01 Background to the case

- Child F's parents had been known to a range of agencies since childhood.
- The mother's first child was removed at birth and her second child's name had been on the Child Protection register because of concerns about parental mental health, alcohol or substance use and non-engagement with services.
- During the mother's pregnancy with Child F, several agencies were concerned about her ability to cope and her frequent contact with the father who was in breach of his bail conditions
- When Child F was 2 months old, medical staff at the hospital found a significant number of injuries caused by non-accidental injury.
- Mother later pled guilty to assault of Child F and was sentenced to 6 years imprisonment.

Guidance 02

Falkirk Child Protection Committee (CPC) conducts Significant Case Reviews in line with national guidance. This case met the criteria for a Significant Case Review and two Independent Reviewers were asked to conduct a Learning Together review.

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 that may impact on other children and to learn lessons which will strengthen child protection systems, locally and nationally. SCRs should be seen in the context of continuous improvement and should focus on learning and reflection on day-to-day practice and the system within which practice operates.

07 Questions for consideration at team meetings and supervision

Is there a resonance between the issues identified in the Findings and current practice?
How do you balance the need to be both supportive and authoritative in practice?
Are we making written assessments of need and risk using tools to analyse and evidence thinking?
How well do we recognise cumulative concerns and develop chronologies to assess need and risk?
Are we always clear about the purpose of the Child's Plan and our intended outcomes?
What informs our thinking about whether a cause for concern is child wellbeing or child protection?
How clear are we about processes of escalation to prevent drift in our decision-making about children?

03 Learning Together

The starting point for a Learning Together Review is that it is reasonable to think most professionals come to work wanting to do a good job and keep children safe. This approach explores why actions were taken or decisions made and reminds us that poor decisions will have seemed sensible at the time.
At the analytic heart of the model are three key 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 more general learning

The underlying issues that influence practice generally are formulated into Findings and the SCR Report poses questions for the Child Protection Committee to consider what is needed to help improve practice more widely. In this case, there were 4 Findings which are important for all staff to consider.

Findings 1&2

Finding 1
This refers to the need for practitioners to consistently recognise the impact of all risk factors which adversely affect parents' ability to safely look after their children so that actions to support or protect children are appropriately targeted to their needs.
Finding 2
This refers to variable understanding among professionals of their collective responsibility in assessing and addressing risk and uncertainty through GIRFEC including Team Around the Child (TAC) and child protection processes making it more likely that children will remain in harmful situations for too long.

04

Findings 3&4

Finding 3
This refers to the resource and demand gap which puts children's services under pressure and over time impacts on professionals' capacity to handle difficulties and demands. Pressure on time impairs the quality of assessment, and limits the frequency and quality of staff supervision. Children's services do not work in isolation and resource pressures in one part of the system impact on another and on service delivery.
Finding 4
This refers to the lack of a formal standardised process for timely case transfer between neighbouring local authorities including processes for escalation meaning that some children and families remain unallocated to a named social worker for longer than necessary.

05

06 Why Does This Matter?

This case provides a useful window on the system because much of the learning is in relation to families because much of the learning is in relation to families practitioners are working with on a regular basis. It is a challenge to balance family history and past events with progress made and the current issues and difficulties they are facing. Professionals need to consider whether the issues require an early intervention to meet wellbeing needs or a protective intervention to keep children safe. These judgments are often finely balanced and professionals can be working with families and children whose situations can deteriorate quickly. Professionals need to maintain awareness and curiosity at all times.

Falkirk Child Protection Committee