May 2010

Serious Case Review

Executive Summary

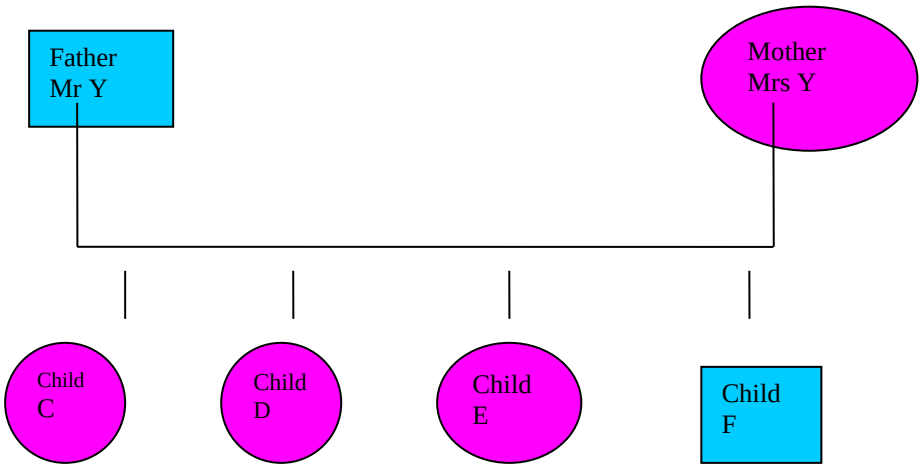
Child C and her Siblings

Contents

1. Introduction

1.1 This report is the Executive Summary of a Serious Case Review commissioned by a Local Safeguarding Children Board into the actions of agencies involved in the case of Child C who died at the age of 17 in November 2008. This report also considers any lessons emerging from agency involvement with the three younger siblings of Child C as these children lived in the same family household at all times. These children will be referred to as Child D, Child E and Child F.

1.2 The family composition in this case was as follows:



Name	Relationship	Ethnicity
Child C	Subject	Asian British
Child D - Sibling 1	Sister	Asian British
Child E - Sibling 2	Sister	Asian British
Child F- Sibling 3	Brother	Asian British
Mrs Y- Parent	Mother	Indian
Mr Y- Parent	Father	Black African

1.3 Child C was the oldest of 4 children

1.4 This Executive Summary is written so that the lessons arising from the case can be understood by professionals and public alike both in the area where Child C lived and elsewhere. However, careful attention has been given to ensuring that this Executive Summary does not inadvertently identify Child C or members of her family as the nature of Child C's death is unusual, there are three children still living in the family and there is no evidence of wrong doing on the part of any member of Child C's family. To this end, the local authority and other agencies are not named either in the report or in the recommendations. It is also the view of the panel overseeing this Serious Case Review that the Executive Summary should be made public in a way which does not identify the local authority, the region or the ethnicity or personal details of the family as these are all likely to indicate possible identification.

1.5 Consideration of maintaining confidentiality whilst also ensuring that lessons are visible has been a matter of some concern for the Serious Case Review panel overseeing this case and this issue is addressed in the final recommendation from this review.

1.6 The circumstances leading to the decision to undertake a Serious Case Review in this case were as follows.

November 2008

Child C died as an in-patient in a hospital due to HIV/AIDS. Child C's immune system was severely compromised as a result of the HIV infection. Child C had been taken to her local hospital by emergency ambulance on 17 October 2008 with a two month history of considerable weight loss, depression, labial infection, anaemia, lethargy and shortness of breath. Following admission to the ward, Child C was diagnosed on 18th October 2008 with retroviral disease and treated. There was no history disclosed that could account for the transmission of the infection.

19 February 2009

The death of Child C was reviewed at the routine regional Child Death Overview Panel meeting which exists to review all unexpected child deaths in the area and to liaise with others where further action or investigation might be required. In view of the fact that Child C had died and that there was no known route of transmission for the HIV/AIDS infection (the Child Death Overview Panel knew also that both parents had tested negative for HIV infection by this time), this panel recommended the case be reviewed by the Local Safeguarding Children Board's Screening and Serious Case Review Working Group.

24 April 2009

A multi-agency strategy meeting took place under safeguarding procedures further to the recommendation of the Child Death Overview Panel. This meeting concluded a need for all agencies involved to undertake checks with regard to involvement with the family and report to the LSCB Screening and Serious Case Review Working Group in June 2009.

15 June 2009

The LSCB Screening and Serious Case Review Working Group met to consider the case of Child C. The group considered all of the information available to them in deciding whether this case met the criteria for a Serious Case Review. The unanimous decision of group members was that the case did not meet the criteria for a Serious Case Review under Chapter 8 Working Together 2006. The working group members then determined that the case required all involved agencies to undertake an Internal Management Audit of service provision so that lessons could be learned where appropriate and so that further attention could be given as to whether a Serious Case Review was warranted.

7 September 2009

A further meeting of the LSCB Screening and Serious Case Review Working Group agreed the terms of reference for the Individual Management Audits agreed at the June 2009 meeting.

23 November 2009

In line with plans made at the above meetings, the Chair of the Screening Group reported to the full LSCB meeting with regard to Child C's case. By this time the Chair of the Screening Group had also been appointed as the Independent Chair of the LSCB itself. The Chair reported that in her view the criteria for a Serious Case Review were met and that there were indications of learning for local agencies such that a review should take place under the terms of Chapter 8 of Working Together to Safeguard Children 2006. In view of this and in line with local safeguarding procedures, the LSCB determined that an emergency meeting of the Screening and Serious Case Review Working Group should take place to reconsider the case and recommend a view about a Serious Case Review or otherwise to the Chair of the LSCB who was in turn mandated by the LSCB to make the final decision without a need to return to the full LSCB meeting.

3 December 2009

The Screening and Serious Case Review Group met and made a recommendation to the Chair of the LSCB that the criteria for a Serious Case Review were now met. The independent author of this report

understands that this decision was reached after some debate and that some agencies had initially thought that the lessons had already been identified through the earlier audit process. The Chair of the LSCB made the decision for a Serious Case Review to take place and formal notifications to the regional Government Office and Ofsted were made; the regional Government Office had been previously notified of the discussions about the case underway.

1.7 The independent author of this overview report was subsequently appointed to this task and a specific Serious Case Review Panel put in place to oversee and agree the review process and report. The first SCR Panel meeting took place on 18 December 2009. Further to the panel meeting of 19 May 2010, permission was sought and granted from and by Ofsted for an extension to the time limit for this review. This was to enable feedback to and seeking of views from health practitioners who had been involved in the case.

1.8 The SCR Panel members for this case were:

- Independent Chair of the LSCB
- Head of Children & Young People's Services
- Detective Inspector, Child Abuse & Investigation Team
- Detective Sergeant, Public Protection Desk
- Legal Manager (Community Services)
- Additional Education Needs Manager, Social Care & Learning
- Consultant Nurse Safeguarding
- Acting Director Children Young People & Family Services (Designate), NHS Primary Care
- Assistant Director, NHS Foundation Trust
- Ambulance Operations Manager, Ambulance Service Trust.

1.9 David Derbyshire acted as the independent author and advised the panel at each of its meetings. David Derbyshire is independent of any agency in the area and has never worked in that authority. He is employed as the Head of Performance Improvement & Consultancy by the national children's charity, Action for Children.

1.10 The agencies required to produce Individual Management Reports (IMRs) for this review were:

- Local authority Children's Social Services
- Local authority Learning and Achievement
- NHS Hospitals NHS Trust
- NHS Primary Care Trust
- Police Service
- NHS Foundation Trust
- Ambulance Service NHS Trust

1.11 Each of the above appointed a senior officer not involved in the case to undertake a review of case records. Each also undertook discussions with staff who were involved in order to answer the questions posed in the terms of reference. Each produced a chronology using the format agreed and a report which analysed the facts of the case from a single agency perspective.

1.12 Each of the IMRs was prepared in line with the terms of reference agreed by the Serious Case Review Panel and Chair. These involved consideration of the questions posed for all case reviews by Working Together to Safeguard Children 2006 guidance. This was the guidance in place at the time that the Serious Case Review was commissioned although this Executive Summary and the overview report are written in line with the guidance contained in the superseding guidance, Working Together to Safeguard Children 2010, which was issued by the Government in March 2010.

1.13 In addition each report was asked to consider questions specific to the case of Child C and her siblings as known at the commencement of the review. These were:

- Were there opportunities to have afforded better protection to Child C and her siblings both in respect of issues relating to Child C's health condition and in respect of any other matters of a safeguarding nature within the family?

- Consider whether there were any observations of behaviour or conduct from Child C, Child C's siblings or parents that might have led to questions of abuse or neglect.

- Why was earlier identification of the HIV virus not made in this case in relation to Child C?

- Why was there not a consideration of the possibility of the risk of child sexual abuse or sexual exploitation within or outside the family in this case?

- What referrals were made to the local authority Children's Services and if none were made why not?

- To what extent did interventions place Child C and/or her siblings at the centre of attention and to what extent were the rights, wishes and feelings of Child C and her siblings considered?

- Was practice influenced and in what ways by the ethnicity, religion or other cultural issues of Child C her siblings and parents?

- How effective were LSCB decision-making processes in ensuring that a review of the circumstances of the case was undertaken further to the Child Death Overview Panel meeting in February 2009

1.14 In addition, the central city hospital NHS Trust was asked to answer a separate single term of reference in lieu of the above. This was to examine how the decision was made not to carry out a post mortem in respect of Child C further to her death and consider whether policies, procedures or practice should be changed as a result.

1.15 The SCR Panel determined that the period under review should run from 1 January 1995 to the end February 2009. The start date related to the fact the first primary health contacts with Child C were reported in 1995 and these required consideration in view of the later diagnosis of HIV. The end date related to the fact that the Panel was advised that the discussions with Child C's parents concerning the nature of transmission were held at the local hospital up to the end of February 2009.

1.16 In line with section 8.30 of Working Together to Safeguard Children 2010, the designated safeguarding health professional for the NHS also produced an overview report and chronology of all health agency involvement. The designated safeguarding health professional had been consulted by a practitioner on 17 December 2008 about the death of Child C.

1.17 During the course of this Serious Case Review, there have been no parallel other processes relating to the death of Child C. There has not been a police investigation as there is no clear criminal offence or allegation in the case. A Sudden Unexpected Incident Review was conducted in December 2008 by the local NHS hospital Trust further to questions about the practice of the sexual health clinic in contact with Child C in August 2008.

1.18 The independent author wrote to Mr and Mrs Y to invite them to meet with him and express their views about services provided to them and their children. Mr and Mrs Y did not respond to this offer. It should be noted that the delay in undertaking this review meant that the request to Mr and Mrs Y was made over a year after the death of their daughter and possibly therefore at a time when the family was making adjustments to coping with life without Child C. In view of this, the panel agreed that it was insensitive to seek to invite Mr and Mrs Y again but that the independent chair and author would seek to meet with them to advise them of the findings of this Serious Case Review upon its completion.

1.19 At the Panel meeting on 1 April 2010, it was agreed that the independent author should seek expert paediatric and HIV advice about the case in view of questions concerning the fact that there

remains no known route of HIV transmission and concerning the significance of potential opportunities to diagnose Child C's condition earlier. Further to this meeting, the independent author arranged for such advice to be provided. Child C's medical notes were not consulted by the experts concerned as these had been subject to scrutiny by the IMR author.

1.20 This advice was provided in writing on 17 May 2010 and considered at the panel meeting two days later. The expert advice has been extremely helpful in enabling the author and the panel to finalise the analysis of lessons in this case. The advice informs the report in a number of places with regard to the terms of reference.

2. Summary of Facts

2.1 Child C attended her family GP on eight occasions in 1995. She was seen for minor ailments including cough and cold, head lice, pre school vaccinations, high temperature, urine infection and a rash over her body. This number of contacts was not common in Child C's contacts with the GP. In 1996, Child C presented twice to her GP with cough and cold symptoms and a rash. In 1997, she attended the GP with a rash on her body as well as head lice, MMR booster and cough.

2.2 On 27 March 1999, the mother of the children called the police via 999 further to an argument with her husband. Police attended the home whereupon Mrs Y reported difficulties in looking after four children and receiving little help from Mr Y. The children were noted to be in tears when the police officers arrived. Three of the four children were seen by the police officers. Both Mr and Mrs Y stated that they were stressed and depressed and were advised by the police officers to seek assistance from their GP.

2.3 One of the police officers visited Mrs Y again on 12 April 1999 as a follow-up and was advised by Mrs Y that the situation at home was now much calmer.

2.4 On 7 September 1999, police responded to a further 999 call made by Mrs Y. On this occasion she had been assaulted by Mr Y in an argument. Mr Y was given a formal warning by the police and both were advised to seek help around their relationship. The children were noted not to have been involved in the argument. Police policy at the time was that records of all such incidents would be sent to the local authority Social Services department but there was not documentary evidence of this having happened on this occasion.

2.5 In 2002, Child C attended a minor injuries unit complaining of an injured foot further to standing on a razor blade in the bathroom.

2.6 Child C's behaviour at school is reported to have begun to deteriorate slightly in 2002 when she was placed on report card for lack of uniform and was involved in threatening to 'beat up' another child whom she called a 'boffin.' This was a transition year for Child C and the latter report would have been in Year 7 at her secondary school.

2.7 Child C was regularly placed on report card in the Spring of 2003 and was warned about smoking in Year 7 on one occasion. In November 2003, Child C was punished at school with detention for truanting and telling a lie to her teacher. Mrs Y rang the school to express concern that Child C thought that she was being unfairly treated.

2.8 In March to April 2004, there were further concerns about Child C smoking and being off school site on one occasion without permission.

She was also found sniffing ‘poppers’ (alkyl nitrates) at school on one occasion.

2.9 The school reports for Child D and Child E remained positive in terms of their being hard-working and conscientious throughout the period under review. Child D was described as sometimes ‘chatty’ but there were no other reports noted by the school.

2.10 On 7 June 2005, the Deputy Head Teacher of Child C’s school made a referral by telephone to the local authority Children’s Social Services. This concerned a report by Child C that on 6 June 2005, there had been a family argument at home and that in anger Mr Y had struck out at Child C’s face. She stated that she had put her arm up to protect herself and that Mr Y then slapped her arm.

2.11 Child C alleged that Mr Y was violent at home and that the police had been called on approximately four previous occasions. This number does not accord with the two instances referenced in the police review of its records. Child C said that she had been very frightened and that her father had threatened ‘to give her a face she won’t forget.’ She stated that Mr Y had also smashed a mirror in his anger on the previous day. Child C said that she had scratches on her hand from picking up the pieces of broken mirror from the floor. Child C stated that she did not have any other injuries.

2.12 Child C alleged that about three years earlier Mr Y had hit her and caused her lip to be swollen for three days. This incident was not known to any professional agency involved at the time according to the IMRs for this Serious Case Review.

2.13 A duty social worker contacted Mr and Mrs Y separately by telephone. Mrs Y confirmed that Mr Y had a temper and said that Child C was a normal ‘lippy’ teenager. She stated that Mr Y would benefit from anger management treatment and that this had been offered further to an incident two years previously following a domestic violence incident. It is not known if this is correct as there is no agency record of such an incident in 2003.

2.14 Mrs Y also said that Mr Y had hit Child C two years earlier further to an argument over her going to the cinema. Mrs Y advised the duty social worker that Mr Y would not attend an office appointment to discuss matters and that a home visit would be necessary. In an earlier discussion, the duty social worker and the senior practitioner working as duty manager for that day had agreed to offer an office appointment to family members.

2.15 In his discussion with the duty social worker, Mr Y accepted that he had hit Child C on 6 June and agreed to attend for an office appointment to see the social worker on 9 June 2005. Mr Y accepted that his behaviour had been unreasonable. The duty social worker re-

contacted Mrs Y to advise of an office appointment for both Mr and Mrs Y on 9 June 2005.

2.16 At some point in the discussions with one of the parents, the duty social worker became aware that one of the younger children in the family was reportedly suffering from shingles. The duty social worker and a different duty senior practitioner considered this in terms of the risk of infection to the worker and agreed to postpone the office appointment until 21 June 2005. Mrs Y was informed and the deputy Head at the school advised. The chronology provided by the NHS Primary Care Trust suggests that in 2005 it was Mrs Y and not one of the children who contracted Shingles.

2.17 The appointment on 21 June 2005 was attended by Mr Y and Child C but not by Mrs Y or the younger children. Child C spoke warmly of her father but stated that she was frightened when he lost his temper at which point he would normally shout and become violent towards objects rather than other family members. Mr Y accepted that he had difficulties in managing his anger but did not wish to enter a formal treatment programme. The duty social worker recorded that she advised Mr Y of the dangers of domestic violence. Mr Y gave written consent for the local authority to carry out other agency checks on him and his children.

2.18 In a supervision discussion on the same day with the first duty senior practitioner, it was agreed that there was no further role for Children's Social Services. There was no further action until the duty social worker wrote the case closure note on the file on 3 August 2005. At this point and with the agreement of the Duty Team Manager, the duty social worker wrote to Mr and Mrs Y to confirm that no further action was being taken and advised about the impact of domestic violence on children and avenues to obtain assistance with anger management.

2.19 The case was finally closed by the Duty Team Manager on 8 August 2005.

2.20 On 14 October 2005, the Head Teacher of Child F's school wrote to Mr and Mrs Y further to a concern about Child F being one of small group of boys who had chased girls at school and hit them with ropes in order to 'hurt them.' This was the only concern about Child F's presentation at school in the period under review other than progress reports in relation to his special educational needs.

2.21 In 2005, Child E presented for a second time to an Accident and Emergency Department with a head injury.

2.22 In 2006, Child C was prescribed two courses of antibiotics within a four-month period by the family GP for a sore throat. Child D was also seen by the GP for further abdominal pains. In 2007, Child C was seen by the GP again for a sore throat.

2.23 Through the course of 2005-06, school reports on Child C were positive and stated that she should achieve good examination results. She was excluded from school on one occasion for three days for bringing the school into disrepute at a parents' evening. However, the records at school showed good attendance and high achievement for the most part by Child C.

2.24 On 17 August 2006, police officers visited the family home at the request of officers in a nearby local authority. This request related to a request to check on the welfare of the children of Mrs Y's brother who was staying at the address temporarily and briefly whilst involved in an acrimonious separation from his wife. The officers visited the home and found the children well and reported this information back to the police service in the nearby authority.

2.25 Child C transferred to the Sixth Form College in September 2007. Child C's attendance dropped to 75% of school time and she was issued with warnings about non attendance at Sociology and Psychology classes in particular. In December 2007, Child C was interviewed formally at school under the college's disciplinary code in relation to her attendance. In January 2008, further to an absence which Child C said related to an assault on a cousin, she said that she had at her previous school seen a school counsellor and had a history of violence in her family.

2.26 The review of Child C's grades at AS Level in September 2008 showed that she had achieved Grade A in Sociology, Grade B in Law and Grade D in Psychology.

2.27 Child C's attendance at college deteriorated further at this point and a note was made that she had been missing from college for four weeks on 13 October 2008. She was withdrawn from her examinations further to more non attendance in November 2008 by which time the college had some information about Child C being unwell as the reason for examination withdrawal was 'medical.'

2.28 Between July and October 2008, Child C was seen on 13 occasions for health appointments. These related an abscess on her labia or boil on her vulva or cyst in her genital area and other appointments around tiredness. Most appointments were with the family GP but she was also seen at the Sexual Health Clinic at the local hospital and by Accident & Emergency staff at the same hospital and by Ambulance service staff. The details of these health contacts are set out below as contained in the Health Overview report.

31st July 2008

Attended primary health care surgery for abscess on labia, seen by practice nurse and required antibiotics Flucloxacillen.

1st August

Attended GP and prescribed Doxycycline

5th August 2008

Abscess on Labia Prescribed Amoxicillin and referred to local Accident & Emergency Department and then subsequently directed to the sexual health clinic. Child C attended A&E, complaining of a cyst in the genital area. She was advised to attend the Sexual Health Clinic or return to A&E if any concerns. The wound swab was negative for infection. (*A&E card not available)*. Child C did not attend the sexual health clinic appointment on 5 August.

7th August 2008

Child C attended the Sexual Health Clinic at the local hospital, accompanied by a referral letter from her GP, requesting that she be seen due to a boil of the vulva. Her next of kin is recorded as her mother. The completed registration form was ticked to indicate that the HIV test, included as part of a sexual health check up, was not required by Child C. It is not clear if she was asked to complete the form herself or if it was completed for her by health care staff. She was examined by the Consultant for Sexual Health, Reproduction and Family Planning, who was accompanied by a chaperone. The doctor recorded the presenting complaint as a 'lump' noticed two weeks ago by Child C, which burst a few days later. Her GP had given her antibiotic treatment 48 hours previously but it was still hurting. It was noted that she stated that she had never been sexually active and there had been no tropical travel. The doctor said in her statement to the IMR author that the patient denied sexual activity and that this information was obtained from the patient when alone. The genital examination notes stated that there was a large ulcer on the vulva that looked like a burn. The genital diagram denoted this was on the left labia with a note that it was an infected ulcer with oedema. Under the heading "Diagnosis and management" the documentation was to continue with current treatment, ice packs, Na Cl (saline) bathing and simple analgesia. There was no further documentation re advice or follow up plan.

Child C attended A&E at 19.25hrs on the same day as she was feeling unwell. Blood was requested for full blood count and urea and electrolytes (FBC and U&E) but there is no record of the results on the pathology system. She was seen by a doctor at 20.32hrs and discharged home at 22.59hrs. Patients usually wait for the results. She requested to be seen by a female doctor but as this could not be accommodated, she left without being assessed.

11th August 2008

Child C attended GP prescribed Amoxicillin

12th August 2008

GP referred to a doctor at a different local surgery for a gynaecological assessment

14TH August 2008

Child C did not attend gynaecological appointment.

19th August 2008

Child C attended GP and was prescribed Amoxil and Flucloxacillin antibiotics.

8th September 2008

GP prescribed ferrous sulphate (iron tablets) for anaemia

11th September 2008

GP prescribed another course of antibiotics but the prescription was not collected.

12th September 2008

Treated for oral thrush, prescribed Fungilin. Parents requested a wheelchair from her GP

2nd October 2008

A '999' call was received by the Ambulance Service at 18.27hrs for breathing difficulties. On examination Child C was not experiencing any pain or feeling faint, appeared to have no difficulty in breathing from a clinical cause and was able to speak in full sentences, indicating she was alert and responsive. All clinical observations appeared to be within expected parameters, save a slightly increased pulse rate. Following assessment, Child C was removed to the ambulance and subsequently conveyed to the local hospital, the ambulance leaving the scene at 18:51 and arriving at the hospital at 19:11.

Child C was seen and discharged home.

3rd & 6th October 2008

Child C was seen by GP and prescribed antifungal throat lozenges.

2.29 On 17 October 2008, at 22:16, a '999' call made to the Ambulance Service by an unknown caller reporting that Child C was having breathing difficulties at home. Upon arrival at the home, Child C

explained that she had been having problems with a boil on her vulva and that she had stopped eating and had lost 2.5 stones in weight since August 2008. She stated that she had been having difficulties breathing and suffering anxiety attacks. Child C said she had developed thrush in her mouth and throat and had been prescribed antibiotics. She said that she had been confined to bed for the last two weeks. The ambulance crew report also indicated that Child C had become incontinent of urine.

2.30 Child C was taken by ambulance to the local hospital that night and admitted although A& E staff initially tried to offer an appointment for Child C to see a member of the urgent care team in the clinic next to the Accident & Emergency Department. Her parents refused this option, however, and insisted on seeing a specialist.

2.31 In the early hours of 18 October 2008, Child C was provided with intravenous drip treatment for dehydration and treatment for thrush. A diagnosis of retroviral disease was made although the parents were not made aware of this at the time. A plan was made to transfer Child C to the hospital's High Dependency Unit (HDU) if her condition worsened.

2.32 Input was provided by the Consultant Microbiologist on 19 October 2008 and s/he advised Child C of the HIV diagnosis. No detailed records exist of this discussion. Further investigations were ordered to consider differential diagnosis of HIV. Treatment was considered to be appropriate with co-trimoxazole treating most causes of typical and atypical pneumonia.

2.33 On 20 October 2008, it was noted that there had been an improvement in Child C's condition.

2.34 Child C saw the hospital's HIV Counsellor on 21 October 2008. Child C was very distressed about the diagnosis and also worried that her parents would think that she had been sexually active. Child C was adamant that she had never been sexually active and had never been forced to have sexual contact of any kind. The HIV Counsellor advised Child C not to say more at that point but to wait until she was feeling stronger.

2.35 On 24 October 2008, Child C had a long discussion with a Senior House Officer on the ward about HIV although was advised that more information could be provided by the HIV Counsellor. The record of this discussion did not indicate a means of HIV transmission in Child C's case.

2.36 On 26 October 2008, Mr and Mrs Y were informed that Child C's condition had continued to improve although they were told that it was not possible to know how Child C acquired HIV without a history a route of possible infection.

2.37 On 28 October 2008, the HIV Counsellor saw Child C again. Child C was anxious and asked lots of questions about the route of infection for HIV. She was not feeling well and the Consultant later noted missed antibiotics in the previous 24 hours. Her temperature was 39 degrees centigrade. The HDU was put on standby but Child C's condition was noted to have improved by the night time.

2.38 On 29 October 2008, at 0800, Child C was reviewed by the registrar. Her saturation levels were 95% and she felt better. Later on the ward round she was withdrawn and not interested in food but was drinking sips of fluid. The plan was to redo blood cultures and continue as before. Her peripheral saturation levels were poor so her ear lobes were used and recorded at 98%.

2.42 On 30 October 2008, Child C's condition deteriorated. At 05.10hrs Child C was reviewed by the SHO and then seen by the registrar and HDU Senior House Officer. She was struggling to breathe, tachycardic (fast pulse) and distressed. Saturation levels fell from 70 – 80% to 67.5% in ear lobe. IV steroids were given. At 05.30hrs Child C was transferred to ITU in respiratory failure and a plan made for likely intubation. A Central Venous Pressure line was inserted and intensive care commenced. At 09.50hrs Child C was reviewed by the HDU Consultant. Note was made of hypoxia secondary to Pnuemocystis Carinii Pneumonia (PCP) and MRSA infection. Advised to chase CD4 blood count, give paracetamol regularly and contact HIV team. At 12.25hrs Child C was seen by a Consultant. The HIV team at a central city hospital was contacted and offered a bed if one became available, but no change in treatment. The consultant microbiologist offered advice on medication.

2.43 Child C was too breathless to speak when the HIV counsellor visited her on 30 October 2008. Discussion with her mother about testing was postponed due to her daughter's critical condition (the hospital team had wanted to test Mrs Y believing that vertical transmission of HIV from the mother to be the most likely cause of infection). At 12.30hrs the ITU registrar explained to Child C and her family the need for intubation. Child C was intubated and ventilated. Blood was sent for culture/ testing. At 17.00 – 18.00hrs the registrar attended to Child C. She had become increasingly unstable from a respiratory point of view. A chest X-ray confirmed that the airway tube was correctly placed and there was no pneumothorax. She was unfit to transfer to a central city hospital although a bed was available and proning was commenced to increase oxygenation. At 19.15hrs a Registrar contacted the infectious disease registrar at the central city hospital and transfer was organised for the next day.

2.44 Child C was transferred by ambulance to the central city hospital on the evening of 31 October 2008 whist intubated. The reason for the transfer was recorded to be that the transfer would enable additional

specialist HIV input to be provided at the central city hospital as this was temporarily unavailable at the local hospital.

2.45 Child C was transferred with a diagnosis of HIV and respiratory failure thought most likely to be due to *Pnuemocystis Carinii Pneumonia* (PCP). This is a form of pneumonia caused by a fungus commonly found in lungs of healthy people which caused opportunistic infection where the immune system is weakened as in HIV/AIDS.

2.46 During her stay at the central city hospital, Child C's condition continued to deteriorate and treatment was withdrawn. Child C died in hospital in the course of November 2008.

2.47 On 17 December 2008, the HIV counsellor and Community Paediatrician met with Mr and Mrs Y by prior arrangement. The Designated Nurse Consultant for the local NHS service was informed of the meeting but did not attend as she was on sick leave. By this time, Child C's mother had tested negative in an HIV test carried out at the hospital. A discussion was held about routes of HIV transmission and also about the possibility of child sexual abuse. The parents were upset but understood the reason for the discussion and the need to test Child C's siblings as it could prevent them from becoming critically ill. Child C's mother requested to be tested again and her father volunteered to be tested.

2.48 On 5 January 2009, all the family members were tested for HIV and all were negative results.

2.49 The HIV Counsellor and Community Paediatrician met with Mr and Mrs Y again on 12 January and 9 February 2009 for further discussions about the cause and nature of Child C's HIV infection. The parents declined the offer of bereavement counselling. Mrs Y stated that Child C had undergone extensive dental treatment at the age of 7 years old and queried whether the dentist could have been the source of infection. The dental surgery had closed and efforts by the police and health service to locate the records of the dentist were not successful.

2.50 The final meeting between the parents, the HIV Counsellor and the Community Paediatrician took place on 11 March 2009. At this meeting, the parents expressed anger with the GP for not doing more but declined the opportunity of further contact. The HIV Counsellor gave them her contact details.

3. Key Issues and Themes

3.1 This section of the report summarises the key issues and themes to emerge from a detailed consideration of practice in this case and considers whether or not services could have been offered to better effect and with better outcomes for the children and whether there are lessons for the future when professional agencies come to deal with a similar case again.

The quality of the local authority response to the school's child protection referral regarding an alleged assault on Child C by her father in 2005

3.2 The referral from Child C's school to the local authority children's social services in 2005 was clear and well made. It was clear that Child C alleged an assault albeit not one resulting in significant physical injury and that Child C was frightened enough to the point of telling her teacher both about the alleged incident and about a previous occasion when she stated she had been hit by her father and about police responses to previous instances of domestic violence in the household. This should have alerted the social work team receiving the referral to the fact that there was more concern than a single incident and that Child C's fear was greater at this point in 2005 than when previous incidents had allegedly occurred and she had said nothing.

3.3 Furthermore, the local child protection procedures require that there be a response to an allegation of assault on a child or young person within one working day and that the child or young person should be seen alone and the parents or carers interviewed. Procedures also require that information be shared with all agencies involved and with the police whenever there is the possibility of a criminal offence having taken place.

3.4 In this instance, a decision was made prior to discussion with any other agency or anyone in the family to offer an office appointment for the parents and Child C two days after the referral. The local authority IMR does not attribute this decision to lack of resources or level of demand but to a misjudgement over the degree of priority which such a referral should receive.

3.5 Matters were compounded when the duty social worker and a supervisor on the day made a decision to delay the appointment by almost two weeks because of a concern about shingles in the household posing a risk of infection to staff in contact. This was an ill-judged decision that created far too long a gap between Child C telling her teacher about an incident on 7 June and a social work response on 21 June. The children were all at school in so far as it is possible to conclude from evidence available in this review and on this basis there should have been no reason to suppose that a social worker in contact with the family on one occasion would be at greater risk of infection

than teachers in contact with the children for five days out of every week. The social workers and her supervisor made no effort to seek advice from a Designated Safeguarding Health professional or from the local authority's own occupational health service or from the NHS public health service.

3.6 Upon seeing Child C and her father, there was no action put into place to resolve an issue around Mr Y's anger so that Child C could have felt safer. Mr Y was offered and refused a referral to an anger management programme and this should have led to some thinking with other agencies involved about how best to ensure the safety of Child C and her siblings. Instead, the letter written to Mr and Mrs Y in August 2005 advised about anger management programmes but also about the impact of domestic violence on children when in fact the issue at hand in June 2005 was an alleged assault on a child and not domestic violence on the household. The practice in this case was perfunctory, slow and not centred on Child C and her need to be and to feel safe. There was no information shared with or sought from the police or any other agencies despite asking Mr Y for permission to do so.

3.7 Notwithstanding the practice deficiencies in the social work response to the referral in 2005, it would be wrong to conclude that a different response would necessarily have impacted on Child C's death over three years later. Perhaps most significant was that Child C was not afforded an opportunity to develop a relationship with a trusted professional based on understanding Child C's vulnerability at that point in time.

The process of diagnosis of Child C's HIV status

3.8 The contacts between Child C and health services in 2008 prior to her admission to hospital in October 2008 also raise some concern about the safeguarding of Child C. This young person had no less than 13 meetings with health professionals between July and October 2008 before her admission to hospital. The majority of these focused on her discomfort in relation to what is variously described in health records as a boil on her labia or vulva or a cyst in her genital area. At no point did any professional question whether these symptoms could have been consistent with sexual activity or sexual abuse albeit there is no independent evidence to suggest that these were the causes.

3.9 The expert advice provided to this Serious Case Review has addressed clearly the practice issues arising from the late diagnosis of HIV with regard to Child C. The advice identified that there were numerous opportunities to consider testing for HIV in the period from 7 August to the point of Child C's admission to hospital on 17 October 2008. In addition, there was an ongoing weight loss issue which in the absence of other explanation, should have indicated a possibility of HIV

infection. The advice provided listed the missed opportunities around diagnosis:

- 'The first significant opportunity for HIV testing which was missed was on attendance at the Sexual Health Clinic on 7th August 2008. Prior to this there are no specific indicators for HIV testing. If Child C had declined HIV testing, this should have been challenged by Sexual Health Clinic and it should have been recorded that testing had been declined despite recommendation for testing.
- The second opportunity for testing came the same day in A&E. She should had been asked if she had any doctors recently and if she had disclosed that she had a vulval lesion this should have triggered the request for HIV testing.
- Oral candida in a 17-year-old is a clear indicator of immune deficiency. There is no question that HIV testing should be offered at the first presentation with this on 12th September and most definitely when it recurred on 3rd and 6th October 2008. This combined with a request for a wheelchair would indicate the strongest recommendation for need for urgent HIV testing.
- On 2nd October the key question with the difficulty in breathing is whether this was on exertion and what the oxygen saturation (SpO2) in the blood was. SpO2 is a routine measurement with a sensor on a finger and if the history had suggested shortness of breath walking then this should have been measured, if normal at rest then after exertion. If there had been this history or a drop in SpO2 then PCP should have been suspected and an HIV test indicated.
- The history of weight loss from August 2008 is not recorded until 17th October. Unexplained weight loss is a cardinal feature of HIV and if the history of weight loss had been obtained earlier should have been an indication for recommending HIV testing.'

3.10 When seen in the sexual health clinic at the local hospital in August 2008, Child C was not asked about or consideration given to testing for HIV. Nor was there a follow up plan made after she was seen at that clinic even though the health care staff had no means of knowing whether the infection and the fatigue would be resolved in a 17-year-old girl. This gap in service provision is all the more stark in the knowledge that Child C returned to the same hospital feeling unwell only hours after leaving the sexual health clinic on 7 August.

3.11 The GP did make referrals for Child C to be seen at the sexual health clinic and by another GP for a gynaecological examination. These were

reasonable actions on the part of a GP without specialist knowledge or training in HIV and AIDS

3.12 A Serious Untoward Incident investigation was completed by the NHS with regard to the manner in which the sexual health clinic dealt with Child C's case. The Health overview report notes that 'A serious untoward incident (SUI) investigation was completed on 19/12/2008 at (the local) Hospital by the Divisional Medical Director and the Genitourinary Medical Consultant once concerns were raised retrospectively regarding the initial management of Child C in the Sexual Health Clinic. There is concern expressed by a HIV consultant in the Sexual Health Clinic that the action plan was not completed and lessons to be learned were not shared appropriately with staff. However, the SUI Report indicates that named professionals with responsibility for completion of actions were identified. A time scale for completion of actions is not documented and there is in fact no evidence from the SUI report that all actions were completed. A clinical incident form was not completed.'

3.13 There was no evidence of any attention paid to Child C failing to attend her first sexual health clinic appointment on 5 August 2008 or her gynaecological appointment made by her GP on 14 August 2008.

3.14 The description given by the ambulance staff who attended to take Child C to hospital on the night of her admission to the local hospital on 17 October 2008 is illuminating. This tells of a young person suffering from anxiety attacks and having difficulty breathing and having lost 2 ½ stones in weight on her own account in the previous two months. It also told of a young person who had become incontinent of urine and bedridden for the two weeks prior to her admission.

3.15 The sharp decline in Child C's health in the late summer and early autumn of 2008 should have been detected by health staff. The family GP was in contact with Child C in September and received a request from Child C's parents for a wheelchair on 12 September 2008 without exploring this further. Child C had also been conveyed by emergency ambulance for assessment at the local hospital on 2 October 2008. She was discharged but there is no evidence in the Health IMRs or overview report in this review of any plan for follow-up at hospital or via the GP. Given the description provided by the ambulance crew on 17 October 2008, it is also difficult to understand how the Accident & Emergency staff at the local hospital could have initially suggested to Mr and Mrs Y that they arrange an appointment with the emergency out-of-hours GP service rather than admission to hospital and it is difficult to conclude in the absence of any other reason provided in the health reports to this review that this initial decision at the hospital was not unduly influenced by a wish to protect the valuable and scarce resource of a hospital bed.

3.16 Nor did any of the health professionals prior to Child C's hospital admission on 17 October 2008 consider the question of HIV. It has been difficult to understand why the sexual health clinic did not seek to undertake a HIV test on 7 August 2008 other than it would appear that Child C's assertion that she had never engaged in any form of sexual activity was accepted at face value and that she was in effect treated as an adult patient because she was over the legal age of consent rather than as a child under the age of 18 as defined by the Children Act 1989.

3.17 The expert advice also addressed the question of the most likely route of HIV infection insofar as Child C was concerned. The advice was clear in stating that the risk of infection from contact with a dental practice at the age of 7 was 'extremely improbable.' The most likely route of infection would usually be vertical, namely from the birth mother to Child C. Assuming that Mrs Y is the birth mother, and the panel had no reason to suppose differently in this case, the next most likely cause would be by sexual contact or injecting drug use. It should be noted that the discussions with Mr and Mrs Y following Child C's death took place in a way not co-ordinated by a multi-agency strategy group, and they gave no consideration to asking Mr and Mrs Y to confirm parenthood of Child C.

3.18 The expert advice also confirmed that while it was most likely that infection would occur some 8-10 years prior to the symptoms presented by Child C, there was no guarantee of this and that there are known cases of shorter and longer periods between infection and symptoms presenting.

3.19 The effect of the above meant that there was a delay in the diagnosis of Child C's HIV status. This also meant that there was a delay in Child C receiving the benefit of anti-retroviral drugs. It is well established that survival and life quality are improved with earlier diagnosis of the HIV virus. The expert advice provided to the panel makes clear that while difficulties and delay in diagnosis of HIV in young people are not at all uncommon in the UK, the number of opportunities presented is such that there is a need for a significant role in raising understanding and awareness of HIV symptoms in primary care and acute specialist units in the borough. Given that this is said by the expert advice not to be uncommon, it will be important that some consideration is given nationally to how well health practitioners and others are equipped to identify possible signs and symptoms at the earliest possible stage.

3.20 There is also a clear need for the NHS to ensure that individuals and services working in the local area are equipped with the knowledge and skills to ensure that such a list of opportunities is not repeated in a future case.

3.24 The Health Overview report states on page 19 of that report that 'There were no obvious risk factors for the infection reported to or identified by

practitioners across health organisations prior to the HIV diagnosis. Child C had denied being sexually active or any intravenous drug use whilst at Queens Hospital. A referral to a specialist service in relation to her initial recurrent symptoms may have instigated further exploration and investigations and revealed other underlying contributory conditions. There was no disclosure of sexual activity by Child C to any practitioner across the health organisations. ‘

3.25 This conclusion sits somewhat at odds with the expert advice provided to the SCR Overview author and indicates a need for practitioners and managers throughout NHS services to understand the nature of HIV symptoms more readily. It is accepted on the other hand that this issue is unlikely to be relevant in one authority alone; the expert advice suggests a widespread concern throughout the country about cases of late diagnosis.

3.26 The expert advice provided made very clear the significance of missed opportunities around diagnosis. It concluded that with earlier diagnosis Child C might indeed not have died at all although there can of course be no certainty about this.

‘When she presented on 2nd October, if HIV had been diagnosed, she would have been treated with high dose cotrimoxazole for PCP infection and she could have made a full recovery.

Even as late as the presentations on 3rd and 6th October with oral candida could have prevented her terminal illness if she had tested for HIV at that stage and had appropriate prophylaxis before 17th October.’

3.27

3.28 The expert advice provided makes clear that HIV is now a manageable, chronic condition with a good prognosis for most patients.

The omission of medication given to Child C on 27-28 October 2008 when an in-patient at the local hospital

3.29 There were three occasions of antibiotics not being administered in this period and the Health overview report to this review concludes that a Clinical Incident form should have been completed to analyse why these errors had occurred and steps to avoid recurrence. This process was not followed.

3.30 The Health reports to this review do not adequately address why these errors occurred but seek to provide assurance of new systems to prevent this happening in future. The Health overview report concludes that the omission of medication is unlikely to have had a significant impact in terms of affecting Child C’s survival. It is however clear in the

local hospital trust report that Child C's chest condition deteriorated further to the absence of medication.

3.31 It is not possible to conclude that the omission of medication had a significant effect on final outcome in this case but the omission was nevertheless a further indication of an opportunity to afford better safeguarding to Child C not being taken.

The consideration of the well-being of Child C's siblings and/or other children further to her diagnosis in October 2008.

3.32 Further to diagnosis of Child C's HIV status, there were a number of occasions in which health staff at the local hospital explained the HIV virus to Child C and asked questions of her. Child C was clear and consistent in her position that she had never engaged in sexual activity although she was never asked specifically about whether she had ever been sexually abused.

3.33 It appears most likely that in the face of Child C's consistent denial of sexual activity, the health staff at the hospital came to believe that it was most likely that the HIV infection had been a vertical transmission from Mrs Y as this is frequently the most common route of HIV infection in children. To this end, Mrs Y underwent the first HIV test within the family.

3.34 There appeared to be no consideration of whether Child C might not be in a position to tell the full truth in the days following HIV diagnosis even if she had ever been sexually active or abused. Child C advised the HIV Counsellor about her distress and fear about the shame she would bring on her family as her parents might suspect her of sexual activity. The impact of these feelings in view of Child C's ethnicity and culture did not receive any attention whilst in hospital.

3.35 Further to the simple acceptance of Child C's account, the health staff at the hospital also appeared to give little or no thought to whether or not the route of transmission could have been via sexual abuse from a perpetrator still in contact with Child D, Child E and Child F. The admission to hospital of a young person with undiagnosed HIV and no clear route of transmission should automatically have alerted the health staff at the hospital to have referred the case of Child C and her siblings to the local authority Children's Social Services so that it could plan a strategy with the hospital staff and police to investigate whether or not any of the children could have been or could still be at risk.

3.36 The HIV Counsellor and Community Paediatrician met with Mr and Mrs Y on four occasions between December 2008 and March 2009 further to Child C's death. Some of these meetings concerned the need to test all the family members for possible HIV infection but they also considered the question of how Child C might have acquired HIV. The designated safeguarding health professional for local NHS service was

advised also of these meetings although did not attend because of her own ill health.

3.37 These discussions should not have happened in this fashion. The health staff at the hospital should have referred the case to the local authority and there should have been a joint plan for enquiries to be made further to the diagnosis of HIV and the realisation that there was no known route of transmission. This would have meant that the discussions with Mr and Mrs Y would have taken place within the framework provided by the multi-agency local child protection procedures and would have addressed the potential safeguarding concerns within the family clearly and unambiguously such that it would be clear from proper assessment whether or not there were any future risks to the siblings of Child C

3.38 It is important that young people aged 17 are afforded appropriate protection and safeguarding and not viewed and treated as young adults before reaching the age of 18. It is far from clear that health service staff viewed Child C as a child or young person in this case. It is also significant that checks and balances to ensure that practitioners who are not working with safeguarding issues on a daily basis are supported to do so effectively did not appear to work in this case. The clinical leads for Child C's case did not identify a potential safeguarding issue at either the local hospital or at the central city hospital and the designated safeguarding health professional did not make further enquiries to ensure that the case was being dealt with properly when alerted to the initial meeting between Mr and Mrs Y and the HIV Counsellor and Consultant in December 2008.

The importance of keeping children at the centre of interventions

3.39 The section above makes clear that Child C and her siblings were not well viewed as at the centre of agency attention and concern. Child C was not provided with a HIV test and nor was the Under-18 risk assessment form used in relation to her at the sexual health clinic. The question of possible risk to Child C and her siblings in the past or the future was not well shared by local hospital staff with any other agency.

3.40 Indeed, the siblings of Child C were not seen at all other than when tested for HIV after Child C's death in November 2008. They were not seen in the local authority needs assessment in 2005 and nor were they considered or seen by the GP when Child C was presenting with persistent health concerns in the summer of 2008. They were not seen by anyone to assess their well-being further to the diagnosis of their oldest sister on 18 October 2008 with retroviral disease.

3.41 The only evidence in the IMRs submitted to this review that Child C and her siblings were placed at the centre of attention was contained in the report of the local authority education service which reported on behalf of the schools concerned in this case. That report painted a clear

picture at least of what Child C was like as an individual in the school and sixth form college setting and this knowledge is only known to this review because of the records and recollections of those working in the schools concerned.

3.42 There was undoubtedly attention to understanding and responding to the wishes of Child C when considering her symptoms at the sexual health clinic as she was asked about sexual activity and was adamant that she had not engaged in any. This might well have been true of course but the approach taken did not seek to question or challenge Child C's assertions and instead took them at face value on the basis that she was in effect a young adult. To this end the case is an important reminder of the need for practitioners working with young people not to lose sight of safeguarding needs when seeking to work in ways which promote the rights of children and young people.

The impact on practice of considerations of the ethnicity, religion and culture of Child C, her siblings and parents

3.43 It is impossible to conclude with total certainty about the extent to which practice was unhelpfully influenced by misplaced considerations around the family's ethnicity and culture. However, there are strong indications in this case that Child C did not receive a good service and that this was partly likely to be related to misconceptions about how a family from the ethnicity concerned would not be troubled by an issue such as HIV.

3.44 There is some evidence reported in the Health overview report that some practitioners held preconceptions about the likelihood of HIV infection occurring in certain ethnic groups. However, there is not evidence that these practitioners would not have acted upon clinical symptoms appropriately had they had more knowledge and understanding of HIV and AIDS. The GP in his interview with the Health authors was clear that he would have referred Child C onto specialist services had he known about her being or likely to be HIV+. Indeed, the GP did refer Child C onto specialist sexual health services even without this knowledge of HIV.

3.45 There is note made in the Health overview report of the fact that staff at the central city hospital did suggest to the parents that they might wish to seek out support from within their own cultural community but there is no record of assistance being made with this and there is an implicit assumption therein that the members of this community would in some way support Mr and Mrs Y without the need for formal referral or arrangement of support that might be applied ion other situations.

The effectiveness of LSCB decision-making processes in ensuring that a review of the circumstances of the case was undertaken further to the Child Death Overview Panel meeting in February 2009

3.46 In spite of considerable efforts by LSCB agencies to review this case, there has been extensive delay in bringing this case to a Serious Case Review. The point of such reviews should be to learn lessons as speedily as possible in order to implement any improvements in the event of similar cases arising again.

3.47 The first delay followed the initial Child Death Overview Panel meeting in February 2009 as the strategy meeting to consider the issues was not then held until April 2009. This delay was too long given that a strategy meeting takes place in order to consider and plan a strategy to reduce risk and meant that there was a potential further two-month extension of risk to Child C's siblings at this point. None of the IMRs address this particular delay or the reasons for it.

3.48 There was then an elongated process of considering individual management audits undertaken outside of the scope of a Serious Case Review. This process in effect started upon the recommendation of the April 2009 strategy meeting to refer the matter to the Screening and Serious Case Review working group of the LSCB until the November 2009 LSCB meeting when the LSCB Chair was concerned that the criteria for a Serious Case Review were met. This is not to say that managers were not busy as all had commissioned an internal audit of case records in the case prior to November 2009.

3.49 The debate at the initial meeting of the LSCB's Screening and Serious Case Review working group meeting concerned the question of whether or not the case met the criteria for a Serious Case Review under the terms of Working Together to Safeguard Children 2006. There was no doubt that the case contained issues about inter-agency working which required some form of review but the working group members were not convinced that there was sufficient evidence to know or suspect that child abuse or neglect had been a factor in this case before Child C's death.

3.50 This was a reasonable debate as there remains no evidence of abuse or neglect in Child C's family or elsewhere in this case. However, the Screening and Serious Case Review working group was too focused on the narrow words of criteria contained in the guidance and not sufficiently focused on the wider question of whether this young person's death, preceded as it was by concerns over non-diagnosis or identification of potential concerns was just so serious that only a Serious Case Review would be properly merited. In the view of the author, the LSCB Chair was right in November and December 2009 to insist on a Serious Case Review taking place but most of the information leading to that view was known at the point of the initial meeting of the Screening and Serious Case Review working group in June 2009.

3.51 It will be important that the LSCB Chair and others reflect on the delay in this case and on a need to be less preoccupied with the detail of criteria being met or otherwise in future as the sole point of guidance in making a decision about Serious Case Reviews. This point mirrors guidance set out in Working Together to Safeguard Children (2010), which was not the guidance in operation at the time that the LSCB agencies were considering the case in 2009. In the end in this case, all agencies had to spend considerably more time reviewing the case as a result of the initial process of review being followed by the more robust Serious Case Review process.

Procedures and compliance

3.52 Each of the organisations supplying an IMR to this Serious Case Review was clear that it had in place procedures for dealing satisfactorily with safeguarding and promoting the welfare of children. The learning in the case does not suggest that further procedures are needed, especially across the health sector providers concerned.

3.53 Practice in this case did not meet the requirements of the procedures in place. The response to the alleged assault on Child C in 2005 was carried out by the local authority without reference to any other service. The concerns about Child C's deteriorating health and possible implications for other services in view of the unknown route of transmission of HIV were not shared outside primary care or acute health care services.

3.54 These practices fell short of practitioners and managers ensuring proper compliance with the local child protection procedures.

Consideration of whether a post mortem examination should have taken place

3.55 In setting the terms of reference for this Serious Case Review, the panel was concerned to understand whether there should have been a post mortem examination in respect of Child C and whether such an examination would have assisted in identifying the cause of HIV infection or whether or not there might be a continued risk to the other children.

3.56 The decision not to refer Child C's case for consideration of a post mortem by the Coroner was made at the central city hospital where Child C died.

3.57 That hospital has reported that as there was no doubt about the cause of Child C's death, there was not considered to be any need for a referral for a post mortem. This decision has been reviewed by senior medical staff at the hospital in the light of this review and confirmed as the correct decision.

3.58 Furthermore, the report also asserts that a post mortem would not in any event have assisted in detecting whether or not there were any concerns for the other children or the route of transmission. Even if it had been established that Child C had been sexually active, this would not in itself have established route of HIV transmission and nor would it have occasioned significant evidence in establishing whether there was a risk of childhood sexual abuse unless it were also possible to link DNA evidence with a perpetrator of abuse. Good practice guidelines concerning the investigation of child sexual abuse have long advised of the need not to seek medical evidence alone to establish abuse as such evidence is necessarily complex.

3.59 The opportunity to consider sexual activity, exploitation or abuse as a possible route of HIV transmission in this case occurred between August and November 2008 when Child C's symptoms should have led to greater consideration of the possibility of HIV infection. Had information been shared with the local authority and the police in view of the absence of any clear route of infection, there could have been a clearer consideration given to speaking with Child C and her parents and, if necessary, her siblings about the question of sexual exploitation. This would have been a matter considered by a multi-agency strategy meeting held under child protection procedures. However, a post mortem after Child C's death would have been a very unlikely proxy even had child protection enquiries been made.

Examples of Good Practice

3.60 It is important that a Serious Case Review should identify good practice where it exists in order that the review process is perceived to be fair and full. The two best examples of practice over and above the standard which should be expected in this case were:

- The local Child Death overview panel identified this case as one requiring further attention by LSCB agencies in February 2009, without which the lessons identified in this case would not have been made clear.
- The police officer dealing with the initial call by Mrs Y about domestic abuse visited Mrs Y again to check how she was doing although not required to do so by police procedures.
- The school and sixth form college responsible for education of Child C clearly built up a good understanding of and relationship with Child C from the detail of her contained in the Education IMR in this review.

4. Priorities for Learning and Change

4.1 There are a number of significant lessons arising from this Serious Case Review. These inform a small number of recommendations from this overview report to add to the single agency recommendations contained in the various IMRs from individual agencies.

4.2 The principal lessons arising from this case are:

- A need for health practitioners to be aware of and take steps to investigate possible HIV infection at the earliest point possible in all cases.
- A need for health practitioners to regard 17 year-old young people as young people and not as young adults when considering the use of an HIV risk assessment form at the sexual health clinic and when considering self reports by a young person aged 17 years old.
- A need for health practitioners to understand and act on indicators of possible sexual abuse or sexual activity which might be harmful to a young person under the age of 18 years old.
- A need for health and social services agencies to keep the child at the centre in all interventions
- A need to ensure that health practitioners are attuned to the possibility of wider safeguarding or child protection issues when treating young people and where there are also younger siblings in a household.
- A need to ensure that child protection issues referred to the local authority children's social services are dealt with as just that and receive a thorough analysis of need including the need for protection.
- A need for the LSCB to ensure that its decision making processes are based more on the notion of the likely usefulness of a Serious Case Review rather than a narrow definition of the guidance contained in the Working Together to Safeguard Children guidance.
- A need to consider careful guidance about striking a balance between publication of lessons learned on the one hand and defending the confidentiality of the family members on the other.

4.3 The most significant issues in this case were undoubtedly the omission of an HIV diagnosis prior to Child C's admission to hospital in October 2008 and the failure of health practitioners to identify a possible child protection issue in relation to the younger siblings in view of the fact that the means of transmission of the HIV infection with regard to Child C remained unknown.

4.4 None of the health reports to this review identify the significance of the delayed diagnosis of Child C's HIV status. The overview author had expressly requested such an analysis of the Health overview report but understands that the author of the Health Overview report did not have the level of professional understanding of HIV that would have enabled her to do so. The author, with the agreement of the panel, therefore sought external expert advice with regard to this question.

4.5 It is clear from that expert advice that the case highlights a need for health agencies locally to take steps to improve the early detection and diagnosis of HIV in young people. It is also clear that this issue reaches much further than the boundaries of this one geographical region.

4.6 It is also clear that with earlier diagnosis, a young person can live for some time with HIV with the benefits of modern medicine.

5. Action Plan

The LSCB action plan draws together the recommendations from the overview report as below. This plan will be that used by the LSCB to chart progress against the overview report recommendations.

Recommendation	Timescale for	Lead Agency and Officer/	Progress

	completion	Practitioner	
1. The NHS should ensure that its medical and nursing practitioners in GP services, sexual health services and acute hospital services are trained and provided with information about signs and symptoms of HIV infection and what to do in the event of concerns.	31 December 2010	NHS	
2. The Chair of the LSCB should refer to the Department for Education and the Department of Health the question concerning a need for a wider professional awareness of the signs of HIV in view of the expert advice to the panel with regard to the fact that missed early diagnosis is not uncommon in the UK.	July 2010	LSCB Chair	
3. The NHS should take steps to ensure that the health practitioners involved in this case understand the concerns raised in the Health Overview report and should satisfy itself and the LSCB that there are safeguards in place to avoid repetition of such concerns wherever possible.	30 June 2010	NHS	
4. The NHS Primary Care Trust and the Hospital NHS Trust should ensure that all practitioners are advised in writing of the need to ensure that 17-year-old patients are children under the law and should be viewed as children whenever matters possible abuse or neglect arise. This will involve but not be limited to changing any pro forma	31 July 2010	NHS	

which stipulate that child protection concerns need only be considered for those aged 16 or under.			
5. The NHS Primary Care Trust and the Hospital NHS Trust should take steps to ensure that GPs and practitioners at the local hospital primarily involved in this case receive training to inform: (i) Their understanding of the signs and symptoms of child sexual abuse and sexual exploitation and that this training should inform them of what to do in the event of a concern. (ii) The need to consider the potential for child protection or safeguarding concerns to affect other children in the same family even though they may not be patients and the responsibility to refer on such concerns.	31 December 2010	NHS	
6. All future multi-agency training commissioned by the LSCB should ensure that it stresses that child abuse and neglect are found in all cultures and that the child or young person and their siblings are the centre of attention in all assessments and interventions and this should be reflected in all future training specifications.	31 October 2010	LSCB – coordinated by LSCB Business Manager with audit undertaken within each member agency.	
7. The local authority Children's Social Services should satisfy the LSCB that it has checked and found that responses to single incidents of alleged assault are investigated thoroughly and	30 September 2010	Local authority	

within the local multi-agency child protection procedures.			
8. The Chair of the LSCB should advise members of the LSCB and the LSCB Screening and Serious case Review sub-committee of the implications of this case in needing to make decisions about case reviews based on a less narrow definition of criteria contained in Working Together to Safeguard Children 2010.	30 June 2010	Independent Chair of LSCB	
9. The Chair of the LSCB should communicate with Ofsted and the Department for Education about the means to make public the Executive Summary of this Serious Case Review in a way which does not threaten the confidentiality of Child C or members of her family.	30 June 2010	LSCB Chair	