Briefing note

Learning Summary of a Significant Case Review on Child A

A significant case review is a multi-agency process initiated by chief officers and child protection committees in accordance with National Guidance[1] [2] . These reviews are intended to establish the facts of, and lessons from, a situation where a child has died or have experienced significant harm. The process of this kind of review should focus on learning and reflect on day-to-day practices and systems. The Perth and Kinross Public Protection Chief Officers Group and the Child Protection Committee are committed fully to reviewing actions and decisions and identifying all lessons that need to be learned from Significant Case Reviews where appropriate.

In this case it is important to protect the anonymity of the child and family members who have been affected and the Learning Summary provides a brief anonymised account of the circumstances surrounding Child A and focuses primarily on the learning points and recommendations arising from them. An anonymised report and learning summary from the findings of the review will be published by the Perth and Kinross Child Protection Committee on Tuesday 25 June 2019.

Background

Child A was under two months old when a joint child protection investigation was commenced. This followed two admissions to a NHS Tayside hospital in short succession. The first admission related to a suspected infection and at the second admission serious non-accidental injuries were identified.

The Child Protection Committee commenced a review of the case and a Significant Case Review was commissioned by the Perth and Kinross Public Protection Chief Officers Group. Dr Jacqueline Mok was commissioned to be the independent lead reviewer acknowledging her expertise in child protection and paediatrics and in conducting case reviews.

The comprehensive review was completed recently with the assistance of a multi-agency review team and Dr Mok's review has identified further learning for all partners and made a number of recommendations for both local and national arrangements.

---

[1] Link to National Guidance for Child Protection Committees for conducting Significant Case Reviews https://www.gov.scot/publications/national-guidance-child-protection-committees-conducting-significant-case-review/

[2] Local guidance on conducting Initial and Significant Case Reviews https://www.pkc.gov.uk/media/40312/Perth-and-Kinross-CPC-Joint-Protocol-for-ICRs-and-SCRs/pdf/Joint_CPC_Protocol_ICRs_and_SCRs_17.08.30.pdf?m=636445431538030000

Briefing note

Findings of the Significant Case Review

The Learning Summary report identified six key practice areas relating to:

- communication and information sharing within and between agencies
- the parents' lack of engagement and co-operation
- risk assessment and review processes
- missed opportunities
- guidance, policies and protocols
- record keeping

A total of 13 recommendations are made in the report to inform practice improvement for all relevant services and agencies including NHS Tayside; Perth and Kinross Public Protection Chief Officers Group; Perth and Kinross Child Protection Committee, City of Edinburgh Council and NHS Education Scotland (NES). The Learning Summary Report also highlighted strengths and examples of good practice demonstrated by staff and agencies involved in the case.

The Chief Officers Group and the Child Protection Committee have accepted all of the recommendations. Improvement actions were taken forward by the Child Protection Committee immediately after this case was highlighted and in advance of the completion of the Significant Case Review.

A summary of the recommendations, improvements already taken, and ongoing actions will be published by the Child Protection Committee alongside the learning summary on 25 June 2019.

How the learning is being taken forward

Key areas for development already in place include:

- updated the NHS Tayside Unborn Baby Protocol and Arrangements and improved communication during the pre-birth period and at transition between midwifery and health visiting services;
- strengthened the Perth and Kinross Unborn Baby Multi-Agency Screening Group (Unborn Baby MASG) and Guidance;
- taken forward a partnership approach to early help and support during the pre-birth period and into the first year of life (NHS Tayside and Perth and Kinross Council) in conjunction with the Centre for Excellence for Looked After Children in Scotland (CELCIS);

Briefing note

- revised the Tayside Multi-Agency Practitioner's Guidance on the use of Chronologies; and
- updated and disseminated the Perth and Kinross Code of Practice on Information Sharing, Confidentiality and Consent to reflect new data protection legislation.

The Significant Case Review process provides an opportunity to focus on learning and reflect on practice and the learning highlighted in this report will be used to shape staff training and development as well as practice improvements.

Ongoing improvement work will be co-ordinated by the Child Protection Committee with progress monitored and reported via its multi-agency Improvement Plan.

25 June 2019