Notes on redaction of this Significant Case Review Report

In the interests of transparency, every effort has been made to disclose as much of the SCR as is lawfully possible. The only editing prior to disclosure is the redaction of personal data, disclosure of which cannot be justified under the General Data Protection Regulation and Data Protection Act 2018.

Although there has been some media coverage of this case disclosure of the personal data contained in this report must still comply with data protection law. This means that even though some of the redacted information may already be publicly available, it cannot automatically be disclosed, as data protection law contains certain conditions which must first be met.

June 2018

Significant Case Review: Child A

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Introduction

1. Why this case was chosen to be reviewed?

1.1 Child A was born [redacted] 2016. At 14 weeks old, Child A was admitted to the intensive care unit at St John's Hospital, Livingston during the evening of [redacted] 2016 and later that evening transferred to the Royal Hospital for Sick Children, Edinburgh. At the time, Child A was acutely unwell with seizures and in shock. A CT scan showed loss of gray-white matter differentiation indicative of cerebral oedema and hypoxic, ischaemic encephalopathy (HIE). For the next few days, Child A remained critical and died on [redacted] 2016.

1.2 During an Initial Case Review follow-up meeting on 12 August 2016, West Lothian SCR subcommittee of the Public Protection Committee agreed to conduct a Significant Case Review regarding Child A in line with national guidance[1] that '*When a child dies and the incident or accumulation of incidents (a case) gives rise to significant/serious concerns about professional and/or service involvement or lack of involvement*.' (p.8).

2. Succinct summary of case

2.1 Child A was born in West Lothian to young parents who had recently moved into the area and were living in homeless accommodation. The father, who was 20 at the time, originated from West Lothian, where his mother continued to live, but following an itinerant lifestyle from leaving care at the age of 16 had moved to live with his father in [redacted] 2012. The relationship with his father was volatile and subsequently broke down and in September 2015 he returned from [redacted] with his pregnant girlfriend, aged 18, to live with his mother. This situation proved untenable and in [redacted] 2016 the couple presented as homeless. This was close to the birth of Child A and the couple were placed within [redacted] Family Unit – Emergency Accommodation Unit for Homeless persons. The unit offered on-site support and advice in respect of budgeting, applications for housing and opportunities for group work.

2.2 Child A was born [redacted] 2016 and during the Health Visitor's first notification visit ([redacted] 2016), bruising to her cheeks was observed. The original reason given by the parents - that Child A had pinched her own cheeks - was challenged by the Health Visitor. The baby's father then explained that the child had sustained the bruising when he was trying to wind her. The family was referred to the Community Child Health Paediatricians (Hub) and Child A was admitted to St John's that night for observations. An Inter-agency Referral Discussion (IRD) was instigated and a joint paediatric forensic medical examination (JPFME) was undertaken two days later.

2.3 The JPFME and other tests concluded *'that bruising to both cheeks is consistent with dad's fingers when holding [Child A's] head. To have caused bruising requires a significant degree of force, inappropriate to caring for a young baby, which dad now appears to recognise*' (Health Report, SCR subcommittee, 26 June 2016). The outcome of the IRD was to progress to an initial child protection case conference. Six days later, Child A was discharged to her parents' care (unsupervised contact) with an Interim Safety Plan in place. Health visitor, housing support staff, early years practitioner and social worker agreed to each visit weekly to monitor the situation and staff within the homeless unit agreed to check the family twice daily.

[1] Scottish Government (2015) *National Guidance for Child Protection Committees Conducting a Significant Case Review*. Edinburgh: Scottish Government.

2.4 The decision at the child protection case conference was to not register the child. The Interim Safety Plan became the Child's Plan and professionals agreed to meet monthly to support the family and to monitor the situation. Although Child A was presenting well and the parents were meeting her needs, there remained concerns about the family's vulnerabilities due to the parents' own childhood experiences, father's history of aggression and isolation of the family from the community. During the next eight weeks, two child's planning meetings were held with the family. Dad's resistance to working with social work increased and the regular visits by professionals were felt increasingly intrusive by the parents. After the first planning meeting, visits were reduced in recognition of the positive development of Child A and Dad's admission to causing the original bruising. By the second meeting, the family had been offered a new tenancy, but resisted attempts from all professionals to help and support the family with this move. Social Work decided to keep the case open for a further period but would not be directly involved provided the family engaged with health and housing.

2.5 Following the second child's planning meeting, the family did not return to the homeless unit and it is thought they stayed with the paternal grandmother for the weekend. On [redacted] May, the Grandmother contacted [redacted] Medical Practice seeking advice on Child A's vomiting and was told to seek further medical advice if the child's condition worsened. On [redacted] May, Dad called NHS 24 regarding the baby's intermittent vomiting. Child A was admitted to St John's Hospital, Paediatric Ward with possible viral gastroenteritis for a period of observation. Child A was alert and active, and the child's head measurement was normal. Staff concluded it was likely Child A had a viral illness and was discharged.

2.6 On Monday [redacted] May, the parents contacted the children's ward at St John's at 7:30pm for advice about Child A and were advised to call 999 and bring baby to A&E. Thirty minutes later, Mum called NHS 24 and described the child's symptoms, NHS 24 called an ambulance. Child A was admitted to the children's ward at St John's and transferred to the Royal Hospital for Sick Children later that evening. She remained in a critical condition and died six days later on [redacted] 2016.

3. Methodology

3.1 The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the 'deeper', underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case and changing them will contribute to improving practice more widely.

3.2 At the analytic heart of the Learning Together model are three key questions:

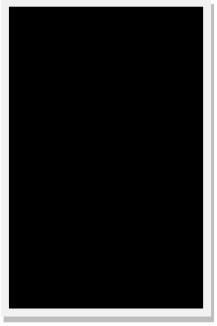
- *What happened?* Reconstructing the case and surrounding context as experienced by the professionals involved;
- *Why did it happen?* Analysing practice in detail appraising individual practice and looking at individual, local and national influences on practice; and
- *What are the implications for wider practice?* Exploring whether issues identified in the case apply more widely in consultation with staff and managers and their relevance to achieving better safeguarding.

3.3 Using this approach for studying a system in which people and the context interact requires the use of qualitative research methods to improve transparency and rigour. The key tasks are data collection and analysis. Data comes from semi-structured conversations with involved professionals, case files and contextual documentation from organisations.

Review Team and Case Group

3.4 The Learning Review was undertaken by two Lead Reviewers, who are experienced in using the SCIE's Learning Together methodology and have no connection to West Lothian agencies. The Reviewers were supported by a Champion and Review Team whose membership were drawn from across agencies involved in the case and had not held any decision-making responsibility in relation to the case. Collectively, their role was to contribute to the analysis of data and inform the final report. SCIE's Deputy Head of Learning Together provided methodological oversight and quality assurance. Ownership of the final report lies with the West Lothian Public Protection Committee as commissioner of the case review.

3.5 Membership of the Review Team included:



Group Manager Social Work
Group Manager Social Work
Early Years Manager
Health Visiting Team Leader
Consultant Paediatrician
Housing Manager
Police Scotland
Lead Officer as Champion

3.6 The SCIE model involves gathering and making sense of information about a case through meetings with the Review Team and a Case Group of practitioners who had been directly involved in the case. Draft research questions were shared and refined in consultation with the Review Team and Case Group, and the conversations with individual practitioners were reconstructed and shared with the Review Team and Case Group. Both groups were involved in the analysis of practice on the specific case and in discussions to identify the wider systemic findings. Attendance at all meetings was requested but not always possible.

3.7 The Lead Reviewers met the Case Group and Review Team on five occasions:

10th October 2017	Information session for Case Group and Review Team members
18th December 2017	Case Group meeting – feedback from conversations
18th December 2017	Review Team meeting – feedback from conversations
26th January 2018	Case Group meeting – follow-on meeting
26th January 2018	Review Team meeting – follow-on meeting
20th January 2018	SCIE supervision
8th February 2018	Meeting with Champion
15th March 2018 (postponed from 28th February)	Case Group meeting – follow-on meeting
15th March 2018 (postponed from 28th February)	Review Team meeting – follow-on meeting
11th April 2018	Case Group meeting – draft findings
11th April 2018	Review Team meeting – draft findings

3.8 Fourteen conversations were held with seventeen members of staff - some were individual conversations and some were with groups of two or three professionals.

Research questions

3.9 The research questions identified for this review were:

1. Across the multi-agency partnership, what is professional understanding of risk, factors that inform initial risk assessments, analysis of risk, decision-making and subsequent planning?
2. What can we learn about our approach to parenting assessments such as their purpose and how we do them?
3. Do professionals in West Lothian understand each other's role/work? How does this understanding impact on information sharing and working together?

Methodological comment and limitations

3.10 The focus of this review was the period from [redacted] to [redacted] 2016. There were issues, which emerged from the review but are not presented as Findings in this report. This is either because the issues relate to practice outwith the timescale of the SCR or there was not enough evidence to suggest these issues were underlying patterns in practice. Nevertheless, the Review Team considered it important to highlight these issues and these are discussed later in report at paragraph 10.2. We also acknowledge that some changes and developments to practice have taken place in light of findings from the Initial Case Review.

3.11 Due to sickness absences and holidays, it was not possible that all members of the Review Team could meet together on all occasions, however, every effort was made to seek the views of colleagues.

4. Sources of data

Conversations and case group

4.1 The Lead Reviewers conducted semi-structured conversations with staff in the following roles, who together formed the Case Group for the review:

Manager	[redacted] Unit
Support Worker	[redacted] Unit
Support Worker	[redacted] Unit
Health Visitor	NHS Lothian
Team Leader	Health Visiting, NHS Lothian
Child Protection Nurse Advisor	NHS Lothian
Consultant Paediatrician	NHS Lothian
Consultant Paediatrician	NHS Lothian
Senior Charge Nurse	NHS Lothian
Advanced Child Nurse Practitioner	NHS Lothian
Detective Sergeant	Police Scotland
Detective Constable	Police Scotland
Early Years Practitioner	West Lothian Health and Social Care Partnership
Social Worker	West Lothian Health and Social Care Partnership
Team Manager	West Lothian Health and Social Care Partnership
Team Manager	West Lothian Health and Social Care Partnership
Reviewing Officer	West Lothian Health and Social Care Partnership

Documentary evidence

4.2 The review was also informed by the following documents:

- *Advice for Professionals Attending Child Protection Case Conferences*
- *Agenda and Script for an Initial/Pre-Birth Child Protection Conference (Form 4)*
- *Child Protection Escalation Procedure*, *Child Protection Committee Procedures* (2015)
- *Child Protection Visiting Policy* [2016]
- *Complaints to West Lothian Public Protection Committee*
- *Dissent at Case Conferences and Core Group*, *Child Protection Committee Procedures* (2015)
- *Inter-agency Child Protection Procedures Edinburgh and the Lothians* (2015)
- *National Child Protection Guidance in Scotland* (2014)
- *Health Professional Case Conference/Children's Hearing Report* [new format]
- *West Lothian Child Protection Committee: Advice For Professionals Attending Child Protection Case Conferences (Form 6)*
- Case notes - SCET [[redacted] 2016]
- Case notes – Discharge Planning Meeting [[redacted] 2016]
- Case notes - Child's Planning meeting [[redacted] 2016]
- eIRD – NHS Lothian
- eIRD – Police Scotland
- Initial Care Conference Child Protection Conference – Community Child Health Report
- Initial Care Conference Child Protection Conference – Family Centre Report
- Initial Care Conference Child Protection Conference – GP Report
- Initial Care Conference Child Protection Conference – Health Visitor Report
- Initial Care Conference Child Protection Conference – Police Scotland Report
- Initial Care Conference Child Protection Conference – Family Unit Report
- Initial Care Conference Child Protection Conference – Social Work Report
- Initial Care Conference Child Protection Conference – Police (Restricted Information)
- Initial Care Conference Child Protection Conference – Community Child Health Report
- Initial Case Review, Information for SCR subcommittee: Report from Early Years
- Initial Case Review, Information for SCR subcommittee: Report from Health Visitor
- Initial Case Review, Information for SCR subcommittee: Report from Community Child Health
- Initial Case Review, Information for SCR subcommittee: Report from Housing
- Initial Case Review, Information for SCR subcommittee: Report from Police Scotland
- Initial Case Review, Information for SCR subcommittee: Report from SCET
- Initial Case Review, Information for SCR subcommittee: Report from Review Team
- Initial Case Review, Information for SCR subcommittee: Report from Social Policy
- Initial Case Review, Additional information for SCR subcommittee: Social Policy
- Initial Case Review, Additional information for SCR subcommittee: NHS Lothian
- Multi-agency Chronology – Child A
- Note of a meeting – Discharge Planning Meeting [[redacted]]
- Note of a meeting – Initial Child Protection Case Conference [[redacted]]
- Note of a meeting – Initial Case Review [30.06.2016]
- Note of a meeting – Initial Case Review: Follow-on meeting [12.08.2016]

Perspectives of family members

4.3 No conversations took place with family members as legal proceedings were underway.

5. Structure of the report

5.1 Guidance (Scottish Government 2015) for those producing SCR reports suggests a consistent structure to make it easier for people to read. The report structure and content of the SCIE Learning Together model is outlined in full in Annex 5 of Scottish Government guidance and, in line with that, this report includes:

- A contextual introduction
- A succinct summary of practice
- An appraisal of practice on the specific case
- Findings, categorised using a systems typology
- Considerations for the CPC to help reach decisions about solutions and changes required.

Findings

6. Introduction

6.1 A Case Review plays an important part in efforts to achieve a safer child protection system, one that is more effective in its efforts to safeguard and protect children. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies in the child protection system. The particular case acts as 'a window on the system' (Vincent 2004, p.13).

6.2 Case Review Findings therefore need to say something more about the Public Protection Committee area or about agencies and their usual patterns of working. They exist in the present and potentially impact in the future. It makes sense to prioritise the findings to pinpoint those that most urgently need tackling for the benefit of children and families; these may not be the issues that appeared most critical in the context of a particular case, however they may present the most risk to the system if left unaddressed. In this review, the prioritisation of findings is a matter for the Public Protection Committee.

6.3 In order to help with the identification and prioritisation of findings, the systems model that SCIE has developed includes six broad categories of underlying patterns, each of which relates to different aspects of multi-agency child protection work:

a. Innate human biases (cognitive and emotional)
b. Family-professional interaction
c. Responses to incidents
d. Longer term work
e. Tools
f. Management systems

7. Appraisal of practice

Period 1 Homeless Referral and Birth of Baby ([redacted] 2016)

7.1 In [redacted] 2016, the couple presented as homeless and were appropriately prioritised due to their vulnerabilities such as stage of pregnancy and age, and were accommodated in accordance with West Lothian's Housing Allocation Policy. The couple were placed within [redacted] Family Unit (FU) which provides emergency accommodation for homeless families. FU offered on-site support and advice in respect of budgeting, applications for housing and opportunities for group work. FU was a more secure environment for a newborn baby than other alternative housing options. Child A was born [redacted] with no postnatal complications recorded. All relevant post-natal checks were carried out and the family was discharged from midwifery care and the case transferred to the Health Visiting team. Although vulnerabilities were present which should have indicated that additional support may be required, no concerns were passed on to Health Visiting by the Community Midwifery. **This period is outwith the scope of this review so the role of Community Midwifery and the transfer of care to Health Visiting is not a Finding, but remains something that Public Protection Committee might want to explore further**.

Period 2 First Inter-Agency Referral Discussion ([redacted] 2016)

7.2 Bruises on Child A's cheeks were identified by the Health Visitor during the first home visit. The Health Visitor responded quickly and appropriately raising her concerns with the Child Protection Hub, providing a clear explanation to the parents about the need to escalate her concerns and communicated clearly with other professionals. Professionals from social work, health and police responded speedily to the concerns reported by the Health Visitor and that evening Child A was admitted overnight to the children's ward at St John's Hospital for observation and assessment.

7.3 The Inter-agency Referral Discussion (IRD) was initiated the following day, although there was some confusion between professionals with colleagues from the Child Protection Hub believing it had been initiated the previous evening. This confusion manifested in two ways: there was a lack of clarity about how and when the IRD was initiated; and there was inconsistent recording of information across the agencies involved in the IRD discussions. Local procedures were not followed by all agencies: '*Every stage of inter-agency referral discussion will be fully recorded without delay by each agency involved, using the relevant form.*' (Inter-agency Child Protection Procedures Edinburgh and the Lothians 2015, p.31).

7.4 While working partnerships were effective there was an issue of what professionals understood by the terms and language used every day and what information was recorded at the crucial inter-agency referral discussion stage. This did not delay the action or response by professionals in this case, however, this confusion is not uncommon. **The issues around the IRD are explored in Finding 1 and the issue of the interpretation of professional terminology is explored in Finding 2**.

Period 3 Discharge Planning Meeting ([redacted] 2016)

7.5 The joint forensic medical assessment confirmed bruising to both cheeks consistent with the father's fingers when holding Child A's head and to have caused bruising required a significant degree of force, inappropriate to caring for a young baby.

7.6 During the Discharge Planning Meeting (DPM), professionals clearly identified both risk and protective factors, however, the protective factors were more persuasive in the decision to allow Child A to return home. Various factors contributed to this including: the parents' initial cooperation with professionals, the fact they were living in a family unit with staff able to offer support, support from the paternal grandmother and the willingness of other professionals to engage with the family and offer intensive support.

7.7 From the medical staff perspective, there was no evidence either medically or through the observations by ward staff to keep Child A in hospital. There was, however, no toolkit to help structure the observations by ward staff of family interaction and observations were conducted within a 'false' environment in that the family was being observed outwith the stresses of everyday life and their own home.

7.8 The interim safety plan agreed at the DPM was a good example of professionals coming together and supporting the family across a range of identified needs with the primary focus of minimising risk to Child A, but there should have been more exploration about the nature of the regular visits and the observation offered by U staff.

7.9 This was the first meeting which considered the information available from a range of perspectives and also observations from the ward staff. Several risk factors were identified and an interim safety plan was put in place. Given the significance of the risk factors identified, alternative options to discharging the

baby home should have been discussed. Furthermore, the contingency plan was to refer Child A to the Children's Reporter, but this would not have helped to keep Child A safe if the situation had changed significantly and speedily. Greater focus should have been given to the significant force behind the injury, isolation of the family and attention to the parents' motivation to engage. The interim safety plan identified the contribution of different professionals, but there was no consistent process to record and share the plan with all professionals involved, including those who could not, or would not necessarily, attend the meeting. The minutes should have been shared beyond the social work system. **The interface between the Discharge Planning Meeting and the child protection system is explored in Finding 3**.

Period 4 Initial Assessment and Initial Child Protection Case Conference

7.10 During this initial assessment period, information provided by the parents was sparse. Dad was closed off and guarded, and reluctant to share information with Social Work in particular.

7.11 The reports submitted to the Initial Child Protection Case Conference (ICPCC) outlined professional involvement to date and identified protective and risk factors. The reports were generally positive in terms of tone and language, which may have unwittingly given others not involved with the family, but part of the decision-making process, a different perspective of the family dynamics and engagement with professionals.

7.12 The decision of the ICPCC was not to place Child A's name on the Child Protection register. The reasons were that: Child A was developing; there were no major concerns about the parenting of Child A; the parents were engaging with most professionals; the baby had been discharged into the parents' care with unsupervised contact; the information shared about Dad's violence was from his past; Dad had admitted to causing the bruising; there were no further medical concerns; and professionals would continue to be involved. While, the decision not to register was understandable it was based on the robustness of the interim safety plan, but did not take account that the parenting assessment had only just started and the parents' parental capacity was relatively unknown and had not been fully tested in more stressful circumstances.

7.13 There was dissent about the need for registration within the conference and participants were not encouraged to review the information to try and reach a decision in line with local procedures (*Dissent at Case Conferences and Core Group*, *West Lothian Child Protection Committee Procedures* 2015). Following the meeting, there was no formal challenge to the decision not to register by professionals or their immediate line managers as West Lothian procedures on dissent relate to disagreement about the plan and not the decision to register; in this case, all staff were in agreement about the plan moving forward. However, it was also evident that there was a general lack of clarity about the procedures for escalating concerns.

7.14 Furthermore, there was no independent scrutiny by the Public Protection Committee in line with National Guidance for Child Protection in Scotland which states: '*Where there is no clear consensus in the discussion, the Chair will use his or her professional judgement to make the final decision, based on an analysis of the issues raised. In these circumstances, the decision-making needs to be subjected to independent scrutiny from a senior member of staff with no involvement in the case guidance*.' (Scottish Government 2014, p.110, para 422 (hard copy)). This is also reflected in the *Edinburgh and Lothians Inter-agency Children Protection procedures* which states: *'Where a Chair of the child protection case conference has made the final decision, local Child Protection Committee guidance on independent scrutiny will be followed, as per the National Guidance* (2015, p.58).

7.15 Overall, there was an opportunity to raise questions about the significance of 'historical' information in a case where the parents were young and were working positively with some agencies but not all, in particular social work. The functioning of, and the dynamic within, this initial case conference meant that many of these concerns were not fully explored to the point of reaching a consensus. **The importance of considering all relevant information as 'evidence' is explored in Findings 4 and 5**.

Period 5 Progressing the Child's Plan ([redacted] 2016)

7.16 All professionals continued to be involved, meeting regularly to progress the Child's Plan within agreed timescales. The Early Years Worker provided guidance on safe handling and delivered elements of the mellow parenting programme while the Health Visitor monitored baby's development. Although Child A was growing and developing, the Social Worker had continuing concerns. Dad was not engaging with social work, which compromised the assessment of their parenting capacity and willingness to change. There remained concerns about the family's isolation, particularly Mum, and despite encouragement by professionals neither parent linked into the group activities within FU or into wider community resources offered.

7.17 At the first child planning meeting on [redacted], professionals agreed that contact would reduce and the reduction in visits was communicated positively in recognition of the baby's progress and did not reflect workers' wider concerns. Just prior to the second planning meeting there was still no signs of a willingness to engage in the parenting assessment. During this period there were continuing concerns about Mum's isolation and Dad's lack of engagement with social work. The parenting assessment agreed as part of the safety plan could not be undertaken because of Dad's avoidance, but the contingency plan was not actioned.

7.18 An essential part of the assessment process is an evaluation of the parents' ability and motivation to change. This is characterised by parents accepting responsibility for their own actions, sustaining changes over time and taking up offers of support and resources from services. While Dad appeared to have accepted responsibility for the injury, his lack of engagement overall resulted in services reducing without a key component of the parenting assessment being undertaken by the social worker.

7.19 This case highlights the challenges of working with families who do not want to be involved with services, and particularly social work services. Decision-making in this case was based more on the physical appearance and growth of Child A. However, the role of other factors such as the vulnerability of Mum and Child A, the family dynamics and the parents' social isolation in professional decision-making was less clear. **The challenges for professionals working with parents in these circumstances are explored in Finding 6**.

Period 6 Child's Planning Meeting ([redacted] 2016)

7.20 By May, the family had been offered social housing close to Child A's paternal grandmother. Concerns remained about the relationship between the parents and their attitude to services and the social worker was advised by her manager to close the case as the risks to Child A appeared to have reduced and other services were beginning to withdraw with a re-focus into community resources. The main focus of professional involvement with the family was now the move from emergency accommodation to their new home and linking them into community resources

7.21 During the meeting, all professionals noticed that Dad was visibly angry and volatile and because of this, the social worker decided not to close the case as planned and although not directly involved, this would be on the basis that the family worked with housing and health. The lack of a parenting assessment, Dad's refusal to accept services, escalation of Dad's challenging behaviour towards Mum and professionals, and the family's ongoing isolation in the community could have been an opportunity to explore implementing the contingency plan or increase social work involvement with the family. **The challenges for professionals working with involuntary service users is explored in Finding 6**.

7.22 On [redacted] May, Child A was admitted to the children's ward at St John's and later transferred to the Royal Hospital for Sick Children. She remained in a critical condition and died six days later on [redacted] 2016.

8. Good Practice: What worked well?

8.1 Although good practice is acknowledged throughout the appraisal of practice, the Lead Reviewers wanted to highlight some aspects in particular:

- **Timely allocation of homeless accommodation:** Housing appropriately prioritised the couple due to their vulnerabilities such as stage of pregnancy and age, and accommodated them in accordance with West Lothian's Housing Allocation Policy.

- **Good early identification of, and immediate response to, bruising on Child A:** Health Visitor responded quickly and appropriately raised her concerns with the Child Protection Hub. She provided a clear explanation to the parents about why she was escalating her concerns. There was also clear communication with other professionals and she completed the Cause for Concern paperwork.

- **Good response at the initial stage of the child protection investigation:** Duty SW responded timeously. She attended the JPFME of Child A and began an early assessment of the parents. The SW identified several risk factors in relation to the family and liaised appropriately with colleagues in preparation for Discharge Planning meeting and developing the Interim Safety Plan. There was also a full medical examination of Child A including the joint paediatric forensic medical examination, skeletal survey, MRI scan, CT head scan and ophthalmology test.

- **Good response by professionals in preparation for DPM:** the DPM was a good example of professionals coming together and supporting the family across a range of identified needs with the primary focus of minimising risk. The good working relationships between staff enabled the plan to be quickly put into place and gave confidence about being able to deliver the plan until considered more fully by the ICPCC.

- **Good plan to use a structured practical tool for parenting assessment:** the plan by the Social Worker to use a structured practical tool as part of the parenting assessment of the parents and Child A was good practice (*A Practitioner's Tool for Child Protection and the Assessment of Parents*, Fowler 2002). The tool provides detailed checklists for collecting information.

- **Good inter-agency working between key professionals:** despite the decision not to register, all professionals continue to be involved, meet regularly and discuss the Child's Plan within timescales.

9. In what ways does this case provide a useful window on our systems?

9.1 This case provides a useful window on the system precisely because much of the learning is in relation to families with whom practitioners are working with on a regular basis. Assessing risk and the nature of evidence are challenges practitioners face on a daily basis with many of the families they work with. There are processes for protecting children when the risk of significant harm is clear. There are also services, which can be offered when families need to be supported rather than children needing to be protected. Where the evidence is less clear, practitioners have difficult decisions to make about how best to protect a child while assessments of the family are completed. This case highlights the challenges practitioners face in identifying and assessing risk, balancing action to protect a child alongside working with parents who might be opposed to receiving services and how well systems within West Lothian support this.

10. Summary of findings

10.1 This Significant Case Review has identified six systems findings:

Finding 1 **Tools and human interaction**

In West Lothian Health and Social Care Partnership the existence of different information systems across agencies for recording Inter-agency Referral Discussions decreases the likelihood that records will be consistent resulting in decisions about child protection being made on inaccurate data.

Finding 2 **Communication and collaboration in longer term work**

There is a tendency for professionals to assume meaning rather than verify language that is open to interpretation and this can lead to assumptions and misunderstandings about the nature of services involved in protecting children.

Finding 3 **Management systems**

Across West Lothian Health and Social Care Partnership, there is a lack of shared organisational and professional clarity about the interface of the Discharge Planning Meeting with the formal child protection system, which can compromise the safety and wellbeing of children.

Finding 4 **Management systems**

In child protection decision-making fora in West Lothian, there is a clear focus on the importance of evidence, but not enough credence given to 'grey areas', which increases the likelihood of assumptions being made about the safety of parents' behaviour in the future.

Finding 5 **Communication and collaboration in longer term work**

When key decisions are being made in cases of physical injury to babies and young children, there is a tendency for the medical contribution to be given prominence by other professionals, but parental and environmental factors must be considered and failure to do so can impact on the multi-agency analysis of risk.

Finding 6 **Family and professional interaction**

Professionals' inclination towards optimism with parents who are adept at keeping them at arm's length can result in the assessment of risk to children being compromised.

10.2 In addition to the findings detailed above, there were several issues to emerge which we think are useful to bring to the attention of the Public Protection Committee:

- **Community Midwifery**: at the point of transition between Community Midwifery and Health Visiting services, no concerns about the family were identified by the Community Midwifery team. However, while there was limited background information on the family and an absence of maternal medical records, there were several vulnerabilities that should have been discussed at the point of handover.

- **Procedures**: three issues emerged in relation to the management of local procedures:

  - First, it emerged that West Lothian procedures in relation to child protection case conferences are inconsistent with *Edinburgh and the Lothians Inter-Agency Child Protection Procedures* (2015) and the National Guidance in terms of managing dissent within case conferences. The Edinburgh and Lothians' procedure states '*where a Chair of the child protection case conference has made the final decision, local Child Protection Committee guidance on independent scrutiny will be followed, as per the National Guidance (2014)'*. Independent scrutiny in West Lothian applies only where there is disagreement with the child protection plan, not dissent in itself;
  - Second, there is occasionally dissent in the decisions made in child protection case conferences, and managing this dissent is an important part of the meeting. It emerged from this review that there may be different approaches to managing dissent within the Reviewing Officer team; and
  - Nor was there wide knowledge across professionals of the procedures for managing dissent and escalating concerns further.

- **Child protection Hub**: the Child Protection Hub was developed to provide a consistent health response to IRDs across Edinburgh and Lothians. This development reflects the arrangements for the role of health in decision-making in the early stages of a child protection investigation. In West Lothian, one social work manager and a police officer of supervisory rank within the Public Protection Unit has responsibility throughout the IRD process, but senior paediatric staff within the Child Protection Hub cover four local authority areas within Edinburgh and Lothians. The Hub is managed on a rota basis with the result of frequent changes in senior staff throughout the IRD process; for example, by the time the decision was taken in this case to proceed to initial child protection case conference, six paediatricians were involved in the IRD. Every effort is made to ensure that one Consultant Paediatrician from the Hub oversees the case once it is designated a complex case. Until this decision is made a range of colleagues can be involved increasing the potential for gaps in, and misinterpretation of, information shared between the core agencies. The aim to provide a consistent health response to IRDs across all four authorities may have unintentionally compromised communication between the Hub and its partner agencies in West Lothian.

- **Analysis of risk**: Analysis of risk is not embedded within practice in all agencies; for example, the ICPCC pro forma is not consistent across all agencies and nor is it used consistently by all professionals. The reports varied in terms of the quality of analysis presented at this ICPCC. Generally, the report format used for ICPCCs supports information gathering but not analysis. Different organisational priorities and

cultures may impact on the expectations given to the preparation and analysis of information contained within reports. In some, this is a summary of the information rather than a full analysis of risks and protective factors in relation to Child A; for example, analysing the information in terms of low/high strengths and low/high concerns in the resilience vulnerability matrix (*National Risk Framework* 2012).

11. Findings in detail

11.1 Finding 1

In West Lothian Health and Social Care Partnership the existence of different information systems across agencies for recording Inter-agency Referral Discussions decreases the likelihood that records will be consistent resulting in decisions about child protection being made on inaccurate data.
[Tools and human interaction]

Information systems are only as effective as the quality of the information recorded and will always be susceptible to human error and the range of systems in place means that information can be recorded and remain unchallenged.

How did it manifest in this case?

11.1.1 The inconsistent recording of information manifested in two ways.

11.1.2 First, there was a lack of clarity about when the *Inter-agency Referral Discussion* (IRD) was instigated. Health recorded that the discussion between the out of hours Paediatrician and Social Work out of hours team (SCET) following the referral by the Health Visitor was an IRD, but social work records indicate this was not the case. The Paediatrician attempted, but was unable to make contact with Police colleagues overnight and decided to defer the call until the following morning as the baby was safe. In the morning, the Hub Paediatrician was asked by Social Work to initiate the IRD with Police before it could be considered as an IRD by three core agencies.

11.1.3 Second, each agency recorded a different outcome for the IRD. Health recorded that the case would proceed to an Initial Child Protection Case Conference, whereas Police recorded that colleagues had been informed by Community Child Health that the injury was accidental and would not proceed to case conference. There was no social work record of the decision. The confusion did not delay a child protection case conference being convened, however, it did contribute to the Police decision that no further police investigation was needed at this stage.

How do we know it's an underlying issue and not unique to this case?

11.1.4 Each agency continues to work within its own information system and need systems which supports the work of each agency, but there is no means of sharing information at points within the child protection system where the three core agencies of police, health and social work come together and make decisions about the level of immediate risk to a child.

How widespread and prevalent is the issue?

11.1.5 The Case Group and Review Team were clear that there was often confusion about when an IRD is initiated which was widespread across the three locality areas of West Lothian. Colleagues from the

Hub reported that in some cases of physical injury, particularly if initial concerns are of possible injury or trauma to a child, an IRD will be initiated pending the outcome of medical assessment. This is in line with *Inter-agency Edinburgh and Lothians Child Protection Procedures* (2015), which state: 'that in all cases where any form of abuse or neglect of a child is suspected the needs for medical assessment must be discussed during the inter-agency referral discussion.' (p.43). All staff, who conduct IRDs, have previously been advised that they must be explicit that a discussion is an IRD.

11.1.6 In 2017, a total of 519 IRDs were undertaken. The numbers have slightly decreased since 2014, but not significantly. Figures from an audit across NHS Lothian during 2014 (NHS Lothian Child Protection Service 2015) note that 18% of IRDs involved SCET in West Lothian suggesting that this confusion is unlikely to be unique to this case. The Review Team, however, was clear that this confusion is not confined to out of office hours discussions.

Why does it matter?

11.1.7 A safe system relies on accurate information being recorded and shared, but will always be susceptible to human error. The IRD processes, therefore, should help rather than hinder professionals when they need to make immediate judgements about potential risk to children and take any necessary action to keep them safe.

11.1.8 Significant changes to the wider organisational structures of NHS Lothian and Police Scotland in recent years has meant a change for West Lothian in that the recording of IRDs is not shared across agencies on one electronic system instead three different systems are now in operation. The decision by West Lothian's Chief Officers Group for a shared eIRD (electronic system) across NHS Lothian, Police Scotland and West Lothian has recently been implemented with a shared system going live on 30 April 2018. It is important, however, that current systems in place support the agencies in recording decisions and outcomes consistently until the shared eIRD is embedded in practice.

Finding 1

In West Lothian Health and Social Care Partnership the existence of different information systems across agencies for recording Inter-agency Referral Discussions decreases the likelihood that records will be consistent resulting in decisions about child protection being made on inaccurate data

[Tools and human interaction]

The importance of inter-agency referral discussions in child protection is widely recognised in national guidance (Scottish Government 2014) and local procedures across Scotland. It is key that decisions made about the immediate risk of harm to children is based on the most up-to-date information known at that point and is recorded accurately as this informs future decision-making.

Questions for PPC to consider:

- How can the PPC be assured that there is consistent professional understanding of an IRD?
- How can the PPC be assured that the core agencies involved in IRDs are consistently recording decisions and outcomes?
- How will themes identified from the IRD review process be reported to the PPC?

11.2 Finding 2

There is a tendency for professionals to assume meaning rather than verify language that is open to interpretation and this can lead to assumptions and misunderstandings about the nature of services involved in protecting children.
[Communication and collaboration in longer term work]

Throughout this case, there were examples where professionals used language that was either misunderstood or led to assumptions being made about the nature of services involved. From the beginning, this set a tone for how some professionals viewed the family and introduced a confidence in the assessment of the family's situation and the resulting plan developed. Attributing meaning to words and language is something Reder and Duncan (2003) have commented on in child protection professional networks:

> '*It must be the responsibility of both the message initiator and the message receiver to ensure that their communication is being understood by the other and that each one is attributing the intended meaning to all parts of the message*.'
>
> (Reder and Duncan 2003, p.87)

How did it manifest in this case?

11.2.1 There were several examples of how language impacted on professional assumptions.

11.2.2 First, there were misunderstandings around the language used in the description around the bruising of Child A. At all times, there was recognition by professionals of the significant force required to cause the bruising on the cheeks of Child A, however, the term '*accidental*' began to appear in records, case notes and minutes. At no point was the intent behind the bruise established. When initially questioned by the Health Visitor, Mum offered the explanation that Child A had pinched her own cheeks, which had caused the bruising. The Health Visitor challenged this and Dad then admitted that he had caused the bruising while winding Child A. The explanation offered by Dad and his subsequent engagement with health staff early in the child protection investigation became an influential factor in later decision-making in relation to Child A. Terms used to describe Dad's parenting included '*inexperienced*' or *'heavy-handed*' and the bruise was later described as '*accidental*' (Minute of Initial Child Protection Case Conference [redacted] 2016). The minute also records that the bruise to the cheeks had been immature handling with no malicious intent by Dad and the level of risk would not warrant Dad being supervised with Child A.

11.2.3 Second, there was a lack of clarity across all professionals about the nature of the '*observations'* undertaken by St John's ward staff where Child A was first admitted to hospital. The Consultant Paediatrician from the Hub was clear with the Acute Consultant Paediatrician that ward staff were to observe the parents to determine whether they: could recognise the baby's needs; dress and undress Child A, put a nappy on, observe their technique and to record other information they thought would be useful to inform decision making. Discussions at DPM recorded in social work cases notes report that the ward staff had observed '*strong attachment*', yet Ward staff attending the Discharge Planning Meeting were clear about the limitations of the observations.

11.2.4 Third, assumptions were made by some professionals about the nature of services offered by Family Unit. It was agreed at the Discharge Planning Meeting that staff at the Unit would undertake *checks*

twice daily rather than the normal practice of once a day. These checks consist of a quick visit to confirm that visitors to the family have left the Unit and that all is fine with the family. Staff do not usually enter the family flat, however, with the couple's agreement the staff would go into the flat in the morning and *observe* the conditions including who was feeding or holding Child A, and put a note of this on [social work IT system]. The limit of these checks and observations was understood by some professionals, but not all, and added to a picture of more intensive monitoring of the family. Similarly there was a misunderstanding by professionals, who perhaps had less frequent contact with the Unit, about the nature of the accommodation. Some agencies were clear that this was a homeless unit for families, whereas other professionals described this as '*supported accommodation'*, '*family unit*' or '*mother and baby unit*' which offer a different type of service.

How do we know it's an underlying issue and not unique to this case?

11.2.5 This is unlikely to be unique to this case because all practitioners have busy workloads and competing demands and may use terms and language to describe the needs of children and families, which is common within their own professional organisation but may be interpreted by different professionals in different ways.

11.2.6 The feedback from professionals throughout the review was that there was a lack of understanding about the role or work of others involved in the child protection process. This did not necessarily impact on the good working relationships between colleagues or their approach to sharing information, however, it did impact at times on the accuracy of the information shared and on subsequent decision-making and understanding of the nature of services in place to support the family.

How widespread and prevalent is the issue?

11.2.7 The Case Group and Review Team both commented that how words and terms are understood and the assumptions then made about the nature of services offered is commonplace across West Lothian. The Review Team also acknowledged that these issues had come to light in other case reviews. This is likely to be more widespread than West Lothian as this has been a finding in previous Serious and Significant Case Reviews (Reder and Duncan 2003).

Why does it matter?

11.2.8 Increasingly practitioners are working together across professional organisational boundaries. During times when professionals in busy jobs are making judgements and prioritising workloads based on limited information, a safe system relies on professionals sharing information, which is accurate and with descriptions understood by all professionals. Professionals should have the confidence to seek clarity and challenge the language and terms used regularly in different organisations.

11.2.9 Practitioners need to make judgements about vulnerability factors, unmet needs and adversity as well as family strengths and resilience and on an inter-agency basis. Professionals are reliant on communication which, if not well defined, impacts on decision-making and the understanding of the level of risks to a child and how this is managed.

Finding 2

There is a tendency for professionals to assume meaning rather than verify language that is open to interpretation and this can lead to assumptions and misunderstandings about the nature of services involved in protecting children

[Communication and collaboration in longer term work]

Practitioners need to make judgements about vulnerability factors, unmet needs and adversity as well as family strengths and resilience and on an inter-agency basis. Professionals are reliant on communication which, if not well defined, impacts on decision-making and the understanding on the level of risks to a child and how this is managed.

Questions for PPC to consider:

- Is the PPC confident that professionals working across the boundaries of child protection networks understand each other's roles and responsibilities?
- Is the role of acute services in observing children understood by all agencies, particularly where there are child protection concerns?
- Is the name of [redacted] Family Unit misleading?

11.3 Finding 3

Across West Lothian Health and Social Care Partnership, there is a lack of shared organisational and professional clarity about the interface of the Discharge Planning Meeting with the formal child protection system, which can compromise the safety and wellbeing of children.

[Management systems]

The Discharge Planning Meeting (DPM) is an important decision-making forum for children being discharged from hospital, however, the status of this meeting and the Interim Safety Plan developed to allow children to return home is unclear particularly as the DPM does not form part of the formal child protection activities set out in national and local inter-agency child protection procedures, which are designed to address the risk of significant harm.

How did it manifest in this case?

11.3.1 The decision at the Discharge Planning Meeting to send Child A home from hospital with an Interim Safety Plan suggested that the professionals involved with the family considered that the child may be at risk of significant harm, yet the Discharge Planning Meeting does not form part of the formal child protection system and is not referenced within the *Edinburgh and Lothians Inter-agency Child Protection Procedures* (2015).

11.3.2 In this case, two key decisions from this meeting were not recorded, but informed the views and thinking of some professionals at the Initial Child Protection Case Conference – that Child A would be discharged home to the care of her parents and that Dad would have unsupervised contact with his daughter. The case notes from the meeting did not record whether supervised contact with Dad, alternative forms of care or the reasons for the contingency plan were considered or discussed. The Interim Safety Plan allowed the child to return home from hospital in anticipation that it would be agreed as the child protection plan at the ICPCC, however, as there was a subsequent decision at the initial child protection case conference not to place Child A's name on the child protection register, there was no child protection plan nor a discussion at the end of the ICPCC about whether the interim safety plan would become the child's plan to ensure the continued wellbeing and safety of the child.

11.3.3 Social Work decided to 'manage' this as a child protection case, however, the consequence of this was a lack of clarity on the status of the plan and what could be expected by the family's engagement. In the short period between March and May, two planning meetings were held. Dad's lack of engagement and attitude to Social Work deteriorated quite significantly following the case conference, and aspects of the plan, such as the social work part of the parenting assessment, were unable to be taken forward; this should have been key in determining the parents' ability to care for their child, yet no changes were made to the plan.

11.3.4 The contingency plan within the *Interim Safety Plan* was to refer the child to the Children's Reporter, however, this would not have secured the child's immediate safety had her situation changed.

How do we know it's an underlying issue and not unique to this case?

11.3.5 The Discharge Planning Meeting makes key decisions about a child's safety and wellbeing, but there is no universal understanding of its purpose, no guidance or shared understanding of the issues the meeting needs to address. The meeting is not formally minuted and the note of the meeting is captured as social work case notes and not consistently shared beyond those professionals who can access [social work IT system] Other professionals are expected to record the discussion and outcomes on their own agency's recording systems. In this case, the case notes could only be accessed by Social Work and some professionals from other agencies, but not all; Health colleagues and Police Scotland cannot access these notes.

11.3.6 Nor are all professionals expected to attend; for example, there is no expectation that a locality Consultant Paediatrician from the Hub will attend a Discharge Planning Meeting as consultants have other clinical commitments and priorities.

11.3.7 A full summary of the meeting is not expected, therefore, it is unclear how wider discussions from the DPM feed into the initial case conference and child protection processes.

How widespread and prevalent is the issue?

11.3.8 Discharge Planning Meetings do not feature in the *Edinburgh and Lothians Inter Agency Child Protection Procedures* (2015), instead this document sets out the expectation that 'an initial child protection case conference must take place prior to the baby's discharge from hospital' (2015, p.50).

11.3.9 The Case Group and Review Team acknowledged that DPMs are not part of the formal child protection process and are not given administrative support. The lack of clarity about its purpose and status meant that no information was available on the numbers of children this might affect, but colleagues thought it was unlikely to be unique to this case.

Why does it matter?

11.3.10 The decisions made at DPMs can shape the thinking of professionals towards families. This is a meeting where decisions are made resulting in a plan to keep a Child A safe, yet there is no clear format for what should be discussed at the meeting, no formal record made and not all information is made easily available to professionals who may have a role in taking forward the plan. The decisions made at the DPM are considered by the ICPCC.

Finding 3

Across West Lothian Health and Social Care Partnership, there is a lack of shared organisational and professional clarity about the interface of the Discharge Planning Meeting with the formal child protection system, which can compromise the safety and wellbeing of children
[Management systems]

In situations where there are child protection concerns and the child is leaving hospital, this is a key meeting where decisions are made resulting in a plan to keep Child A safe prior to an initial child protection case conference. Decisions made at the DPM influence issues considered by the ICPCC, yet the DPM does not form part of the formal child protection system.

Questions for PPC to consider:

- Does the purpose and status of the DPM need clarifying?
- Where there are child protection concerns, how does the Discharge Planning Meeting fit with *Edinburgh and the Lothians Inter-agency Child Protection Procedures* (2015)?
- Should DPMs have more formal administrative support?

11.4 Finding 4

There is a clear focus on the importance of evidence in child protection decision-making fora in West Lothian, but not enough credence given to 'grey areas', which increases the likelihood of assumptions being made about the safety of parents' behaviour in the future.
[Management systems]

Those working in child protection will, at times, be involved with families for whom they have concerns which are difficult to voice. Situations where not all information is known or shared by the family and professional niggles, doubts, concerns or intuition are often described as 'grey areas'

How did it manifest in this case?

11.4.1 The Initial Child Protection Case Conference (ICPCC) was the first formal decision making forum following the child protection investigation. In this case, a range of professionals had varying levels of contact with the family in the first ten days since they had become known to services. Reports to the ICPCC reflected this and meant that the ICPCC became the space to consider and analyse all information in terms of the child's vulnerability, adversity, protective factors and resilience with the Chair's role to facilitate information sharing and analysis. The meeting at this point was key as more information had come to light about the family background.

11.4.2 There was a requirement for professionals to provide evidence of risk of significant harm, which they found difficult to articulate as factual evidence. Some of their concerns took the form of uncertainties, perceptions and intuition, but it was deemed that this was insufficient evidence presented to the meeting in terms of assessment of the risk of future harm to the Child A. The recent history of the parents' childhood experiences and Dad's aggressive behaviour in his youth was not given sufficient consideration as evidence of risk factors which could detrimentally impact on Child A in the future as both parents appeared to be engaging with services and had bonded with Child A. Both their parenting capacity and their willingness and ability to work with services was yet to be gauged as the joint parenting assessment (early years and social work practitioners) was not yet complete at the time of the ICPCC.

How do we know it's an underlying issue and not unique to this case?

11.4.3 National guidance (Scottish Government 2014) sets out that an ICPCC should be held within 21 days of the initial referral unless there are clear reasons for a delay to the case conference. This timescale can present challenges for practitioners. For example, in West Lothian, the time period of 21 days is from the point an Inter-agency Referral Discussion (IRD) is initiated and this can take two to three days to conclude, which shortens the time available for information gathering and early assessment to inform the ICPPC, particularly when families are new to the area. Practitioners need time to reflect on the information they and others hold on a family prior to a conference, and it is the job of the conference to provide this reflective space and ensure that all relevant information held by each agency has been shared and is analysed on an inter-agency basis.

11.4.4 Local guidance[2] for Chairs of Pre-birth and initial child protection case conferences state that: '*The Chair should encourage consensus. Where someone continues to disagree with registration their reasons for doing so should be noted and the Chair makes the decision re registration based on the evidence*.' (p.2), however, this focus on evidence is interpreted differently across the team of Reviewing Officers.

How widespread and prevalent is the issue?

11.4.5 The *Agenda and Script for ICPCC* states that members of the meeting need to consider '*what evidence there is of how risk factors affect or will affect the child*.' It continues that '*where a child has already been exposed to actual harm we need to consider the extent to which they are at risk of repeated harm and the potential effects of continued exposure over time*'. Analysis of other SCRs in Scotland suggest that family and environmental factors such as 'troubled childhoods: poor attachment, lack of parent role models, and 'social isolation, lack of family or community support' are among the risk factors identified for infants (Care Inspectorate, 2015 p.32).

11.4.6 The Case Group acknowledged that workloads and timescales in undertaking assessments to inform child protection case conferences means that this is an issue which impacts on the extent of information gathered and quality of assessment and analysis in reports. The Case Group were also clear that some professionals may have had very little or no contact with families prior to a case conference.

11.4.7 Both the Review Team and Case Group acknowledged different perspectives across professionals on what is considered as 'evidence' is influenced by their professional education and training and organisational cultures.

11.4.8 Throughout this case, professionals working with the family were clear about the potential risks to the safety of Child A, however, the interface of how professional judgement informs the child protection process is not consistent across the Health and Social Care Partnership. There is no shared understanding of what constitutes as evidence within the child protection process: factual evidence is often the domain of medical and police colleagues whereas social work and health visiting often have to deal with intuition and feelings based on professional experience and judgement. There also needs to be a place for recent and historical information as well as knowledge of the present circumstances.

[2] Form 4 - *Agenda and Script for an Initial/Pre-Birth Child Protection Conference*. West Lothian Child Protection Committee (2015).

There needs to be a place for both in the child protection process, particularly in the early stages of a child protection investigation for families where little information is known.

Why does it matter?

11.4.9 In cases, where parenting capacity has not been assessed and the child is very young, the evidence and the understanding of potential effects of continued exposure over time will be limited. In the early stages of child protection, all forms of evidence need to be considered. Grey areas are themselves evidence that need further validation; they may not result in later concerns, but should be explored in the early stages of information gathering and risk assessment.

11.4.10 Research indicates that a record of previous violence, level of previous offending of any type and being male increases the risk of violence (Munro 2008) and services had not been in place long enough to assess whether the parents would continue to engage. Kellett and Apps (2009) have written that gut instinct is a kind of interface where professional and personal factors and objective and subjective observations meet. They conclude: '*that more could be done to support professionals in the fine-tuning of their 'gut instincts' in order to pick up more subtle messages from families in need of support*.' (p.45). The interaction of risk factors is complex and a key protective factor is the parent's insight into professional concerns and their capacity for change, if required.

11.4.11 A safe system requires needs, risks, support and protection to co-exist in a relationship with one another. In decision making forums these factors need to be aligned and the purpose of child protection case conferences is to 'share information in order to identify risks to the child collectively and the actions by which these risks can be reduced' (Scottish Government, 2014 p.103). Risk factors are in a complex interaction with protective factors and one of the most vital is the parent's capacity for change. Assessment of risk needs to consider: what are we worried about; what's working well; and what needs to happen. Making sense of the first two involves thinking about what is known and what is suspected; both constitute evidence. Where families have been transient and there is limited background knowledge, assessments of risk will require involvement of professionals over a longer period of time, particularly in the situation with new babies. As child protection is not an exact science there has to be a place for doubt as well as certainty.

Finding 4

There is a clear focus on the importance of evidence in child protection decision-making fora in West Lothian, but not enough credence given to 'grey areas', which increases the likelihood of assumptions being made about the safety of parents' behaviour in the future

[Management systems]

Where families have been transient and there is limited background knowledge, assessments of risk will require involvement of professionals over a longer period of time, particularly in the situation with new babies. As child protection is not an exact science there has to be a place for doubt as well as certainty.

Questions for PPC to consider:

- How can the PPC support professionals in their understanding of evidence and the analysis of risk of future harm?
- How is the PPC assured that there is consistent decision-making at Child Protection Case Conferences?

11.5 Finding 5

When key decisions are being made in cases of physical injury to babies and young children, there is a tendency for the medical contribution to be given prominence by other professionals, but parental and environmental factors must be considered and failure to do so can impact on the multi-agency analysis of risk

[Communication and collaboration in longer term work]

Within health and between agencies, the specialist knowledge, expertise and status of Community Child Health Paediatricians (Hub) within NHS Lothian means that weight is given to the information or evidence presented by medical professionals regardless of their wider experience of child protection and direct knowledge of the family. This impacts on the importance given to the information shared.

How did it manifest in this case?

11.5.1 Based on the medical information received by Police following the Inter-agency Referral Discussion that the injury to Child A was interpreted as 'accidental', there was no separate police investigation in relation to the bruise. Police colleagues made the decision solely based on the medical opinion.

11.5.2 Emphasis was given to the information provided by the medical team at St John's Hospital at the Discharge Planning Meeting and the Consultant Paediatrician representing the Child Protection Hub during the Initial Child Protection Case Conference. This was despite the fact the Ward staff had only observed the family during one weekend within a hospital setting and without the pressures faced by new parents in their daily routine, and that the Consultant Paediatrician did not have a good knowledge of the family equal to other professionals. Other health professionals, such as the Radiographer, also commented on how well the parents had engaged and coped with the medical investigations of Child A which perhaps added weight to the medical opinion.

11.5.3 At the Discharge Planning Meeting, the medical team were aware of the limits to any observation undertaken by ward staff and as the observations were conducted within a 'false' environment in that the family were responding to the baby outside the stresses of everyday life and within their own home. From the medical staff perspective, however, there was no medical reason to keep Child A in hospital, and despite support from the Hub, the acute paediatrician did not feel sufficiently knowledgeable or confident in speaking about bruising in very young babies at the Discharge Planning Meeting as the skills, knowledge and experience in relation to bruising, and child protection more widely, were perceived to lie within the Hub.

11.5.4 Throughout this case, undue weight was given to Dad taking responsibility for the injury once the Health Visitor had challenged the initial explanation that Child A had pinched her own cheeks. The combination that Dad's explanation was plausible, that he had admitted to causing the bruising and the family appeared willing to engage and did not present as hostile to most professionals inadvertently implied a lower level of risk to some medical staff despite the force required to cause the original bruise. By the Initial Child Protection Case Conference, the note of the meeting records that the Consultant Paediatrician '*did not feel that Child A was at risk of significant harm*' although no professional could have known Dad's intent at the point of Child A sustaining the injury.

How do we know it's an underlying issue and not unique to this case?

11.5.5 At the early stage of professionals beginning to work with families, the lack of knowledge among professionals about the family background and current social circumstances contributes to reliance on the medical opinion about nature of injury and the risk presented by parents. For this reason, this is likely to be an underlying issue.

How widespread and prevalent is the issue?

11.5.6 The Case Group acknowledged that the focus on the positive factors in cases of physical injuries is partly caused by an over-reliance by other agencies on the medical information presented. The Review Team also reported, that in cases of physical injury, particularly where there is no disclosure, a Child Protection Order would be granted by the Sheriff weighted on medical opinion.

11.5.7 In 2017, 28 children under the age of two were placed on the child protection register with a concern of physical harm noted.

Why does it matter?

11.5.8 In cases of physical harm to a child, medical evidence is a significant part of the analysis of risk of harm, but forms part of the jigsaw that includes social, family and environmental factors. The family's engagement with medical professionals and the plausible explanation offered as admission by Dad inadvertently implied a lower level risk of harm to Child A and was influential in shaping the views of some professionals involved in the case. The medical opinion shared with the police - that the injuries were consistent with the explanation given by Dad - was recorded by police as: '*accidental injury caused by rough handling by child's father. No requirement for case conference meantime*' [Update recorded by Public Protection Unit [redacted]2016], which influenced the decision not to take the police investigation further.

11.5.9 In cases where children are unable to disclose physical harm and abuse the medical evidence is important to ascertain the nature of the injury, however, where the intent of the injury is unknown a wider assessment of risk is needed to ensure that the force required to cause the injury is not unintentionally minimised by the explanation given by parents.

Finding 5 **When key decisions are being made in cases of physical injury to babies and young children, there is a tendency for the medical contribution to be given prominence by other professionals, but parental and environmental factors must be considered and failure to do so can impact on the multi-agency analysis of risk** **[Communication and collaboration in longer term work]**
In cases of physical harm to children, medical opinion is a significant part of the analysis of risk of harm but forms part of the jigsaw, which includes social, family and environmental factors. Where the intent of the physical injury is unknown a wider assessment of risk is needed to ensure that the force required to cause the injury is not unintentionally minimised by the explanation given by parents. **Questions for PPC to consider:** • How can the PPC be assured that professionals understand that an injury being consistent with the explanation given by parents does not reduce the risk of future harm?

- How can staff be supported to feel confident in challenging information presented at key decision-making meetings?
- How well is the recently implemented *Management of Unexplained Bruising in Non-Mobile Babies Protocol* understood by all professionals?

11.6 Finding 6

Professionals' inclination towards optimism with parents who are adept at keeping them at arm's length can result in the assessment of risk to children being compromised.
[Family and professional interaction]

An optimistic approach is an important factor in effective work with children and families, however, in child protection work there is a dual task of supporting families while at the same time taking action to protect a child and both roles have to be reconciled. This can be more challenging when parents have not requested services and are ambivalent to receiving help.

How did it manifest in this case?

11.6.1 Throughout this case Dad did not fully engage with social work and by the second Children's Planning Meeting was resisting the support of all agencies. Social Work also had concerns about possible coercive control by Dad with Mum. Mum may have wanted to speak with Social Work alone, but the opportunity did not arise for the Social Worker to speak with Mum. Health Visiting and Early Years professionals working with the family were made aware of the situation and made themselves available to Mum should she wish to speak with them. Child A was developing, meeting physical milestones and was well presented, which made it easier for parents to keep professionals at arm's length in relation to their parental relationship and links with the wider community.

11.6.2 Another consequence of Dad's behaviour meant that the parenting assessment – a critical aspect of the Child's Plan – was not completed. Child A was growing and developing, and presented as well cared for, but there was some chaos in the lives of the family through being homeless and an increasing unwillingness by Dad to engage with some services. The situation was made more difficult as both parents engaged with services where the focus was on Child A, such as health visiting and early years, but resisted scrutiny by services when the focus was on their own relationship. There was awareness among professionals that the family viewed the number of visits as intrusive and increased the stress for the family at a time when Child A was progressing and developing.

How do we know it's an underlying issue and not unique to this case?

11.6.3 The Case Group acknowledged that they work with many families in West Lothian where parents are ambivalent to the professionals, but appear engaged or are adept at manipulating contact with professionals.

How widespread and prevalent is the issue?

11.6.4 The Review Team acknowledged that colleagues across West Lothian work with families where resistance to advice and help is a feature of the relationship, but that numbers are not known as this is not information that is collected regularly. The Case Group also reported that professionals are often over-optimistic in working with families and want to maintain as far as possible the opportunity for

babies to bond with their parents. The positives in a given situation need to be balanced with careful consideration that compliance is often temporary and tokenistic.

11.6.5 This is an issue, which has been reported in several Serious and Significant Case Reviews, which have been published previously (Newcastle SCR).

Why does it matter?

11.6.6 The way in which parents respond to attempts to build a working relationship can also provide valuable insights into the likelihood of establishing a longer term joint plan with parents. Recent research suggests that the problems that affect parenting capacity are frequently not tackled and unless the root problems affecting parenting capacity are assessed and addressed, children are likely to experience or continue to experience harm (Farmer and Lutman 2010). Ambivalence by parents needs to be considered as a possible risk indicator, which can impact on the wellbeing of children.

11.6.7 Generally, parenting assessments should consider the parents' ability to care for their child in a variety of settings and focus identifying strengths and weaknesses in relation to parenting such as: basic care; ensuring safety; emotional warmth; stimulation; guidance and boundaries; and stability. A parenting assessment should also take into account the impact of wider factors on parenting and the child's development including: family history and functioning; extended family; housing; employment; income; and social integration and community resources. Parents need to put their children's needs first and also meet their health and developmental needs providing routine and consistent care. A key part is for parents to acknowledge problems and engage with support services. Kellett and Apps (2009) identified that risky parenting was associated with neglecting a child's basic needs; putting their own needs first; chaos and lack of routine; and an unwillingness to engage with support services.

Finding 6
Professionals' inclination towards optimism with parents who are adept at keeping them at arm's length can result in the assessment of risk to children being compromised
[Family and professional interaction]

Lessons from Serious Case Reviews in England highlight that professionals need to strike a balance between building a relationship with parents, being optimistic that parents can change and having *'respectful uncertainty'* in trusting what might really be happening within the home (Laming 2003). While failing to engage with services is the parent's choice, it is not the child's choice.

Questions for PPC to consider:

- How confident is the PPC that professionals understand the challenges of working with resistant families without losing sight of the children?
- How can multi-agency reflective practice be developed and supported?
- How confident is the PPC that practitioners recognise and respond to behaviour that includes non-engagement or ambivalence?

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How the SCIE Model Works