CSCP Serious Case Review Child A and Baby N — Learning Summary

CSCP
CROYDON SAFEGUARDING CHILDREN PARTNERSHIP

Outline

In March 2016, Baby N at 2½ weeks old was admitted to hospital in a critical condition having suffered a cardiac arrest. He was transferred to a specialist paediatric unit but sadly died a few days later. Baby N had suffered a subdural haemorrhage, where blood collects between the surface of the skull and the brain. His death was subsequently determined to be associated with a head injury. A specialist post-mortem concluded he had suffered a fractured skull and a fractured knee.

Child A (half-sibling to Baby N), had previously been presented to hospital on two occasions with head injuries - in 2014 (aged 5 months) and in 2015 (aged 11 months). A specialist report in November 2014 concluded that Baby A had suffered a fractured skull.

Baby N was known to universal services. His older sister, Child A, had come to the attention of Children's Social Care (CSC) in 2014 following her admission to hospital with a serious head injury.

Once it had been determined that Baby N's injuries were non-accidental, the criteria for a SCR were met. The SCR was to consider the effectiveness of safeguarding practice relating to Baby N and Child A.

Child A & Baby N

Child A and Baby N were half-siblings, their mother is white European, the fathers for each child are black British/African and black British/Caribbean, respectively. At the time of Baby N's death, Child A was 21 months and the mother and Baby N's father were living in the same household with both children.

Critical Events Child A

In November 2014, Child A was presented at hospital with a large boggy swelling to the side of her head. Child A was 5 months old and pre-mobile. The explanation given was that she'd toppled from a sitting position. The Paediatrician was unsure as to whether the injury was accidental or non-accidental. Child A was admitted for further investigation, and Children's Social Care (CSC) were notified by telephone and a written referral highlighting safeguarding concerns. These included – inconsistencies in mother's account, delay in seeking care, that the baby was in the care of an 18yr old uncle and the possibility that the injuries were not accidental.

Children's social care discussed the contact and agreed that escalation would be dependent on the outcome of medical tests and any other agency information. MASH continued to seek agency information. Updates from CUH was that the full x-ray found non skull-fracture.

CSC records show that despite outstanding concerns as to how the injury occurred, CSC reduced the level of risk to Child A from amber to green, and closed the contact with a referral to Croydon Health Visiting service to follow up. The evidence base for the decision to downgrade the risk, appears inadequate as it did not consider the seriousness of the injury, wider safeguarding needs beyond the medical findings given, the age of the child and inconsistencies in explanation for the injury. The matter did not progress to a strategy meeting or assessment; this was not in line with procedures. Additionally case recording does not indicate this feedback to CUH.

In May 2015 Child A, aged 11 months, was presented at the Urgent Care Centre at CUH. Child A had a bruise on her cheek and swelling around the right eye. The explanation given was that she had rolled and hit her head on a table.

Although details could have been accessed by the UCC, this second presentation was assessed in isolation from the first injury 6 months prior. On this occasion, no contact with CSC was made. Information of this episode was passed to the GP and HV Service, however the HV Service were unable to prioritise the visit.

The full Child A and Baby N SCR report, findings and recommendations—follow this link

CSCB Child A and Baby N SCR (Jan 2019)

Critical Events—Baby N's Death and Child A Removal

On 15th March 2016, Baby N, aged 2½ weeks was admitted to hospital in a serious condition. He had suffered cardiac arrest and had bleeding between the skull and the brain.

On admission, a CT scan was carried out which showed evidence of bleeding between the skull and the brain, for which trauma is the common reason. The Hospital took full family and social history, and details of their accounts of what events prior to Baby N's injuries. The hospital safeguarding nurse also sought History was also sought from HV and GP and made contact with CSC, stating that investigations in to possible cause were being explored and both organic and possible non-accidental injury, were being considered. CSC informed the hospital that the family had previously been referred to CSC in 2014 in relation to a head injury to Child A.

The hospital continued to provide further updates on the nature the injuries and that non-accidental injury was a possibility (but with limited corroborating evidence). Despite the fact that the referral clearly stated that non-accidental injury was a possibility, Croydon Children's Social Care did not progress the contact to referral and assessment, did not share information with the Police and did not give consideration as to the welfare of Child A.

However, it is recorded that a CSC Manager did use internal escalation to request the case be progressed, this was not supported by senior management.

Baby N died on 21st March 2016. This was a suspicious death of a baby, and this should have triggered a strategy discussion and a child protection investigation. As an unexplained death the case was referred to the coroner's office. The Coroner's office referred the death to the police on 22nd March 2016, as an *unexplained death* it required a police investigation.

Initial information provided by CSC to Police indicated that Baby N's death was *not suspicious*. It is unclear how this opinion was formed by CSC but was accepted by the police and influenced their decision not to undertake a fast-time response.

In early April a specialist post-mortem took place with the Police in attendance. The initial post-mortem indicated that Baby B's death was suspicious. On the same day Police were informed of the previous injuries to Child A. With this information the Police considered the risks for Child A to be significant. With CSC and Police, Child A was removed from her home address during the early hours the following day.

Key Learning Points

- Compliance with London Child Protection Procedures to help ensure timely & evidenced decision making
- Use of strategy meetings to exchange information and share/understand professional views
- Re-referrals should raise curiosity about patterns of safeguarding risks
- Agency history on family to be actively reviewed especially with repeat incidents
- Determining causes of head injury in pre-mobile babies and young infants within safeguarding AND medical contexts
- Need to respond curiously to baby & infant head injuries to know what happened including considering NAI
- Recognising indicators of neglect, its different presentations and impact
- Record keeping to be of a standard that it aids information exchanges, history and current decisions
- Ensuring 'visibility' of fathers to agencies to obtain a whole family assessment of past/current risk & protective factors
- Recording details of all adults accompanying children at Hospitals
- Application of professional curiosity to the known information & circumstances
- Applying difference between expert views/decisions/standards and broader safeguarding needs

Child A and Baby N Serious Case review briefing sheet

Croydon Safeguarding Children Partnership
Serious Case Review Child A & Baby N
Summary learning points

1 Critical Events

Baby N was 3 weeks old when he died. His death was associated with a head injury, further investigation also found fractured knee and skull. Child A (half-sibling) had a history of head injuries including skull fracture

2 Safeguarding Concerns

- Child A at 5months hospitalised with head injury; Non Accidental Injury (NAI) considered
- Delay in seeking medical attention & inconsistent explanation
- Child A at 11months second head injury; considered non-suspicious
- Second head injury not assessed with first injury
- Baby N at 2 ½ weeks in cardiac arrest and with bleeding between the skull and the brain
- Cause of Baby N's head injury as a NAI was initially considered

3 Findings

- Both children suffered fractured skulls and had episodes of injury which were not assessed against single & multi-agency information
- Poor quality of information sharing, assessment of information and exchange, including feedback and updates between CSC and C.Uni.Hospital (CUH)
- Lack of compliance with London Child Protection Procedures, including lack of strategy discussion
- Poor evidence of management decision making in CSC
- Not pro-actively managing re-referrals or repeat of similar incidents within CUH and MASH
- Insufficient enquiry or using recorded information of fathers & members of household
- Challenges in determining causes of head injury in pre-mobile babies and young infants within safeguarding AND medical contexts
- Insufficient consideration of safeguarding needs of siblings
- Lack of use of recorded history and information to inform and evidence decision making, and plan interventions (led to delayed & unplanned removal of Child A)
- Lack of understanding of medical information by MASH
- Missed opportunities to apply single agency safeguarding knowledge & practice (CSC, CUH & Police)
- Poor record keeping
- Lack of professional curiosity
- Appropriate and good standard referrals to CSC from CUH
- Appropriate use of escalation within CSC

4 Learning

- Compliance with procedures & recording standards to meet children's safeguarding needs
- Quality of communication/dialogue, including use of strategy meetings to give clarity on different professional opinions
- Agency history on family to be actively reviewed, especially with repeat incidents, & discussed across inter-agency and intra-disciplines
- Responding curiously to baby & infant head injuries within context of safeguarding protocols, medical & NAI research
- Recognising indicators of neglect
- Engaging fathers & recording adults in child's household
- Application of professional curiosity & challenge
- Agency feedback / agency follow up on referral submissions

5 Achieving change

Reflect on the findings & discuss the implications for you team/practice

Outline steps you/team will take going forward

The full SCR Report can be downloaded at www.croydonlscb.org.uk

This SCR was published 2019