

## EAST AYRSHIRE SIGNIFICANT CASE REVIEW

### EXECUTIVE SUMMARY: BABY L

1. While left in the care of the father in the family home, at age 13 weeks, Baby L suffered life changing and lifelong injuries.
2. Prior to the birth, professionals considered this to be a vulnerable pregnancy as the parents were young, inexperienced and had limited family support. Consequently, a range of agencies were providing support to the family.
3. In the initial weeks following Baby L's birth, the parents' accepted support from multi-agency services. The parents were observed to be confident in their care and handling of the baby.
4. Prior to the incident, the parents increasingly defaulted on appointments. The parents gave reasonable explanations for this and continued to welcome the involvement of professionals. The way in which the parents worked with professionals positively influenced how professionals viewed their parenting capacity.
5. Within the first 12 weeks of Baby L's life, the parents made five separate contacts to out of hours health services for advice and assistance about injuries / concerns about the health of the baby.
6. On the day of being injured, the father reported concerns about Baby L's breathing and when taken to hospital, was found to have non-accidental injuries.
7. The father was the subject of a police investigation, resulting in him pleading guilty to an assault to severe injury to Baby L, for which he subsequently received a custodial sentence.
8. A Significant Case Review was commissioned by the East Ayrshire Child Protection Committee (EACPC). This was undertaken by two independent Lead Reviewers, and was reported to the East Ayrshire Chief Officers' Group.
9. The review was undertaken using the "Learning Together" model, which adopts a systems approach to learning and improvement in child protection practice, with professional oversight by the Social Care Institute for Excellence (Scie).
10. The review focussed on two research questions:
  - a) *What can we learn about barriers and aids to effective information sharing both within and between agencies? And;*
  - b) *What can this tell us about professional understanding of risk and risk indicators (including assessment and planning) what works well and where improvement is needed?*

11. The review considered 'What happened'? ; 'Why did it happen?' and 'What are the implications for wider practice? This led the Reviewers to identify eight findings which required consideration by the EACPC.
12. The Significant Case Review findings related to: innate human biases, family-professional interaction, guidance, supervision, intervention thresholds, quality assurance, use of intelligence; communication and collaborative working in longer term work.
13. The findings have been addressed by a range of actions including:-
  - Introducing a revised approach to practice at the point of referral for paediatric assessment;
  - introducing a revised approach to risk assessment in health services which strengthens the focus on the impact of parental health on children and young people;
  - developing guidance for health professionals to assess and review infant head growth;
  - undertaking to identify and consider resource and practice issues in developing a sustainable midwifery/health service to respond to unborn/newborn babies with additional needs;
  - arranging for multi-agency guidance to be issued about the use of police intelligence;
  - undertaking a review of the Multi-Agency Referral Group (MARG) in respect of quality assurance arrangements; and
  - designing a learning programme for practitioners and frontline managers on a multi-agency basis to enable the sharing of the learning arising from this review and to encourage further suggestions about improvements and developments in child protection practice, including supervision.
14. The East Ayrshire Chief Officers' Group has considered and agreed the findings and will support and resource the EACPC to respond to the matters raised.
15. For transparency, the Chief Officers' Group has decided to make the full report publicly available and every effort has been made to disclose as much of the SCR as lawfully possible.

<https://www.east-ayrshire.gov.uk/Resources/PDF/C/SCR-Baby-L-Final-Redacted-Report.pdf>

Some personal data has been redacted due to the disclosure not being justified under the Data Protection Act 1998 (DPA). While there has been a significant amount of personal data available within the public domain, the disclosure of personal data in this report must still comply with the DPA. The decisions about what information to redact reflects judgement about the balance between:

- considering the interests of the child, family and practitioners involved in terms of the right to respect for their private and family life in terms of Article 8 of the European Commission on Human Rights.

- due consideration to whether the information is sensitive data; and
- the commitment to transparency, within the context of the overall purpose of the SCR; the nature of child protection practice and the public interest.

16. Finally, we appreciate the comprehensive and inclusive approach taken to this review by the Independent Lead Reviewers, along with the clinical supervision and oversight provided by Scie. Their approach has been welcomed by practitioners and managers, who have reflected on their individual and organisational learning, leading to practice improvements.
17. This collaborative learning and improvement approach has undoubtedly developed greater joint understanding about supporting families who present with a myriad of needs and challenges, and who often conceal their thinking, behaviours and circumstances from people who could help.

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Fiona Lees

Chief Executive

East Ayrshire Council

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John Burns

Chief Executive

NHS Ayrshire and Arran

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Paul Main

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Police Scotland

20 July 2017