Learning Summary

from a

Significant Case Review on Child C

Undertaken on behalf of

Fife Child Protection Committee

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Date of Publication: 20th June 2017

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FOREWORD

The Lead Reviewer would like to thank all those who participated in and contributed to this Significant Case Review (SCR). A SCR is a multi-agency process for establishing the facts of a situation where a child has died or been significantly harmed, within a child protection context, in order to learn lessons. SCRs provide an opportunity to focus on learning and reflect on practice, and the systems within which professionals practice on a day to day basis.

In this particular case, while providing opportunities to reflect on practice and learn, it is important to protect the anonymity of family members who have been affected by the events. All relevant information is provided in the full report.

This learning summary provides a brief, anonymised account of the circumstances of the case and agency involvement. It presents the process and findings, with an analysis overview, learning points and recommendations. It will not refer to all of the particulars of the case. The learning points, recommendations and action points are replicated in full.

Fife Child Protection Committee, (comprising of representatives from Fife Council, NHS Fife, Health & Social Care Partnership, Police Scotland, Voluntary Sector, Scottish Children's Reporter Administration, Armed Forces, Fire Scotland), and NHS Lothian, fully participated with the SCR and have already made a number of changes to their processes and procedures following the death of Child C.

1. BACKGROUND TO REVIEW

Child C was aged 2 years when he died. Throughout his life, he was never the subject of any Statutory Requirements nor was his name ever recorded on the Child Protection Register.

The Chief Officers endorsed the decision by the Child Protection Committee to carry out a Significant Case Review led by an independent lead reviewer. The purpose of the review was to establish whether there were corporate lessons to be learned about how better to protect children. To that end, the review is a process for learning and improving service provision and is a means of recognising good practice. The review assessed the agency and inter-agency decision making and involvement with the family and others relevant to the case.

The review also considered some aspects of the circumstances of other children living in the household, one of whom was admitted to hospital.

The mother and her partner were found guilty of murder and acts of physical and emotional abuse to Child C and the other children in the household. They were sentenced to life imprisonment.

2. REMIT OF THE REVIEW

Specific issues considered in the review were:

- History of agency involvement with the family
- Response to concerns notified to the range of agencies involved with Child C and the other children, both single and multi-agency
- Response to concerns noted by agencies involved with Child C and the other children, both single and multi-agency
- Quality of assessments, including risk assessment, and decision making undertaken regarding planning for the children.
- Information sharing
- Transfer of responsibilities between staff within agencies
- Adherence to policies, protocols and practice guidance for all agencies
- Consideration of how Child C died, if relevant, in terms of agency involvement

3. DATA PROTECTION AND PUBLICATION

Detailed consideration has been given to the extent to which information contained within the full Report can be placed into the public domain. As there have been criminal proceedings and extensive media coverage of this case, a significant amount of personal data (including sensitive personal data) is publicly available. Any disclosure of personal data and sensitive personal data must comply with relevant laws such as the Data Protection Act 1998; Article 8 of the European Convention of Human Rights (the right to respect for private and family life) and the law of confidentiality.

Whilst no personal names are included within the body of the full report, it contains a significant amount of personal data relating to living individuals who could be identified from that data and other information in the public domain. As a result, all partners in the SCR have agreed that it would not be lawful to release the full report. This learning summary has been published to include all information which can lawfully be placed in the public domain.

4. JOINT INTERAGENCY REVIEW TEAM

A joint interagency review team was established to provide support and a reference point for the lead reviewer. The following agencies were represented:

- Fife Council Education and Children's Services
- NHS Fife
- NHS Lothian
- Police Scotland

Agencies were requested to undertake a single agency initial review and submit a chronology of events.

5. PROCESS OF THE REVIEW

The SCR took place in 2 phases. Phase 1 involved reading of files and some policies / guidance in existence during the period under review. An interim report was issued after Phase 1 which considered information available from files, records and policies / procedures in place prior to the death of Child C. Any learning from this was reported to and acted on by agencies.

Phase 2 commenced after the conclusion of criminal proceedings and consisted of meetings with staff involved with the family. Thirty-four key professionals met with the lead reviewer to discuss their involvement with the case and to reflect on practice. The review team member from the respective agency sat in on these discussions and contributed additional information and comment as appropriate.

6. ANALYSIS OF KEY ISSUES AND LEARNING POINTS

During any case review, the benefit and vision of hindsight often reveal a different perspective and understanding of the circumstances under which professionals worked at the time.

> *It is important to be aware how much hindsight distorts our judgement about the predictability of an adverse outcome. Once we know the outcome was tragic, we look backwards from it and it seems clear which assessments or actions were critical in leading to that outcome. It is then easy to say in amazement "how could they not have seen x" or "how could they not have realised that x would lead to y".* (Munro, E. 2011. The Munro review of child protection: Final Report. A child-centred system. London, Department for Education).

Professionals do not work in a vacuum and any potential constraints within single or multi-agency systems must be considered during the review process. Systems which existed at the time need to be examined to explore how staff assessed the information they held and how this might have affected their assessment.

While the death of Child C could not have been predicted, there were missed opportunities across services to intervene to provide support to the family. This may have led to a better understanding of the treatment of the children living within the home and could potentially have prevented the harm Child C suffered at the hands of his mother and her partner, which subsequently led to his death. However, it must be understood that in many ways the manipulative and devious nature of the mother and her partner hindered this from happening.

6.1 Focus on the demands and needs of the mother and her partner

It must be acknowledged that both the mother and her partner were extremely devious and used extraordinary measures to fabricate signs and symptoms in Child C. They sought to

convince professionals that he had a medical condition, to deflect suspicions about his injuries. No professional involved with the family could have understood with any sufficiency the dynamics within this household which could have potentially impacted on the children because of the conduct of the mother and her partner. During his short life, Child C was not seen as a child in need of protection against the backdrop of his mother and her partner's very controlling behaviour. The mother and her partner were adept at playing the system and used disguised compliance in playing one professional against another.

Learning points: (Recommendations 10, 11, 17)

- Professionals should maintain a central focus on the child(ren) and not allow themselves to be distracted by the demands or needs of the adults.

- There was no diagnosis of physical abuse or risk to the children. The prospect of emotional abuse or neglect was and is harder to assess, especially in the face of disguised compliance and there was no legal basis for workers to demand access to the children.

6.2 Communication and information sharing within and between agencies

One of the major difficulties faced by professionals working within complex organisations is the inability to access appropriate information and this was seen across all agencies. Within the NHS, numerous sets of records exist for children at different locations (both paper and electronic). In social work there was uncertainty by a member of staff about accessing wider information on case systems and from the police there was limited access to some historic information on the night Child C died.

Different systems and language used by staff across agencies also added to confusion. This includes use of abbreviations and different definitions for terms used in different parts of the country.

Clearly identifying a referral as a child protection referral and documenting the identified risks will help to facilitate an appropriate response from child protection agencies.

Analysis of agency records and interviews with staff also suggest that across and within agencies there were elements of silo working and some opportunities for triangulation of information were not pursued.

There is evidence throughout of gaps in information sharing and multi-agency planning, resulting in an inability to recognise the potential for harm to Child C.

The lack of paediatric involvement / advice at initial discussions may have led to inadequate decisions made during the first child protection investigation regarding bruising to Child C.

Learning points: (Recommendations 7, 8, 9, 11, 12, 16)

- Information systems at the time did not fully support information sharing.

- When speaking to professionals from other agencies / services, all staff must use language which is understood by all, or seek clarification on terms they are not accustomed to.

- Sharing of information should be accompanied by professional clarity about their own role and an understanding of other professionals' roles and systems.

- There was lack of professional curiosity. Explanations provided by the mother and her partner were, at times, accepted without challenge.

- Insufficient attention was paid to existing available information, which was not reviewed nor considered before decisions were taken.

- In the context of child protection investigations, a medical opinion should be sought before a decision is made not to conduct a medical assessment.

6.3 Ownership of concerns

There tended to be an over-reliance on social work involvement as an indicator of concern or risk with some services stating that they would see things differently if social work were involved.

Amongst professionals who dealt with the family, there was inadequate understanding of the roles and responsibilities of other agencies. There was no clear understanding who was in charge of the case. The role of the named person under the principles of Getting It Right for Every Child (GIRFEC) policy was relatively new in Fife at the time and not always fully understood by professionals, and may have contributed to confusion as to who was co-ordinating care for the family.

Work between the geographical areas (Lothian/Fife) caused logistical issues as well as differences in opinion as to how to proceed with a case.

Learning points: (Recommendations 2, 11, 12, 13)

- There was an over-reliance on social work involvement as the sign that a child or family is vulnerable.

- Staff should address and take ownership of their concern and try to solve the problem, rather than assume that another colleague / agency would deal with their concern.

- When admitted to hospital, there was a lack of continuity of care caused by different named consultants who may not actually have seen the child.

6.4 The bigger picture

When information was appropriately shared, it was sometimes not utilised and as a result, no purposeful action followed. There was a tendency to pass on information rather than own the problem and try to resolve it. Past information was not being considered and without this, professionals did not have the benefit of understanding the level of previous concerns or patterns of care and events.

Most incidents were dealt with sequentially but in isolation, individually and without aggregating them into a picture of wider concern.

There were numerous occasions when incidents occurred which in turn generated opportunities for assessments to be undertaken and for decisions to be made about the need for professional interventions.

Learning points: (Recommendations 14, 15)

- The cumulative effect of professional concerns was not sufficiently recognised by any of the involved agencies in a timeous way.

- Staff in all agencies should consider past information in order to see the bigger picture and recognise the accumulation of concerns.

- A chronology which is focussed on significant events and scrutinised regularly would have highlighted the impact of events on the children.

- Short appointment times for GPs do not allow time to access all information and different GPs who saw the family did not see the whole picture.

6.5 Missed opportunities
Two important opportunities for assessment and intervention were the child protection investigations carried out because Child C presented to the childminder and private nursery staff with injuries.

In the first investigation, the assessment was undertaken at home by a police officer and a social worker which led to the conclusion that no crime had been committed because the explanation fitted the injury seen. Further work could have been done with the source of these concerns to help provide a more comprehensive assessment.

During the second investigation, abuse was suspected but the medical opinion was not definitive. The clinicians accepted the mother's explanation that Child C was self-harming and added that lack of stimulation contributed to the self-harm. This led to a de-escalation of concerns. In the majority of occasions in child protection assessments, the medical evidence is not definitive, as it was on this occasion. For professionals to have accepted the mother's explanation that the injuries were self-inflicted, without further robust enquiries led to an incomplete assessment.

At the medical examination Child C's weight loss was not recognised, and child abuse and neglect were not considered as likely differential diagnoses for his presenting problems. Serial growth measurements plotted on a growth chart would have provided objective evidence of faltering growth or failure to thrive. Had all the concerns been taken into account, the balance of probability would have led to the conclusion that the injuries and concerns were likely to be the result of abuse.

Learning points: (Recommendations 5, 11, 20)

- There was an over-reliance on social work involvement or child protection registration as indicators of concern.

- There was an over-emphasis on whether a crime has been committed before a joint paediatric forensic examination was sought.

- When there is an accumulation of concerns, professionals must think the unthinkable and consider abuse and neglect as explanations.

6.6 Risk assessment and review processes
There was little evidence from the records of a comprehensive or multi-agency assessment of need or risk and as a result professionals involved with the family did not recognise the accumulation of risk factors. There was no evidence of any risk assessment tools being used by the health visitors when allocating Child C to the appropriate level of the Health Plan Indicator and no cause for concern forms had been submitted by education staff.

Reassessments were not undertaken in relation to new concerns which led to little recognition of an accumulation of risk factors. Instead, action was a reactive response to

isolated incidents rather than looking more broadly at underlying issues and taking a holistic view with existing historical information.

Learning points: (Recommendations 11, 14, 15)

- Professionals saw assessment as a one-off event rather than an ongoing process.
- Assessment did not involve critical analysis; no account was taken of accumulating information.
- A chronology which is focussed on significant events and scrutinised regularly would have highlighted the impact of events on the children.
- Patterns of cooperation should be monitored and explored to detect changes which might be indicative of increased levels of risk.

6.7 Record keeping

Records were too descriptive and not sufficiently analytical. For example, records that related to home visits were detailed and reflected specific concerns observed at the time but key actions, decisions and reasons for decisions were not documented. The records showed little evidence of multi or inter-agency planning.

On the other hand, during interviews with the lead reviewer, staff gave descriptions of the house, vivid observations of family behaviour and life within the family which were not recorded in the case notes. More was obtained at staff interviews by staff who relied on recall but admitted they did not have time to write extensive notes.

From the agencies' records, there were inaccuracies and inconsistencies in spelling of the surnames of the mother and her partner, which could have impacted on how checks were made when concerns were raised.

Learning points: (Recommendations 16, 18)

- Some record keeping practices fell short of expected standards.
- Record keeping practices should support concise and analytical recording.
- Referral letters and referral templates should use language understood by other agencies and clarify what action is being requested.

6.8 Working with manipulative and controlling parents

The records showed little evidence of professional curiosity. The mother and her partner's allegations of Child C's self-harming behaviour were accepted by professionals from all services despite statements to the contrary from staff who saw or worked with him.

Patterns of engagement which the mother and her partner deployed with various professionals from all services were complex. Rather than not engaging at all, there were periods when they did engage and periods when they did not. The mother and her partner frequently changed appointments for home visits and positive reports were usually documented when a visit was pre-arranged.

On some occasions the mother and her partner used, what can be seen with hindsight, as disguised compliance. When home visits were arranged, they appeared to welcome offers of help and support from workers, but these were never taken up.

Learning points: (Recommendations 10, 14, 15)

- In working with the mother and her partner, there was a lack of professional curiosity and their accounts and reports of events were rarely challenged.

- Disguised compliance can manifest as repeated cancellations and re-scheduling of appointments. This should be treated with the same degree of concern as repeated non-attendance.

- Chronologies which focus on significant events and their impact on the children's lives would have permitted analyses of what was happening in this household.

6.9 Resource issues and organisational difficulties

An important issue that was identified across all agencies was around capacity and resources. Examples were given to the lead reviewer of all services operating under financial constraints. Workloads rose because services were under-staffed in relation to demand.

Specialist medical staff in the tertiary children's hospital were trained in adult care and lacked experience in recognising and responding to situations when they suspected abuse or neglect of children.

Learning points: (Recommendations 1, 3, 4, 6, 19)

- There is a difficult balance between rising public and political expectations, budget cuts and finite resources.

- Effective management of workload, professional support, reflective, critical supervision and oversight are vital as workloads rise and working conditions become stressful.

- In tertiary hospitals, while specialist staff have opportunities to train, they may lack experience in the recognition of and response to situations where they suspect child abuse or neglect.

- The rota system of working in most hospitals mean that the named responsible consultant for a patient may never see the child during his admission to hospital. Another consultant colleague saw the child in the operating theatre.

- Providers of private services (childminder and nursery) should review their processes both in terms of how information should be shared and how the working relationship with the public sector could have been better co-ordinated.

7. STRENGTHS AND GOOD PRACTICE

Those who were spoken to by the lead reviewer demonstrated a high level of dedication and professionalism, despite very stressful working conditions. Examples of good and effective practice are recorded by professionals in several agencies and it is clear that many individuals made strenuous efforts to act in Child C's interests in what is now known to be disguised compliance and extreme manipulation by the mother and her partner. Some examples of good practice are listed below:

7.1 In the records seen by the lead reviewer, there was considerable evidence of some practitioners recording events in detail and sharing of information with workers in other agencies.

7.2 The childminder kept comprehensive notes of Child C's developmental progress and activities.

7.3 The social worker from the Children and Families team showed initiative and persistence when Child C's mother said he had been checked by the GP for his sore neck. She phoned the surgery to check this and discovered that the child had not been seen by the GP.

7.4 The health visitor recognised the increasing level of risk and changed Child C's Health Plan Indicator from Core to Additional after the second child protection investigation.

7.5 Another health visitor reflected on the information gathered, which led to phone calls to the social worker to discuss lack of contact between family and health professionals.

7.6 When the mother and her partner persisted with their belief that Child C had autism, two members of staff from the private nursery attended a course on autism to learn more about the condition.

7.7 When child protection concerns were raised, interagency referral discussions were held which led to child protection investigations.

7.8 When police received information from an anonymous caller about a child being left alone, a home visit was carried out to check the circumstances.

8. CHANGES IMPLEMENTED SINCE THE DEATH OF CHILD C

Agencies across children's services in Fife and NHS Lothian have reviewed their practices following the death of Child C. Agencies and services implemented a number of changes to address the immediate learning after his death which have been continually reviewed and monitored, promoting a culture of learning, critical reflection and improved practice. These changes are listed below.

Multi- Agency

- The use of the multi-agency Child Wellbeing Pathway is now a standard approach across all relevant agencies and services. The Pathway emphasises that early concerns should be responded to through multi-agency actions to support children and families in getting the help they need at the earliest stage. **(Recommendation 11)**

- All key agencies and services have supported the embedding of multi-agency chronologies to improve risk assessments. A review of both single and multi-agency chronology guidance has been completed and the updated guidance was issued on 1 June 2017. **(Recommendations 11, 14, 15)**

- Agencies and services have alerted staff to the Child Protection Committee Guidance on Hostile and Non-engaging parents / carers, highlighting the need for staff to apply this where patterns emerge. This is also highlighted in single and multi-agency child protection training. **(Recommendation 10)**

- Multi and Single Agency Child Protection Training has been revisited and where appropriate strengthened in respect of focusing on the needs of the child, risk assessment and planning, information sharing and supervision/support. **(Recommendations 5, 12, 14, 15, 16, 17)**

- A training programme featuring Child Protection and Information Sharing has been agreed for the training of private providers of pre-school care. The uptake of this training will feature in future commissioning criteria.**(Recommendations 6, 7)**

- The Child Protection Committee Inter-Agency Child Protection Guidance 2016 has been updated to include clarity on the types of and criteria for paediatric assessments. Also included is a clear statement that the need for a medical examination must be discussed during the initial Interagency Referral Discussion and that the decision to undertake or not to undertake this, in relation to health needs, must be made by the Paediatrician on-call for Child Protection in discussion with other core agencies. **(Recommendations 5, 8)**

- The multi-agency 'Child Protection/Joint Paediatric Medical Examination Protocol 2015' has been in place to support Interagency Referral Discussions and decision making between appropriately trained and experienced Paediatricians and colleagues in Police and Social Work with regards to the nature and timing of medical examinations. **(Recommendations 8, 9, 12).**

NHS Fife

- The NHS Fife Child Protection Core Training Framework has been developed and implemented. This details the minimum training which is required to be undertaken by all NHS Fife staff, as relevant to their role within the general, specific or intensive workforces. A 3-year plan was commenced in December 2016 to support the incremental implementation of the Framework, and associated Training Needs Analysis Tool, across the range of services within NHS Fife. **(Recommendations 6, 10, 11, 12, 14, 15, 16)**

- The NHS Fife Child Wellbeing Assessment Tool and associated guidance was developed and implemented across children's services. Wider implementation has commenced incrementally across NHS Fife in 2017, including key adult services. This tool will support practitioners to conduct robust analysis and the recording of clinical judgements and decision-making and includes the consideration of the views of the child, as relevant. **(Recommendations 10, 11, 12, 15)**

- The plotting of height and weight assessments has been routinely monitored through established annual case file audits since 2014. This information regarding growth trends is made available to medical staff undertaking Joint Forensic or Specialist Medical examinations to support clinical assessments. **(Recommendations 6, 8, 9, 11, 12, 20).**

- A senior nurse post has been introduced within the Acute Services Division to support staff within Paediatrics and the Emergency Department with a specific responsibility to deliver child protection clinical supervision and training within these departments. **(Recommendations 6, 10, 11, 12, 14, 15, 16, 19, 20)**

- The Lead Paediatrician and Associate Specialist for Child Protection are now based within the Paediatric Department to provide easy access to specialist advice and support for medical staff, including peer review. **(Recommendations 6, 10, 11, 12, 14, 15, 16, 19,20)**

- Separate ‘child wellbeing’ and chronology sections have been introduced within paediatric records to allow relevant information to be more readily available and to support practitioners to consider escalation and accumulation of risks within their assessments.**(Recommendations 6, 10, 11, 12, 14, 15, 16)**

NHS Lothian

- Targeted training sessions have been established and delivered. This includes the consultant body, specialist services and now a regular induction slot has been introduced for specialist trainees, emphasising the importance of recognising medical neglect and having an enquiring mind. **(Recommendation 4)**

- Information across geographical and agency boundaries is available to all staff who undertake Interagency Referral Discussions, to ensure communication is clear. **(Recommendations 2, 12)**

- Children’s weights are now documented on TRAK (electronic patient system), allowing trends to be visible both at the hospital and in the community (only applies to children who reside in Lothian). **Recommendation 20)**

Fife Council Education Service

- Education representatives were partner agencies in the Interagency Referral Discussion process but the process has evolved considerably since 2014. The Education representative now routinely seeks information regarding other children within the same household. The school would be telephoned on the morning of the Interagency Referral Discussion by education, alerting them to an email coming in from education that they must respond to by answering five specific questions around the children’s wellbeing. This must be returned in a timely manner so the information can support the Interagency Referral Discussion. **(Recommendations 12, 13, 17)**

- The Child Wellbeing Pathway has been rolled out to all schools. **(Recommendations 11, 16)**

- Police ‘Cause for Concern’ forms are routinely shared with schools where children are involved. **(Recommendations 12, 13)**

- The route for referral to the Children’s Reporter has been streamlined, linked to the wellbeing pathway and school coordination processes e.g. School Liaison Group. **(Recommendations 12, 13, 16)**

- Child Protection Coordinators have mandatory annual training that takes account of assessment and recording procedures as well as all current policy guidance. **(Recommendations 10, 18)**

- Getting It Right (GIR) groups have reshaped their agenda to focus more on risk and child protection. GIR training has been delivered within schools. **(Recommendations 10, 11, 16)**

- The Education Care and Welfare form has been updated to include a wellbeing assessment tool. **(Recommendation 16)**

- Education Child Protection guidelines are being reviewed and updated in line with local and national policy. **(Recommendation 16)**

- SEEMIS training on record keeping and planning is being rolled out to named persons. **(Recommendations 12, 14, 16)**

- Additional guidance on information sharing has been provided to Education staff and this has been reinforced through a structured training programme**.** **(Recommendation 12)**

Police Scotland (P Division)

- Updated Interagency Referral Discussion multi-agency guidance has been agreed and in place. **(Recommendations 8, 13)**

- The process in a joint investigation has been reviewed and this now ensures that where concerning injuries are noted that medical advice is obtained from a paediatrician regarding assessment of the injury / bruising. This is now embedded into all practice for officers involved in joint investigations and supported by enhanced scrutiny and supervisory capacity within the Public Protection Unit. **(Recommendations 8, 9)**

- The Interagency Referral Discussion / joint interviewing process has been reviewed to ensure to ensure interviews with any children who are in the same household and / or contact is now considered in all investigations. This is now standard practice and a consideration of supervisors in all child protection investigations within the division, with a requirement to record decision-making rationale if this is not considered appropriate. **(Recommendation 17)**

- The Vulnerable Person's Database (VPD) introduced by Police Scotland within Fife involves the direct referral of vulnerable persons to the service supporting earlier and effective interventions. Well-being concern reports, including those that do not meet the child protection threshold are processed by a dedicated divisional Risk and Concern Hub that applies standardised business processes to the assessment and sharing of information with partner agencies. This includes a system of triage of reports, research and assessment of concerns and application of a resilience matrix to decision-making surrounding information. This matrix includes consideration of resilience, adversity, vulnerability and protective factors. **(Recommendations 6, 11, 12, 16)**

- Internal review of supervisory capacity in relation to child protection undertaken resulting in an uplift of 1 x Detective Inspector posts and a re-structure of the department that will ensure operational focus on current threat, risk and harm and "live" child protection investigations are protected. **(Recommendation 1)**

- Realignment and uplift in dedicated resource to child abuse investigations: The restructure, increase and realignment of supervisory roles is augmented by a dedicated team of officers tasked with investigating historical abuse. The newly appointed dedicated Detective Inspector will hold responsibility for policy, self-evaluation and delivery of training that will ensure training, learning and SCR recommendations are embedded in practice and that a culture of continuous

improvement and self-reflection is developed. **(Recommendations 1, 8, 9, 10, 11, 12, 17)**

- Early Effective Intervention principles have been embraced with a review of practice, introduction of standardised job descriptions and enhanced supervision (additional Detective Sergeant post) within the Risk and Concern Hub, dealing with wellbeing concerns and the identification of cumulative concerns. The application of standardised business processes within the hub, include an escalation protocol which identifies multiple concerns for individuals and families within a short space of time that automatically demands scrutiny at a supervisory level to ensure all possible interventions to engage with partners and reduce harm are identified. **(Recommendations 6, 11,12, 16)**

- A Crime Management divisional improvement plan will work towards developing a culture of continuous improvement and staff development, focusing on empowering and challenging staff to contribute that has seen the continuing delivery of a number of key themes surrounding quality of service delivery, innovation and best practice, efficiency and personal development. **(Recommendations 1, 10)**

- Re-alignment of staff performing research functions, specifically for multi-agency case conferences, into the Risk and Concern Hub that will ensure a holistic approach to information-sharing and early and effective intervention. **(Recommendations 11, 12)**

- Introduction of a continuous training programme for front-line officers and supervisors to identify child protection and wellbeing concerns and refer these appropriately. **(Recommendations 1, 10)**

- New Video Recording Interviewing equipment has been secured and older, unreliable equipment replaced, providing increased capacity and improved resilience in support of joint interviews of children. **(Recommendation 17)**

Fife Children & Families Social Work Service

- Staff capacity and supervisory capacity within front line social work teams and the child protection team has been significantly increased. Supervision arrangements have been enhanced by 17 newly created supervisory senior practitioners posts and a refreshed supervision policy is in place. Peer support groups and group supervision are now embedded and ongoing. Monthly case evaluation audits have been embedded for two years and continue to be evaluated. **(Recommendation 1)**

- The Interagency Referral Discussions / joint interviewing process has been reviewed to ensure to ensure interviews with any children who are in the same household and / or contact is now considered in all investigations. The need for a medical assessment is discussed at the Interagency Referral Discussion. **(Recommendations 5, 8, 9, 12, 13, 17)**

- New Video Recording Interviewing equipment has been secured and older, unreliable equipment replaced, providing increased capacity and improved resilience in support of joint interviews of children. **(Recommendations 5, 8, 9)**

- A number of processes have been reviewed an updated including: case recording guidance; first contact arrangements to ensure escalating concerns are addressed; assessment guidance; specific guidance for recording children's and parents' views; guidance in relation to working with hostile or non-engaging families; information sharing. The duty process and chronology guidance have been reviewed and updated. The child wellbeing pathway is embedded and used frequently. **(Recommendations 5, 10, 11, 12, 14, 15, 16)**

- New arrangements for multi-agency meetings through the child wellbeing pathway are in place to assist with the coordination of interagency support to families. **(Recommendations 11, 12, 16)**

- Single agency and multi-agency training is in place for all staff in relation to child protection. **(Recommendation 6)**

- Quality assurance and auditing practice has been reviewed and expanded. **(Recommendations 1, 5, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17)**

9. RECOMMENDATIONS

The recommendations which have followed the section on Key Issues and Learning Points are summarised below, according to agency responsibility. All staff and students in social work, social care, education, health, the police and the third sector should receive training on issues that have arisen from this Significant Case Review.

National consideration

1. The Scottish Government should give consideration across Scotland to the impact of a changing picture of risk to children, new policy directives and financial challenges. This must be accompanied at a local level by strategies to strengthen systems of support, supervision and critical reflection for all staff and to ensure adequate administrative support.

Outcome – Adequate resources for staff working to protect children.

2. The National Guidance for Child Protection in Scotland (2014) should be revised to provide guidance on working relationships where services cross geographical boundaries and sectors (eg working with independent providers of early years' services).

Outcome – Seamless support for children across local authority and agency boundaries.

3. The Scottish Government should consider, within the General Practitioner contracts, an obligation to mandatory child protection training for GPs and other general practice staff, and introduce this into staff annual appraisal processes.

Outcome – Improved recognition and referral of children who may be at risk.

4. NHS Education Scotland, with the Health Boards, should introduce mandatory child protection training for trainees and consultant staff in specialist areas. One pan-Scotland training event per year should be dedicated to child protection training. Attendance should be monitored through appraisal processes.

Outcome – Improved recognition and referral of children who may be at risk.

Fife Child Protection Committee

5. Fife CPC inter-agency guidance and web-based information (updated 2016) should be reviewed and revised, to provide clarity on the types of and criteria for paediatric assessments of children in whom there are suspicions of all types of abuse.

Outcome – Understanding of need and process for arranging paediatric assessments of children.

6. The training of all staff working with children including private providers should be re-enforced to ensure that staff are aware of referral processes when they suspect child abuse, which would include possible concerns about weight loss.

Outcome – Improved recognition and referral of children who may be at risk.

7. Fife CPC must work with private providers of pre-school care to ensure a full understanding of roles, responsibility and accountability together with a clear process for sharing information.

Outcome – Practitioner clarity about roles, responsibilities and accountability.

Fife Education and Children's Service / Police Scotland P Division / NHS Fife

8. In planning a child protection medical assessment or forensic medical examination, discussion with a paediatrician is essential. Decisions about the nature and timing of medical examinations should be made by appropriately trained and experienced medical staff and discussed as part of the Interagency Referral Discussion (IRD).

Outcome – Paediatrician included in the IRD process to ensure that the welfare / wellbeing needs of the child are considered together with the need to collect forensic evidence.

9. All children with concerning injuries (including bruising) should have a medical examination by experienced paediatricians. Where injuries are complex or multiple, the paediatrician should discuss the need for a joint paediatric forensic examination with a forensic physician.

Outcome – All children with concerning injuries receive comprehensive paediatric care.

10. Practitioners involved in assessing the needs of children should have training and confidence in dealing with disguised compliance / non-engaging families.

Outcome – A central focus on child(ren) rather than the demands or needs of adults.

11. Accumulating information must be critically analysed to allow evaluation of increasing risk especially when a case is not considered to be 'child protection' or does not meet the criteria for statutory intervention.

Outcome – Practitioners working with children and families maintain professional curiosity and continue to consider concerns to children.

12. All available information must be reviewed and taken account of before decisions are taken on the future management of the child's wellbeing. Sharing of information should be accompanied by professional clarity about their own role and an understanding of other professionals' roles and systems, especially that of the named person.

Outcome – Effective sharing of information.

13. Where there are child protection concerns, an electronic system for Interagency Referral Discussions, shared between key agencies, should be considered.

Outcome – Effective sharing of information.

14. Chronologies should focus on significant events and their impact on a child's life. They should be scrutinised regularly to understand cumulative adversities. Services should ensure that training is offered to key practitioners in creating a chronology and that standards for chronologies are embedded in guidance.

Outcome – Single and multi-agency chronologies will enable staff to see the bigger picture, challenge parents and think the unthinkable, especially the potential for disguised compliance.

15. Repeated cancellation and re-scheduling of appointments may be one sign of disguised compliance and should be treated with the same degree of concern as repeated non-attendance. Services should have missed / cancelled appointment protocols in place and professionals should collate the number of cancelled and missed appointments within a chronology to enable risks and concerns to be identified.

Outcome – Single and multi-agency chronologies will enable staff to see the bigger picture, challenge parents and think the unthinkable, especially the potential for disguised compliance.

16. All agencies should review and update their procedures for record keeping and referral processes to ensure that records contain detailed analysis, effective decision making and care plans. This is especially important where there are wellbeing concerns which do not meet child protection criteria. When making a referral, staff must use language which is understood by all, or seek clarification on terms they are not accustomed to.

Outcome – Evidence to identify accumulation of risk.

Police Scotland P Division / Fife Education and Children's Services
17. When there is a child protection investigation other children living in the same household should be spoken to as appropriate, for an account of what happened.

Outcome – A complete and holistic assessment of the investigation.

Fife Education and Children's Services
18. Education staff should follow child protection / wellbeing procedures to formally document all concerns and relevant contact with parents and external agencies and all documentation should be kept in the child's confidential care and welfare file. This should include written logs of any discussion or meeting arranged with professionals or parents and any follow-up work needed as a result.

Outcome – Evidence to identify accumulation of risk.

NHS Fife
See recommendations regarding training and appraisal processes **(3; 4)**.

19. NHS Fife should review their paediatric service with a view to enhancing its contribution to protecting children and examine succession planning, infrastructure and support available to community and hospital paediatricians to enable them to do this work.

Outcome – Improved paediatric service to children at risk of harm.

20. Where there are concerns regarding growth, height and weight assessments must be undertaken and plotted on a growth chart within the professional health record. This is especially important when a child is admitted to hospital or is referred onto another practitioner when these and previous measurements can be used to assess growth.

Outcome – Identification of faltering growth.

NHS Lothian
See recommendation regarding training of specialist staff and appraisal processes **(4)**.