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

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