01 Background

Child D's family had been known to public services for many years.
Services had concerns about the children's developmental delay, their mothers mental health, her mild learning difficulty and willingness to engage. The children had presentations to hospital over time with injuries and sometimes unlikely explanations. A period of child protection registration had been put in place before, due to levels of care and neglect.
The critical incident happened when life threatening injuries were inflicted on Child D by their mother's partner. The services working directly with the family did not know this adult lived in the home.
Looking beyond the incident, Child D was experiencing neglect at home.

Significant Case Review 02

The case met the criteria for a Significant Case Review (SCR) and an independent reviewer was asked to conduct a Learning Together Review.
Falkirk's Child Protection Committee (CPC) conducts SCRs in line with national guidance.
In Scotland, SCRs examine the circumstances and context of a child being harmed or killed, to evaluate the nature and quality of professional contact with the child, to identify any system problem which may impact on other children, and to learn from the incident lessons which will strengthen child protection systems, locally and nationally. SCRs should be seen in the context of a culture of continuous improvement and should focus on learning and reflection on day-to-day practices, and the systems within which those practices operate.

03 Learning Together

The starting point for a Learning Together Review Is that when it comes to keeping children safe it Is reasonable to think that most people come to work wanting to do a good job. The approach explores why actions were taken or decisions were made and reminds us that even seemingly poor decisions will have seemed sensible at the time.
There are 3 principles:
1. Avoid hindsight bias - understand how those involved saw the case as it unfolded at the time.
2. Appraise practice and explain why that practice occurred.
3. Move from the case specific to general learning.
A Learning Together Review produces findings and asks questions which the CPC considers. In this case there were 5 findings which are important for all staff to consider.

Findings 04

Finding 1 is about inter agency assessment and planning in cases that are not currently within the child protection system. When all agencies are fully engaged with the risk and need assessment process, it makes joint working, effective information sharing and making a difference in children's lives more likely.

Finding 2
Service demands raised thresholds for social work case allocation and child protection action impacting across the system and services. It made recognising and responding to child neglect harder.

Finding 3
Across Falkirk, practitioners should be supported to assess the impact of mental health issues and learning disability on parenting.

Findings 05

Finding 4
When it's recognised that clear child protection concerns have occurred and appropriate time and resources are allocated, services in Falkirk work effectively and skilfully together.

Finding 5
The Reporter plays an important role in making enquiries where children's needs may not be being met and everyone should have an understanding of this.

06 Why Does This Matter?

This case provides a clear window on the system because much of the learning can relate to the families that practitioners are working with on a regular basis.
Professionals need to follow key processes in the GIRFEC approach to share information, hold multi agency meetings, write assessments of risks and needs and use chronologies to inform decision making or referral to the Reporter. Strains on resources raise challenges and it is important to strengthen quality assurance.
Good practice happens when services work in an integrated way at times of child protection crisis.

07 Questions for team meetings and supervision

How relevant do you feel the Findings are for your own and others practice?
- How can we always follow key GIRFEC processes?
- How well does supervision work to ensure non engagement is identified and does it support you to be professionally curious and bring out the child's voice?
- How do you challenge and use your authority if children are denied opportunities to access support and how do you challenge a mindset of "this is just how it is around here"?
- When there are examples of good practice, how can we share these to assist practitioners in understanding the GIRFEC approach and child protection system?
- How can we become more confident about the role of the Reporter and refer appropriately?