Serious Case Review
Executive Summary
Re: Child H

Author:

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Chair:

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1. Introduction

1.1 This report is a summary of the findings of a Serious Case Review (SCR) that was undertaken to critically examine the role of agencies involved with Child H and his family following an incident where Child H received serious head injuries inflicted by his father in May 2007.

1.2 Working Together to Safeguard Children 8.6 (2006) requires Local Safeguarding Children's Boards to give consideration to conducting SCR's where:

'A child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect **and** the case gives rise to concerns about the way in which the local professionals and services worked together to safeguard and promote the welfare of children'.

1.3 Child H's case was first presented to Rochdale Borough Safeguarding Children's Board (RBSCB) Case Management Sub-Group on 28th June 2007. It was agreed that the circumstances of the case met the criteria (outlined in 8.6 above) for a SCR and a recommendation to proceed was made to the Chair of the RBSCB. The recommendation was accepted and Ofsted and Government Office North West (GONW) were informed on 2nd July 2007 that a SCR was to take place.

1.4 The SCR was concluded and the Overview Report and Executive Summary were submitted to Ofsted on 10th December 2007. These were followed by the multi-agency and single agency action plans on 31st January 2008.

1.5 There was delay in Ofsted evaluating the submissions and before this was done, the Chair of the RBSCB was notified that two earlier SCR's had been evaluated as 'inadequate' by Ofsted. On the basis of these two evaluations the Chair reviewed the submissions in relation to Child H and concluded that these too would attract an inadequate evaluation. He requested permission to withdraw the original submission so that the SCR could be reworked (in order to promote learning and improve outcomes for children in Rochdale). The request was granted and formal notification of withdrawal was sent to Ofsted on 13th March 2009.

2. Circumstances that led to the Review

2.1 There were early concerns about Child H's health shortly after his birth and he was cared for on both the post natal ward and the Special Care Baby Unit (SCBU). During this time there was an incident in which Adult A became aggressive with hospital staff and he was arrested and removed from the ward to prevent a breach of the peace.

2.2 Child H made a full recovery and was discharged into his parents' care. He was presented at A & E six weeks later with bruising to his arm, forehead and abdomen. Non-accidental injury (NAI) was suspected and Child H was referred to the Paediatric Team and Children's Social Care (CSC) was informed.

2.3 In the course of the enquiries into Child H's injuries, Adult A removed him from the ward on two occasions without medical permission. On the second occasion Adult A was seen to handle Child H roughly.

2.4 Because of the delay caused by Adult A leaving the hospital, the concerns about Child H remained unresolved for 36 hours, during which time there were three different Paediatric Registrars, two Consultant Paediatricians and three Emergency Duty Team (EDT) Social Workers involved.

2.5 In the course of the enquiries into Child H's injuries, Adult A initially said he did not know how the injuries to his son's arm had occurred, but later suggested that they may have been self-inflicted through banging his arm on the rails of his cot. He offered two different explanations for the bruising to Child H's forehead. The marks on Child H's abdomen were reviewed and considered to be a blemish, rather than bruising.

2.6 The third EDT Social Worker who was involved with the case interviewed Adult A and undertook a home visit where she saw Adult B. The Social Worker concluded, on the basis of her assessment, that while Child H's injuries may have been caused by one of his parents – they had not acted wilfully. The Social Worker ascribed Child H's injuries to inexperience and lack of parenting skills on the parts of Adults A and B. As a consequence, she concluded it would be safe for Child H to be discharged into his parents' care. She recommended this course of action to the Paediatric Registrar and Police Officer who were involved at the time and they acceded to her recommendation.

2.7 On the following weekend Child H was presented by his mother at A & E in a collapsed state. He was found to be floppy, unresponsive and having fits. Upon examination and following brain scans, he was found to have suffered a subdural haemorrhage consistent with having been shaken.

3. Process of the Review

It was agreed that the Review would:

3.1 Receive Individual Management Reviews (IMR's) from key statutory agencies involved with Child H and his parents.

3.2 Cover the period from 7th December 2005 until 15th April 2009. This extended timeframe allowed the Panel to give proper consideration to Adult A's earlier life as a care leaver and to review Child H's progress following his serious injuries. It also allowed the Panel to reflect on the actions of the Police and decision making of the Crown Prosecution Service (CPS) in relation to the criminal investigations into Child H's injuries.

3.3 Appoint an Independent Chair and separate Independent Author of the Overview Report. The Chair of the Panel was the Head of Schools Service for Rochdale MBC and had had no previous involvement with Child H and his family. The Author of the Overview Report was an independent consultant with 25 years' involvement in child protection work and previous experience of writing both independent IMR's and Overview Reports. He had had no previous involvement with or knowledge of Child H and his family.

3.4 Consider to what extent family members were able to contribute to the review process and what form this should take. The Chair of the Panel made contact with Adult A, Adult B, Adult C and Child A to inform them that the SCR was to take place and to invite them to contribute. Adult B and her father, Adult C, agreed to become involved and were seen by the Independent Author and the Development Officer of the RBSCB. Both adults were able to make a useful contribution and provided valuable insights into both the dynamics of Child H's family and their experiences of the services they had received from agencies, both before and after Child H sustained his serious injuries.

3.5 Receive Individual Management Reviews (IMR's) from the following agencies:

- Greater Manchester Police
- Pennine Acute Trust (Medical)
- Pennine Acute Trust (Midwifery)
- Pennine Acute Trust (Nursing
- NHS Heywood, Middleton & Rochdale Community Health Care (Health Visiting)
- NHS Heywood, Middleton & Rochdale PCT (GP Services)
- Rochdale Borough Council Children's Social Care

All of these agencies were represented on the SCR Panel.

3.6 The Panel also received correspondence from the CPS relating to the decision making process which resulted in no charges being brought in relation to Child H's injuries. In addition, the Panel received e-mail correspondence on the same subject from Rochdale MBC Legal Services Department.

3.7 Consider the following case specific terms of reference:

- To what extent were the indicators of risk present in this case recognised and taken into account in the decision making process about Child H and his family?
- Were single agency and multi-agency policies and procedures followed in this case?
- Did agencies communicate effectively and work together to safeguard and promote Child H's welfare?
- Was there evidence that the presentation of Child H's parents and their challenging behaviour influenced professionals in their dealings with the family?
- Were there any cultural, linguistic or disability related needs that needed to be taken into account in providing services to Child H and his family?
- What were the reasons for delay with the CPS reaching the decision not to proceed with this case and what were the implications of this decision for other agencies?
- Consider whether there are similar issues in this case compared with earlier SCR's, both local and national, and are there common themes present?
- Did professionals working with Child H and his family receive appropriate supervision and support?
- Was there adequate managerial control and oversight exercised in this case?
- From the information that was available could the incident that led to Child H's serious injuries have been predicted or prevented?

3.8 In order to ensure independence and transparency of the process, none of the authors of the IMR's had had any line management responsibility for the practitioners involved in this case and none had had any previous contact with Child H and his family.

3.9 The SCR Panel met on the following dates:

- 2nd June 2009
- 8th July 2009
- 24th August 2009
- 17th September 2009
- 2nd October 2009
- 7th October 2009
- 22nd October 2009
- 4th November 2009

All the meetings lasted approximately four hours, except for 7th October 2009 which was a full-day meeting.

4. Family Composition and Profile

4.1

Subject	Child H
Ethnicity	White/British
Father	Adult A
Ethnicity	White/British
Mother	Adult B
Ethnicity	White/British
Maternal Grandfather	Adult C
Ethnicity	White/British
Paternal Uncle	Child A
Ethnicity	White/British

4.2 Adult A had been ‘looked after’ for a number of years before moving into independence in 2006. He had had a difficult childhood and had experienced many disrupted placements. Adult B had also had a difficult childhood. She was abandoned by her mother when she was 12 years old and had left home at 16 years because of her strained relationship with her father.

Adult B met Adult A in July 2006. They quickly became partners and shortly thereafter Adult B learned that she was pregnant. At the time of Child H’s birth his parents were young and inexperienced, and still in the early stages of their relationship. They lived on benefits in a one-bedroom flat in an area of relatively high deprivation in Rochdale. Home conditions were satisfactory, but the couple were quite isolated with no contact with any of Child H’s grandparents at that time. There was evidence that they were both cannabis users.

5. Brief Summary of Events

5.1 When Child H was born there were some early health concerns that required him to be moved between the post natal ward and SCBU of the local hospital. In the course of one of these transfers Adult A became angry with staff on the post natal ward and the Police became involved. Adult A was arrested to prevent a breach of the peace.

5.2 Post natal ward staff alerted their colleagues on the SCBU of the incident. Child H remained in hospital for a further ten days and Adult A did not visit again. Child H recovered well and was seen to be well cared for by his mother. He was discharged home without a pre-discharge planning meeting being convened (even though the need for such a meeting had been identified by post natal ward staff).

5.3 Six weeks after he was discharged Child H was presented by his father at A & E with a large, unexplained bruise to his left arm, bruising to his forehead (for which Adult A provided two different explanations) and bruising to his abdomen (which later, on review, was believed to be a blemish). The examining doctor was concerned and suspected NAI. He referred Child H to the Paediatric Team and informed Children's Social Care (CSC).

5.4 When Child H was seen by the Paediatric Registrar and he began to make enquiries into the injuries, Adult A became angry and removed Child H from the ward without medical consent. The Emergency Duty Team (EDT) Social Worker (1) was informed. She made contact with Adult A and persuaded him to return Child H to the ward – which he did three hours later. EDTSW1 did not commence a S.47 enquiry into Child H's injuries.

5.5 Shortly after his return, Child H was seen once again by the Paediatric Registrar who requested permission from Adult A to do an x-ray examination and take photographs of Child H's injuries. This angered Adult A further and he was aggressive towards the doctor and removed Child H from the ward, again without medical consent. He was observed to handle Child H roughly.

5.6 CSC were notified of these events and EDTSW2 (who was now on shift) contacted the Police for help in locating Child H and made provisional arrangements for a foster placement for Child H when he was located. She also discussed with the Duty Inspector the possibility of a Police Protection Order (PPO) if parents would not give permission for Child H to be accommodated when he was located. The foster placement was required because the Consultant Paediatrician had indicated to EDTSW2 that Child H could not be readmitted to the Children's Ward when he was found as his case was a 'social not medical' problem.

5.7 Child H was located many hours later in the company of both his parents at the home of a friend of Adult A. Child H was taken back to hospital by his father and his mother returned to the family home. By this time, a third Social Worker (EDTSW3) was on duty. While waiting for the Consultant Paediatrician to come on duty, EDTSW3 familiarised herself with the events of the previous day and undertook further enquiries, including a joint home visit with the Police to Adult B at the family home.

5.8 In the course of this visit she learned that the bruise on Child H's arm had been seen at 9:00am by his mother (he had not been taken to hospital until 13:30 hours) and it was suggested by Adult B that Child H might have caused the injury himself, by banging his arm on the rails of his cot. EDTSW3 suspected that Adult B might have been under the influence of cannabis during this meeting.

5.9 On the basis of the information she received, EDTSW3 concluded that Child H's injuries might have been caused by his parents, but this had not been 'wilful cruelty', but the result of inexperience and limited parenting skills. As a consequence, she decided it would be safe for Child H to be discharged into his parents' care. She discussed her decision with the Paediatric Registrar on duty at the time and the Police Officer who had accompanied her on the home visit and they agreed with her recommendation. Child H was discharged without being seen by the Consultant Paediatrician.

5.10 EDTSW3 did not forward the information that she had about Child H to CSC until two days later. On this day, CSC held a strategy meeting that involved a representative from GMP, but not the hospital or Health Visiting Service. At this meeting the information about the events of the previous weekend was available plus additional information provided by the first examining Paediatric Registrar in a telephone conversation that morning, who told a CSC Social Worker that 'NAI could not be ruled out as an explanation for Child H's injuries'. On the basis of this information the strategy meeting concluded there was insufficient evidence to justify a S.47 enquiry and it was decided to defer a decision on this pending written confirmation of the medical opinion of Child H's injuries.

5.11 Three days later, Child H was presented again to A & E in a collapsed state. He had been left in the care of Adult A for a number of hours and when Adult B had returned home, she found Child H to be cold, floppy, unresponsive and having seizures. Upon examination, it was believed that Child H's injuries were consistent with him having been shaken.

5.12 Child H was at first made the subject of a PPO, then an Emergency Protection Order. He later became the subject of an Interim Care Order and, having made a good recovery, he was discharged into foster care 16 days after admission.

5.13 Adult A and Adult B were arrested and questioned about Child H's injuries 17 days after his second presentation at A & E. They denied any responsibility for the injuries and were bailed pending further enquiries. In the course of their questioning both Adult A and Adult B accused Child A and his girlfriend (who had been staying at the family home at the time) of causing the injuries.

5.14 In the civil proceedings in relation to Child H the Judge made a Finding of Fact that either Adult A, Child A or Child B had been responsible for the injuries to Child H's arm and that Adult A had caused Child H's serious head injuries. He found that Adult B was not implicated in any of Child H's injuries.

5.15 Child A and his girlfriend were not interviewed until five months after the incident when they denied all knowledge of and responsibility for Child H's injuries. Adult A and Adult B were never interviewed again as suspects in this investigation.

5.16 The Investigating Police Officer made contact with the CPS six months after Child H sustained his injuries to seek advice on whether charges could be brought. He was informed that more information was needed and he was given an unrealistic timescale to complete the tasks he was set. He did not meet this deadline and did not contact the CPS again for 11 months.

5.17 Between these dates the Investigating Officer made efforts to obtain the information required, but was not assisted in this by the responses of the Local Authority Legal Department and an expert witness that had been involved in the civil case.

5.18 The Investigating Officer submitted the file on the case to the CPS 23 months after Child H sustained his injuries. The CPS advised that no charges could be brought as 'a Court would be likely to find that the delay was such that it would mean that a fair trial would be impossible due to the effect on witness recollection'.

5.19 During this time Child H remained the subject of an Interim Care Order while assessments were undertaken on Adult B. Following the Finding of Fact relating to Child H's injuries and the confirmed separation of Adult B from Adult A, it was agreed that Child H could return to his mother's care. At the final hearing Child H was made the subject of a one-year Supervision Order and Adult B was given a Residence Order. Child H has continued to thrive in his mother's care. He appears to have made a full recovery from his serious injuries and is making developmental progress. He is shortly to commence nursery.

6. Similarities with Other SCR's and Relevant Research

6.1 Within the same timeframe as Child H (18 months), there were three other SCR's (involving four children) commissioned by RBSCB. There are a number of similar issues present in those cases that are evident in Child H's case. These include:

- In two cases children were seen at hospital (one of them on more than one occasion) with bruising that was either unexplained, or for which there was no satisfactory explanation. Both of those children were discharged without being seen by a Consultant Paediatrician and subsequently reinjured.

- In all four cases there was evidence that both underlying risk factors and high risk indicators were not recognised and did not impact upon the decision making.

- There was poor intra-agency communication and poor inter-agency communication, including a lack of clarity about the reason for and extent of the concerns about one child. There was little evidence of effective inter-agency working.

- Record keeping across all agencies was of a poor standard and not 'fit for purpose'.

- There was no evidence of discharge planning meetings being considered or convened.

- The failure of staff from all agencies to fully implement single and multi-agency Child Protection Procedures.

- Poor supervision of staff and lack of managerial oversight and control (including similar issues relating to EDT Workers as evidenced in Child H's case).

6.2 A number of these issues echo the findings of the review of the SCR evaluations undertaken by Ofsted between April 2007 and March 2008 published in the document Learning Lessons, Taking Action. The following themes were identified:

- The failure of staff to identify and report signs of abuse.

- Poor recording and communication.

- Lack of knowledge about and failure to implement policies and procedures.

- Issues of culture, religion, race, language and disability were not taken into account in providing services to families.

- Parent centred practice, including accepting parents' self-report at face value.

6.3 In addition, there were many features of this SCR which corresponded with the findings of Improving Safeguarding Practice (A Study of SCR's 2001-2003), Rose and Barnes, and Analysing Child Deaths and Serious Injury Through Abuse and Neglect: What Can We Learn? (a biennial analysis of SCR's 2003-2005) Brandon, Belderson, Warner, Howe, Gardner, Dodsworth and Black (particularly in relation to physical assault and head injuries in babies). The features relevant to this SCR were:

- Poor assessment and analysis relating to risk of harm to children.

- Not recognising indicators of risk.

- Poor information sharing and recording.

- Failure to follow child protection procedures or S.47 processes.

- Insufficient supervision and lack of management oversight of cases.

- Presence of current or recent domestic violence and the failure of the mother to recognise the danger this presented for the child (domestic violence was present in this case, but not disclosed by Adult B).

- Children who had spent their early days or weeks in SCBU's.

6.4 The Review considered the following pieces of research relevant to Child H's case:

- Dalgleish and Drew (1989)
  Risk Indicators: The relationship of child abuse indicators to risk assessment in courts' decisions to separate

- J Warner, Journal of Social Work, 2003
  An initial assessment of the extent to which risk factors are taken into account when assessing risk in CP cases

- Ann Hagell, Bridge Child Care Development Service (1998)
  Dangerous Care: Reviewing the risks to children from their carers

- Understanding Child Abuse
  Jones, Picket, Oakes, Barbor
  Palgrave McMillan (1987)

- Framework for the Assessment of Children in Need and Their Families
  Department of Health, 2000

- Looking After Children: Research into Practice: The Second Report of the Department of Health on Assessing Outcomes in Child Care
  Ward H, HMSO (2000)

- The Assessment of Parenting Capacity
  The Child's World: Assessing Children in Need.
  Jones, DPH, NSPCC (2000)

7. Lessons to be Learned

7.1 It was the conclusion of the SCR Panel that there was no evidence that one single agency or individual was responsible for not preventing Child H's serious injuries. Rather, he was the victim of a multiple failure of those agencies with which he and his parents had contact to recognise the full extent of the risks to which he was exposed and to take protective action.

7.2 The process of the Review identified the following important messages:

- Child H was the fifth child in Rochdale who had been the subject of a SCR over a limited timeframe, and in each of these a number of similar failings and shortcomings were identified. The most important message from this Review is that RBSCB **must** learn the lessons from SCR's and the recommendations for change **must** be implemented and embedded into practice.

- Practitioners from all agencies with safeguarding responsibilities must have the necessary skills to recognise situations that might prevent risk of harm to children and be provided with guidance on how this should be recorded and reported.

- Staff from all agencies need the skills and support to deal with the coercive behaviours of unco-operative or pseudo-compliant adults to enable them to address their concerns and focus on the welfare of the child.

- In order to safeguard and promote the welfare of children it is important for practitioners from all agencies to implement and adhere closely to agreed single and multi-agency policies and procedures.

- All agencies need to develop and maintain fit for purpose recording and recordkeeping systems to underpin effective safeguarding practice.

- All agencies need to ensure that the work of practitioners is supported with rigorous and challenging supervision and that there are arrangements in place to exercise appropriate managerial oversight and control over the work of practitioners.

- In order to optimise the learning from SCR's it is essential that agencies are able to provide timely , 'fit for purpose' IMR's

8. Recommendations

To address these issues the Panel agreed the following single and multi-agency recommendations.

Multi-Agency Recommendations

1. RBSCB to develop a strategy to ensure that the messages from this SCR are disseminated to staff in all agencies to ensure that lessons are learned.

2. All agencies make arrangements to ensure the work of practitioners is supported with rigorous and challenging supervision and there are arrangements in place to exercise appropriate management oversight and control over the work of practitioners.

3. All agencies to clarify for staff the limits of their professional autonomy in relation to decision making and provide guidance on consulting with managers.

4. RBSCB to:

   ◊ Ensure safeguarding training for all agencies includes specific, detailed reference to risk recognition (to include messages from SCR's).

   ◊ Develop a multi-agency recording instrument available for recording risk which identifies underlying risk factors and high risk indicators.

   ◊ Provide guidance for all staff in relation to reporting identified risks to Children's Social Care.

5. When professionals from any agency have concerns about their own personal safety, they must always consider the implications for children from exposure to the same risk factors.

6. All agencies to make arrangements to provide support to staff working with hostile/unco-operative parents that ensure their personal safety and allow them to focus on the safeguarding needs of children.

7. All agencies to require staff to adhere to agreed policies and procedures (including recording procedures) relating to safeguarding children and develop an audit framework to ensure compliance.

8. RBSCB to develop a strategy to ensure that authors are provided with the necessary preparation, training , support and guidance to provide timely,' fit for purpose' IMR's.

Single Agency Recommendations

Rochdale Children's Social Care

1. Develop a Formal Protocol between Pennine Acute NHS Trust and Children's Social Care relating to the discharge of children from hospital where non-accidental injury is apparent or suspected.

2. Referral for pre-birth assessments to be made from YPST to the Access and Support Team (formerly the Duty and Assessment Team), when it becomes known that a young person who is receiving their services or their partner becomes pregnant, becomes mandatory practice.

3. Ensure that Social Workers have access to, understand and adhere to the RBSCB Child Protection Procedures and Rochdale MBC Children's Social Care procedures governing their responsibilities in responding to and working to agreed process and standards for:

    - ◊ Child Protection Referrals
    - ◊ Initial Assessments
    - ◊ Section 47 Enquiries

    The procedures should be informed by Working Together to Safeguard Children (HMSO, 2006) and any subsequent practice guidance issued in supplement. Existing performance management frameworks to be amended to ensure evidence of compliance/non compliance is available for Senior Management scrutiny and action.

4. Ensure policy and practice information and guidance on recordkeeping is adhered to therefore ensuring that fit for purpose individual case records are kept. Develop an audit framework to report on and allow for management scrutiny of recordkeeping standards.

5. Ensure that all staff and managers comply with the Local Authority's policy on supervision and maintain fit for purpose records of all supervision meetings/sessions.

Heywood, Middleton & Rochdale Health Visiting Services

1. Health Visitors should receiving training on recordkeeping in line with NMC Guidance.

2. Research relating to safeguarding children should be disseminated, together with learning from local and national serious case reviews at the appropriate health visiting forum.

3. Develop agency specific policies on:

   ◊ No access visits to homes where there are vulnerable children/babies.

   ◊ Attendance at strategy meetings (in partnership with CSC).

   ◊ Staff supervision, including guidance on how and when supervision may be accessed by staff (threshold criteria).

4. Commissioners need to ensure that there is an appropriate level of adequately skilled Health Visitors in post to meet the organisation's responsibility under Section 11 of The Children Act 2004 and their compliance with C2 of Standards for Better Health.

Heywood, Middleton & Rochdale GP Services

1. GP's need to be made aware of the importance of detailed information gathering and detailed recordkeeping.

2. GP Practices to develop a system process whereby they can flag up important information within the incoming letters and divert this immediately to the attention of the GP.

3. Training of colleagues in the area of safeguarding must be adjusted to incorporate raising awareness of risk of harm, improved skills in details information in medical records, including specifically psychosocial information and improving communication both within the practice and between agencies and care sectors. This is to be incorporated into the local GP child protection training programme. The outcomes of this SCR and the lessons learnt to be incorporated into GP child protection training programme.

4. The practice involved in this SCR to review this case using the Significant Event Proforma.

Greater Manchester Police

1. Ensure information is provided to Child Care Services so they are fully aware of the correct procedures to follow when specialist staff from the Public Protection Unit are not on duty to respond to and immediately deal with allegations surrounding suspected child abuse.

2. The Learning Delivery Unit of Greater Manchester Police, in conjunction with the 'Quest' project to look at and identify opportunities for continued professional development of all staff regarding issues of vulnerability and safeguarding.

   This is currently a live recommendation arising from the Bolton Serious Case Review RS and SS. Consequently, there is no obligation for this to be an action from this SCR.

3. Working on consultation with the Force Leadership Team, the 'Quest' Project will endeavour to identify an Optimum Policing Model for the work of the PPIU's across the force. This will ensure both common minimum standards that will governance policy and procedure, and will also align sufficient resources to ensure a robust and coherent approach to domestic abuse and safeguarding.

   This is currently a live recommendation arising from a recent Bolton Serious Case Review. Consequently, there is no obligation for this to be an action from this SCR.

Pennine Acute Trust (Nursing)

1. Documentation policy should be adhered to at all times and staff need to be informed that it is mandatory, and that they are accountable for their standard of recordkeeping.

2. There is a need for safeguarding training for all nursing staff and robust training records should be maintained. Training needs to address clear guidance for staff in relation to their duties, responsibilities and the challenging of any decision making. Training also needs to address the identification of high risk indicators and course of action to be taken once identified.

3. There is a need for discharge planning meetings and discussions to take place prior to the discharge of any child with safeguarding concerns and these needs to be documented with clear actions and individuals' responsibilities.

4. Clear guidance to be developed in relation to supervision support for nursing staff in relation to safeguarding issues when staff are confronted with challenging behaviour. Staff should be discussing all safeguarding issues with their line manager.

Pennine Acute Trust (Medical)

1. Documentation policy should be adhered to at all times and the medical team should be made aware of this and informed that it is mandatory and also that they are accountable for the standard of their recordkeeping.

2. There is a need for a discharge planning meeting/discussion before children are discharged where child protection concerns exist. Medical staff will be made aware that once non-accidental injury is entertained, the guideline for investigating and managing such cases should be adhered to strictly.

3. The policy regarding admission of young children with suspected NAI pending the outcome of medical and risk assessment should be made clearer and circulated widely.

4. Consultant needs to see/review all children with child abuse prior to discharge.

5. Ongoing safeguarding training for all grades of staff. As a matter of urgency – all staff with responsibility for the care and discharge of children with suspected NAI to have training in recognition and referral and the medical role in the investigation process and case management.

Pennine Acute Trust (Midwifery)

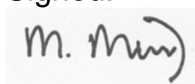
1. Ensure that staff are aware of the policy for the management of patients/ visitors who pose a risk of harm to children, young people and vulnerable adults (February 2008) and that their actions are compliant and accurately recorded. This should be included in the Child Protection mandatory Training Programme.

2. In line with the above policy for the management of patients/visitors who pose a risk of harm to children, young people and vulnerable adults (February 2008), ensure that staff carry out risk assessments in relation to the risk posed to the child/young person and inform Children's Social Care.

3. Review and update the Hospital Discharge Policy to make explicit reference to the need to arrange a pre-discharge meeting/discussion at the point that the risk is identified. Children's Social Care to be involved in all pre-discharge discussions and invited to all discharge planning meetings.

4. Via the Child Protection Training Programme reinforce the Hospital Discharge Policy and the need for midwifery staff to work closely with other members of the multi-disciplinary team.

Signed:



M Muir
Independent Author

Date: 04/11/2009