



Edinburgh Child Protection Committee (ECPC) Executive Summary of Learning Review-Baby J

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Introduction

This Learning Review Report evaluates the multi-agency response to Baby J, who came into contact with a range of Edinburgh services after sustaining physical injuries within the first eight weeks of life in early 2025.

The review assesses the effectiveness of the child protection partnerships, the thoroughness of risk assessment procedures, and the depth of understanding regarding the nature of the harm identified.

Learning Review Process

In line with the [National Guidance for CPCs Undertaking Learning Reviews \(2021 - Updated 2024\)](#), Edinburgh Child Learning Reviews Panel received a notification from NHS Lothian in June 2025.

The Learning Review Notification and background information were subsequently discussed by Edinburgh's Child Protection Committee (ECPC) Learning Review Panel in August 2025 and September 2025, recommending an independently facilitated practitioner/ manager reflective event. This decision was ratified by Chief Officers and logged with the Care Inspectorate in October 2025.

The learning review examined how well the partnership responded, shared information, assessed and managed risk and carried out early, effective interventions. The timeline covered the period from birth until the discharge from hospital after the second set of injuries were investigated, when the child was placed in the care of a family member. The review also examined guidance, policies, child protection systems, and how professional and family actions shaped decisions.

This was achieved through:

- Case Record review by the ECPC Independent Chair and Lead Officer to the ECPC.
- A Senior Officer Reflective Discussion taking place, which informed The Terms of Reference for the Learning Review.
- Reflective events with practitioners and senior managers.
- An individual meeting with NHS Community Midwifery service, who did not attend the reflective events
- Report written by the ECPC Chair and Lead Officer and agreement by the local Review Team.

The Learning Review Report was agreed by a Learning Review Team of Senior Managers from the ECPC in May 2026 and is presented to Chief Officers in July 2026 for final approval.

Baby J's Circumstances

Baby J was born in February 2025 and discharged home with first time parents.

Medical notes indicate that there were challenges in hospital on the day of Baby J's discharge. Baby J's parents had become angry about the length of time the discharge was taking and an 'altercation' took place that involved the maternity coordinator and security staff being called to the ward.

On discharge, the Community Midwifery team were informed, so they could observe any further incidence. Community Midwifery visited the home the next day, at which point Baby J's mother was apologetic for losing her temper in hospital and there were no further concerns of this nature noted.

Community Midwifery visited again on day five and day ten and also made successful telephone calls on day four and day eight. No issues were noted during these contacts and Baby J's care was transferred from Community Midwifery to Health Visiting, as per NHS Lothian procedure.

At two weeks old, Baby J was taken to A&E by their parents due to exhibiting distress and pain. Staff noticed an unexplained cheek bruise and signs of distress and quickly initiated the NHS Lothian Child Protection Protocol for the Management of Unexplained Bruising in Pre-mobile Babies (NHS Lothian 2020). They contacted the NHS Lothian Child Protection Hub and an Inter-Agency Review Discussion (IRD) commenced.

Baby J was admitted to hospital for further investigation and parents subsequently explained that they thought the bruise occurred from winding. Following the Joint Forensic Paediatric Medical Exam, medical staff recorded that they had considered the handling of Child J to be excessive.

As part of the Child Protection Investigation an Interim Safety Plan was developed at a multi-agency professionals meeting. Concurrently, a Family Group Decision Making Meeting had also taken place, presenting a Family Plan. It was agreed Baby J could return home with their parents, but Baby's care would require constant supervision by either maternal or paternal grandmother, including overnight. This was confirmed and intimated to parents and family members at the Discharge Planning Meeting in hospital.

Following discharge, the family were visited every few days by either the Social Worker or Health Visitor.

Three weeks' later the results of the second skeletal survey had come back with no further concerns, suggesting the bruise to the cheek was an isolated injury. This was intimated in a sensitive and timely fashion to the family and the professionals involved.

A further multi-agency professionals meeting was held at this time. Staff in the community had built positive working relationships and regard for the family and there was disagreement on the need to progress to Initial Child Protection Planning Meeting (ICPPM), with requests to further relax the safety planning.

The lead paediatrician confirmed the medical assessment that Baby J's injuries were likely attributable to an unexplained abusive cause. It was, therefore, agreed that the supervision arrangements within Interim Safety Plan would remain in effect until the

information could be presented and discussed at the scheduled ICPPM to take place a week later.

The ICPPM took place 24 calendar days after the IRD was initiated. The meetings are chaired, on behalf of the ECPC, by an Independent Reviewing Officer who is part of City of Edinburgh Council's Children and Young People's Review Team (CYPRT). It was well-attended by a range of professionals, both in person and through a hybrid link. There were also five family members present, making it a long and busy meeting. This was in addition to a full set of single-agency reports received from:

- Children's Social Work
- Community Child Health
- GP (x3 Mother, Father, Baby J)
- Police
- Family Group Decision Making Family Plan.

Within the Child Protection Plan, it was agreed that the 24/7 supervision by family members could be 'relaxed to allow Baby J to spend unsupervised time with parents.' The plan made reference to the Family Group Decision Making Family Plan. This was following an understanding amongst professionals attending the meeting that the family were cooperative with both social work and health professionals, and no issues regarding parenting had been observed.

The new Child Protection plan detailed that a family member was scheduled to visit daily and could quickly provide extra support when needed. Baby J would also spend weekends with grandparents, offering further assistance to his parents. All ICPPM attendees agreed that the plan was suitable and proportionate.

At this point, many of the staff involved in the initial investigation stepped away from the day-to-day care planning, as Baby J was no longer under the care of the hospital, Police were winding up their investigation and Social Work responsibility transferred from the Child Protection Resource to a Locality Social Work Team.

An initial Core Group Meeting took place on 24 March 2025 and was combined by the Health Visitor's 6-8 week post-birth check. No concerns for Baby J's health or wellbeing were raised.

Around this time, Baby J's father had sought advice around his own wellbeing from his General Practitioner, noting he was struggling with the care of a newborn. He had been sent details of the [ICON Project](#), which is a preventative public-health approach aimed to reduce the risk of abusive head trauma. It is particularly designed to appeal to male caregivers.

Two weeks later Baby J was admitted to the Royal Hospital for Children and Young Person's (RHCYP) after the GP noted bruises to the back, thigh, and chest during Baby J's routine 6-8 week post-birth check.

A referral was made to NHS Lothian's Child Protection Hub and a further Child Protection Investigation was initiated by the receiving hospital paediatrician, following the NHS Lothian Child Protection Protocol for the Management of Unexplained Bruising in Pre-mobile Babies (NHS Lothian 2020).

During the initial medical investigations, Baby J's mother tried to leave the hospital with them, despite being told she could not. This involved emergency planning, through the IRD process, between Health, Social Work and Emergency Services, in order to ensure Baby J was kept safe and would continue to receive medical assessment and treatment as required.

Baby J's parents expressed dissatisfaction and concerns regarding the medical staff during the investigation of Baby J's injuries. They repeatedly requested changes to the acute medical team responsible for Baby J throughout his admission.

Baby J was reviewed by three dermatologists, as a result of parental requests for a second and third opinion. All dermatologists concluded that there was no skin condition to explain Child J's bruising. Yet, the parents continued to challenge the assessment and had asked for further opinions due to dissatisfaction.

A Joint Paediatric Forensic Medical Examination was planned but consent was withdrawn after less than 10 minutes. As a result, a multi-agency face-to-face IRD meeting agreed to seek a Child Protection Order (CPO) to authorise the required medical investigations, which was subsequently granted.

A skeletal survey and head CT completed on in early April showed that Baby J had five separate fractures:

- Bilateral healing eleventh posteromedial rib fractures with callus formation (at least 2 weeks old)
- Healing right femoral fracture.
- Healing right tibia and fibular fractures.
- There was also an abnormality, therefore possible fracture on Baby's left radius and humerus but would require follow up X-rays to determine if these are fractures.

None of these fractures were apparent on the skeletal survey undertaken one month previous, during the initial Child Protection Investigation. The injuries were deemed by paediatricians to be highly likely to be abusive/inflicted.

Given the seriousness of the results, it was agreed by multi-agency child protection partners that Baby J would be discharged into the care of a family member, with no direct contact to take place between the parents and Baby J over the weekend. This was supported legally by the CPO already in place.

Baby J's parents continued to provide several explanations for the injuries, ultimately attributing the fractures to the radiographer who performed the survey during the initial child protection investigation in March 2025.

Multi-agency Child Protection Core Group Meetings continued to take place and there were also Children's Hearings on 8 and 16 April 2025, in line with the expectations following a CPO. On the 16 April 2025 the grounds for a Children's Hearing were sent to the Sheriff for Proof and Baby J was placed on an Interim Compulsory Supervision Order away from home with a direction of family time with parents.

Key Learning Points

1. Recording and Information Sharing

There was lots of strengths identified in the level of recording and information sharing undertaken during the first eight weeks of Baby J's life. The Child Protection Protocol for the Management of Unexplained Bruising in pre-mobile babies (NHS Lothian 2020) was employed in a timely and effective manner by NHS Lothian staff on both occasions.

The 'Bruised Baby Protocol,' as it is known in practice, is designed to identify infants and young children at risk of abusive head trauma, support medical staff in carrying out a full investigation into the circumstances of the injuries and aid effective safety planning.

In this situation, it did what it was supposed to do and led to an effective multi-agency child protection response. Baby J's rights and needs were kept firmly at the centre, with agencies and services communicating well with one another through different stages of the process.

There was evidence of good information sharing between professionals, particularly those involved in the IRD. Although, there were some instances when this information was poorly shared with medical staff not directly involved in child protection that could have had an impact on their direct care of the baby and family.

Single-agency case recording; the multi-agency e-IRDs record; and reports for the ICPPM also contained a good level of detail.

The Learning Review did highlight that further analysis of background information and vulnerabilities, could have improved things further.

2. Rights-respecting Practice

The family's GP took an early, proactive approach to the risk of abusive head trauma following an appointment where he actively listened to the parent and followed this up by sharing the [ICON Project](#) resources with Baby J's father.

The family were also afforded the opportunity to meet with Family Group Decision Making ahead of the first Discharge Planning Meeting and subsequently brought a Family Plan to the ICPPM, which was considered as part of the meeting and formed the basis for the alterations to the safety plan. This is evidence of the commitment in the Edinburgh and Lothians Multi-Agency Child Protection Procedures to involve and include parents and carers wherever possible.

There were several instances throughout the Learning Review where, despite a lot of tension and noise, between the family and professionals, the focus was firmly kept on Baby J. The voice of the infant was included and therefore Baby J's rights upheld.

3. Language

During the second child protection investigation, there was evidence of decisive and assertive practice with regards to modelling risk-based language in relation to inflicted injury. Further a lead medic empowered other professionals to follow this approach, presenting a consistent picture to the family.

There were other points in the Learning Review, however, where practitioner from non-medical professions were unsure of medical language or where practitioners recognised that inconsistent, nuanced language in relation to inflicted injury and injuries caused by excessive force had been used, which could be confusing for non-medical professionals.

Work is ongoing in Edinburgh and the Lothians, both single-agency (NHS Lothian) and through multi-agency IRD Workshops to address consistent use of language in inflicted injury cases, especially where these are disputed by family members. This would benefit from a sustained culture changes, which may well be supported by a multi-agency protocol around unexplained bruising in infants and young children.

A Multi-Agency Protocol would cover both the initial child protection investigation (ICPPM) but also the holistic assessment of family dynamics and parenting capacity following a discharge from hospital or an ICPPM.

4. Child Protection Plans

The purpose of a Child Protection Planning Meeting is clearly outlined in the Edinburgh and Lothians Multi-Agency Child Protection Procedures (2024) as a meeting ‘to decide whether the child is at risk of significant harm and devise a plan to reduce the risk.’ Practitioners in this Learning Review, as in other local Reviews, have reflected on the challenges in balancing a range of expectations at a CPPM. However, practitioners should not lose sight of the primary purpose to collectively devise a risk reduction plan, alongside a family.

Edinburgh require to develop their CPPM structure and be assured on the competence of staff in developing SMART Child Protection plans that address concerns, draw out assessment and assure future meetings that children are safe and risks are reducing, in order to consider whether they can be removed from the Child Protection Register.

Developmental discussions are already underway with key services and future multi-agency quality assurance and audit work could ascertain what difference this has made to outcomes for children and young people subject to Child Protection registration.

5. Professional Core Group Meetings and/or Opportunities for Multi-Agency Reflective Case Consultation

The practitioners within the Learning Review were very clear about the benefits of face-to-face IRDs and other opportunities to reflect and professionally challenge one another, out-with their engagement with the family. They felt these meetings and discussions ensured that there were clear, concise and consistent explanations about safety planning that could be shared separately with Baby J's parents and family members.

This learning review has helped cement some understanding of the times and circumstances that professional-only facilitated group reflection could be offered in enabling practitioners to work together to meaningfully drive forward child protection planning.

6. Parental Mental Health

Throughout the Learning Review practitioners spoke candidly about the challenges of working with a parent who had a history of 'adverse childhood events' and presented in a controlling, divisive manner, likely as a result of their own trauma and anxiety.

Professionals told the review that they would welcome further support to understand and transparently address parental mental health, particularly how to make sense of the risk and impact it may have on their capacity to provide for a child's needs. Further workforce development in this area would strengthen effective risk assessment and planning.

Recommendations

The following recommendations highlight important lessons, which have been shaped by input from Practitioner and Strategic Manager events, audits of available information, and discussions within the Learning Review Team.

Recommendation 1

ECPC Should continue to enhance or update training for practitioners and first-line managers to address challenges in engaging families, focusing on:

- Maintaining professional curiosity
- Recognising and addressing signs of disguised compliance or parental resistance

Evidence of the impact of learning opportunities in this area of practice should be integrated into routine practice and monitored through systematic multi-agency audits.

Recommendation 2

ECPC should build on the positive practice examples shared across the two recent Learning Reviews in relation to addressing inflicted injury of infants and young children by allowing a period of development and consolidation of the following guidance and practice:

- Timely identification and initiation of dedicated protocols and procedures
- Early information sharing and collective decision making on safety planning through the IRD
- Consistent use of risk-based language on inflicted injury that emphasises the potential harm/impact
- Clear ownership and single points of leadership within a child protection agency during the child protection investigation
- Further development of multi-agency guidance on holistic, whole-family assessment and planning following a discharge from hospital in relation to unexplained injury.

While the Review demonstrated that NHS Lothian staff have a good basis for understanding practice around injuries of infants and young children, which hangs on the Child Protection Protocol for the Management of Unexplained Bruising in Pre-mobile Babies (NHS Lothian 2020), there is a need for Police, social work and other non-medical partners to be better informed on the warning signs as a precursor for future abuse, which could be aided by a multi-agency guidance.

Recommendation 3

The ECPC should conduct a review of policies and procedures to ensure the multi-agency partnership effectively engages with hard-to-reach individuals using rights respecting and trauma-skilled approaches. This should include specific learning in relation to working with complex cases in which parental mental health is a factor. Quality

improvement could be evidenced by examining documentary evidence, discussions with practitioner groups, and gathering a body of valuable insight.

Recommendation 4

Edinburgh should consider developing a model to provide independently facilitated multi-agency reflective case discussion for complex cases where families are hard-to-reach, display resistance or where a multi-agency team around the child encountering barriers to achieving change and reducing risk in a child protection plan.

4. Conclusion

The cause of Baby J's injuries remains unknown, although health professionals are highly confident that the injuries were inflicted. Staff employed the Child Protection Protocol for the Management of Unexplained Bruising in pre-mobile babies (NHS Lothian 2020) in a timely and effective manner, which prompted the child protection investigation and ongoing processes.

There were numerous strengths in information sharing, assessment and analysis in relation to some parts of the process. Other parts of the Review indicated that there is still work to be done in Edinburgh in ensuring sufficient examination of all information and preventing against over-optimistic risk assessment. This was impacted by difficulties in consistently engaging with Baby J's parents, despite tenacious efforts to do so.

It cannot be stated with certainty which actions could have reduced risk or prevented further harm to Baby J during both the first and second hospital admissions.

Yet, the Learning Review highlighted a lack of robust outcomes focused planning, with SMART objectives around ongoing assessment. This could be supported by a multi-agency guidance resources into the holistic assessment of a child and family who experience inflicted injury, injury by excessive force and/or are at further risk of abusive head trauma.

Key insights surfaced from reviewing the documentary evidence and discussions with the Practitioner Groups and Review Team. There was a strong sense of practitioners' commitment to Baby J and participants worked well to reflect on the significant events that had already impacted the first months of Baby J's life. They should be credited with their dedication to practice development.

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