Edinburgh Child Protection Committee (ECPC)

Learning Review Executive Summary

Examining the multi-agency response to Child F & G who were subjected to harm, abuse and neglect. Including a focus on the effectiveness of partnership working, risk assessment, understanding of the type of harm presented.

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Introduction

1.1 Following consideration of the circumstances relating to Child F and Child G at Learning Review Panel in February 2024 Edinburgh Child Protection Committee (ECPC) agreed to commission a learning review. The decision to hold a Learning Review was ratified by Chief Officers in December 2024. This was on the grounds that the case met the criteria laid down in the National Guidance for Child Protection Committees Undertaking Learning Reviews (2021, updated 2024).

1.2 Child F was born in July 2021; they were 18 months old when they sustained unexplained injuries to the left upper arm including a fracture and bruising in January 2023. Child F resided out-with the Edinburgh City area for the first 17 months of their life, their parents separated when they were 12 months old in the summer of 2022. They later moved with their mother and her new partner to Edinburgh in early January 2023.

1.3 As a result of Child F's injuries they were placed on the City of Edinburgh Child Protection Register (CPR) for a period of 3 months between February and April 2023 to enable an assessment of need and risk to be completed. Safety planning was in place during this time. Following this assessment Child F's name was removed from the CPR and a support plan put in place for the family. Child F's case was closed to Edinburgh City Children's Services in June 2023.

1.4 Child G was born in October 2023 and is Child F's half-sibling. Living in the family home were Child F, Child G, the children's mother and her partner (biological father of Child G). Child F's father had regular contact with them throughout this time.

1.5 Child G was 7 weeks old when they sustained unexplained injuries including bruising to the scrotum, skull fracture and a fracture to the lower left leg in November 2023. A further Child Protection investigation was launched and both children were subsequently placed on the Child Protection Register in December 2023. Between December 2023 and April 2024, a safety plan was in place and both children's names remained on the Child Protection Register (CPR).

Sharing and Personal Data

Edinburgh Child Protection Committee has given due consideration to the extent to which personal data can be shared in any Learning Review Executive Summary being placed in the public domain. The report has been anonymised, insofar as is possible, and includes only information that can be lawfully shared.

Any disclosure of personal data must comply with the Data Protection Act 2018 and the General Data Protection Regulations (2018): Article 8 of the European Convention on Human Rights (the right to respect for private and family life) and must have acted in accordance with these requirements.

The Executive Summary Report is a limited version of the full report.

Review Process

2.1 The review was undertaken by an Independent Lead Reviewer and supported by the Lead Officer (ECPC), and a Review Team made up of senior managers from all agencies represented at ECPC, chaired by Police Scotland. The team met regularly following the commencement of the review on 20 January 2025. The review followed the methodology for Learning Reviews as described in the National Guidance for Child Protection Committees Undertaking Learning Reviews (Scottish Government, 2021) which offers a public protection related methodology to support collaborative learning.

2.2 The aim of the Learning Review is to examine the multi-agency response to a child subject to harm, abuse and neglect. To include a focus on the effectiveness of partnership working, risk assessment, understanding of the type of harm presented.

2.3 The period covered by the Review is from **January 2023**, when Child F was first presented to Health Services with regards to an injury, to **April 2024**, when both children were subject to Review Child Protection Case Conferences.

2.4 The Learning Review was asked to consider:

A. Were child protection procedures and other multi-agency guidance/protocols, including infant bruising applied and were risk assessments sufficiently robust in order to effectively protect and reduce risk of or actual harm to children?

B. How did different thresholds and values play out in terms of effective risk assessment and was there shared understanding of language across multi-agency partnership?

C. What does parental /adult presentation tell us about the impact on children of significant harm? Was decision making influenced by this? Did parents' use of complaints to deter from professional involvement/assessment and effective safety planning for the children?

D. Was there cognisance of the 1st child in the family with previous registration on CPR at the time of the child protection investigation into the injuries to the 2nd child?

E. How can the impact and history of the adults in the household be effectively assessed to understand possible risk to children?

F. Was it proportionate that the acceptance that Child F had an injury, albeit unexplained, without knowing any background led to de-registration after only 3 months? Was this collective decision-making?

2.5 Two reflective events were held, one involving the multi-agency practitioners that had been involved with the family and one involving senior managers from the agencies.

2.6 The children's family were not directly involved with the Learning Review, as a result of advice from Crown Office and Procurator Fiscal Service, but were informed that the Learning Review was taking place.

Learning Arising from the Review Process

This section of the Executive Summary examines each of the elements of the Terms of Reference and highlights any specific learning that arose in relation to each one.

A. Were child protection procedures and other multi-agency guidance/protocols, including infant bruising applied and were risk assessments sufficiently robust in order to effectively protect and reduce risk of or actual harm to children?

3.1 The Review found that the initial action taken in respect of Child F in respect of initiating an IRD, information sharing and the interim safety plan were appropriate an proportionate.

3.2 The reports provided to the Initial Child Protection Case Conference (ICPCC) for Child F were brief and contained very little background information. This is not unusual given the family had no previous history with services beyond universal services and the limited time available prior to the ICPCC being held. Key information, however, available was not referred to and very little analysis of the information provided undertaken. Risk factors and ongoing potential risks to Child F were not clearly articulated within the social work report, some of these issues were referenced within the health visitor's report.

3.3 The lack of integrated assessment of need and risk meant that there wasn't one collectively owned risk assessment identifying and exploring all the potential risk factors for the family that were evident even at this early stage. These included:

- Maternal mental health issues
- Lack of knowledge regarding mothers' partner
- Recent house moves and impact upon family
- Differing explanations for an unexplained injury
- Reported strong smell of cannabis in child's room at hospital – albeit there is confusion in terms of recording the circumstances surrounding this. Social work recording suggests that this occurred on a ward with other families present, health records suggest this was a single room for the family. At the practitioners event it was clear that confusion remained, with some thinking

that several members of the family were prescribed cannabis despite this not being fully explored.

3.4 The ICPCC should provide a forum for these issues to be further explored, however it appears that this opportunity was not fully realised from the record of the meeting, despite reference to them in the report provided by the health visitor.

3.5 The record of the ICPCC noted that Child F had not been referred to the Scottish Children's Reporter Administration (SCRA), but that a referral should be made within 5 working days of the ICPCC. It appears this was not done, and this may have had an impact upon the future decision making by the SCRA in respect of Child G.

3.6 Whilst the reports provided for the Review Child Protection Case Conference (RCPCC) three months later contained more information regarding the work undertaken with the family they still lacked key information and analysis regarding:

- The men in Child F's life
- Family relationships breaking down in relation to contact and both parents reporting concerns about Child F's care by the other
- Child F's mothers' pregnancy
- Child F's mother described Child F's father as being controlling in terms of finances, physical and sexual abuse

The reports were very weak in relation to articulating and exploring risk within the family.

3.7 The RCPCC went ahead despite key family members not attending. There was a restricted period held when the breakdown in the relationship between parents was discussed and information around the alleged domestic abuse shared. The Police reported that they had no new information since the ICPCC, despite a parent's recent attendance at a Police station seeking advice (4 days prior to the RCPCC). It appears that practitioners viewed this information very differently. Police Scotland took the view that the individual was exploring their options in relation to reporting possible domestic abuse but did not make a specific allegation. Police Scotland did undertake appropriate background checks in respect of the enquiry and assessed that there wasn't enough information provided at that time to raise a crime report. The social work records were very clear, however, that the individual had made very serious allegations of financial, physical and sexual abuse including rape. These allegations do not appear to have been fully explored at this time; indeed, very little significance seemed to be attached to them. This is concerning as Child F was later placed in the full-time care of the alleged perpetrator.

3.8 The reports presented in relation to Child G for the ICPCC held following the identification of unexplained injuries in December 2023 were similarly weak in relation to articulating and exploring the previously identified risks and vulnerabilities for the children and family. The review highlighted the challenge presented to practitioners when trying to differentiate between risk factors and complicating or contextual factors

within the family. In this case this is evidenced by the risk factors articulated in 3.3 and 3.6 above seen to be 'complexities' as opposed to potential areas of risk.

B. How did different thresholds and values play out in terms of effective risk assessment and was there shared understanding of language across multi-agency partnership?

3.9 It was clear that Getting it Right for Every Child (GIRFEC, Scottish Government, 2022) is not embedded across Edinburgh. The lack of integrated risk assessment contributed to little or no shared understanding and exploration of the risks and vulnerabilities within the family, especially at the point of de-registration for Child F. It was concerning that separate reports were presented by agencies at both the ICPCC and RCPCC for Child F. There was little or no understanding of the role of 'Lead Professional' as described in both the National Practice Model (GIRFEC) and National Child Protection Guidance (Scottish Government 2021) in relation to pulling together the information to create one integrated report.

C. What does parental /adult presentation tell us about the impact on children of significant harm? Was decision making influenced by this? Did parents' use of complaints to deter from professional involvement/assessment and effective safety planning for the children?

3.10 It was clear that the family relationships were complex and tense, and this had an impact upon both the assessment and decision making:

- Child F's mother raised concerns about Child F's father's behaviour during their relationship involving serious allegations in relation to financial, physical and sexual abuse.
- The relationship between Child F's mother and father deteriorated to the point where they could no longer be meetings together and one parent did not attend the RCPCC, as a result.
- Despite the serious allegations made by Child F's mother there was very little exploration of them or to the potential impact of living in a household where domestic abuse may have been present on Child F's development.
- There was a lack of exploration in relation to the mother's mental health issues, her trauma history, the complexity of her relationship with her mother and what the impact of this may look like for her children.

3.11 One area of concern explored at the practitioners' event was that of 'disguised compliance' or 'resistance', a term used to describe parental behaviour that appears to be cooperative but prevents meaningful engagement. Many of the key issues to understanding the risks and improving practice in relation to this concept are evident throughout this case, during the period reviewed there were an increasing number of cancelled and rescheduled appointments and meetings, many at last minute. Numerous complaints were submitted in relation to medical staff, a Reviewing Officer and their dealings with the family.

D. Was there cognisance of the 1st child in the family with previous registration on CPR at the time of the child protection investigation into the injuries to the 2nd child?

3.12 At the point of initial presentation for Child G at the Emergency Department, Royal Hospital for Child and Young People (RHCYP) the team were not aware of the previous history, the letter given to the family by the General Practitioner (GP) was not handed over and there was no other way for them to get the information. Had the GP sought advice from the CP Hub prior to attendance at the Emergency Department the initial response from staff may have been different. It wasn't until the Health Visitor followed up the referral two working days later that appropriate action was taken.

3.13 Whilst recognition was given to the previous injury to Child F none of the resulting reports to ICPCC considered the repeating pattern in terms of changing explanations for the children's injuries from the parents.

3.14 Scottish Children's Reporter Administration (SCRA) were unable to take account of Child F's previous history in their decision making at the time of the referral in relation to the injuries for Child G. This was because a referral was never received following the ICPCC in respect of him (see para 4.5).

E. How can the impact and history of the adults in the household be effectively assessed to understand possible risk to children?

3.15 The Review identified the complexities of the family dynamics and relationships. The lack of a fully integrated assessment and analysis of need and risk in respect of either child meant the practitioners were unable to fully assess and understand the impact of history upon them.

3.16 In order to fully assess and understand the impact of this history it is important that practitioners:

- Use evidence based integrated assessment tools for both risk and need
- Fully understand not just a baby's basic care needs but also their emotional and psychological needs, and how these can be met within the context of the family dynamics including both strengths and vulnerabilities
- Engage and involve parents to help support and educate them to safely care for their baby
- Be professionally curious about the family

F. Was it proportionate that the acceptance that Child F had an injury, albeit unexplained, without knowing any background led to de-registration after only 3 months? Was this collective decision-making?

3.17 Given the poor quality of the reports provided for the RCPCC for Child F it is not surprising that the collective decision on the day was to deregister Child F. The focus of the RCPCC was on the family and family dynamics, the meeting appears to have lost sight of the seriousness of the injury and the lack of credible explanation for it.

3.18 It would be pertinent to consider that Child F's registration on the CPR should have been continued in the light of issues examined previously, or that a pre-birth case conference would have been relevant for the unborn sibling.

General Observations

3.19 The Reviewer had access to the Executive Summary of Learning Review Report for Child E. There are a number of similarities in the findings of the two reviews despite the very different circumstances that led to the two reviews.

- Child E's review highlights concern around the application of GIRFEC and the effective use of multi-agency chronologies.
- The review comments upon the 'variable quality' of risk assessments and offers up suggestions for improvement.
- Agreed referrals to SCRA did not take place, this was also the case in respect of Child F.

3.20 The Reviewer also had sight of a staff briefing in respect of an Initial Case Review carried out in May 2021 which bore remarkable similarities to the case being reviewed. Both practitioners and managers were asked if they were aware of the ICR or the 7-minute briefing that had been produced by ECPC. Practitioners were unaware of the information, some of the managers were aware of it but there was little clarity around how it had been used to inform practice.

Identified Good Practice

3.21 After the initial referral to the Emergency Department, RHCYP for Child G the GP and HV contacted the CP Hub as soon as they could, recognising that they had not heard anything further in relation to the case. Had this not been actioned then the injuries to Child G may not have been identified.

3.22 The social work team involved in the case received training in relation to Non-Accidental Injuries from the Consultant Paediatrician.

3.23 ECPC also ran an IRD workshop on Non-Accidental Injury to Infants and Young Children, with over 60 participants and other interested parties in February 2025, with inputs form Community Paediatricians, Children's Social Work and the Crown Office and Procurator Fiscal Service.

3.24 The same social work practitioner was allocated to work with the family throughout, thus ensuring continuity of knowledge and relationships.

Conclusion and Recommendations

4.1 There is no doubt this was a complex case with challenging issues to be addressed. It is difficult to be definitive in relation to what actions would/could have reduced risk and may have prevented further harm to children. The reality for Child F and Child G is no one knows how they were injured; experienced and knowledgeable health colleagues are clear that the likelihood of their injuries being accidental is extremely low. The health report submitted for the ICPCC held in December 2023 following Child G's injuries states – "Unintentional bruises in pre-mobile infants are rare, with a prevalence of <1%. Infants who are yet to acquire independent mobility should not have bruises without a clear explanation. Abusive bruises are often located away from bony prominences and are found predominantly over soft tissue areas. Bruises on soft parts of the body such as the genitalia are rarely seen in non-abused children, in contrast to abused children."

4.2 Both health and social work colleagues knew the family well and, overall, had established positive working relationships with them. However, this was not reflected within the assessments.

4.3 The lack of multi-agency risk assessments, chronologies and analysis led to information being missed or not recognised as important to the overall assessment of the family. This also meant that explanations were not tested or challenged, and emerging patterns of behaviour were not identified.

4.4 The quality of assessments was compromised due to little or no examination of:

- Maternal mental health issues
- Lack of knowledge regarding both fathers
- Recent house moves and impact upon family
- Differing explanations for an unexplained injury
- Reported strong smell of cannabis in child's room at hospital
- Family relationships breaking down in relation to contact and both parents reporting concerns about Child F's care by the other
- New pregnancy
- Allegations of financial, physical and sexual abuse

4.5 The failure to fully implement and embed GIRFEC (Getting it Right for Every Child) across all Children's Services in Edinburgh contributed to the shortcomings described in 4.3 and 4.4 above. There is no doubt that to prevent similar issues in the future it is necessary to embark upon significant culture change across all agencies, one which **everyone** involved in Children's Services must actively endorse and embrace. The challenge and scale of this change will require strong leadership, commitment and investment from Chief Officers, without this there is a very high probability of similar circumstances being repeated with potentially devastating outcomes for a child.

4.6 The reviewer is grateful to all practitioners and managers that actively engaged with the reflective sessions or met on a one:one basis. Their contribution helped to clarify many points and began to form the findings for the recommendations.

These recommendations should be actioned alongside those from the Learning Review Report for Child E.

Recommendation 1

Getting it Right for Every Child (GIRFEC) is Scotland's consistent framework to ensure joined-up assessment and planning for children, even at the urgent end of the continuum. Therefore, Chief Officers should review the implementation of GIRFEC across all Children's Services in Edinburgh with a view to ensuring:

- A consistent approach to collaborative, integrated assessments of risk and need through the introduction of an agreed framework across all agencies to support the multi-agency assessment, analysis and decision making in relation to child protection cases.
- A consistent approach to the creation and use of integrated chronologies ensuring they are used to support the ongoing assessment and analysis of risk and need.

Recommendation 2

The CPC should consider:

a) Developing further or revising existing learning opportunities for practitioners to understand the complexities of working with families who are struggling to engage based around:
   - Building meaningful relationships with parents and carers
   - Maintaining a high level of professional curiosity
   - Ensuring the child's needs remains the focus of all work
   - Identifying and responding to behavioural patterns that point to 'Disguised Compliance'

As far as possible these learning opportunities should be offered on a face-face basis within localities to facilitate greater understanding of roles and responsibilities and support the further implementation and embedding of GIRFEC as described in this report.

b) Developing further or revising existing learning opportunities to ensure male care givers are identified and assessed within assessments given the vital role they play in children's lives. (NSPCC 2022)

c) Developing further or revising existing learning opportunities for practitioners in relation to working with families where there have been unexplained injuries to children.

d) Ensuring that supervision guidance is updated to reflect the messages contained within this report.

e) Ensuring that these learning opportunities are embedded into practice through regular audit to establish:
   - Impact of learning on practice
   - Attendance
   - That lessons from learning reviews are incorporated into local training

f) Engaging with IRISS in relation to a new project they are launching to explore professional curiosity across the public protection arena (IRISS, 2025). This is in the very early stages of development and offers an opportunity to contribute to and learn from the project.

Recommendation 3

The CPC should develop a communication strategy for ensuring that learning from Learning Reviews and audit work is fully disseminated across all agencies. This should include ensuring that learning and training is updated to reflect the findings.

Recommendation 4

NHS Lothian should:

- explore ways for improving information sharing, particularly in relation to GP's ability to share information electronically with emergency departments.
- remind all GP's about the correct procedures for contacting the CP Hub where they may have concerns about child protection.

Recommendation 5

The CPC should reissue guidance to practitioners to ensure:

- Multi-agency consideration of making a referral to SCRA at IRDs and CPPMs.
- That supervisors and the Chairs of CPPMs ensure that any recommendation to refer is actioned within the 5 working days required.
- This is audited, where appropriate, during any future self-evaluation exercises.