SBNI

Safeguarding Board for Northern Ireland

Case Management Review
Executive Summary Report

Francis

Safeguarding Board for Northern Ireland
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Introduction

This Case Management Review concerns the child Francis who, when a young baby, sustained injuries.

The Safeguarding Board for Northern Ireland (the Board) is an independent statutory body established by the Department of Health, Social Services and Public Safety (DHSSPS) under section 1 of the Safeguarding Board Act (Northern Ireland) 2011 (the 2011 Act). The Board was established in recognition of the fact that children are more likely to be protected when agencies work in an all-inclusive, coordinated and consistent way.

The Board is made up of key partner organisations from the statutory, community and voluntary sectors, along with lay members who are public appointments. The statutory objective of the Board is to co-ordinate and ensure the effectiveness of what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children.

In carrying out its duties, the Board shall ensure that there is co-operation between itself and the persons and bodies who are represented on the Board. In order to achieve this, the Board shall ensure that organisational boundaries do not act as barriers to protecting children and young people up to the age of 18 years of age.

Section 3(4) of the Safeguarding Board Act (Northern Ireland) 2011 provides for a Case Management Review (CMR) function and the establishment for a CMR Panel to undertake the CMR function on the SBNI's behalf. Section 3(4) of the Safeguarding Board Act (Northern Ireland) 2011 ("the 2011 Act") places a duty on the Safeguarding Board to carry out Case Management Reviews (CMRs) in prescribed circumstances. These circumstances are prescribed under regulation 17 of the Safeguarding Board for Northern Ireland (Membership, Procedure, Function and Committee) Regulations (Northern Ireland) 2012 ("the 2012 Regulations"). Section 7(1)(c) of the 2011 Act places a duty on the Safeguarding Board to establish "a committee to be called "the Case Management Review Panel" ("CMR Panel"). In accordance with regulation 38 of the 2012 Regulations, the functions of the CMR Panel include "holding a case management review in such circumstances as are described in regulation 17(2) and (3); and establishing arrangements for sharing the findings of case management reviews." CMRs are undertaken not to find fault with individual practice but rather to examine the organisational systems and processes that assist or allow individuals to make decision or to act in certain ways in meeting the needs of children and their families, and keeping vulnerable children safe.

The focus of the CMR is on learning, that is:

- learning from what has worked well and then build upon it; and

- what has not worked well and determine how this should be prevented in the future.

Other processes co-exist to determine how a child may have died or been seriously injured, or whether individuals need to be held to account for their actions in respect of the child. These issues are not the responsibility of the SBNI.

The DHSSPS has issued Guidance which sets out clear principles underpinning the CMR processes:

- there should be a culture of continuous learning and improvement across the organisations which work together to safeguard and promote the welfare of children – identifying opportunities to draw on what works and promote good practice;

- the processes should be conducted with appropriate transparency and sufficient openness to engender professional and public confidence in it;

- the scope of reviews must be proportionate according to the scale and level of complexity of the issues being examined;

- CMRs must be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;

- professionals must be involved in reviews and invited to contribute their perspectives without fear of blame for actions they took using their professional judgement and with good intentions;

- families, including surviving children, should be clear about how they are going to be involved in reviews and their expectations should be managed; and

- improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

The Board is committed to undertake all CMRs in line with these principles.

CMR – Francis

The case which is the subject of this CMR, was referred by a Health and Social Care Trust (HSCT) to the former Regional Child Protection Committee (RCPC), which was a non-statutory committee tasked with carrying out CMRs prior to the establishment of the Board. The RCPC decided that the case met its criteria for a CMR but the act of commissioning of the review was deferred until such time as the Board was established. In 2013 the Board commissioned a CMR to be undertaken in respect of this case with full membership of the CMR Panel Team accomplished in September 2013.

The CMR Team has borne in mind the passage of time since the case was initially referred for a CMR and has listened carefully to the views of professionals and available family members, has examined case records and individual agency reports, has factored in the prevailing cultures and pressures within respective organisations and has endeavoured to produce recommendations which are pertinent to safeguarding practice in 2014.

A number of agencies contributed to the Review including the:

- Police Service of Northern Ireland,
- A Health and Social Care Trust in whose area the family lived,
- A Non-Government Organisation,
- General Practitioner.

Terms of Reference

The terms of reference required a primary focus on a six month period which comprised of four months prior to the birth of Francis and two months after the birth at which time Francis was placed in foster care.

Specific objectives of the review required examination of the following:

- assessments undertaken of Francis' mother who was a young care leaver, whose family had been the subject of assessments, and she herself had subsequently been the subject of a residential assessment in relation to her first baby.

- the balance achieved in supervision of the mother and her partner and them being afforded opportunity to care for the child.

- the operation of the child protection system both in hospital and a residential centre.

- the steps taken by professionals to determine whether there was medical or child abuse causation for injuries to the child.

- how the child welfare system reacted to the uncertainties in relation to the paternity of Francis.

Summary of family history and agency involvement leading to the Review

Francis' mother and her partner at the time of Francis' birth were both over 18, but were younger parents. Little was known about the background of the partner. However the mother's family had been known to Social Services and other community professionals during her own childhood in relation allegations of physical abuse, neglect and emotional abuse when support services had been provided on an intensive basis. Francis' mother and her siblings were eventually placed in care. However this intervention was belated, occurring just before Francis' mother had her seventeenth birthday.

Francis' mother had a previous child, ten months older than Francis who, after a residential assessment, was placed with the father under a Residence Order. Francis' mother then had a brief relationship with another man before meeting her next partner. Her next partner believed he was the father of Francis. However a paternity test conducted approximately three months after the birth of Francis proved conclusively that the biological father was the man with whom Francis' mother had a brief relationship previously.

Francis' birth and subsequent events

Francis was born prematurely and was immediately admitted to a Neonatal Intensive Care Unit (NICU) for approximately six weeks. Francis' mother and her partner stayed in a parents' room in the hospital for two nights prior to Francis' discharge. A routine baby check carried out prior to discharge found three small bruises on Francis' back. The bruises were considered not to be consistent with fingertip bruising. Medical tests were undertaken, which were normal. Francis was discharged to the care of the mother and partner to a residential placement organised by the HSC Trust.

A number of days after discharge Francis was seen at an Accident and Emergency Department with further bruises but returned the same day to the residential centre. This bruising was initially brought to the attention of residential staff by the mother's partner. A health visitor who saw Francis later on the same day, arranged an appointment with the General Practitioner who then referred Francis to A&E. Francis was again admitted to hospital a number of days later, due to further bruising appearing on the body, having been referred by the Out of Hours Doctor. Non accidental injury was not considered to be the primary explanation and Francis remained in hospital for one week to allow tests for any underlying physical cause or illness. Although none of these tests were conclusive, Francis was discharged again to the care of the mother and her partner.

The following day new bruises were noticed by the family and brought to the attention of the health visitor who advised that Francis should be taken to hospital. Francis was admitted yet again to hospital. A full skeletal survey and CT scan of the brain were arranged. Possible medical explanations were noted and X-rays revealed multiple rib fractures which had not shown up on an x-ray taken on a previous admission. An MRI scan confirmed several bleeds to the brain of different ages. It was estimated the multiple rib fractures were between two and four weeks old. Trauma, either accidental or non-accidental, was now considered to be the primary explanation for the rib fractures, the bruising and the injury to Francis' brain.

Francis, on discharge from hospital, was made the subject of an Emergency Protection Order and was subsequently placed in a long term kinship placement.

The Child's experience of daily life

Francis is a lovely little child. The kinship carer has indicated her long term commitment to caring for Francis, who is currently the subject of a Care Order.

Francis suffers from a range of long term physical and cognitive disabilities. It remains a grey area as to exactly what extent Francis' various disabilities were caused by injury as a result of major trauma, an infection during pregnancy or a possible genetic syndrome (the latter is suspected but, as yet, remains unconfirmed).

Analysis of agency involvement with the children and family

Working with Francis' mother, her family and latterly her partners placed considerable demands on all of the services especially social care. A response was required on virtually a daily basis over several years. Social Services were acutely aware of the risk posed to her children by lifestyle issues/neglect and organised a residential placement immediately after the birth of the children. The outcome of the assessment regarding a sibling was a placement with the father. In Francis' case, the opportunity for assessment was severely curtailed as the placement in the residential centre was only of a very short duration.

The Review highlighted good practice, such as:-

- the prompt action of the health visitor for Francis, a newly qualified member of staff, when bruising was brought to her attention.

- the middle grade doctors who, on the third admission of Francis, completed very thorough records, liaised with nursing staff and the consultant paediatrician and included non-accidental injury as a possible causation of the bruises.

- the social worker for Francis' mother and her partner who managed the often difficult and antagonistic dynamics with Francis' mother's family most ably.

The Review however concluded that there are a considerable number of lessons to be learnt from the analysis of practice in this case.

Key learning from this case;

- *Improved Guidance on Safeguarding Babies at Birth when there is a Risk of Significant Harm*
  In the case of Francis the necessary UNOCINI assessment was not completed on a timely basis especially when the mother's partner became a member of the family unit and, although the baby was born prematurely, there had been adequate time to convene a Pre-Birth Child Protection Case Conference. Unfortunately this was not done. The result was that the multidisciplinary services were reactive to events rather than proactive. Current safeguarding procedures require both a timely assessment and pre-birth case conference when risk of significant harm to a baby is anticipated. However, the Review Team noted that current guidance is not sufficiently comprehensive and requires revision to include, the Care Pathways, the Birth Child Protection Plan, arrangements for consent to accommodation of the baby or legal requirements if removal is deemed necessary, and planning for out of hours births and premature births.

- *Recognition*
  It is of concern that different hospital based medical and nursing staff noticed bruising to Francis, but did not explore whether these might have been caused through non-accidental injury rather than having a medical cause. Insufficient use was made of child protection specialists in both medicine and nursing, who could have helped staff to see the bruises to Francis within the wider context of the child's social circumstances. There must be acceptance among disciplines that robust challenge, as the occasion demands it, is a healthy state. When physical trauma to Francis was still not considered a potential explanation for the child's bruises by hospital medical staff, other disciplines were not prepared to sufficiently challenge this view.

- *Improved Recording in Hospitals*
  The Neonatal Intensive Care Unit (NICU) noted telephone calls and visits by Francis' mother and her partner but detail regarding the quality of the contact with the baby was not recorded. There is a case for a structured recording format to be introduced in all maternity wards, neonatal intensive care units and paediatric wards where children are admitted and are deemed to be at risk of harm and where those children are either cared for or visited in hospital by parents/carers, or others who may potentially pose risk to the child.

- *Fostering a Team Approach to Safeguarding Practice in Hospitals*
  When child abuse is one element of a differential medical diagnosis, good practice dictates a multi-agency strategy discussion involving both acute and community services. This would ensure that the wider context is always considered and would provide checks and balances in investigation and decision making.

- *Adoption of a single Regional Protocol regarding Bruising in Babies not Independently Mobile*
  A twin track approach should be maintained when investigating bruising in children that keeps the possibility of non-accidental injury 'alive' while another medical reason is sought. Bruising in pre-mobile infants needs particular attention and merits a single protocol to be followed by all medical professionals. The CMR Team was assured that the Board acknowledges this requirement and the Board's Policies and Procedures Committee is currently taking this matter forward. For this reason it is not included as one of the Report's recommendations.

Overall Conclusion

The answer to who or what caused the multiple rib fractures and bleeding to Francis' brain, and precisely how the injuries occurred, remains the subject of speculation. Medical opinions sought, as part of the care proceedings, found consensus in the fact that baby Francis suffered the injuries as a result of physical trauma. Francis' mother and her partner were the main carers when the injuries were incurred. In a non-mobile infant the causation had to be either an accidental or non-accidental injury. Enquiries did not produce a plausible accidental cause. Francis' mother and her partner have continued to deny that they either individually, or, as a couple, ever physically abused Francis. In the absence of any explanation that Francis suffered an accidental injury, it therefore remains probable that the injuries were caused by a non-accidental physical trauma.

There were opportunities to intervene more decisively in Francis' case. The lack of a Pre-Birth Child Protection Case Conference critically affected strategic planning based on a comprehensive assessment of the mother and her new partner about whom nothing was known. Another opportunity arose for intervention when Francis was due for discharge from the NICU of the Maternity Hospital. Unexplained bruising on the baby's spine should have triggered a Child Protection Case Conference especially when the child's name was already on the Child Protection Register and Francis was the subject of a Child Protection Plan. The focus of subsequent medical investigations remained steadfastly on a medical cause for new bruising when non-accidental injury should at least have been part of the differential diagnosis. There were aspects of good practice by the disciplines involved with Francis, the mother and her partner, but practice as a result of the missed opportunities tended to lack a co-ordinated strategic direction.

Recommendations

- SBNI to prepare detailed multidisciplinary guidance to support practitioners in relation to safeguarding unborn babies and specifically also in managing the risks following birth. The guidance should, inter alia, include the Pre-Birth Assessment; the Pre-Birth Child Protection Case Conference; the Birth Protection Plan; arrangements for consent to accommodation of the baby, or legal requirements if removal is deemed necessary, and planning for Out of Hours births and premature births.

- SBNI to remind all constituent agencies represented on the SBNI Board that child protection is 'everyone's business' and that professional challenge based on rigorous systematic thinking and analysis is critical to the safeguarding of children.

- SBNI to include in the forthcoming rewriting of the Regional Child Protection Policy and Procedures, guidance on the Why, When and How of paternity testing when the safeguarding of children is an issue.

- HSC Trusts to introduce in all maternity wards, neo-natal intensive care units, and paediatric wards a jointly agreed structured recording format for nursing staff to monitor visiting/rooming-in of parents and/or carers of 'at-risk' babies.

- The forthcoming rewriting of the Regional Child Protection Policy and Procedures should include a protocol which requires a multidisciplinary information-sharing meeting, or similar to include both hospital and community professional staff in cases where child abuse is considered to be one element in a differential diagnosis.

Individual Agency/Discipline

HSC Trust to:

- review current support arrangements, including consultation arrangements with named child protection professionals, for all hospital medical staff, and nursing/midwifery staff involved in providing direct care for a child where complex alleged or suspected safeguarding issues arise.

- work with the Health and Social Care Board (HSCB) to implement the National Institute for Health and Care Excellence (NICE) Clinical Guidelines on Pregnancy and Complex Social Circumstances via a multidisciplinary working group in order to advance antenatal assessment.

- review the role of the social work service in relation to child protection provided in hospital.

- issue guidance to all medical and nursing and midwifery staff (hospital and community) on the collation, recording and storage of information relating to suspected, alleged or confirmed child abuse.

- to review the system of quality control to provide a means of assurance that social workers' supervision takes place as outlined in the Regional Supervision Policy and includes an opportunity for reflective practice.

- ensure that prior to seeking a residential family assessment, social services should undertake a robust community based holistic risk assessment to determine the readiness of the parent to avail of the opportunity for a placement at the Residential Centre.

- provide Human Factors training as a part of the on-going safeguarding training programme for paediatricians and neonatologists to support the development of multidisciplinary and multiagency child safeguarding teams.

- ensure that all grades of medical staff, both community and hospital based, who are involved with babies and children participate in regular formal multidisciplinary child protection training which is informed by the lessons learnt from CMRs and latest research.

The Non-Government Organisation to:

- ensure that there is clarity in its guidance on admissions to the Residential Family Centre and that professional staff are empowered to insist that all referral documentation is completed to a satisfactory level, in particular the UNOCINI assessment and police checks. It should also include guidance on Emergency Admissions.

- review, in consultation with HSCT, the service provided by the Residential Family Centre with a view to reconfiguring the service to encompass a secondary level of early intervention e.g. day assessment; preparation of parents for return of their child(ren).

- ensure that risk posed by unresolved lifestyle issues of parents/carers to a successful placement in the Residential Family Centre is contained in the HSCT's UNOCINI assessment and that risk identification forms a distinct part of each referral meeting.

HSCB to:

- emphasize to social work staff the necessity of giving due weight to historical information when undertaking a UNOCINI assessment and thereby reducing the likelihood of "start-again syndrome".

- ensure that social work staff complete a comprehensive assessment at an early stage in the child protection process and that this forms the basis of a pathway assessment which is updated at regular intervals.

- provide general medical practitioners with further guidance on the referral of children to hospital when child abuse is deemed to be a differential diagnosis.

Developments since the CMR Review

- Work is on-going under the SBNI Policy and Procedures Committee to ensure that a single regional protocol regarding Bruising in Babies Not Independently Mobile is developed for all health and social care professionals and adopted by all HSC Trusts.

Additional learning from the CMR Review

- The SBNI should seek agreement with HSCTs on a panel of senior medical practitioners who will be available on request from SBNI to become a member of a CMR Team.

- The SBNI and the HSCB to seek agreement on how GP practices may be supported to enable them to prepare an Individual Agency Review which meets the accepted standards.