LEARNING FROM A SERIOUS CASE REVIEW

Child AA

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The SSCB conducted a Serious Case Review in relation to a ten week old baby known, for the purposes of the review, as Child AA.

Synopsis

Child AA was admitted to hospital in June 2014 with severe brain trauma associated with Non Accidental Injury. Child AA is the second child of young parents and the mother had also been known to Surrey agencies whilst a child herself. Child AA was born prematurely in April 2014 at 31 weeks gestation and since discharge from hospital at four weeks of age, lived with the parents in a hostel for the homeless. At the time of birth, the sibling was just under a year old and subject to a Child In Need plan.

Main Theme

A clear theme in this review is that of inter professional trust and collaboration. There were differences of opinion between the children's service and the community health service around the level of risk which were further compounded by the lack of a current assessment and coordinated planning. At times it seemed that instead of agencies working together, they worked in parallel and the review considered how this could be addressed to improve arrangements.

Good Practice

- All professionals who worked with the family since the birth of Child AA demonstrated significant commitment to ensuring that the needs of both children came first.
- Hospital extended Child AA's stay in hospital until the Local Authority had secured accommodation in a hostel for the homeles.
- Local council prioritised the children's needs and offered immediate accommodation. Likewise, it sought to avoid eviction despite parents' failure to complete necessary paperwork.
- GP practice registered the family locally, when they moved back into the area, without delays or historical paperwork. Also, GPs responded in a timely and protective manner to potential safeguarding concerns about both children.
- Health visiting professionals raised safeguarding concerns in a timely and appropriate manner.

- Ambulance service followed up concerns about the children in an appropriate manner.
- Evidence that the LSCB escalation policy would be used had events not overtaken.

Recommendations for the SSCB

1. The SSCB to request that Children's Service report that guidance for social workers on assessment includes the following requirements:

    - Joint visiting with other professionals to share perceptions and views
    - Clear 'triggers' for reassessment when circumstances change in families
    - A focus on history and chronology
    - Understanding the role of fathers
    - Challenging assumptions and producing clear evidence for professional opinion
    - Identifies risks as well as needs and strengths, regardless of whether the case is CIN or CP
    - That, where children are subject to CIN plans, social work visits are both announced and unannounced in order that the child's whole context can be understood

2. The SSCB to satisfy itself through its learning and improvement framework and a system of audit that:

    - The risks to new-born babies and premature babies are fully understood and the expertise of community health professionals are acknowledged in this area
    - The Family Nurse Partnership arrangements are improving the focus on the needs of very young parents and in particular the focus on the parents as children in need themselves and therefore improving outcomes for them and their children

3. The SSCB should continue to ensure that the Escalation Policy is brought to professionals' attention and in particular the urgency in the case of very young children.

4. The SSCB to consider how best to support joint training and consideration of the appreciative inquiry or a similar model as a means of promoting common dialogue and developing positive shared practice.

5. Sutton Safeguarding Children Board: to assure itself through audit that policies and procedures reflect the requirement to vigorously pursue and share information and concerns, where there are families with additional vulnerabilities who move between health practices.

6. The SSCB to ensure that a full debrief is held between health and children's services staff involved in the review to consider how joint working arrangements could be strengthened and update the SSCB with their recommendations.

Anastasia Drenou
SCR and Training Administrator
01372 833358
anastasia.drenou@surreycc.gov.uk