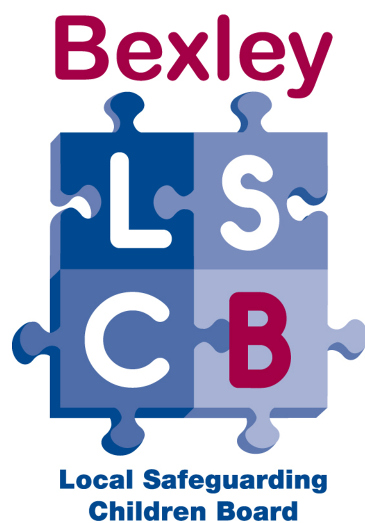

BEXLEY LOCAL SAFEGUARDING CHILDREN BOARD

EXECUTIVE SUMMARY

SERIOUS CASE REVIEW

'CHILD N'

4 August 2010

1 Introduction

1.1 CHILD'S DEATH AND RECENT INVOLVEMENT OF LOCAL AGENCIES

1.1.1 This review concerns Child N, a white British baby boy aged 13 weeks who was one of twins, his sister being Child P. The mother is referred to as Mrs R and the father as Mr R. For the purposes of confidentiality these are not the real initials of the family members involved. Mr and Mrs R were older first time parents, married and in a stable relationship. Mr R was employed as an ambulance technician by the London Ambulance Service.

1.1.2 On 23 October 2008 Child N was admitted to Queen Mary's Hospital Sidcup by ambulance accompanied by Mr R in a critical condition. Mr R said he had found Child N not breathing and without a pulse after he had briefly left him lying on a sofa to get a cold drink. Child N was subsequently transferred to Kings College Hospital but died of his injuries on 25 October 2008 after life support was withdrawn.

1.1.3 On the 27 October 2008 a post mortem skeletal survey identified evidence of "*multiple fractures in various stages of healing*". These included fractures to ribs, leg and arm.

1.1.4 A skeletal survey carried out on Child P at Queen Mary's Hospital on 27 October 2008 revealed nine old rib fractures that had not been apparent during her then current admission at the hospital for bronchiolitis.

1.1.5 On the 28 October 2008 both parents were arrested and both denied any involvement in the injuries to the children and the death of Child N. Following the police investigation Mr R was charged with murder of Child N and GBH in relation to Child P. No charges were made against the children's mother, Mrs R. Child P was placed with foster carers following her discharge from hospital and care proceedings are ongoing at the time of publication. On the 2 August 2010 Mr R was found not guilty of murder, not guilty of manslaughter, guilty of one count of assault, section 20, for the injury to Child N's arm.

1.1.6 On the 29 October 2008 a preliminary post mortem report on Child N recorded that Child N died from a head injury noting "*subdural haemorrhages with brain swelling* [and] *bilateral haemorrhages around the optic nerve and retinal haemorrhage*".

1.1.7 Child N was admitted to Queen Mary's Hospital on 7 October 2008 after being brought in to hospital by Mr R. Mr R stated to A&E staff that he had noticed Child N's left arm was immobile. Child N was diagnosed with a spiral fracture of the humerus bone in the arm. At the time Child N was 10 weeks old. Mr R admitted causing this injury accidentally by grabbing at Child N to prevent him from falling while he was feeding him.

1.1.8 Child N was admitted to the ward as the A&E staff had concerns that he may have sustained a non-accidental injury because he had a spiral fracture which is indicative of abuse, particularly in children of this age. However, no additional medical examinations such as a skeletal survey were undertaken despite such examinations being normal practice. Child N's injury was diagnosed as accidental by the Consultant Paediatrician after consideration of Mr R's explanation and internal discussions with the Orthopaedic Consultant and the Named Doctor for Safeguarding in Queen Mary's Hospital.

1.1.9 During the period of just over a week following Child N's discharge, a number of hospital and community based health professionals including the GP, health visitor, a second Consultant Paediatrician and an Orthopaedic Specialist were notified of the spiral fracture or saw Child N for routine health appointments. None of these medical professionals challenged the diagnosis of accidental injury despite a spiral fracture in a baby being suggestive of non-accidental injury. This highlighted the primacy of the original medical diagnosis that once made was unlikely to be challenged subsequently.

1.1.10 On the 22 October 2008, Child N's twin sister Child P, was admitted to Queen Mary's Hospital from Mr R's ambulance following breathing difficulties. Child P remained in hospital accompanied by her mother, Mrs R, during her brother's subsequent hospital admission and death.

1.1.11 Prior to his presentation to hospital on the 7 October 2008 Child N had been known to universal services such as GP and health visiting. These services had not identified any child protection concerns for either child during this period of time.

1.1.12 The following is an anonymised executive summary of a more extensive report (containing confidential details of family and professionals) arising from a serious case review completed in April 2009 and contains:

- reasons for and process followed by those undertaking the review
- an overview of the involvement of local agencies with Child N's family during his life
- conclusions and lessons to be learnt from this serious case review
- all recommendations contained in the full report, which have been accepted in their entirety by relevant agencies and have been implemented

1.1.13 This summary reflects any relevant evidence given and the outcome of the trial of Mr R which concluded in August 2010 that was not known when the serious case review was conducted.

1.1.14 For the purposes of clarity the anoymised family relationships are outlined below:

Child N	Subject of this review
Child P	Twin sister of Child N
Mr R	Father of Child N and Child P
Mrs R	Mother of Child N and Child P

2. Serious Case Review Process

2.1 INITIATION AND CONDUCT OF REVIEW

2.1.1 When any child dies, and abuse or neglect is known or suspected to be a factor in the death, Local Safeguarding Children Boards (LSCB) are required to undertake a serious case review (SCR) as set down in Working Together 2006 chapter 8. The purpose of the SCR is to establish whether there are lessons to be learnt from the way local agencies work together, what those lessons are, how they will be acted upon and as a consequence improve inter-agency working to safeguard children and improve their well being.

2.1.2 Bexley's Safeguarding Children Board immediately recognised that Child N's death required a SCR and on the 29 October 2008:

- Convened a serious case review panel with an independent chairman and relevant professionals who had had no direct involvement with services offered to Child N or members of his family
- Gave details of the serious case review panel membership as set out in Section 6, Terms of Reference
- Agreed, in consultation with the Government Office for London, what time period should be considered and the specific questions to be addressed by those contributing to the serious case review
- Formalised the focus of the serious case review by 'terms of reference' which (anonymised where necessary) are appended to this summary
- Notified Ofsted, the relevant Government regulator, the role of which in such cases is to evaluate the rigour and effectiveness of serious case reviews

2.1.3 An independent author, Bob Cook, Independent Consultant, was commissioned through Willis Palmer Consultancy to write a composite overview report bringing together the facts and analysing the findings of the management reports and chronologies produced by all the involved agencies and provide appropriate challenge. A timetable was established for submission of individual management reviews and consideration of the resulting overview report in April 2009.

2.1.4 The panel met on 5 occasions and meetings of the respective authors of individual management reviews was convened on 1 occasion, supplemented with telephone and email correspondence as required. The overview report writer attended meetings of the Serious Case Review Panel and the authors' group.

2.1.5 Mr and Mrs R were invited to participate in the SCR but chose not to do so citing legal advice. Mrs R asked that the review recorded *“We would have liked to contribute but were unable to do so due to the timescales imposed by those conducting the Review”.* The SCR was conducted in line with the time requirements set down in the then current *Working Together* 2006.

2.1.6 The overview report was considered by the Serious Case Review Panel on 15 April 2009 and it was formally signed off by the Chairman of the LSCB on behalf of the full Safeguarding Board on 22 April 2009.

2.1.7 The Serious Case Review was evaluated by OFSTED as “Good” on 29 July 2009.

2.2 AGENCIES CONTRIBUTING INDIVIDUAL MANAGEMENT REVIEWS

2.2.1 Individual management reviews and chronologies on which the overview report is based were provided by:

- Bexley Care Trust (BCT)
- Queen Mary’s Sidcup NHS Trust (later reorganised to be South London Healthcare NHS Trust) (SLHT)
- Metropolitan Police Service (MPS)
- London Ambulance Service (LAS)
- Kings College Hospital NHS Trust (KCHT)

2.2.2 Given the centrality of medical diagnosis and assessment of health agencies involvement in this SCR an independent medical expert, Professor Jonathan R Sibert OBE MD FRCPCH Emeritus Professor of Child Health, Cardiff University was engaged by the panel. Professor Sibert was asked to address the following points:

- Analysing of health reports, with particular reference to the Royal College of Paediatrics and Child Health Guidance and the action that was taken in response to a previous injury
- Interpretation of post mortem reports which included details of previous injuries and the dating of such injuries
- Relevant research in respect of previous presentation of fractures in such a young child
- Relevant research in terms of the prevalence and impact of maternal mental health
- Review of the analysis of health information included in the Overview Report

3. Overview of Agencies' Involvement with Child N's Family

3.1 BACKGROUND: THIS SECTION PROVIDES A CHRONOLOGICAL OVERVIEW OF AGENCIES' CONTACT WITH THE FAMLY

3.1.1 In December 2007 Mrs R had a multiple pregnancy confirmed and Mrs R accessed routine ante-natal care.

3.1.2 Mrs R informed the midwife at her booking appointment at Queen Mary's Hospital of a previous history of depression. A routine referral to the Pregnancy Support Team based at the hospital that would normally be initiated following such a disclosure was not completed. Such a referral could have resulted in additional support to Mrs R during pregnancy and in the post natal period.

3.1.3 Mr R's history was not noted ante-natally, it came to light during the SCR that he had a previous history of stress related problems, anxiety and depression. Mr R had a separate GP to Mrs R and subsequently Child N and Child P.

3.1.4 Child N and Child P were born in July 2008. Their parents, Mr and Mrs R were married, both were employed and they had an extended family and social network to support them as older first time parents with twin babies. Child N and Child P were not known to children's services or the police prior to the incidents that initiated this review. The family accessed routine community health services.

3.1.5 The twins were born by elective caesarean section at 38 weeks gestation, both babies were well and were discharged home 3 days later. Routine midwifery and health visiting visits were undertaken with additional visits by the health visitor also made to support Mr and Mrs R as new parents of twins. Both parents and extended family were seen during these routine visits and nothing untoward was noted.

3.1.6 On the 1 October 2008 Mrs R was asked to complete a routine post natal moods and feelings screening tool by the health visitor whilst at clinic. The responses were within normal limits, however Mrs R was offered additional support that she declined. During this clinic visit Mrs R was also seen by a Practice Nurse who recorded that Mrs R had 'lots of baby blues' but she did not discuss this with the GP or health visitor.

3.2 Child N's Presentation to Hospital on 7 October 2008

3.2.1 On 7 October 2008 Child N was taken to Queen Mary's Hospital A&E department by Mr R.

3.2.2 Child N was diagnosed with a spiral fracture to his upper arm. The hospital's safeguarding children procedures were initiated and Child N was seen by the paediatric medical team. Mr R gave a consistent explanation for this injury that had occurred the previous day. Mr R said that he had

been advised by the midwife to feed Child N using a particular hold that is only used for very premature babies. Mr R was not challenged on this explanation by hospital staff at this presentation and nor was the explanation cross checked with the midwifery team at the time. All those interviewed for this SCR in 2009 denied giving such feeding advice to either Mr or Mrs R. Following the completion of the criminal trial in August 2010, Mrs R said that a midwife had given her this feeding advice hours after the babies were born and another midwife the next day repeated this advice to both Mrs and Mr R.

3.2.3 The child protection medical proforma used in A&E as part of the safeguarding assessment process and which would have highlighted the need for multi-agency discussion, was not completed. The injury was recorded as a possible accidental injury but, in order to rule out non-accidental injury, Child N was admitted to the paediatric ward. By the time Child N was admitted to the ward Mrs R and Child P, his twin sister, were also present. Nursing staff reported that Mr R 'felt terrible' about what had happened but was polite and compliant, Mrs R was visibly upset.

3.2.4 During the course of the SCR process the Ward Sister noted that Mr R had made a comment that implied this was not the first time such an incident had occurred. This comment was not explored further with Mr R or shared with the medical team at the time.

3.2.5 Once on the ward further medical examinations were undertaken and the x-rays reviewed with the orthopaedic team. Child N's case was discussed by the Consultant Paediatrician in charge of Child N's care with the Consultant Orthopaedic Surgeon and the Named Doctor for Safeguarding.

3.2.6 The Consultant Paediatrician was of the opinion that the injury was consistent with the explanation given by Mr R thereby concluding that the injury was accidental and, therefore, no child protection referral was made to either children's social care or the police.

3.2.7 A skeletal survey was not undertaken despite this being recommended under the Royal College of Paediatricians and Child Health guidance *"Child Protection Companion".* A full medical history of Child N and Mrs R's ante-natal history was not available to the medical team on the ward. A telephone check was made with Children's Social Care to see if Child N was known or subject to a Child Protection Plan (previously known as the child protection register); Child N was not known or subject to a Child Protection Plan. No information was gathered from the community health visitor. The liaison health visitor was not on duty during Child N's admission and discharge (a period of 2 hours) so was unable to facilitate information gathering and discussion. However her absence should not have precluded the paediatric medical and nursing staff from seeking this information.

3.2.8 As noted above the medical records for Child N were not available and the hospital medical notes for Mrs R were not requested. If obtained, Mrs R's

hospital notes would have contained reference to Mrs R's previous history of depression, although historical and treated at the time, the information may have acted as an additional trigger for multi-agency enquiries or support.

3.2.9 Child N was discharged from hospital after 2 hours as it had been concluded that his injury was accidental, with routine follow up required at fracture clinic. There was a delay in notifying the health visitor about Child N's admission to hospital.

3.2.10 On the 9 October 2008 Child N was seen by a second Consultant Paediatrician for a routine outpatient appointment for both Child P and Child N to follow up on their general development unrelated to the incident on the 7 October 2008. The same day the GP received the hospital notification regarding Child N's injury; however the GP did not discuss the notification with the health visitor. Neither of these doctors queried the diagnosis of accidental injury of a spiral fracture to an immobile baby due to the practice of deference to the original diagnosis made by the consultant paediatrician at the Hospital.

3.2.11 On 13 October Mrs R rang the health visitor to inform her of Child N's injury, at this time the notification of the hospital admission had not been received by the health visitor. A clinic appointment was made for 15 October 2008; however, Mrs R was unable to keep this appointment as she had other conflicting appointments.

3.2.12 On the 14 October 2008 Child N was reviewed by the orthopaedic team at Queen Mary's Hospital, a routine follow up appointment for his arm fracture.

Child P's Presentation to Hospital 23 October 2008

3.2.13 On the 23 October 2008 Child P, Child N's twin sister, was brought to Queen Mary's Hospital in Mr R's ambulance, accompanied by Mrs R and Child N. Child P was admitted to hospital with bronchiolitis.

3.2.14 On the 23 October 2008 Child N returned home with Mr R whilst his twin sister, Child P, remained in hospital with Mrs R.

Child N's presentation to Hospital 24 October 2008

3.2.15 During the evening of the 24 October 2008 Child N was brought to A&E at Queen Mary's Hospital accompanied by Mr R. Child N was floppy with no respiratory effort and a full resuscitation had been started. Mr R stated that Child N had become irritable during the evening and would not accept his feeds. He became significantly worse and began irregular breathing. Mr R commenced resuscitation and dialled 999 for an ambulance.

3.2.16 Child N was transferred as an emergency to King's College Hospital on life support. Following further tests at King's College Hospital, on the 25 October 2008 Child N's life support was turned off.

3.2.17 Child P remained in Queen Mary's Hospital during this time. As a result of Child N's death a skeletal survey was undertaken on Child P on 27 October 2008. Child P was found to have 9 old fractures to her ribs. Child P was made subject to care proceedings and was discharged from Queen Mary's Hospital on 29 October 2008 into foster care.

4 Findings and Lessons Learned

4.1 THIS SECTION FOCUSES ON THE KEY FINDINGS AND LESSONS LEARNT FROM THIS REVIEW THAT HAVE BEEN TAKEN FORWARD TO IMPROVE SAFEGUARDING

4.1.1 The analysis in this case shows that there were no concerns about the welfare of Child N or his twin sister, Child P, prior to October 2008. They had been known to universal health services and their parents had accessed these services appropriately.

4.1.2 However, the analysis does indicate that there was a pivotal moment where different action could have been taken to protect Child N. Given that Child N had a spiral fracture to his arm, had appropriate procedure been followed and a skeletal survey carried out, in all likelihood Child N would have been removed from his parents and taken into care from hospital. A skeletal survey would have revealed a potential history of physical abuse (previous injuries) which was not visible to the clinicians.

4.1.3 At the time the consultant paediatrician was making the critical diagnosis regarding Child N's spiral fracture the history of the family was not collated in a way that would have informed the consultant paediatrician in making this diagnosis. There was information relating to the potential vulnerability of the parents in relation to their past history of depression that was not available to the consultant paediatrician whilst Child N was on the ward on the 7 October 2008.

4.1.4 There was also a lack of reassessment or questioning of the accidental injury diagnosis made on 7 October 2008 during follow up medical appointments. However, these secondary learning points would not alone have resulted in a different outcome for Child N.

4.2 The key learning points can be summarised as follows:

4.2.1 Compliance with Procedures

- The most significant issue identified in this SCR is the failure to follow the guidance set out in the Royal College of Paediatricians and Child Health guidance (RCPCH) *"Child Protection Companion"* (2006) which states that

a spiral fracture of the humerus in a baby is highly indicative of abuse. This guidance recommends that a skeletal survey and bone scan be undertaken on both twins and a referral and strategy meeting to be held prior to the child's discharge. Had these procedures been followed it is highly likely the findings would have resulted in Child N and Child P being taken into care.

- The London Child Protection Procedures (2007) also state that where there have been non-accidental injury concerns, as there were in this case, a referral should have been made to Children's Social Care prior to discharge. This did not happen.

4.2.2 Professional Challenge

- There was a lost opportunity for the staff within Queen Mary's Hospital to exercise appropriate professional challenge while Child N was in hospital and for the doctors and other Primary Care Trust staff to do the same after his discharge. This challenge should have been made in relation to the diagnosis that the spiral fracture was accidental given it is clear in the RCPCH Child Protection Companion that such fractures are highly indicative of abuse. This SCR also highlighted the primacy and importance of that original diagnosis, once the diagnosis of accidental injury had been made it was unlikely for that this would either be challenged or changed.

- Checks were undertaken by Queen Mary's Hospital with Children Social Care however no referral was made.

- The reasons for this centre on the missed opportunity to consider, evaluate and share information. The following paragraphs address these specifics.

- Too much credence was given to the father's account of the injury. Mr R gave a consistent explanation as to the cause of the fracture that was accepted by the medical staff and the feeding position he described was not challenged or explored further despite its very unusual nature. In addition the statement made by Mr R that implied this was not the first time that such an incident had occurred was not challenged by the senior member of the nursing staff who witnessed the comments on 7 October 2008.

- It is possible that these judgements were made, at least in part, on the basis that the parents' professional status and presentation ruled out the possibility of abuse, although this is denied by those involved. The recognition of the possibility of child abuse in all sectors of the community, and of those who work in the caring professions, should be to the forefront of all professionals' thinking while the dangers of over reliance on what parents say was highlighted in the OFSTED *Learning Lessons 2007-8* report.

4.2.3 Management issues

- Recording and file retrieval systems in Queen Mary's Hospital and midwifery services were poor and resulted in, most significantly, information about the mother's historical mental health history, which could have acted as a secondary trigger for multi agency discussion, not being available to Queen Mary's Hospital staff on 7 October 2008.

- A temporary reduction in hours of the liaison health visitor's (LHV) role[1] due to maternity leave, may have had an impact as the LHV was not available on 7 October 2008, while Child N was on the ward. This denied Child N the specific safeguard of a discussion between the LHV and the parents about the circumstances of the injury. There was a delay in the transfer of information about the admission and injuries to the health visiting team by the liaison health visitor through the internal post.

4.2.4 Information sharing

- Following 7 October 2008 the opportunity to revisit and share the known parental history of depression, once the information about the nature of the fracture was known, was not taken forward by Primary Care Trust staff who would have had access to this information. This was an opportunity to consider this as an additional vulnerability factor. The reminder of the importance of the constant reassessment of risk based on new evidence provides a further learning point.

- The chronology of agency involvement with this child provides some evidence that poor information sharing resulted in deficiencies in care and the full discussion and provision of appropriate support. This included a lost referral to the pregnancy support team and a failure to make the father an integral part of the ante-natal assessment. In contrast, the high levels of visiting, post birth, by both midwifery and health visiting should also be acknowledged as good practice.

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[1]The LHV liaises with the community teams in regard to all hospital attendances of children under the age of eighteen regarding health, support and safeguarding needs of children and pregnant women

5 Recommendations

RECOMMENDATIONS MADE AT THE TIME OF THE SERIOUS CASE REVIEW IN APRIL 2009 AND SUBSEQUENTLY ACTED UPON

5.1 INTRODUCTION

5.1.1 Recommendations have been accepted and have been acted upon by the appropriate safeguarding board or individual agency.

- An interagency Action Plan was produced and all actions have now been completed. The completed Action Plan will continue to be monitored by Bexley LSCB

Bexley Local Safeguarding Children Board

1. The LSCB with its representatives from the health economy should consider how the lessons from this SCR in relation to the identification, assessment and response to fractures to babies and very young children might be disseminated both within the LSCB area and more widely to contribute to improving child protection services for children in hospital identified in the Health Care Commission report 'Improving Services for Children in Hospital: Report of the follow-up to 2005/06 Review' published in March 2009.

2. The LSCB should disseminate the following specific lessons of this SCR to all constituent agencies in relation to the importance of understanding:

   - The need to fully consider the possibility of physical abuse, as set out in the RCPCH guidelines, when fractures are seen in any child under the age of 2
   - The potential for child abuse in all sectors of the community, including those involved in caring professions
   - The requirement for a referral to the LADO when there is any suggestion of abuse to the child of a member of the caring professions
   - The dangers of over reliance on what parents say as highlighted in the OFSTED *Learning Lessons* report
   - Assessment must be an ongoing process that takes account of new information and uses this to reflect back on what is already known in order to address both need and risk
   - Identification of who provides support within the family and friends network is of critical importance in assessing the quality of support

3. The LSCB should require all constituent agencies generally and South London Healthcare Trust and Bexley Care Trust particularly, to review their arrangements for staff information sharing and challenge of concerns about decisions made by colleagues, including more senior staff, including the use of formal whistle blowing procedures.

4. The good practice elements in the process by which Child N’s last hours were managed in KCH in balancing support for the family, with child protection and child death review requirements should be disseminated both within and outside the LSCB area.

5. The joint mental health protocol should be amended to ensure it more clearly addresses how multi agency assessment and referral might best be implemented in situations where there are lower level mental health concerns, including support needs associated with multiple births.

Recommendations for individual agencies

1. **South London Healthcare Trust**

- Should review its file retrieval systems to ensure information pertinent to child protection assessment is immediately available. This should consider the use of electronic systems for critical information to aid retrieval when hard copy records have to be transferred to other sites.

- Ante natal booking records need to be matched with women's main notes. Midwifery management to set up a steering group to look at improving communication between community midwifery teams, hospital staff and the members of the primary care teams. To complete a review of maternity documentation with the aims to ensure all information is collected into a single, accessible file.

- Midwives to receive training to highlight their safeguarding responsibilities when booking a woman with a mental health history and the implications of this. Midwives are responsible for sharing this information at booking and following up that it is actioned.

- At the maternity booking father's mental history to be obtained.

- BLSCB Joint Protocol to Meet the Needs of Children and Unborn Children Whose Parents or Carers have Mental Health Problems June 2008 to be publicised within the Trust.

- Mother's medical records to be obtained for medical staff when children less than 6 months admitted to hospital with safeguarding concerns.

- Guidelines in regards to Safeguarding Children flow chart to be amended to ensure that the practice of checking to see if the child has a protection plan or if the family is known is replaced with full consultation with social care.

- To ensure that when a child with suspected abuse is admitted a full and detailed social history is taken and documented.

- The Named Doctor for Safeguarding to develop an Integrated Care Pathway for Safeguarding Children. Pathway to set out guidelines for skeletal survey

in accordance with the guidance in the *Child Protection Companion Royal College of Paediatrics and Child Health 2006 .* The guidelines to state that skeletal surveys are to be preformed in cases of all children suspected of abuse aged under one year of age, and low thresholds to be held for non verbal and unwitnessed injury in children under 3 years of age.

- Audit the use of the Child Protection Medical Proforma documentation.

- Training for all children's workforce to raise awareness of links between fractures and abuse detail. QMS will implement this over the next six months.

- All doctors who see children (surgeons, anaesthetists, A&E and orthopaedic) to attend annual training, covering responsibility, challenging and decision making within safeguarding practices to encourage an environment of collective responsibility.

- When discharging a child in whom abused has been considered liaison with agencies such as the health visitors and GPs is essential prior to discharge. (Amendment to be made to Safeguarding Flow Chart)

- A review is to take place between QMS and Bexley Care Trust in relation to the role and function of the Liaison Health Visitor . This will involve the discharge process.

2. **Bexley Care Trust and South London Healthcare Trust**

- In addition to the single agency recommendations about improving information sharing and liaison, BCT and SLHT should specifically ensure that written information that may pertain to child protection concerns is sent electronically either by fax or secure email to those who need to know and followed up by telephone calls to ensure it has been safely received.

3. **Bexley Care Trust**

- Information systems between GP's and midwifery services should be designed to ensure any risk factors in either parent which may have implications for their ability to care for their children is analysed and shared.

- Should ensure information sharing systems between general practice and health visiting are effective by ensuring arrangements for regular and ad hoc meetings are in place and access to GP records is facilitated.

- GP practices should identify a lead GP for safeguarding, who will receive extra training in child protection and so be a resource for advice and support to colleagues. The development of the role of lead safeguarding GP in each practice should address the wider safeguarding agenda including ensuring that children grow up in circumstances where a case does not meet the s47 threshold

- Health visitors to discuss and record a comprehensive past medical history on both parents as part of the routine family needs assessment. Any significant past medical/social history should be explored fully (by accessing GP records).

- All health professionals safeguarding training should be strengthened with particular reference to the importance of remaining vigilant to risk of harm to babies where a parent has a history of, or current mental ill health in spite of presenting as able and coping.

- All health professionals should be updated on research about the relationship between fractures and physical abuse in young babies through mandatory half day workshops.

- Should review the induction process, support and supervision offered to newly appointed health visitors particularly in relation to safeguarding responsibilities.

- Should review the job description of the hospital liaison health visiting service to strengthen the safeguarding remit and ensure priority is given to ensuring timely liaison in high risk presentations. This should include a review of the cover arrangements for the liaison health visitor role on days when the post holder is not on site to ensure:
  - These are clear and understood by all hospital staff so that inter-agency information sharing is facilitated where immediately necessary
  - There is no compromise to children's safety when the liaison health visitor is not on site

- Should review standard 12 '*The management and follow up of A&E attendances 0-5years'* to ensure expected action is made explicit and audit implementation in June 2009.

- Bexley Care Trust in partnership with LSCB should develop a public health campaign giving clear strategies on how to manage stress related to the care of young babies.

4. **Bexley Social Care**

- Should undertake an audit of duty contacts to ensure that all referrals and enquiries are being appropriately addressed .

5. **Kings College Hospital**

- Staff involved in this case should be briefed on the findings and learning from the internal management review, with particular reference to documentation.

- PICU team should review the system for recording pre-admission communication with retrieval teams.

- A reminder should be sent to all clinical child health staff regarding the need to ensure dated, timed and appropriately signed records and to record where histories are taken from. Also to jointly review and sign entries pertaining to sensitive information/conversations in which several professionals have participated.

- The child health department should develop documentation on which to record visiting/observation record.

- When requesting routine chest x-rays in cases of suspected non-accidental injury doctors should provide full clinical detail to radiology and ask for comment on presence of rib fractures.

6 Terms of reference

Bexley LSCB recognised that Child N's death required a serious case review. The decision was taken by the LSCB Chairman, Deborah Absalom, following a recommendation from the Serious Case Review Panel (SCRP) on 29 October 2008. An independent chairman, Andrew O'Sullivan, Senior Assistant Director, LB Greenwich, was appointed to the Serious Case Review Panel for the term of this serious case review. The following terms of reference were adopted.

- The focus of the terms of reference was to consider, following the death of Child N and the injuries to his twin sister Child P, whether there had been any opportunity for agencies to have done anything before the incident on 23 October 2008 that might have protected both children. This was reviewed through the criteria in *Working Together* (2006) 8.12 and consideration of the following specific points:
- The nature of information sharing and joint agency analysis and planning at all stages of the case in the time period involved in the scope of the review
- The decisions made in respect of the health care needs of each child and whether further multi-agency discussions and planning or services should have taken place prior to birth, during their period living after birth and prior to the separate admissions of each child to hospital 23 October 2008 and in relation to Child N’s earlier hospital admission on 7 October 2008
- The existence and availability of procedures and good practice guidance for use by individual practitioners and managers; how fit for purpose such procedures or guidance were and the reasons why individual practitioners or managers did not comply with any good practice guidelines if that is the finding of individual reviews
- The significance of the fact that the parents in this case were employed as health care professionals and were well known to health and possibly other staff
- The significance if any of the presentation of both parents as coping and able parents

- Whether the lessons in the case give rise to the need for additional safeguards to be developed for children locally and nationally

The time period of the review was agreed to be from the point the pregnancy was confirmed in December 2007 to the point that Child N was pronounced dead and Child P's safety secured through police protection on 27 October 2008. Additionally chronologies were requested that included all historical information known by agencies about Mr and Mrs R.

Serious case review panel members and chairman of the panel

Title	Reason for membership
Senior Assistant Director, Children's Services LB Greenwich	Independent Chair
Deputy Director, C&YPS, Social Care and SEN	No agency involvement. Includes local authority's education responsibilities
Head Teacher, Bexley School	No agency involvement. Brings independent perspective
Director of Nursing & Governance, Oxleas NHS Foundation Trust	Independent of agency involvement, provides mental health perspective
Director, Queen Mary's Sidcup NHS Trust (now South London Healthcare NHS Trust)	No line management of Child N's case
Chief Operating Officer, Bexley Care Trust	SCRP standing panel member
Designated Doctor in Bexley Care Trust	Safeguarding lead. Challenge role in respect of medical information
Superintendent Operations, Metropolitan Police Service	Independent of all agencies. Brings independent perspective
Operations Manager London Ambulance Service	No personal management involvement in case
Bexley Voluntary Services Council Partnership Officer	Independent of all agencies. Brings independent perspective

LSCB officers supporting the panel

Title	Reason for membership
LSCB Manager	Independent of all agencies. Role in developing action plan and disseminating learning
LSCB Business Officer	Minute taker