Practice issues from Serious Case Reviews

7. Confusion about interpretation of medical information on cause of injury

What is the issue?

Agencies interpret health input about possible causes of injuries as definitive, rather than one of a range of possibilities

When a child or young person presents with an injury and there are safeguarding concerns, medical professionals may be asked to provide their opinion about the cause of injury. Our analysis of the SCR reports found several examples in which agencies such as social care and the police wrongly interpreted medical advice about cause of injury as being definitive, when in fact it was only one of a range of possibilities. For example, advice that an injury **could be** consistent with the parental explanation being interpreted as meaning that the injury **did** have an accidental cause.

For example, in one case a child was taken to hospital with leg fractures. A strategy meeting was held and it was agreed that a medical investigation was needed before any action could be taken. The medical investigation concluded that the injury could be consistent with parental explanation. The SCR report notes that:

> *'The strategy meeting accepted this view as confirmation that the injury did have an accidental cause, not that this was one of a range of possibilities.'*

This document is one of a set of 14 briefings intended to support managers, senior managers and practitioners by:

- identifying difficult issues in multi-agency safeguarding work, focusing on interprofessional communication and decision-making
- exploring why these issues arise, and therefore how they might be addressed.

The briefings are based on analysis of 38 Serious Case Reviews (SCRs) published between May 2014 and April 2015, augmented by information gathered from multi-agency summits in London, Leeds and Birmingham. The summits were held in September 2015 and were attended by 194 practitioners and managers from across children's social care, health, education, police, probation and Local Safeguarding Children Boards (LSCBs).

The briefings are the result of a pilot process that developed and tested new ways that SCR findings can be shared and used to support improvement.

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Why does this occur?

The **analysis within the SCR reports** for these cases highlights a number of reasons for wrong interpretation of advice from health professionals, including:

- a general over-reliance on medical opinion to determine risk, rather than the weighing up of a range of types of evidence
- a 'clash' between social care and police pursuit of categorical explanations from medical professionals with a norm among medical professionals of giving differential diagnoses in which anything is possible until it is ruled out.

Participants at the three summits also identified a number of underlying reasons for this issue including the following:

Concepts of evidence

Participants talked about the desire among many professionals to find definitive evidence of abuse and neglect. There was some suggestion that doctors were expected to give people the 'answers':

> *'Health workers … have to be clear that there is no definitive answer but they are often told they need to "make a decision".' (Designated Doctor)*

This was thought to be driven to some extent by the court process, and participants talked about social workers 'demanding' skeletal surveys as:

> *'They need medical evidence, that's what the judge wants.' (Lead Nurse)*

'Giving the benefit of the doubt'

Comments suggested a 'bias' towards an optimistic interpretation of the advice. One participant said:

> *'If paediatricians can't definitively say an injury is non-accidental, other agencies veer on the side of accidental.' (LSCB Business Manager)*

This may be a cognitive bias, similar to the 'rule of optimism'[1] but may also be linked to scarcity of resources. As another participant said:

> *'There's almost a sigh of relief – we can't prove it so we don't need to take action.' (Clinical Commissioning Group member)*

Status, challenge and supervision

Participants discussed the perceived status differences both within the health service (e.g. between junior doctors and consultants) and between health professionals and other types of professionals. One participant said:

> *'It's a cultural issue. It's how confident and comfortable professionals are to challenge medical staff. What a consultant says … would not be challenged.' (Safeguarding Lead)*

The concept of status and challenge was linked to a lack of, or poor quality, supervision to support practitioners to challenge advice and decisions as needed.

1 Dingwall, R., Eekelar, J. and Murray, T. (1983) 'The protection of children: state intervention and family life', Oxford: Blackwell.

Attendance at multi-agency meetings

Having opportunities to discuss medical opinion face-to-face within the wider multi-agency group was seen as important, but this often could not happen due to constraints on health professionals' time. On occasion this meant that social workers had to present complex health information. Others pointed out that, as doctors were often not able to attend meetings, they were reliant on written reports which can make people even more reluctant to give definitive information, in case it was later proved to be wrong.

Solutions suggested by summit participants

Participants at the summits mentioned the following actions which had been taken in their own areas to address this issue:

- one site had adapted the forms for reporting medical advice to include a list of possible causes of an injury with a scale of 1–10 where doctors can mark where on the balance of probability each potential cause lies
- change to police child abuse investigation guidance to make it clear that medical findings should not be 'automatically accepted' as a reason to downgrade risk
- change in terminology in police management reviews – use of the phrase 'unexplained injury'
- training sessions for police on differential diagnosis.

Questions for you to consider

Unpicking the issue

1. Is this issue familiar to you?
2. Locally, is the issue exactly the same as described above? If not, what does this issue 'look like' for you?
3. What good practice is there in relation to this issue? Are there weaknesses you are aware of and how would you describe them?

Why do you think this happens in your local area?

1. Do some or all of the reasons described above apply in your area?
2. Is it an issue that has been identified in local SCRs, audits or inspection feedback? What light have these activities shed on the issue?
3. What knowledge do you have from your own experience about why this happens?
4. What organisational factors are involved locally?
5. How does local culture, custom and practice, within and between agencies, contribute to this?

Thinking through the solutions

1. Have there been previous efforts locally to address this issue? What was the result?
2. Given your understanding of the reasons for this issue, what further actions do you think would be helpful in addressing it?
3. What strengths can you build on, and what are the areas of difficulty?
4. What action would need to be taken at a strategic or leadership level?
5. Who would need to be involved to achieve improvement?
6. Are there any unintended consequences you anticipate for the different agencies and professions involved?
7. How will you know whether any actions have had an impact?

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For more information see nspcc.org.uk/lipp or scie.org.uk/lipp