For further information please contact
Cynthia New, Quality Assurance Officer - 01483 517090
Cynthia.new@surreycc.gov.uk

Or

Angie Tregoning, Serious Case Review Officer - 01372 833318
angie.tregoning@surreycc.gov.uk

LEARNING FROM A SERIOUS CASE REVIEW

Child X

www.surreycc.gov.uk/safeguarding

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The SSCB conducted a Serious Case Review as a result of events in 2012 when child X became seriously unwell. Medical investigation highlighted that the baby had suffered a number of serious injuries the most serious of those leading to permanent impairment. Records indicate that the child had a number of bruises which occurred during the first month of life.

The review highlights issues about failure to follow procedures, lack of effective communication and record keeping and failure to challenge professional optimism and preconceived views

Synopsis

This baby lived with her young parents. Her mother had declined early universal support. In the first three weeks of the baby's life several bruises and eye haemorrhages had been noted, but none were deemed to be caused by abuse. The early injures were primarily believed to have had a medical cause and there was no significant challenge to this hypothesis. By the time the baby was admitted to a regional unit due to the seriousness of the baby's condition the baby was found to have brain haemorrhages, leg and foot fractures, and multiple rib fractures. Once the full nature of the injuries was discovered Children's Services became involved and a Police Investigation commenced, which is still ongoing. The baby is now the subject of Care Proceeding and there has been a finding of Fact Hearing which confirmed that the injuries were caused non accidently.

The main lessons that have emerged

Guidance and procedures relating to bruises in non mobile babies and children was not followed, in part some staff were unaware of their existence, there was also a contradiction between the guidance and procedures which may have added to the confusion. This has been rectified

There was significant administrative weakness and delay in transferring records, the quality of the health records was generally deemed to be poor and there was poor communications between partners

Confusion about whether Children's Services received a referral or information is being addressed through the redesign of the multi agency referral form.

There was a lack of information sharing and consultation which may have supported a review of the prevailing hypothesis.

There was a lack of professional challenge and evidence that the rule of professional optimism prevailed.

There was a lack of consistent involvement by the same professional in all areas of the baby's care

Whilst there are many lessons to be learnt from this serious case review there is no way of knowing if the serious injuries to the baby could have been prevented. However opportunities were missed which may have lead to a different outcome.

Key Recommendations

The SSCB should ensure that there are effective processes in place to ensure that the purpose of referrals (and this does not just apply to referrals to social work) is clear

The SSCB should facilitate discussions with a wide range of professionals about the implementation of guidance on bruising to children who are not independently mobile in order to understand why it has been so poorly implemented, and to make any adjustments and training necessary.

The SSCB should monitor the circulation and take up of any revised guidance on bruising, and undertake case audits with partners to ensure that guidance is followed and recording of injuries is as expected.

The SSCB should review its web site and how procedures are linked to ensure there is a much simpler way for staff to identify what guidance they must follow.

The SSCB should reiterate for all agencies that any suspicious marks must be recorded on a body map in order that there is a permanent record, and one which can help build a picture over time.

The SSCB should receive ongoing reports from the relevant NHS body on compliance with required training for GPs.

The SSCB, through the promulgation of findings from this SCR should emphasise the importance of admin processes and record keeping, and through case audits monitor their quality

The SSCB and its member agencies should consider the degree to which 'challenge' is encouraged as an important part of professional work, and valued as something in the interests of children.

The SSCB should ensure that the human tendency to optimism in the face of evidence and reluctance to change judgements are understood in training, and that member agencies examine their processes to be sure that there are appropriate management and supervisory structures in place to minimise the impact of such tendencies.