Learning Summary

from a

Significant Case Review on Child A

Undertaken on behalf of

Perth and Kinross Child Protection Committee

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Date: 25 June 2019

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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 been significantly harmed or died, 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 practise 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 the child and 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, strengths, good practice identified 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.

Perth and Kinross Child Protection Committee, (comprising of representatives from Perth and Kinross Council, NHS Tayside, Police Scotland), and City of Edinburgh Council, fully participated with the SCR and have already made a number of changes to their processes and procedures following the incidents involving Child A.

1. BACKGROUND TO REVIEW

Child A was the first child of the parents who arrived in Perth and Kinross as a homeless couple. In late 2016, Child A was admitted to hospital with a possible infection and after in-hospital care and treatment was discharged home into the care of the parents.

Two days later, Child A was re-admitted to the same hospital and found to have further serious injuries to the head and neck area. At the time of the second admission, the diagnosis of a previous infection was reassessed and subsequently thought to have been more serious.

The Consultant Paediatrician's opinion was that these multiple injuries were non-accidental in nature and a joint child protection investigation commenced. Child A was taken into foster care. The parents were charged with wilful ill-treatment and neglect. They were bailed with the condition of no unsupervised contact with anyone <16 years.

On 23 January 2017, Perth and Kinross Public Protection Chief Officers Group instructed Perth and Kinross Child Protection Committee (CPC) to undertake a Significant Case Review (SCR) and to appoint an Independent Lead Reviewer. In April 2018, the Crown Office and Procurator Fiscal Service decided not to proceed with criminal charges.

2. REMIT OF THE REVIEW

The purpose of an SCR is to establish whether there are corporate lessons to be learned about protecting children across the full range of services involved with the child and family. To that end, the review is a process for learning about systems, culture and practices and a means by which areas for improvement are identified in a way which promotes change and good practice recognised. The SCR assessed the effectiveness of agency and inter-agency involvement with the family and others relevant to the case.

The CPC had already acknowledged that missing a series of opportunities to intervene early; failing to seek and share information appropriately and not carrying out a multi-agency risk assessment, had a negative bearing on this case. The independent reviewer was asked to consider in detail the circumstances surrounding:

- Inter-authority communication in relation to a young homeless and pregnant woman entitled to social work services from another authority;
- Assessment of needs and risks prior to Child A's birth and the discrepancies across services in relation to an assessment of the parents' capacity from pre-birth onwards;
- Processes and referral pathways for vulnerable unborn babies within health services;
- Processes and pathways leading to multi-agency screening of vulnerable unborn babies;
- Processes and practices governing the sharing of information to the Named Person in health between the pre-birth and neo-natal period and in particular at the point of transfer from Midwifery Services to the Health Visitor;
- Systems and practices which inform the decision-making of GPs and Community Mental Health Services to ensure the proportionate communication about paternal mental health or wellbeing to relevant staff working with the child and other family members and in particular the Named Person;

- Communication between acute hospital services and community health-based services and the Named Person; and
- Arrangements for discharge planning from hospital and return to the community for a vulnerable infant and young family

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. Any disclosure of personal data and special category data must comply with relevant laws such as the General Data Protection Regulation 2018; 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 MULTI-AGENCY REVIEW TEAM

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

- Perth and Kinross Council Education and Children's Services
- NHS Tayside
- Police Scotland
- City of Edinburgh Council

Agencies were requested to undertake single agency initial case reviews (ICRs) and submit a chronology of events. A multi-agency chronology was composed from single-agency chronologies.

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 to Chief Officers after Phase 1 which considered information available from files, records and policies / procedures in place prior to the incidents involving Child A. Any learning from this was reported to and acted on by agencies.

Phase 2 commenced after the Crown Office and Procurator Fiscal Service decided there would be no criminal proceedings. Twenty-three 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 EVENTS AND LEARNING POINTS

It should be remembered that the review took place with the benefit of hindsight, which can reveal a different perspective of circumstances surrounding the case. The analysis therefore considers the actions of services within the context of the circumstances of the time.

While the injuries suffered by Child A could not have been predicted, there were missed opportunities across services to intervene to provide support to the family. The mother was a child looked-after by one local authority and ended up in another, with a partner and a baby. As a young adult, she opted to minimise her difficulties, painting a rosy picture of her circumstances while very little was known about the father who chose not to engage. Staff who dealt with the mother, the father and Child A recorded observations and information which were not acted upon because there was a tendency to minimise or normalise the observed behaviours.

Six key issues were identified, relating to:

- Communication and information sharing within and between agencies
- The parents' lack of engagement and cooperation
- Risk assessment and review processes
- Missed opportunities
- Guidance, policies and protocols
- Record keeping

6.1 Communication and information sharing within and between agencies

Analysis of agency records and meetings with staff suggest that across and within agencies there were elements of silo working and some opportunities for seeking or sharing information were not pursued. In particular, the needs of the unborn baby were not recognised nor communicated within and between agencies.

Learning points: (Recommendations 5, 8, 11)

- Policies, protocols and procedures in place during the review period and made available lacked guidance on when to share information.
- Where policies, protocols and procedures were printed they were not always the most up to date copy.
- Social work and Housing staff hold important information which should be shared with other agencies.
- Adult mental health and GP services should review their guidance, policies and procedures to ensure that reference is made to sharing information when there are concerns regarding the wellbeing or risk of harm to a child.
- Insufficient attention was paid to existing available information, which was not shared effectively, reviewed nor considered before decisions were taken.
- Observations and information held by staff were often perceived as 'normal' and therefore not worth sharing. As a result, important pieces of the jigsaw did not come together.

6.2 The parents' lack of engagement and cooperation

Previous SCRs have identified troubled childhoods and lack of positive parental role models as factors which might have a negative impact on the young person's lifestyle and parenting ability. From her records, the mother appeared to have little insight into her circumstances. Information documented by staff about adverse events in the mother's life did not lead to in-depth assessments. There was scant information on the father's past because he was not seen as a significant person in the lives of either the mother or the baby.

Learning points: (Recommendations 9, 10)

- It was difficult to establish if some descriptions of the mother's behaviour were due to the side effects of her medical condition, her medication or both.
- There were numerous occasions in the mother's records which should have resulted in further assessments or a review of her plan, or an assessment of the father as a significant person in her life.
- In working with the mother as a young adult, there was a lack of 'professional curiosity' amongst staff who accepted and rarely challenged her accounts and reports of events.
- Professionals were often unable to contact the mother, or she chose not to engage by painting a positive picture of her circumstances.
- Social isolation should be considered a risk factor.
- The social work services in Edinburgh should have sought assistance from social work services in Perth and Kinross to assess the lifestyle and circumstances of both parents in relation to the unborn baby.

6.3 Risk assessment and review processes

Professionals involved with the mother did not recognise the accumulation of risk factors in her relationship with the father, because he chose not to engage. There was little evidence from the records that any agency undertook a comprehensive or multi-agency assessment of need or risk. Reassessments were not undertaken in relation to new concerns which led to little recognition of an accumulation of risk factors. There was insufficient evidence of professionals looking broadly at underlying issues and taking a holistic view of the couple with existing historical information. There was no analysis of historical information and the impact this may have on parenting ability. It must be acknowledged that the mother was a young adult who chose to minimise her difficulties.

There was no evidence that a review of the parents' past history was undertaken, at any point of contact with the Health services (GP, mental health, midwifery, health visiting). There were positive reports documented by community nurses (midwives and health visitor) when they visited at home. The house was said to be warm and clean, and appropriate maternal and paternal bonds described. It is not clear if staff who visited the home witnessed the parents handling Child A. Reports by nursing and social work staff during Child A's hospital admissions would suggest a lack of basic practical skills in caring for a young baby.

Learning points: (Recommendations 9, 10)

- There were numerous occasions in the mother's records which could have resulted in further assessments or a review of her plan, or an assessment of the father as a significant person in her life.

- Professionals did not consider the impact of the parents' past medical and social history, financial circumstances and isolation on parenting.
- No professional working with the mother or the father recognised their chaotic lifestyle nor the impact this might have on their ability to parent Child A.
- Assessments, when undertaken, did not consider historical and accumulating information.
- A chronology which is focussed on significant events and scrutinised regularly would have highlighted the impact of events on the lives of the parents and their baby.

6.4 Missed opportunities

From review of files and in discussion with staff, there is evidence which suggests that incomplete sharing of information and a lack of 'professional curiosity' led to missed opportunities for assessment and intervention by professionals. Examples are listed below.

6.4.1 Assessment of parenting skills

Staff in the homeless accommodation recorded episodes of possible domestic abuse. There was no evidence of any assessment of the impact of this relationship on the mother's wellbeing. At focus group discussions, staff tended to 'normalise' the mother's behaviour and focussed on the positive outcomes achieved by a young person who had been looked-after.

The father had consulted both the GP and the mental health nurse because of problems. Both were aware of the mother's pregnancy but did not conduct any assessment on how the father's mental health might impact on the baby, nor was this information passed on to maternity services. Another opportunity for assessment was missed when the father presented for the second time to his GP, expressing concerns about his compulsive behaviour in case *"something bad would happen to his partner or his new-born child"*. The NHS Tayside policies do not appear to mention possible risks posed by a parent's mental health on their parenting and there is little guidance on who to share this information with.

A midwife attempted to raise an alert according to the Unborn Baby protocol. However, this was not sent to the correct address and was never received. There is no evidence that the midwife followed up on the referral. Even if they had, any resultant assessment would have been incomplete without information on the mother's past history as a looked-after child, or on the father's mental health.

6.4.2 Child A's lack of weight gain

The health visitor records contained a series of weights obtained on Child A. At 6 weeks, the child's weight had dropped to the 9th centile from a birth weight on the 25th centile, indicating faltering growth. In December 2016, a weight is recorded which showed a further decline to the 2nd centile. It is not obvious who recorded these weights or where Child A was weighed, but it is clear that no one appreciated the significance of Child A's failure to thrive. Investigation of this might have led to assessments of the couple's parenting and organisational skills.

6.4.3 Possibility of NAI raised during Child A's first hospital admission

During Child A's first admission to hospital with an *"infection"*, the GP who referred the child to hospital documented what could be traumatic injuries to the face. I can find no evidence of any reference to the GP summary in the hospital medical or nursing records. The possibility of non-accidental injury (NAI) as a cause for the clinical findings was not considered when circumstances required it.

A further opportunity for a diagnosis of NAI was raised when the clinician requested further review by the paediatric team. At a subsequent meeting with the lead reviewer, the paediatric trainee described that this was the trainee's first case of non-accidental injuries as a junior doctor in paediatrics. An inadequate assessment by the paediatric team led to Child A being allowed to go home without consideration of a multi-agency discharge planning meeting. It is not clear if the consultant responsible for Child A's care was involved in this decision.

Learning points: (Recommendations 1, 2, 12, 13)

- There were numerous occasions when incidents were recorded which could have led to opportunities for assessment and planning.
- No professional working with the mother or the father recognised their chaotic lifestyle nor the impact this might have on their ability to parent Child A.
- When a care-experienced young adult chose not to disclose her difficulties the obligations of local authorities were not fully explored.
- The impact of paternal mental health was not adequately explored, both in the antenatal period or when Child A was aged 4 weeks.
- When dealing with child protection concerns, junior doctors in paediatrics did not appear to be supervised by a consultant.
- There was no consistent approach to growth monitoring.

6.5 Guidance, policies and protocols

The protocol for concern regarding an unborn baby was established in 2009 and updated in 2014. It appears to have been developed only by NHS Tayside, with details on when and how to make a referral. Differences in email addresses to send the referral (depending on the woman's residence) have resulted in confusion and loss of the referral in the mother's case.

NHS Tayside Child Protection Operational policy (established 2006, updated 2014) applies to all health professionals and outlines the protocol for the examination of children who are in-patients and within the community. The referral flowcharts are cumbersome and probably outdated, containing titles such as 'Designated Doctor', a term no longer recognised nor used in Scotland.

There was also lack of clarity (as documented in the chronology compiled by a social worker) on when a joint paediatric-forensic examination should be done. The consultant paediatrician had apparently questioned the need for a *"stage 2 medical examination unless a Child Protection Order"* was sought.

Learning points: (Recommendations 3, 4, 7, 8, 12)

- There is a need to rationalise the numbers of policies and protocols published by NHS Tayside relating to child protection issues.

- Where policies, protocols and procedures were printed they were not always the most up to date copy.
- There was lack of clarity in and ownership of the *"Concern for Unborn Babies"* protocol, which seems to have been developed by NHS Tayside without consultation with other key services and agencies.
- There did not appear to be any policy on circumstances when it might be appropriate to plot a baby or child's weight on the growth chart.
- The value, need and purpose of a joint paediatric-forensic examination were not widely known nor appreciated by paediatric staff.

6.6 Record keeping

A major issue faced by professionals working in large organisations is the inability to access appropriate information. Within NHS Tayside, records exist for each discipline (eg General Practice, Mental Health, Paediatrics, Midwifery, Health Visiting) which are not easily accessible to a practitioner outside that discipline. GP records may not link up family members where children are at risk of abuse. In the City of Edinburgh Council, staff based at one department cannot upload or retrieve reports onto the 'G drive' (secure shared drive), which might be why some of the pathway plans and progress reviews were missing. Plans are in place in the City of Edinburgh Council to migrate from the Learning & Teaching network to the corporate server.

The issue of whether the mother has a learning disability remains unknown due to either an inaccuracy in record keeping or confusion in interpretation of information recorded.

The records showed many instances of handwriting which was illegible or difficult to decipher. Some sections of the maternity and paediatric records contained entries made by midwives and paediatric doctors of unknown identity and status, as handwriting and signatures were not always legible.

From the agencies' records, there were inaccuracies and inconsistencies in spelling of the mother's name and surnames. This could have impacted on how checks were made for existing information had concerns been raised about the wellbeing of the mother or her baby.

The records available showed little evidence of multi-agency planning. Very few professionals documented key actions, decisions and reasons for them, identified person responsible for carrying out the action, or any plans for monitoring or review.

Learning points: (Recommendation 6)

- Staff should be made aware of the importance of spelling the names and surnames of their client.
- Good record keeping practices were not always adhered to.
- Case records should contain an analytical component with all available information taken into account.
- Case records should include evidence of care plans and actions assigned to an individual or agency, with time scales for action and how these should be achieved.

7. STRENGTHS AND GOOD PRACTICE

Those who were spoken to by the lead reviewer demonstrated a high level of dedication and professionalism, despite stressful working conditions. Examples of good and effective practice were recorded by professionals in several agencies and many individuals made strenuous efforts to act in the interests of Child A and the mother. From reading the files and speaking to staff, several examples of good practice should be highlighted.

7.1 Staff at one department in Edinburgh kept their door open even after the mother left their services. She contacted them on several occasions to seek advice on various matters.

7.2 When informed that the mother had been a looked-after child in Edinburgh, the housing support officer in Perth and Kinross contacted the social work department in Edinburgh and despite being informed that there had been no involvement with the mother since June 2015, the housing support officer persevered and managed to discover that the mother was an *"open case"* with social work. The mother's contact number was given to her social worker.

7.3 The midwife identified that the mother would require additional support for her medical condition and assigned her to the *Maternity Services Keeping Childbirth Natural and Dynamic* 'red pathway' for obstetric care.

7.4 The health visitor was proactive in the early postnatal period in trying to contact the parents, making several wasted visits and phone calls. The health visitor eventually made an unscheduled visit which resulted in Child A being admitted to hospital.

7.5 Having suggested that the parents took Child A to the GP for a problem with the head and neck area, the health visitor followed this up and checked that Child A had indeed been seen by the GP. On return from the weekend, the health visitor checked the GP records and found out that Child A had been admitted to hospital.

7.6 During Child A's second admission to hospital, NAI was diagnosed promptly and a child protection inter-agency referral discussion took place.

7.7 After the diagnosis of NAI, a phone call was received by a ward nurse from a person pertaining to be a grandparent seeking information. The nurse followed good practice and declined to give the information.

7.8 During supervised visits to Child A in hospital, the social worker assessed that the father and the mother lacked parenting skills. The social worker observed the parents' behaviour with Child A and concluded they were *"meeting their own needs to see (Child A) in… new clothes rather than respecting (Child A's) need to sleep"*.

8. CHANGES IMPLEMENTED SINCE INITIAL CASE REVIEWS

In the *Joint Inspection Report Services for Children and Young People in Perth and Kinross* (Care Inspectorate: April 2018), partnership improvement work was reviewed, and Inspectors reported that *"the NHS Tayside Unborn Baby Protocol was being extensively reviewed and refreshed. An improvement plan was underway to further strengthen multi-agency protocols and practice to ensure the timely identification and management of vulnerability and risk to pregnant women and their unborn babies".* Inspectors also noted that *"the revised unborn baby protocol had impacted positively on the timely identification of risk during pregnancy. An increasing number of appropriate referrals were being received in relation to child protection concerns thereby enabling services to offer support at an early stage".*

Following the reported non-accidental injuries suffered by Child A, in parallel with the joint police and social work child protection investigation and subsequent criminal investigation process, Perth and Kinross Child Protection Committee (CPC) commenced an Initial Case Review (ICR) investigation which identified immediate corporate learning for a number of services and agencies.

NHS Tayside, working in partnership with Perth and Kinross CPC, led, developed and implemented a very comprehensive Multi-Agency ICR Improvement Plan to quickly address these learning points, whilst awaiting the outcome of, and recommendation from, the Significant Case Review (SCR) process.

Amongst the key changes and improvements made since the ICR (from 20 December 2016), the following are the key service, agency and partnership improvements implemented so far:

1. Refreshed, revised and consulted on the NHS Tayside Concern for Unborn Baby Protocol; supported by a centralised NHS Tayside Generic E-Mailbox now provides a more coherent and consistent approach to the management of all Unborn Baby Referrals.
2. Published, distributed, disseminated, implemented and embedded the NHS Tayside Concern for Unborn Baby Protocol across all NHS Tayside services; supported by staff awareness raising sessions and briefings, particularly within midwifery services, health visiting services (including those who fulfil the role of Named Person), mental health services and substance misuse services. It remains available to all NHS Tayside staff via the NHS Tayside staffnet (intranet) and has been shared widely with partner services / agencies.
3. Improved the existing partnership referral and screening pathways for all Unborn Baby Referral Forms, by strengthening and monitoring the Perth & Kinross Unborn Baby Multi-Agency Screening Group (UBB MASG) arrangements.
4. Improved the information sharing and communication arrangements within NHS Tayside; particularly during the pre-birth period and at key transition stages between midwifery services and health visiting services.
5. Improved the existing partnership approaches to early and effective intervention; particularly during the pre-birth period and into the first year of life, by working to develop a needs-led early intervention pathway to support pregnant women who are vulnerable and to help prepare them for parenthood and ensure their unborn babies have the best start in life. This ongoing partnership work is being carried out between the Centre for Looked After Children in Scotland (CELCIS), Perth and Kinross Council and NHS Tayside.

6. Reviewed the Tayside Joint Paediatric Forensic Medical Examination Protocol.
7. Published, distributed and disseminated a Perth and Kinross Code of Practice: Information Sharing, Confidentiality and Consent for all staff across the public, private and third sectors across Perth and Kinross to support and empower lawful and proportionate information sharing between and across all services and agencies. This has been supported by multi-agency staff learning and development opportunities and has been kept under constant review to reflect legislative change.
8. Housing services updated their internal child protection policy and procedures and made relevant additions. Housing services also introduced additional supervision and quality assurance of Housing Support Officers and a systematic approach to annual child protection training of staff.
9. Refreshed and updated the Perth and Kinross Code of Practice: Information Sharing, Confidentiality and Consent to reflect The Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

ICR Learning – Next Steps

1. Complete the ongoing / current partnership work to develop the NHS Tayside Concern for Unborn Baby Protocol into Tayside Multi-Agency Unborn Baby Guidance; supported by a streamlined referral process and multi-agency staff learning and development opportunities as this is seen as a shared responsibility across all services and agencies;
2. Consolidate the ongoing / current partnership work to develop a needs-led early intervention pathway to support pregnant women who are vulnerable and to help prepare them for parenthood and ensure their unborn babies have the best start in life;
3. Complete the revision of the Tayside Joint Paediatric Forensic Medical Examination Protocol.

9. RECOMMENDATIONS

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

NATIONAL CONSIDERATION

1. NHS Education Scotland and NHS Tayside should review and revise their policies on child protection training for medical staff, especially paediatric trainees and career grade staff. The revised policy should stipulate the need for less-experienced staff to be effectively supervised in the clinical management of child protection cases and highlight more robust appraisal of child protection competences of paediatric trainees and career grade staff.

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

NHS TAYSIDE WITH PERTH AND KINROSS PUBLIC PROTECTION CHIEF OFFICERS GROUP

2. The training of all staff working with babies, children, young people and their carers should be re-enforced to ensure that staff are aware of indicators of child abuse, assessments and referral processes when they suspect child abuse.

Outcome – Improved recognition of babies, children and young people who may be at risk of harm; confidence to refer using appropriate channels.

3. Perth and Kinross Child Protection Committee should lead a review of processes and pathways leading to screening of vulnerable unborn babies, with the aim of developing a protocol which should be owned by all relevant services and agencies across Tayside. This must be accompanied by training of relevant staff across Tayside.

Outcome – Improved recognition of factors which impact on parenting and referral of unborn babies who may be at risk of harm.

4. NHS Tayside, together with Perth and Kinross Public Protection Chief Officers Group, should review and revise systems and practices about parental mental health problems and its impact on child care and wellbeing. Any resultant protocol should be launched with training to relevant staff working with the child and other family members, especially to GPs and Community Mental Health Services to ensure proportionate communication. (See also Recommendation 5)

Outcome – Improved understanding of risks to children's wellbeing, resulting in effective sharing of information.

5. All agencies, especially adult mental health and GP services, must review their guidance, policies and protocols on information sharing where there are concerns about parental mental health issues which might impact on parenting. (See also Recommendation 4)

Outcome – Improved understanding of risks to children's wellbeing, resulting in effective sharing of information.

6. All agencies should review, and, where appropriate, update their procedures for record keeping and referral processes to ensure that records contain accurate information, detailed analysis, effective decision making and care plans. Any resultant protocol must be accompanied by training of relevant staff.

Outcome – Records are fit for purpose and contain evidence of multi-agency planning where there are concerns regarding risk of harm to a child.

7. NHS Tayside, together with Perth and Kinross Public Protection Chief Officers Group should review, revise and rationalise protocols for the planning and conduct of paediatric forensic assessments / examinations, taking into consideration recent guidance (2014) from the Scottish Government and the Child Protection Managed Clinical Networks.

Outcome – All children with concerning injuries receive comprehensive paediatric care and assessments. Improved understanding of need and process for arranging paediatric assessments of children.

8. Where policies, protocols and procedures are printed all staff must ensure they are using the most up to date version.

Outcome – All staff are working to the most up to date documents.

9. Patterns of engagement and cooperation should be monitored by all staff and any changes should be explored as they may indicate increasing levels of risk.

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

10. Historical and accumulating information must be sought, examined and critically analysed by staff in all agencies to allow evaluation of increasing risk. All agencies should ensure that training is offered to key practitioners in creating a chronology and that standards for chronologies are embedded in guidance. Chronologies should focus on significant events and their impact on the life of a child or young person. They should be scrutinised regularly to understand cumulative adversities.

Outcome – Single and multi-agency chronologies will enable staff to see the bigger picture, recognise trends and 'think the unthinkable'.

11. All staff must review and take account of available information before decisions are taken on the future management of the wellbeing of the young person or baby.

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

NHS TAYSIDE

12. NHS Tayside should develop a policy for nursing and medical staff to follow whenever a baby or child is weighed. Where there are concerns regarding growth, weight assessments must be undertaken and plotted on a growth chart and filed

within the professional health record. Investigations undertaken because of the growth concern should be documented in the child's file.

Outcome – Identification of faltering growth.

13. NHS Tayside should consider, within the General Practitioner contracts, an obligation to mandatory child protection training to at least Level 3 (Inter-Collegiate guidance) for GPs, and monitor this at annual appraisal processes.

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

CITY OF EDINBURGH COUNCIL

Some of the above Recommendations also apply to the City of Edinburgh Council. These are:
Recommendations 6, 8, 9, 10 and 11.