2023

West Lothian Child Protection Committee

LEARNING REVIEW: CHILD F

Executive Summary

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Introduction

Child F presented at St John's Hospital with bruising to their body. In the following days, a Forensic Medical Examination took place and a skeletal survey showed fractures on two ribs. During the mother's pregnancy, a range of services had been working with the parents and the unborn baby's name had been placed on the child protection register in 2022.
A Learning Review Notification[1] was submitted to West Lothian Child Protection Committee (CPC) and the decision was made to undertake a Learning Review as this situation met the criteria, specifically:

"When a child has died or has sustained significant harm or risk of significant harm as defined in the National Guidance for Child Protection in Scotland and there is additional learning to be gained from a review being held that may inform improvements in the protection of children and young people and one or more of the following apply:

- Abuse or neglect is known or suspected to be a factor in the child's death or the sustaining of or risk of significant harm
- The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR or was a care experienced child (i.e. looked after, or receiving aftercare or continuing care from the local authority). This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death or sustaining of significant harm, unless it is absolutely clear to the Child Protection Committee that the child having been on the CPR or being care experienced has no bearing on the case
- The child's death is by suicide, alleged murder, culpable homicide, reckless conduct, or act of violence"

(Scottish Government 2021, p.5) [2]

The time frame under consideration in this review was from the point of the domestic abuse concerns raised by community midwifery in early 2022 to the Review Child Protection Case Conference 5 months later. Due to an ongoing police investigation, West Lothian CPC was advised by the Procurator Fiscal that the Learning Review could not include the time period when injuries to Child F were identified and nor should the family be involved in the review.

The process of the review

In accordance with national guidance[3], this Learning Review adopted a systems approach. Such an approach goes beyond individual or professional practice to explore underlying systemic elements, the links with organisational factors and the wider context. A key feature of this approach was to bring together agencies and practitioners to reflect and learn from what had happened, and to identify learning and strategies for practice improvement. The purpose of the review was not to establish who or what caused the injuries to the child, but to identify learning for practice and for the wider organisations.

The Learning Review was commissioned by West Lothian Child Protection Committee's (CPC) Learning Review subcommittee. Prior to the review starting, the subcommittee identified the significant issues, clarified the focus of the Learning Review, developed a terms of reference and identified participants to be invited to the Practitioner and First-line Manager event. It was also agreed that, as members of the Review Team were the same as those who would be involved in a Senior Manager event, the activity of both groups would be aligned.

The Learning Review subcommittee also recommended that the review be undertaken by two reviewers independent of West Lothian. The lead reviewers are experienced in using systems methodology for undertaking reviews and had no connection to agencies in West Lothian. Support to the reviewers was provided by the Lead Officer of West Lothian's CPC.

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[1] Scottish Government (2021) *National Guidance for Child Protection Committees: Undertaking Learning Reviews Annex 1.1*. Edinburgh: Scottish Government.
[2] Scottish Government (2021) *National Guidance for Child Protection Committees: Undertaking Learning Reviews*. Edinburgh: Scottish Government.
[3] Scottish Government (2021) *National Guidance for Child Protection Committees: Undertaking Learning Reviews*. Edinburgh: Scottish Government.

The learning review was conducted online between March - June 2023 and its key focus was to consider:

- What more can we learn about assessments and decision making?
- How were parents being assessed and was there sufficient attention on domestic abuse, the father's mental health and the fact that bail conditions had been in place for the period of multi-agency involvement?
- What influenced professional decision making at the pre-birth and review child protection case conferences?
- What were the reasons and purpose of unannounced visits?

Evidence was gathered from various sources: a review of all relevant documentary evidence, individual conversations with seven staff, two practitioner and first-line manager events (referred to as practitoner events) and two Review Team meetings.

During two practitioner events, staff were asked to discuss and reflect on their involvement with Child F and their family focusing on assessments, decision-making and actions as well as identify areas of effective practice, suggested changes and strategies for improvement. Six members of staff attended the first event and seven attended the second. This included representatives from: community midwifery, Family Nurse Partnership, Police Scotland, children and families social work and youth justice services. Both events were facilitated by the reviewers.

The Review Team was brought together by the Lead Offficer for West Lothian's CPC and meetings were facilitated by the reviewers. Members represented community child health services, social work services, Police Scotland and criminal justice services. The Review Team brought a strategic perspective, reflected on the issues emerging, identified gaps in the information available and presented, and contributed to the identification of emerging themes and issues. They also participated in the analysis of the information, and provided critical comment on the draft report.

The final report was agreed by West Lothian CPC's Learning Review subcommittee.

Acronyms and terminology

There is a challenge in writing a report which protects, as far as possible, the privacy of all individuals concerned but provides sufficient evidence to support the learning points identified. Every effort has been made to write as clearly as possible and to disentangle the elements of the system, and how practitioners work within it. It is also important to note that terms and language used to describe child protection processes relate to Scottish Government's national guidance (2014) and the current Edinburgh and the Lothians child protection procedures. Revisions to the child protection procedures are currently being consulted on locally.

Limitations

The review was limited by the fact that the reviewers could not speak to all involved. This included family members and the community midwife and Duty and Child Protection social worker first involved with the family. Both professionals had previously left their roles. Nor were reviewers able to explore with staff and managers the circumstances at the time of the child's injuries due to ongoing legal processes or speak with the family directly.

Case Summary

Child F's father had a difficult and chaotic childhood. In his early teens, the father was diagnosed with 2 mental health conditions and referred to Child and Adolescent Mental Health Services to help address this. A referral was made to Youth Justice services following an assault, however, support was withdrawn within months due to a failure to engage. In 2021, the father was again referred to youth justice services by the Procurator Fiscal as a diversion from prosecution. Initially, he did not engage. Later that month, he reported feeling suicidal and was taken to hospital for assessment. At the

beginning of 2022, the father did engage with youth justice services for the duration of the three-month diversion.

Child F's mother was not involved with social work during her childhood and early adolescence. In 2017, she attended the GP following two incidents of self-harm. During her teens, she described a close and supportive family unit with her father, mother and siblings. Relationships between her parents remained friendly at the point of their separation late in 2021.

The parents had known each other throughout school and began a relationship about three years before the birth of Child F. In early pregnancy, the mother was admitted to hospital, reported feeling stressed and there were several police reports of her partner's aggression and suicide attempts. By the time the mother was 16 weeks pregnant, her father had died, she was homeless, stayed briefly in a hotel and was estranged from her mother. When the mother was about 18 weeks pregnant, the father appeared in court in relation to an alleged domestic offence against her. Bail conditions were imposed.

Due to concerns about domestic abuse, the father's mental health and substance use, an Inter-agency Referral Discussion (IRD) agreed to proceed to a Pre-birth Child Protection Case Conference (PBCPCC). The Duty and Child Protection Team (DCPT) was allocated the case to undertake social work's initial assessment. There was also a Multi-Agency Risk Assessment Conference (MARAC) discussion about the case.

The PBCPCC placed the unborn baby's name on the child protection register. As part of the plan, the Youth Justice service was to stay involved with the father for a further month to provide guidance and support and to signpost him to supports in relation to his mental health.

A few weeks later the father contacted Youth Justice Services (YJS) to advise he had been charged in relation to an alleged offence of assault. YJS submitted a closure report to the Procurator Fiscal advising of the father's successful completion of the diversion order in relation to the original incident of domestic abuse.

The case transferred from DCPT to the social work practice team. Child F was born and discharged from hospital the following day. A few days later the mother was readmitted to hospital for a few days. The maternal grandmother cared for the baby.

The virtual Review Child Protection Case Conference unanimously decided to remove the child's name from the register. Professionals felt the parents were working with the plan and could not evidence new or increased risk of significant harm. Following de-registration, the Child's Plan was for the family to continue to work with social work and the FNP's intensive programme of care and support.

Two weeks later Child F was taken to hospital on the advice of a GP and subsequent medical examinations indicated the baby's injuries were non-accidental.

During the time under review, the key agencies involved with the family were community midwifery, Family Nurse Partnership[4], Youth Justice services, Children and Families social work and Police Scotland.

[4] The Family Nurse Partnership is an intensive home visiting programme for first time parents age 21 and under. The FNP programme is offered to a mother usually after her 12-week scan and the usual timescale for an agreement to participate is four weeks.

Organisational learning

Learning Point 1: Pre-birth support for vulnerable preganancies including the Vulnerble Pregnancy Service should be reviewed and a clear pathway established (links to LP2)

Evidence from the case

At the point of the mother's booking appointment, no service other than community midwifery was involved with the mother until she agreed to work with the FNP two weeks later. The FNP and community midwifery agreed not to involve the VPS as the mother and unborn baby would be subject to an IRD at 24 weeks once it was clear there was a viable pregnancy. The DCPT was not involved with the parents as it was practice not to engage until the outcome of an IRD.

The result was that for six weeks, two health professionals were working with the mother and there was no early social work or early years support and intervention for the family or referral to specialist services. This was during a period where the extent of the partner's domestic abuse, mental health difficultes and possible drug and alcohol use was uncertain. Six weeks was a significant amount of time where there was potential for the risks to increase and, in this case, the mother had also experienced the death of parent, a short period of homelessness, threatening behaviour from her partner and had to cope with his suicide attempt as well as her own health problems.

Why does it matter?

Young pregnant mothers are few and not all will need additional services. Some young women, however, have few support networks they can access and often lead chaotic lives where situations can escalate quickly. While this mother met the criteria for the FNP, there will be other young women in similar circumstances who are only slightly older. Community midwifery has a particular role in the delivery of antenatal and postnatal care and, if it has been decided that an IRD referral will be made at 24 weeks, it is unclear which early intervention services would be available to support young mothers during that critical six to eight week period. The early stages of pregnancy provide an excellent opportunity for early assessment and intervention to then shape which supports and services are needed.

Learning Point 2: Transfers between Duty and Child Protection Team, and Practice Teams should be more timely (links to LP1)

Evidence from the case

Child protection concerns had been identified and shared with relevant agencies at an early stage, and it was recognised that longer term intervention was likely. The assessment did not start for another two months. While it is expected that the DCPT should undertake an initial assessment only, this work could have started earlier. It was five months later that the case was allocated to the Practice Team.

Starting the assessment after the IRD only allowed the DCPT three weeks to begin the assessment to inform the pre-birth child protection case conference. The case was then transferred from the DCPT to the Practice Team shortly after the PBCPCC. In addition to the change of social work, the mother had also experienced a change in community midwife and GP due to changing her address. An earlier transfer might have helped to ensure some continuity in terms of the social worker.

Why does it matter?

Scottish Government's *Pregnancy and Parenthood in Young People Strategy* (2016)[5] stated that: "Pregnancy in young people is often a cause and a consequence of social exclusion and should not be seen narrowly as a health challenge." (online). The strategy continues that young people, who are at higher risk of becoming parents, tend to have poorer health and social outcomes compared with older parents, and these are generally intensified as a result of becoming a parent. It identifies that young mothers tend to have poorer perinatal health outcomes, experience poorer mental health and are at a higher risk of mental health issues, have higher than average feelings of isolation

[5] Scottish Government (2016) *Pregnancy and Parenthood in Young People Strategy* [online]. Available at: https://www.gov.scot/publications/pregnancy-parenthood-young-people-strategy/ [**Accessed: 24 April 2023].**

and low self-esteem, often experience problems in relationships with the father and face significant socio-economic disadvantage. Young fathers have double the risk of being unemployed aged 30, even after taking account of deprivation, and tend not to engage with health and social services as well as young mothers.

Getting the best start in life for children is a policy priority, which acknowledges the importance on preventing problems and early intervention to improve outcomes. Attention to long-term physical and mental health conditions as well as addressing complex social needs are important for a healthy pregnancy and throughout a child's life.

Learning Point 3: Child Protection Plans should be more explicit and focus on the specific interventions to address identified risks (links with LP4)

Evidence from the case

There were no specific actions in the plans detailing how risks would be addressed. The risks do not appear to have been fully explored in either case conference or core groups and no expert advice had been sought in relation to health and mental health, which meant there was an over-reliance on parental self-report.

While the father was the perpetrator of domestic abuse, much of the plan focussed on the mother's actions and her responsibility. There was no detailed contingency contained in any of the plans produced from either case conferences or core groups.

Despite that fact that the involvement of youth justice with the father was to end and this was recorded in the PBCPCC minute and associated plan, the youth justice service was still named against actions following the RCPCC and subsequent de-registration. There was a lack of understanding about the role and level of youth justice support which was specifically related to the diversion from prosecution and did not extend beyond this. There was also no detailed analysis of FNP's involvement and schedule of visits and meetings.

Why it matters?

The impact of parental mental health on the life of children has already been highlighted in previous reports and that it is not consistently recognised or understood across all child or adult focused services which can leave children living in situations which may put them at risk (Child A). Practice insights identify that mothers, are too often held responsible for the impact of domestic abuse upon their children. There has been a tendency to focus on a mother's decision-making, rather than identify the potential additional risk of the perpetrator's pattern of coercive control.[6]

National Guidance (2021) indicates that plans should include linking the actions to intended reduction or elimination of risk, be current and consider the child's short, medium and long-term outcomes and have detailed contingencies. Each risk is complex and often looks different in each family. Also, the agenda for core groups states that if work or an intervention has finished then the current plan should not include that service unless new actions are identified and incorporated.

Making a child protection plan is a multi-agency responsibility and everyone attending a child protection planning meeting or core group has a responsibility to check the plan after it is produced to ensure that it addresses the needs of and risks to the child.

[6] Scottish Government (2021) *National Guidance for Child Protection in Scotland 2021: Practice insights*. Scottish Government: Edinburgh.

Learning Point 4: Decision-making at child protection case conferences should take account of risks, vulnerabilities and the likelihood of future significant harm (links with LP3)

Evidence from the case

Professionals were empathic and supportive, optimistic and hopeful about progress but there was a pattern of the mother not fully engaging with FNP, which was not explored further, and nor was it escalated by the FNP. The mother also minimised the impact of her partner's behaviour, suicide attempts, and aggressive and controlling behaviour.

The time between the birth of the baby and review case conference was insufficient for a parenting assessment and this should have been recognised. It was unclear what constituted a parenting assessment and how this would link with the child protection plan. The baby was a few weeks old, the mother was in recovery from the birth and it was unclear what role the father would take in the future. The father was also due in court the following month. While professionals thought there was an improving picture, there had been no opportunity to assess how the parents cared for the baby together and insufficient time to see if improvements identified by professionals were sustained.
While the father's previous reported mental health diagnoses was raised as a potential issue at the RCPCC, no contact was made with CAMHS for their professional assessment about how well he could manage with a new baby. Although the father had talked with social work about the techniques he used for managing and that he felt he would be able to manage when the baby arrived, no professional input was sought in addition to his self-reporting. There were also issues in relation to the mother's health which were not explored further. The mother suffered from regular migraine and talked of low mood. As a younger teenager, there had also been a period of self-harm.

Professionals agreed that no new risks had emerged and there did not appear to have been an increase in the severity of current risks identifed. There was not sufficent evidence, however, of a reduction in the vulnerabilities in the family and risks identified at the time Child F's name was originally placed on the child protection register.

Why it matters?

Risk is a central element of child protection. It is uncertain, mutable and focuses on the what is known about the child, the parents and the wider environment. Informed analysis will help determine not just the current circumstances but the potential likliehood of events occurring or recurring. The multi-agency group needs to reflect on all information gathered and analyse whether it corroborates, challenges or contradicts the current assessment of risk.[7] There also needs to be constructive challenge of professional assessments and assumptions as part of the decision making about registration.

Additional learning

The terms of the bail conditions and the sharing of restricted information at case conferences created challenges for all practitioners:

- **Bail conditions:** bail conditions help inform the level of risk in any given situation. In this case, conditions were imposed in relation to charges of domestic abuse and put in place to provide a degree of protection to the mother, but changes to the bail conditions were dependent on self-reports from the father. Infringements of bail conditions often rely on the victim reporting breaches to the police, however, in this case the mother did not want to be separated from her partner making it difficult for practitioners to have a clear understanding of the impact of the bail conditions. The bail conditions also made it difficult for social work to undertake a full assessment of the parents' situation, their relationship with Child F and parenting capacity as the family could not be fully assessed within their home environment until the conditions were lifted.

[7] Scottish Government (2012) *National Risk Assessment Framework*. Edinburgh: Scottish Government.

There was discussion about the national strategy[8] to keep people out of custody, but practitioners and managers reflected that Sheriffs were not always aware of the full circumstances of all involved. As police do not regularly attend core groups, there is no clear mechanism or process for getting updated information between case conferences to inform ongoing decision-making. This is important as bail conditions can be viewed as a key aspect of assessing risk of harm to children and are often considered as a protective factor for children.

- **Sharing of restricted information:** it was unclear how sharing relevant information in relation to criminal justice processes did or did not inform decision-making within child protection processes. Restricted information that was sub judice was appropriately shared verbally at the RCPCC, but it was unclear to what extent that information influenced the discussion and decisions about the protection of Child F.

Effective Practice

Effective collaborative working relationships across the core group of professionals working with this family were clearly evident to the reviewers. Relationships were respectful and practioners made themselves available to colleagues for discussion and to share information. It was also clear from the documentary evidence that immediately following the IRD referral and PBCPCC, the appropriate agencies were involved in discussions and attended all relevant meetings.

Suggested strategies for improving practice and systems

The following suggested strategies for developing and improving practice and systems were identified through discussion with practitioners and review team members. These are suggestions for the Child Protection Committee to discuss and not recommendations. Suggestions include:

- Pre-birth support for vulnerable pregnancies (including Vulnerable Pregnancy Service) should be reviewed and a clear pathway established (in relation to LP1 and LP2).
- A working group being set up to review practice in relation to earlier allocation of cases of unborn babies and pre-birth assessment completed by Practice Teams. If long term involvement anticipated, then perhaps cases should be allocated directly and assessment should be undertaken by Practice Teams (in relation to LP2).
- Child's planning was identified in a previous SCR in West Lothian (Child A). The Lead Officer for the Child Protection Committee has written a guide to child protection plans which will be circulated (in relation to LP3).
- Child's Plans need to identify specific actions which include frequency and purpose of all contact with the family and clarity about the role of each professional involved including when interventions start and finish (in relation to LP3).
- CPC Quality Assurance subcommittee should observe child protection case conferences/planning and should also consider the role of reviewing officer (in relation to LP3).
- CPC to consider awareness raising about bail conditions and the need to confirm changes reported by the perpetrator (in relation to additional learning).
- CPC to consider awareness raising the use of restricted access information and how it is taken into consideration when making decisions (in relation to additional learning)

[8] Scottish Government (2022) *National Strategy for Community Justice*. Edinburgh: Scottish Government.