7 MINUTE BRIEFING - CHILD A

1. Background	Child A • Child A was born to young parents who had recently moved into the area and were living in homeless accommodation. Just before the birth of Child A, the couple presented as homeless and were housed in a homeless unit. During the Health Visitor's first visit she noticed bruising to Child A's cheeks. • A child protection Inter-agency Referral Discussion (IRD) was undertaken and a joint paediatric forensic medical examination was conducted. The JPFME concluded that bruising to both cheeks was consistent with the father's fingers when holding Child A's head and that this would have required a significant degree of force. • A Child Protection Case Conference discussed the risk to Child A & a decision was taken not to place her name on the Child Protection Register. A multi-agency plan was devised and implemented. • At 11 weeks old Child A was admitted to hospital in a critical condition and died six days later. Her father subsequently pled guilty to culpable homicide. The case met the criteria for an SCR and the PPC commissioned two independent reviewers to conduct a Learning Together Review.
2. SCR	West Lothian Public Protection Committee (PPC) conducts Significant Case Reviews (SCRs) in line with National Guidance In Scotland, SCRs examine the circumstances and context of a child being harmed or killed, to evaluate the nature and quality of professional contact with the child, to identify any system failures which may impact on other children, and to learn from the incident lessons which will strengthen child protection systems, locally and nationally. SCRs should be seen in the context of a culture of continuous improvement and should focus on learning and reflection on day-to-day practices, and the systems within which those practices operate.
3. Learning Together	The starting point for a Learning Together Review Is that when it comes to keeping children safe it Is reasonable to think that most people come to work each day wanting to do a good job. The approach explores why actions were taken or decisions were made & reminds us that even seemingly poor decisions will have seemed sensible at the time There are 3 principles: 1. Avoid hindsight bias - understand how those involved saw the case as it unfolded at the time. 2. Appraise practice, but also explain why that practice occurred 3. Move from case specific to general learning to effectively inform Improvement A Learning Together SCR produces findings and asks questions which the Public Protection Committee considers. In this case there were 6 findings, 5 of which are important for staff to consider.
4. Findings	**Finding 1** referred to IRDs and different recordings of discussions by each agency. This has been addressed by the introduction of e-IRD system and the multi-agency IRD review group **Finding 2** There Is a tendency for professionals to assume meaning rather than verify language that Is open to interpretation end this con lead to assumptions and misunderstandings about the nature of services Involved in protecting children **FIndIng3** 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 (DPM) with the formal child protection system, which can compromise the safety and wellbeing of children.
5. Findings	**Finding 4** 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** 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** 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.
6. Why does this matter?	The Case Group (those involved with the child and family) met with the independent reviewers about the specific case. The Review Team then met with the reviewers to consider whether issues identified are "findings" i.e. they are recognised as Issues in a wider context than one individual case.
7. Questions for consideration at team meetings & supervision	• Do you recognise the findings? • Are you confident in asking for explanations or clarification and challenging assumptions? • Do you make sure your communications are understood? Do you follow up referrals/discussions in writing? Would this be useful? • What support is required to help you feel confident analysing risk and communicating that risk to others? • What role does supervision play in ensuring non- engagement, disguised compliance and over optimism are identified? • Are you aware of the CPC's Escalation procedure? • Until the local CP procedures are revise • d, how can we ensure better consistency at DPMs? • What does "evidence" mean to you?

Full report can be found at https://publicprotectionwestlothian.org.uk/article/41489/Significant-Case-Reviews