reporting mechanisms for specialist X-ray and imaging are clear.

There was a good response to the medical emergency of the child in respect of the treatment and management. The ambulance response was good and doctors treating the child on admission to the local hospital did so appropriately. This included undertaking a brain CT scan. The abnormal results prompted an immediate request for a further opinion however there was a delay in achieving this as the doctor normally providing this opinion was in the operating theatres. This did not impact on the care and management and clinical advice was appropriately sought by the local hospital from the regional children's' hospital where it was agreed that transfer to a hospital with specialist resources was required. The support of the specialist transfer team that conveyed the child to the regional hospital was praised by the family in respect of their skills and communication. When the CT images were subsequently reviewed,

a different opinion to that given earlier was formed. Whilst the change in diagnosis was not felt to impact on the treatment provided nor on the outcome for the child, the panel agreed that a review should be undertaken of reporting arrangements and how opinions on results are obtained in a timely way.

Conclusion

The findings of this review do not indicate that alternative actions should have been taken by practitioners or that inter-agency practice could have altered the outcome of this case. Areas of good practice were noted and the parents were thankful for the skill and good communication of the team that transferred their child to the Children's Hospital and for the compassion that they were shown by nursing staff. Scrutiny of practice always provides an opportunity to consider ways in which services may be improved and therefore the following recommendations, based on the learning from this case, have been made.

This report was initially completed in March 2014. It was not possible to publish the report at that stage due to the ongoing criminal proceedings and the possibility of a Coroner's inquest. Following the conclusion of these processes it is now possible to publish the report.

Ahead of the intended publication both parents agreed to meet with representatives of the SCR commissioning panel to discuss the report. They were seen separately and they both are thanked for their willingness to discuss and for reflecting on the learning within this report. The father supported the publication of the report, hoping that the learning points about greater inclusion of fathers in ante and postnatal processes could help other families. Similarly the mother supported the publication of the report. The mother hoped it would help practitioners appreciate the resources required to assist families and to develop understanding that all families are unique and have varied arrangements for caring for babies following their birth. Both parents felt that this understanding should be reflected in assessments and the work undertaken with each family and the services they are signposted to.

Improving Systems & Practice

In order to promote the learning from this case the review identified the following actions for Derbyshire Safeguarding Children Board and its member agencies:

1. Derbyshire LSCB should ensure that this report is made available to local practitioners and cross border LSCBs to inform practice and widen learning.

2. Providers of midwifery health services should review working practices to ensure that GP's are informed of their patients' pregnancy and midwifery contact details, in order to facilitate reciprocal information sharing and enhance primary health care team working.

3. Health commissioners and providers of health visiting services should work together to ensure that the vulnerability of new fathers, providing a primary care role to infants, is taken into account in the assessment and provision of services.

4. Derbyshire LSCB, its constituent agencies and the children's centres should give consideration as to how their services engage with men in a parenting role.

5. Derbyshire LSCB should produce and implement a protocol describing the local use of the 'Shaking your baby is just not the deal' film in order to maximise impact and ensure

that this is made available to both parents and other household members who may be potential carers wherever the birth takes place.

6. The Board should review the public health campaign concerned with this matter and work with neighbouring LSCBs in order to sustain and expand the delivery of this message to the potential carers of infants.

7. Derbyshire LSCB should seek assurance from Doncaster and Bassetlaw NHS Foundation Trust and the Operational Delivery Network, that the reporting of images in children has been reviewed and is safe.

Statement by Reviewer

REVIEWER: Lin Slater

Statement of independence from the case
Quality Assurance statement of qualification

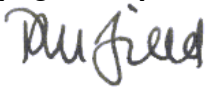
I make the following statement that prior to my involvement with this learning review:-

- I have not been directly concerned with the child or family, or have given professional advice on the case.
- I have had no immediate line management of the practitioner(s) involved.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.
- **The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference.**

Reviewer 1 (Signature) 

Name (Print) **Lin Slater**

Date **March 18th 2014**

Chair of Review Panel (Signature)


Name (Print) **Patricia Field**

Date **March 18th 2014**