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Executive Summary - Significant Case Review for Child B

Beth Smith and Jane Scott with Social Care Institute for Excellence

Contents

Introduction

1. Why this case was chosen to be reviewed?

1.1 Following the death of Child B in suspicious circumstances, West Lothian CPC initiated an Initial Case Review (ICR). The ICR concluded that there should be further inquiry through a Significant Case Review (SCR) on the basis that it met the criteria outlined in the National Guidance (2015) and there was further learning to be gained:

> *'When a child dies and the incident of accumulation of incidents (a case) gives rise to significant/serious concerns and/or service involvement or lack of involvement and one or more of the following apply:*
> - *Abuse or neglect is known or suspected to be a factor in the child's death*
> - *The child is on, or has been on, the Child Protection Register (CPR).....*
> - *The death is by suicide or accidental death*
> - *The death is by alleged murder, culpable homicide, reckless conduct or act of violence*
> - *At the time of their death the child was looked after by, or was receiving aftercare or continuing care from the local authority'*
>
> [Scottish Government 2015, p.8)

2. Succinct summary of case

2.1 The parents of Child B both had difficult childhoods including social work support and involvement. The parents had been together for two years at the time of Child B's birth and had an older child, Child O, together. Each had a child from previous relationships, one of whom, Child K, lived in the family.

2.2 The family came to the attention of agencies, following an allegation against the father of historical child sexual abuse. The father had previously been charged for a serious sexual offence against a minor, but was not convicted. An Inter-agency Referral Discussion (IRD) was initiated when Social Work became aware. A risk assessment was to be undertaken of the father and a capacity to protect assessment of the mother, but there was to be no child protection investigation. There was an agreed interim safety plan of the mother supervising contact between the father and the children.

2.3 Six months later, a second IRD was initiated following Child O's presentation to the Emergency Department after he choked. The child was kept in hospital overnight for observation and was found to have multiple bruising on his body. The outcome of the IRD was that the bruising may have been as a result of the father's reaction to the child choking, but could also have been a non-accidental injury. Health visiting considered the child and the unborn child a cause for concern. At the same time, the Procurator Fiscal service decided not to proceed with a case against the father re historical sexual abuse allegations. Due to the acceptance that the injuries were accidental, there was no further child protection activity.

2.4 A few months after Child B's birth they were admitted to hospital on two occasions with breathing difficulties. A chest X-ray showed changes compatible with infective diagnosis and no rib fractures were noted. Slow weight gain was identified and persisted during this period. Four months later, Police Scotland was called to a minor verbal domestic incident between the parents. The attending officers had no concerns. Health visiting continued to monitor both children.

2.5 A month later, Child B was found unresponsive while in bed with father and taken to the Emergency Department where Child B was pronounced dead that afternoon.

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' 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 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.

Scope of review and research questions

3.4 The decision was taken by West Lothian CPC to undertake a Social Care Institute for Excellence *Learning Together* review without individual conversations. This was to ensure the SCR reported before possible criminal proceedings and previous SCRs in West Lothian had also highlighted similar areas of concern and were within a similar time period. Work was undertaken to develop the key practice episodes from the multi-agency information available to explore in depth with the Case Group and Review Team.

3.5 The research questions were identified as:

a. Across the multi-agency partnership, what is professional understanding of risk, factors that inform risk assessments, analysis of risk, decision-making and subsequent planning?
b. How well does the IRD process link with multi-agency planning processes?

Review Team and Case Group

3.6 The review was undertaken by two Lead Reviewers both of whom are accredited and experienced in using SCIE's Learning Together methodology and have no connection to agencies in West Lothian. SCIE provided methodological oversight and quality assurance.

3.7 The SCIE model involves gathering and making sense of information about a case through meetings with the Review Team, whose membership is drawn from across agencies involved, but who have not held any decision-making responsibility in the case and the Case Group of practitioners directly involved (see Appendix A for membership). The draft research questions were shared and refined in consultation with the Review Team. 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.

3.8 The Lead Reviewers also appreciated the support of the Champion.

4. Sources of data

Case group

4.1 The Lead Reviewers undertook two case groups discussions with staff from a range of agencies, who together formed the Case Group for the review (see Appendix A). Discussions were held with those working in social work, health visiting, community midwifery and police. The Reviewers valued the reflective and thoughtful discussions of the Case Group during a difficult period. The Reviewers also spoke with the GP.

Perspectives of family members

4.2 The Lead Reviewers did not discuss the review with family members on the advice of the CPC.

Documentary evidence

4.3 The review was informed by a range of documents including minutes of meetings, reports and procedures (see Appendix C).

5. Methodological comment and limitations

5.1 The review was undertaken during the national lockdown following the measures announced by the Westminster and Scottish Governments to restrict the spread of coronavirus. This meant that the review was entirely virtual. Discussions within the case group were undertaken in smaller groups rather than one large multi-agency group. Smaller groups allowed discussions to proceed in a virtual environment which allowed people to feel more comfortable in participating, but broader multi-agency discussions were more limited. The Reviewers were grateful to the case group's commitment to the process working within the virtual environment.

6. Acronyms and terminology

6.1 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 findings. Gender neutral terminology has been used throughout this report, but can lead to some clumsiness of expression. Every effort has been made to write as clearly as possible and to disentangle the elements of the system, and how practitioners work in it. There may also be some repetition so that each finding is fully contextualised.

Findings

7. Introduction

7.1 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 the child protection system. The particular case acts as 'a window on the system' (Vincent 2004, p.13).

7.2 Case Review Findings need to say something more about the Child 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 Child Protection Committee.

7.3 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. **Tools** e.g. no detail on the quality or depth of assessments, or difficulties faced in completing them or the influence of case management framework impacts on assessment, planning, implementation and review.
b. **Management systems** e.g. resource-demand mismatch; gaps in service provision; trade-offs between competing priorities; supervision.
c. **Professional norms and cultures - incidents** e.g. organisational culture around priority setting; understanding the nature of the task; overlooking the wider needs of the children in child protection response; the importance of knowing each other; referral procedures and cultures of feedback
d. **Professional norms and cultures - longer-term work** e.g. understanding the nature of the task; assessment and planning as an ongoing process; clarity of roles and responsibilities; what barriers and facilities exist contribute to good team work in longer-term case work; overestimating the remit of service provision of different agencies.
e. **Patterns of interactions with families** e.g. presentation of problems by family members.
f. **Cognitive and emotional biases** e.g. failure to review judgements and plans; drift into failure; attribution error; tunnel vision

8. Recent improvements identified by the Review Team

8.1 Recent developments include:

- **NHS Lothian (2020) *Child Protection Protocol for the Management of Unexplained Bruising in Pre-Mobile Babies***: this protocol is for the management of all pre-mobile babies presenting to staff with unexplained bruising. If a member of staff still has concerns around the presentation of the bruising, either due to its inadequacy of explanation, pattern, distribution or quantity, this protocol is to help guide a sensible approach while assessment takes place.

- **Multi-agency working group**: following publication of a previous SCR (West Lothian 2020), a multi-agency working group was established to take forward the multi-agency child's planning process in West Lothian.

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 because much of the learning is relevant to wider inter-agency working. Assessing risk and the nature of evidence are challenges practitioners face on a daily basis with many of the families they work with and particularly where there are allegations of non-recent sexual abuse and also concerns of possible physical abuse.

9.2 In addition to the findings detailed below, there were several issues to emerge which the Review Team and Lead Reviewers felt it important to bring to the attention of the Child Protection Committee:

- **Consistency of case recording**: it was noted that case recording was not always up-to-date and sometimes incomplete. The Review Team commented that cases which are no longer active can remain open until practitioners update the case recordings. Team Managers have a role in the quality assurance of case notes and ensuring work is completed. It is important that this quality assurance role is undertaken consistently.

- **Managing gaps in service delivery**: all organisations, at times, experience staff absences, lack of capacity, challenges in allocating cases and competing demands on resources. It is important that during such times there is consistency to continue to prioritise the agreed work underway.

10. Findings in detail

10.1 **Finding 1**

Professional attitudes, confidence and skills in dealing with allegations of non-recent sexual abuse, where the perpetrator and victim are both children, hinders speedy allocation and robust, timely assessment which is likely to impact on the safety and wellbeing of some children

[Professional cultures and norms – incidents]

When an allegation of non-recent child abuse is received by any agency, consideration should always be given to whether there are any children potentially at risk from the suspected perpetrator. All practitioners should be confident in identifying and responding to adult behaviour that might indicate a risk to children and investigate thoroughly even if other explanations are offered.

How do we know its underlying?

10.1.1 The Case Group reflected that historical sexual abuse is complex and generally, in these cases, children and families social workers do not feel confident in assessing the likelihood of present or future harm. Identifying risks and protective factors is a challenge particularly when allegations are historical, the parent denies allegations, there is a pending court case or lawyers advise clients not to speak with professionals. Further, the Review Team identified that some groups of staff have limited knowledge of how the decision-making process of the prosecution service operates and therefore, assume that insufficient evidence for prosecution is the same as no evidence. This point also links to Finding 4.

How prevalent and widespread is the issue?

10.1.2 Several challenges and complexities in responding to non-recent child sexual abuse within families have been identified more widely. Much of the recent literature and research relates to either non-recent abuse within care settings or child sexual exploitation, trafficking, and on-line, non-contact abuse. Identification of child sexual abuse through the child protection system is minimal and there are suggestions that this is because of the continuing influence of a backlash from the 1990s and the credibility of social work investigations (Nelson, 2020). The (Draft) National Guidance highlights that *'there have been fluctuations in reporting of sexual abuse in the UK. This may be linked to fluctuations in public awareness and attitude following high profile inquiries'* (2020, p.154).

Why does it matter?

10.1.3 Research and practice have identified that if an individual has abused in the past it can be a good indicator of the likelihood to abuse in the present. This, however, is more nuanced in relation to children where there is less evidence and so, at the very least, a thorough risk assessment is required with input from a range of relevant agencies to help identify current risks. The concern is that busy professionals may misinterpret historical abuse as being *then* and not relevant *now* and do not recognise potential risks to the safety and wellbeing of children or do not know what to do. This is important for cases of non-recent sexual abuse, but also non-contact sexual abuse such as grooming and virtual sexual exploitation.

Question for CPC to consider:
How confident is the CPC that staff are skilled in assessing risk in cases of non-recent sexual abuse or sexual assault including grooming and virtual sexual exploitation?

10.2 **Finding 2**
In Children and Families social work, there is a lack of validated risk assessment tools, training and guidance in assessing allegations of sexual harm which impacts on the quality of assessment and the analysis of risk

[Tools]

The purpose of any risk assessment tool is to provide professionals with a systematic way of collecting and interpreting information to inform risk to children which includes assessing the parent's attitude to the abuse or concerns. To ensure consistency, all risk assessment tools used by professionals should be endorsed by the organisation and integrated into existing assessment and recording processes.

How do we know it is underlying?

10.2.1 There was a general feeling among the case group that the Jeff Fowler workbook is used by several social workers, however, it was thought unlikely that there was time to read the whole book and that workers would be selective in their use of checklists, depending on the context of their assessment. On further exploration, the *Practitioner's Tool for Child Protection and the Assessment of Parents* is more widely used, but less is known about the workbook, *Practitioners' Tool for the Assessment of Adults who Sexually Abuse*

10.2.2 Review Team members were aware of concerns that in using the *Practitioners' Tool for Child Protection and the Assessment of Parents,* social workers were undertaking question and answer sessions rather than using the checklist as a guide to conversations and informing their analysis. As a result, a template and exemplar were devised to guide and to demonstrate to social workers what would be expected in using the tool for both assessment and analysis.

How prevalent and widespread?

10.2.3 This is unlikely to be unique to West Lothian. While not specifically related to the assessment of non-recent sexual abuse, in the learning from Significant Case Reviews (2015-2018) the Care Inspectorate highlights that despite having a common and standardised approach and tool for practitioners and agencies to assess information and analyse risk and need in an informed, structured and evidence-based way, the *'use and application of tools to aid professionals' thinking and inform interventions was variable and inconsistently applied'* (p.25).

Why does it matter?

'Structured assessment frameworks can bring depth and analysis to assessment of children, adults and families. They must be endorsed locally for use by the agency, and practitioners should be trained and confident in their application'

(Scottish Government 2020, p.75)

10.2.4 Any child protection risk assessment is intended to predict what may or may not happen to a child and how safe it is for them to remain in their current situation. As such it considers what is known, past history and future prospects. Parental motivation and capacity to change also needs to be considered as a possible risk indicator which can impact on the wellbeing of children. Professionals conducting the risk assessment engage in an exercise of weighing up probabilities and reaching conclusions on balance. Research has shown that formal assessment tools are more advisable than wholesale reliance on intuition in this context but that both are necessary ingredients of a good risk assessment. If child protection assessment tools are not standardised to a common purpose, there is a danger that tools designed for something slightly different will be used in this context and assumed to be accurate.

Question for CPC to consider:
How can the CPC support the development and consistent use of an agreed risk assessment framework and associated tools for working with adults who may sexually abuse which is aligned with the *National Risk Assessment Framework?*

10.3 **Finding 3**

There is a tendency for professionals to assume the meaning of language that is open to interpretation which can lead to misunderstandings about the level of risk impacting on keeping children safe

[Professional cultures and norms – longer term work]

Professionals' use of language can lead to assumptions being made about the nature of services involved, which can unintentionally change meaning and views on risk. This can set a tone for how some professionals view families and introduces a confidence in the assessment of a family's situation and the resulting plan.

How do we know its underlying?

10.3.1 The Case Group and Review Team commented that use of the phrase '*the injuries fit the explanation*' and the term '*non-accidental*' are not always entirely clear and become shorthand for viewing injuries as accidental and lowering concerns about possible risk of harm. As mentioned this was reflected in case notes and reported conversations as an accidental injury. This re-interpretation of language and use of shorthand is likely to be common in practice.

10.3.2 The Review Team also commented that cases of non-recent sexual abuse needs considerable burden of proof before the report is submitted to the Procurator Fiscal. Generally, the length of

time taken by the Procurator Fiscal to consider a case is not because it is low priority, but because of the serious nature of allegations reported and engaging witnesses. The Review Team though this was probably not fully understood by all professionals.

How prevalent and widespread is the issue?

10.3.3 It is difficult to establish the cause of injuries to young babies and, while the injuries can fit the explanation, it is also possible that the injury is non-accidental. Even if the explanation fits the injuries, the motivation behind the injury is not always known. It is also likely to be more widespread as the understanding of legal processes and decisions made within organisations such as Police Scotland and the Procurator Fiscal Service may not be fully understood by all professionals.

10.3.4 The lack of clarity in language was identified in a previous Significant Case Review (Child A) in West Lothian in 2018 and was also a finding from the Care Inspectorate's review of 25 Significant Case Reviews published in 2019. The SCR in West Lothian found that there was a tendency for professionals to assume meaning rather than verify language that is open to interpretation can lead to assumptions and misunderstandings about the nature of services involved in protecting children. The Care Inspectorate's report reflected that how professionals communicate, including the assumptions that are made about language and the nuances of terms that are used, can lead to misinterpretation or misunderstanding.

10.3.5 Problems with inter-professional communication and its impact upon decision making is a common theme in serious case reviews (SCRs) In England. The NSPCC worked with SCIE and reviewed 38 SCRs, published between May 2014 and April 2015, and identified 44 different practice issues relating to how professionals in different agencies communicate and make decisions, in particular they found that agencies interpret input from health about possible causes of injuries as definitive, rather than one of a range of possibilities as there is often an over-emphasis on medical conclusions as to the cause of injuries. The police progress investigation based on the views of health in relation to physical injury of children.

Why does it matter?

10.3.6 The reflections in West Lothian's SCR in relation to Child A (West Lothian 2018) are still relevant today, in particular that practitioners work across professional and organisational boundaries and are making decisions often based on limited information. It is important that this information 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. Views on risk and key decisions can be made which impact on children's lives as a result of misinterpretation or not fully understanding language. When working with situations of risk and uncertainty, it is important the practitioners have a balanced view and acknowledge that possible intent can be behind actions.

Question for CPC to consider:
How can the CPC evidence sufficient understanding across agencies of professional language and terminology used that informs good decision-making?

10.4 **Finding 4**

Across West Lothian Health and Social Care Partnership, there is a lack of shared organisational and professional clarity about children's planning processes and the interface with the Inter-agency Referral Discussion, which can compromise the safety and wellbeing of children

[Professional cultures and norms – longer term work]

Clear children's planning processes are essential in making sense of information and assessment for children whose wellbeing may be compromised or may be at risk of significant harm. It is important that there is clarity about how different aspects of multi-agency assessment and planning link to ensure processes work effectively to keep children safe.

How do we know its underlying?

10.4.1 The Case Group and Review Team were both clear that there were opportunities for a child's planning meeting at various times in this case. Planning processes are clear for children looked after and accommodated and for those whose names are on the child protection register. The process is less consistent for children for whom there may be wellbeing or initial child protection concerns. A child's planning meeting should take place if social work becomes involved in the role of Lead Professional and then when they no longer have a role and health visiting or education revert to the Named Person. This does not always happen.

How prevalent and widespread is the issue?

10.4.2 The Review Team was clear about the lack of clarity in the interface between the child's planning process and the IRD, and where the planning processes within each agency come together where a range of professionals are working with the family.

10.4.3 As the Care Inspectorate (2019) also reported on 25 Significant Case Reviews:

> '*Social work children and families should ensure robust arrangements are in place to review the quality of assessments, risk assessments and the child plans. This will help ensure risks continue to be accurately identified and plans reflect clear actions linked to the management and reduction of risk*.'
>
> [Care Inspectorate 2019, p.34]

Why does it matter?

10.4.4 All children's planning processes are set out in either legislation or national and local guidance. The IRD is a key part of the child protection planning process and it is important that all agencies are clear about the interface between the IRD and children's planning processes. It is important that the changing needs and potential risks for children are recognised and responded to, and there is clarity about the interface between different relevant organisational processes to make sure children are not left living with risk for too long and the appropriate help is identified at the right time.

10.4.5 Children's planning should bring professionals and families together to share information about progress and consider new or emerging concerns. The safety plans developed as part of the IRD process need to be linked into the child's planning process to ensure that the identified plan is actioned, monitored and reviewed. The plan should be owned collectively by all agencies involved and not viewed as the responsibility of one agency only. This is particularly for cases where there are wellbeing concerns or cases which do not proceed to children protection.

Questions for CPC to consider:

- What can be done to improve the links and interface between the IRD and children's planning process?
- What can be done to improve the links and interface across different single agency planning processes?
- How confident is the CPC that child protection supervision of health visitors consistently considers the need for a child's planning meeting?

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Appendix A

Membership of Review Team

Lead Officer (Champion for review)	Child Protection Committee, West Lothian Council
Group Manager	Social Work, West Lothian Council
Detective Inspector	Public Protection Unit, Police Scotland
Consultant Paediatrician	Community Child Health, NHS Lothian
Trainee Paediatrician (observer)	Community Child Health, NHS Lothian
Team Leader	Health Visiting, NHS Lothian

Membership of Case Group

Community Midwife	NHS Lothian
Health Visitor	NHS Lothian
Child Protection Nurse Advisor	NHS Lothian
Consultant Paediatrician	Community Child Health, NHS Lothian
Team Manager (during review time period)	Social Work, West Lothian Council
Team Manager	Social Work, West Lothian Council
Social Worker (during review time period)	Social Work, West Lothian Council
Detective Sergeant	Public Protection Unit, Police Scotland

Conversation only

GP	Medical Practice

Appendix B

Minutes of meetings, forms and reports

Assessment of risk
Case notes
Child Protection Medical Assessment
Concern Report 1
Concern Report 2
Concern Report 3
ICR Minute 1
ICR Minute 2
ICR Report – Social Work
ICR Report – Police Scotland
ICR Report – Health
ICR Report – Housing
ICR Report – Education
ICR Report – Scottish Children's Reporters Administration
IRD 1
IRD 2
IRD 3
Multi-agency chronology
Referral information 1
Referral information 2
Referral information 3
Referral information 4
Supervision records

Procedures and other documents

NHS Lothian *Bottle Feeding Assessment Tool*
NHS Lothian (2020) *Child Protection Protocol for the Management of Unexplained Bruising in Pre-Mobile Babies*
West Lothian Council *Parenting Capacity Assessment*