Learning Review Summary Report

Child G and Child D

Undertaken on behalf of

Perth and Kinross Child Protection Committee (CPC)

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Introduction and Context

1.1 Perth and Kinross Child Protection Committee (CPC) is a listening and learning partnership; committed to learning and sharing lessons from Learning Reviews (which were previously known as Initial Case Reviews ICRs and / or Significant Case Reviews SCRs).

1.2 This Learning Review Summary Report has been published by Perth and Kinross CPC, following the completion of a multi-agency Learning Review into the circumstances surrounding the hospitalisation of two babies (hereinafter referred to as Child G and Child D); both of whom were found to have sustained significant harm.

1.3 KEY FEATURES OF LEARNING REVIEWS

Learning Reviews are a vital part of our effective and improving child protection system.

Learning Reviews are **not** investigations.

Learning Reviews **are** an opportunity for an in-depth analysis and critical reflection, in order to gain a greater understanding of inevitably complex situations and to develop strategies to support practice and improve systems across all services and agencies.

Learning Reviews – Key Features and the Underlying Principles and Values can be found HERE.

This Learning Review Summary Report provides a high-level summary of the:

- circumstances leading up to the hospitalisation of Child G and Child D;
- review process and methodology used in this review;
- practice and organisational learning identified during this review;
- effective practice identified during this review; and
- suggested strategies for improving practice and systems; including recommendations, which Perth and Kinross CPC has accepted in full.

1.4 In advance of this Learning Review Summary Report being published, Perth and Kinross CPC and key partner services and agencies have implemented a significant amount of single and multi-agency practice change and improvement work; based on our shared learning.

1.5 This is evidenced in the accompanying Log of Recommendations and Key Improvements Table.

Circumstances that led to the Review – Child G

2.1 Child G and their parents were known to multi-agency child protection services and agencies; including social work services; health services; housing services and other adult services.

2.2 In the antenatal period, Unborn Baby Child G was placed on the Child Protection Register (CPR). When Child G was born this CPR registration was continued.

2.3 Child G and their parents had regular and sustained contact with multi-agency services and agencies.

2.4 Child G's mother contacted the GP, as Child G was not feeding well and had fewer wet nappies, as well as occasional vomits. Child G's mother was given advice over the phone, but Child G's mother made contact again, saying she continued to be concerned about the dry nappies and Child G was seen for a face-to-face appointment with the GP.

2.5 Child G was examined and there were no concerning findings, Child G had passed urine and was vomiting less. The GP offered a same day review with Paediatrics, but Child G's mother advised she had no transport and also felt Child G had improved, so no referral was made. Child G was allowed to go home with worsening advice provided (to phone NHS24 if necessary).

2.6 The GP phoned Child G's mother for an update and the mother reported that Child G had improved, with more wet nappies, taking syringes of water and bottles of milk. Child G had a few vomits. Child G's mother received a call back from her own Health Visitor, and everything seemed fine. Child G's mother was advised to carry on as she had been doing and to phone NHS24 if it worsened.

2.7 However, Child G's mother contacted the Health Visitor, concerned again that Child G was not feeding and was vomiting. She was awaiting a call back from the GP. The Health Visitor was unable to contact the GP for advice, so the Health Visitor phoned the Paediatric Department (Ninewells Hospital, Dundee) directly and was advised to get a direct GP assessment for Child G. The GP phoned Child G's mother and heard that Child G had deteriorated. The GP decided to refer to the Paediatric assessment unit directly as Child G had already been seen and was now worse – sleeping more, vomiting and recognised maternal anxiety and that Child G was on the Child Protection Register (CPR).

2.8 On admission to Ninewells Hospital, Dundee, Child G was assessed by a Trainee Paediatrician and was started on treatment for sepsis. Child G's blood gas was indicating Child G was significantly unwell. A timely senior paediatric review was conducted by 2 Consultants, one with a special interest in Cardiology. Child G was found to be in Supraventricular Tachycardia (SVT)1 and had an echocardiogram showing Child G's heart was structurally normal. Child G was promptly transferred to the Hospital's High Dependency Unit and treated appropriately but did not improve. Child G's parents were noted to be smelling of cannabis and it is understood that this led to a request for a urine toxicology sample from Child G to be sent for testing in Dundee. It is acknowledged that the sample was requested 'due to recognition by medical staff that Child G was not following a normal pattern'.

2.9 It was also noted by the Paediatric Registrar that Child G was on the Child Protection Register (CPR) and their Social Worker's name was available and recorded.

2.10 Child G required cardiac compressions and the Team at Ninewells Hospital, Dundee liaised directly with the Cardiology Team at the Royal Hospital for Children, Glasgow for advice. The resuscitation efforts were protracted and difficult. Child G's condition did not improve with their heart rate remaining very high. On the second day of admission, in the early hours of the morning, a urine toxicology sample was obtained and sent to the Hospital's (Dundee) biochemistry lab.

2.11 Child G was subsequently intubated, ventilated and transferred to the Paediatric Intensive Care Unit at the Royal Hospital for Children, Glasgow. Child G was critically unwell. Child G's Health Visitor was informed of this via the Perth and Kinross Social Work Service. A Doctor from the Royal Hospital for Children, Glasgow subsequently contacted the Social Worker to update that Child G was seriously ill but stable.

2.12 Child G's urine toxicology (Ninewells Hospital, Dundee) was reported as positive for Cocaine. Child G's sample was being repeated in Glasgow and this was negative for cocaine. The Consultant Paediatrician in Glasgow contacted Ninewells Hospital, Dundee staff seeking Social Work information to get further background of child protection concerns in view of the positive toxicology. Child G's second urine sample (Royal Hospital for Children, Glasgow) was confirmed as positive for cocaine. At this stage an Inter-Agency Referral Discussion (IRD) was arranged, and a Joint Child Protection Investigation instigated.

[1] Note: Supraventricular Tachycardia (SVT) is an abnormally fast heart rate caused by improper functioning of electrical system controlling heart rhythm.

Circumstances that led to the Review – Child D

3.1 The following events also took place during the COVID-19 pandemic period, albeit there remained a range of generic face-to-face contact, mixed with telephone / indirect contact.

3.2 Child D's mother's first Midwifery appointment was by telephone; followed by a face-to-face appointment where Child D's mother's health history was noted and she reported low mood and anxiety. She was advised to seek support from her GP and the Midwife referred her to the Family Nurse Partnership (FNP). At that time, it was assessed that she did not need an Unborn Baby Referral.

3.3 Antenatal scan appointments were attended. After a number of unsuccessful attempts by the Family Nurse to telephone Child D's mother, a home visit was made. The Family Nurse established that there were housing and unemployment stressors. Support for a housing application was being given.

3.4 The housing situation escalated for the family quickly, Child D's mother's employment was terminated, and she advised they would be homeless imminently. Advice was given from the Family Nurse. No unborn baby referral was made by Housing Services or from the Family Nurse Partnership service.

3.5 Child D's mother continued to engage with antenatal services at this time. The Family Nurse met with Child D's mother in her own mother's home and undertook a life history questionnaire and by this time it had already been established that Child D's mother had adverse childhood experiences. This was not undertaken for Child D's father.

3.6 At around 5 months gestation, a Midwifery Risk Assessment was undertaken, and it recognised there were ongoing issues of anxiety for Child D's mother. The risk was assessed as Normal to Low. The Family Nurse had difficulty contacting Child D's mother, but Midwife appointments were being kept. The GP was sent a 'standard mental health risk assessment'.

3.7 The Family Nurse contacted Child D's mother, who advised that she was staying at a relative's home but finding it cramped. Later Child D's mother made contact with Housing Services and was advised to 'widen their areas of choice', but Child D's mother was unable to do this, due to Child D's father's place of employment. A Housing Association Flat was proposed, but days later the couple presented to Out-of-Hours Services in need of emergency accommodation. They moved to temporary accommodation a few days later and met the Housing Support Officer (SO) within a week of being there. Child D's mother advised the SO she'd had good engagement with Health Services, including the Family Nurse and Midwife. The SO had little contact with Child D's father. Child D's mother reported that she had contact with their families and had a friend. The SO introduced a worker from a housing association and made referrals to the Welfare Benefits Team for Child D's mother's benefits. A secure offer of a permanent address was made 4 weeks after Child D's mother's first call to Housing Services, but the family did not manage to move prior to Child D's birth.

3.8 The Family Nurse contacted Child D's mother and heard of the housing situation.

3.9 A day after Child D was born, Child D's mother advised Housing of the birth and she and Child D were discharged to their temporary accommodation. Child D's mother also informed the Family Nurse. Over the next 3 days Child D's mother and Child D attended Midwifery appointments and it was reported breast feeding was going well. A Family Nurse appointment was arranged for Day 12 of life. They were seen 2 further times by the Midwife and feeding was continually reported to be going well. At the Family Nurse home visit on Day 12, Child D's weight was going up and was fully breast fed.

3.10 It was over the next days to weeks that Child D's mother reported Child D was unsettled with feeding issues and stated that Child D had constipation and was screaming. Child D's mother sent

numerous texts and made phone calls to the Family Nurse in relation to this and Child D's mother requested a home visit; Child D's mother reporting she was getting little sleep. The Family Nurse fully examined Child D and made a referral for a possible tongue tie to the Tongue Tie Clinic. It was noted at this visit that there was an atmosphere between Child D's parents. A FNP Review was arranged.

3.11 One week later, Child D's mother called NHS24 services and reported that Child D 'had a hole in their gum extending to the lip and there was blood on the bed sheets.' This phone call was initially triaged as requiring a Home Visit that evening due to Child D's parent's lack of transport. A re-triage decision overturned this and recommended that Child D be seen at Perth Royal Infirmary the following day, when the family did have transport. At this stage, Child D's mother offered an explanation that Child D did catch their gum with their nail a few days previously.

3.12 Child D was seen by an Out-of-Hours GP Trainee the following day and was found to have a tear to the upper labial frenulum. The GP Trainee (qualified Doctor training to be a GP) had taken a photo of the injury and had discussed Child D with 2 more senior colleagues. Child Protection concerns and physical abuse were not explicitly discussed or considered. There was no assessment or documentation of the cause of the injury. Child D's mother was advised to give Calpol, and worsening advice was offered. No follow up was arranged.

3.13 Child D was seen at the Outpatient Tongue Tie Clinic by a Paediatric Surgeon. No tongue tie was noted but a 3mm area of open mucosa of the labial frenulum was recorded. It is unclear whether this mucosal breach was the frenulum tear, but it was not recognised as a concerning injury or escalated as a child protection concern. Child D was discharged.

3.14 When the Family Nurse undertook a home visit the next day, she was unaware of the Out-of-Hours visit. The Tongue Tie Clinic was discussed, but the torn labial frenulum was not mentioned. Child D's unsettledness and crying was considered to be possible gastro-oesophageal reflux and a GP referral was made. When the GP saw (face-to-face) Child D, they prescribed Gaviscon.

3.15 It should be noted that at this point in time, this was the third occasion the torn labial frenulum had not been recognised / identified as a child protection concern.

3.16 Child D's mother made a second call to NHS24, as Child D had more blood in their mouth. The triaging GP did not explicitly document child protection concerns but did record that Child D was not on the Child Protection Register (CPR), that this type of injury was 'unusual to occur spontaneously' and arranged urgent face to review. Child D was reviewed by a different Out-of-Hours GP, who did not consider physical abuse as a possible cause of the injury but had concern that Child D had been very fractious and irritable and considered rare medical conditions such as an oesophageal web. The triage document did not explicitly document Child Protection concerns but did record that it is 'unusual to occur spontaneously'. On this occasion, the GP made an urgent referral to the Paediatric Department at Ninewells Hospital, Dundee.

3.17 Child D was seen in Ninewells Hospital by the General Paediatric Team Doctors. A skeletal survey and CT Brain scan were arranged and the following day the NHS Tayside Child Protection Advice Line was called to discuss this with a Child Protection Nurse Advisor. She advised the Doctor to contact the Police for an Inter-Agency Referral Discussion (IRD) and a Joint Paediatric Forensic Medical Examination (JPFME). The Doctor had already contacted Children's Social Work and an IRD was convened. The Social Worker contacted the Family Nurse regarding the IRD.

3.18 The IRD was attended by the Paediatricians looking after Child D, by the Family Nurse, Child D's Named Person in health, Police and Social Worker. There were no representatives from the Child Protection Paediatrician or the Child Protection Nurse Advisor, as this was not routine practice at that time. At the IRD, the CT scan result was available and noted to be normal, but the skeletal survey was awaited. There was a decision that no JPFME was needed as Child D had already been examined. It was shared that Child D was not previously known to Social Work or Police

Services. The explanation of causing the injury by their (Child D's) own finger was deemed plausible by the attending Paediatrician, and it was decided Child D was fit to be discharged home. Police in attendance at the IRD raised concerns about the lack of a safety plan. As a result, Child D remained in Ninewells Hospital, Dundee.

3.19 Later that day the skeletal survey was reported as showing multiple fractures, of differing ages in Child D's bones. There was a change to the safety plan for Child D to stay in Hospital. Child D's parents could offer no explanation for the injuries. A JPFME was then undertaken and concluded the injuries were consistent with Non-Accidental Injuries. Child D's parents signed a Section 25 agreement for Child D's discharge to alternative accommodation.

3.20 Whilst on the Hospital Ward in Dundee, Child D's mother fell asleep whilst holding Child D and Child D was dropped, being found in between the bed and cot. Child D sustained a red mark to the head. Child D's mother did not wake to the sounds of Child D's cry and was only alerted by Nursing staff. 2 hours later she was observed as doing this again.

3.21 Child D was discharged to Foster Carers and was to have supervised contact with the parents. A follow up IRD was held, and Police shared that a relative gave a statement that she had seen previous bruising to Child D. There was also information about cannabis use by the parents.

3.22 A Child Protection Case Conference was held, and Child D's name was placed on the Child Protection Register (CPR). A referral was made to SCRA (Children's Reporter).

Review Process – Child G and Child D

4.1 The circumstance surrounding the circumstances of both Child G and Child D were made known to Perth and Kinross Child Protection Committee (CPC). Both cases were thoroughly, but separately reviewed, by a CPC multi-agency Working Group in line with the previous national guidance - National Guidance for Child Protection Committees: Conducting Significant Case Reviews (Scottish Government: March 2015).

4.2 It was agreed by the Working Group, the CPC and the Perth and Kinross Chief Officers' Group that there was further learning to be identified and it was agreed that both cases should be reviewed jointly, in line with the then, emerging national guidance - Learning Reviews.

4.3 A Lead Reviewer and a new Multi-Agency Review Team was established. Terms of Reference for the Review were agreed. All relevant documentary evidence was examined; including service and agency records, reports and chronologies; a multi-agency chronology and CPC reports.

4.4 Key members of staff, across a range of services and agencies were also involved in this Review and actively contributed to the review process; which confirmed the circumstances in both cases; the practice and organisation learning in both cases; the effective practice in both cases and this in turn, informed the suggested strategies for change and improvement and ultimately, the Recommendations.

Practice and Organisational Learning – Child G

5.1 NHS Tayside Paediatric Medical and Nursing staff did not confidently follow the NHS Tayside Child Protection Policy for Children admitted to Hospital who are on the Child Protection Register (CPR).

There is an alert on NHS Tayside's Health database system that highlights a Child's registration status on the Child Protection Register (CPR) when they are admitted to Hospital. There is a policy to follow in these circumstances that ensures that the Child's Social Worker is informed that the child has been admitted to Hospital timeously. This was not undertaken until Child G was transferred to Glasgow, and a message was left due to the normal social worker being away. Information about Child G's admission was later communicated from the Health Visitor and parent to Social Work. Due to the delay in the urine toxicology test results being confirmed as positive, and a lack of understanding of the reason for Child G's registration on the CPR, child protection concerns were not communicated quickly enough to inter-agency colleagues. The Inter-Agency Referral Discussion (IRD) was delayed and safety planning for Child G's siblings was not undertaken in a timely way.

5.2 NHS Tayside Health Record Systems should detail the reason for a Child being on the Child Protection Register (CPR).

Child G was on the CPR, and this was evident on their Health record. This information was recognised by the Medical and Nursing Team looking after Child G in Ninewells Hospital, Dundee, but the reason for CPR registration was not recorded within the Child's EMIS health record chronology. Whilst the Doctors did consider exposure to substances as a factor in Child G's medical condition, the reason for the CPR registration may have triggered this differential diagnosis sooner and may have resulted in Child Protection procedures being taken more timely.

5.3 When considering drug exposure to babies and children in a Hospital setting, Police should be informed immediately.

There was a delay in the Police being informed of the suspicions about Child G's drug exposure and this led to unacceptable delays in Child Protection processes, and ultimately put Child G at further risk of harm.

5.4 Children admitted to Hospital with possible drug exposure should be referred to the NHS Tayside Child Protection Medical Team early to ensure Child Protection expertise feeds into the multi-agency processes e.g. Inter-Agency Referral Discussion (IRDs) in a timely way. This will also assist with liaison between Health Boards, when a child is transferred out of area (as per Out of Area Guidance).

Processes for Child G lacked co-ordination and a Single-Point-of-Contact for all professionals. There were a number of communication streams which led to key pieces of information being unavailable to members of all the multi-agency team i.e. health, police, social work. Documentation of discussions and management plans was below standard and allowed for misinterpretation of advice in the care of a critically ill child. A Single-Point-of-Contact may also have supported discussions between each Health Board area.

5.5 Recognition of disguised compliance[2] across all services and agencies will improve understanding of risk to children.

All practitioners acknowledged that Child G's family had 'disguised compliance', and this may have impacted on their assessments of the levels of substance use, and likelihood of compliance to child protection plans.

[2] *Note: Disguised Compliance is a term used where a parent, carer or family member gives the appearance of co-operating to avoid raising suspicions, to allay professional concerns and ultimately to reduce professional involvement.*

5.6 Review Processes are often duplicated across Health disciplines and services and Health Boards and would benefit from closer collaboration, sharing of learning and monitoring of recommendations. Improvement plans and improvement programmes are essential.

Reviews (including LAERs) were undertaken in silo by different disciplines and services within health, with clear learning and recommendations, but these were not consistently shared between and across different disciplines and services within health, between Health Boards, or with partner agencies, resulting in gaps in learning and development. Partners do not have access to outcomes of single agency reviews, and this could lead to loss of confidence in partners.

5.7 Feedback from Child G's Mother[3]

As part of this Review, the Lead Reviewer spoke directly to Child G's mother. Child G's mother reflected that she found the medical admission and Child Protection enquiry extremely stressful and suggested she would have benefitted from more support from all services and agencies. She highlighted a need for better communication from health staff, and that further consideration should be given to the timing of parenting capacity assessments.

5.8 Feedback from Child G's Father[4]

As part of this review, the Lead Reviewer spoke to Child G's father. He described feeling very judged by professionals throughout the process but felt that Child G's mother was equally judged despite not having anything to do with Child G's illness. He was grateful for hospital staff's care acknowledging they had saved Child G's life but at times thought communication could have been better. He would have liked to have been more aware of the risks in using substances within the home in the presence of children and babies.

Practice and Organisational Learning – Child D

6.1 NHS Tayside's Unborn Baby Protocol and the Tayside Multi-Agency Practitioner Guide: Concern for Unborn Babies, promote a standardised multi-agency approach to identifying risk to unborn babies, but these tools were not utilised successfully across key services and agencies.

There were a number of identifiable factors, including eviction and homelessness and first pregnancy, which did not trigger an unborn baby referral or unborn baby multi-agency discussion. Each practitioner, service and agency worked alone in supporting the family, thus resulting in a suboptimal risk assessment.

6.2 Practitioners within Health who are responsible for assessing young babies and children are not adequately trained in recognition of indicators of physical abuse.

Child D was seen within primary and secondary care, having sustained a serious oral injury (torn labial frenulum), a clear alerting feature of physical abuse. This physical sign was not understood or recognised. Child D was therefore not referred timeously to Child Protection services, putting Child D at risk of further serious harm.

6.3 The requirement for robust information sharing within Health Teams and disciplines is critical in the protection of children.

Ineffective information sharing, particularly within Health, led to an incomplete picture of the family, resulting in Child D not being protected from abuse. Child D's first presentation to OOH health

[3] *Note: Feedback from Child G's Mother – These are viewpoints directly expressed by the parents to the Lead Reviewer and reflect Child G's mothers' perceptions and personal opinions.*

[4] *Note: Feedback from Child G's Father – These are viewpoints directly expressed by the parents to the Lead Reviewer and reflect Child G's mothers' perceptions and personal opinions.*

services identified the torn labial frenulum, but this information did not reach the Team directly around Child D (Family Nurse), leading to further missed opportunities to protect Child D.

6.4 Professional Curiosity is integral to services ability to safeguard children.

Throughout the timeframe under review there was an over reliance on Child D's mother's self-reporting and a lack of scrutiny of her reports. Child D's mother self-reported being well, which was accepted and not revisited. There was frequent contact with Housing professionals, during which Child D's mother reported a strong support network. This was accepted at face value. Child D's mother reported that Child D had injured themself, but this was not challenged. There was also a lack of understanding of the risks that might relate to Child D's father and suboptimal efforts to gain this understanding.

6.5 Children being cared for in a Hospital setting who are subject to a Child Protection Investigation need to be adequately supervised to ensure they are not at risk of further harm.

Child D's mother fell asleep whilst holding Child D and Child D was dropped, falling between the bed and the cot sustaining a red mark to the head. There are no clear protocols or processes for supervision of a child on the ward who is involved in a Child Protection process. Nursing staff are not able to fully provide 24-hour supervision and observation of children and babies due to their clinical commitments. Social Work staff do not have capacity to provide this in-ward supervision. A robust process for in-ward supervision would prevent risk of further harm in such circumstances.

6.6 Children admitted to Hospital with injuries / possible physical abuse, should be referred to the NHS Tayside Child Protection Medical Team early to ensure Child Protection expertise feeds into the multi-agency processes such as Inter-Agency Referral Discussions (IRDs) in a timely way.

Once in the Paediatric Department at Ninewells Hospital, Dundee, Child D's injury was clearly recognised as possible physical abuse and a skeletal survey, CT scan and IRD were arranged. Despite this, no Joint Paediatric Forensic Medical Examination (JPFME) took place at this point, and it was suggested that Child D could be discharged (prior to the skeletal survey results being known). Timely referral to the Child Protection Paediatrician would have provided additional expertise to the case and likely prevented the additional risks. It would also ensure that general Paediatricians are supported in having multi-agency Child Protection discussions.

6.7 Understanding of skeletal surveys (and other medical investigations) – their remit and results – for non-medical colleagues, could support multi-agency decision making in particular around safety planning.

Skeletal surveys are radiological images of all the bones of babies. They look for occult or hidden injuries / bone fractures and can provide valuable information in assessment and likelihood of physical abuse. At Child D's IRD it was considered that Child D could be discharged before the result of the initial skeletal survey. This is incongruous with Child Protection procedures as without the results the risks are not known, and safe discharge planning cannot take place. A second survey is done at 2 weeks as rib fractures are often not seen until the healing of the fracture occurs – safety planning should take this into account. Multi-agency awareness of this will support decision making.

Effective Practice – Child G

7.1 There were robust assessments within Primary Care recognising the combination of an ill infant, maternal and other professional's anxiety and child protection registration.

Child G's mother was listened to by the GP and was seen promptly for face-to-face assessment when it was deemed Child G was not improving. There were follow up phone-calls made to ensure Child G was getting better with the treatment advised and when Child G's mother called in quick succession for further support, Child G was referred promptly for specialist paediatric assessment, recognising that infants can become critically unwell quickly. There was cognisance of Child G's Child Protection Registration and the Health Visitor and Child G's mother's concerns.

7.2 The Health Visitor's communication with Social Work informing of admission and updating on the situation was regular and effective.

Child G's Health Visitor informed Social Work of the admission to Hospital and kept up communication to keep Social Work colleagues updated on Child G's medical condition.

7.3 Paediatric Medical staff recognised the differential diagnoses of intractable SVT early and undertook appropriate investigations.

Child G's medical condition of SVT caused Child G to be critically unwell. Child G's SVT did not respond to the normal, standard treatment in a timely way. Child G's Paediatrician sought to understand this, considering what other possible factors were at play, including the possibility of poisoning. This was done in a timely way, with a urine toxicology sample being requested early and sent within 12 hours of admission.

7.4 The Health Visiting Team were in regular contact with Child G's mother and had built up a strong relationship. This led to a clear understanding of need when Child G's mother was seeking support and the Health Visitor made efforts to expedite assessment of Child G reflecting the urgency of the situation.

In the days prior to Child G's admission, there were many calls to and from Child G's mother to the Health Visitor. Child G's mother was clearly concerned for her baby and was responded to and supported with the Health Visitor attempting to get advice from Paediatrics directly when she was unable to access the GP.

7.5 Cocaine use in the family has impacted Child G's health, although the full extent of this is unknown. The family's understanding of the risks of cocaine exposure to infants and children is similarly not fully known, but it is likely that families would benefit from education around the risks in a similar way to smoking / safe sleeping education.

Where there are known concerns relating to parental substance use, the NHS Tayside's Unborn Baby Protocol and the Tayside Multi-Agency Practitioner Guide: Concern for Unborn Babies are useful tools in terms of identifying and sharing concerns for unborn babies pre-birth, which then allows for these concerns to be explored further after birth. It would be helpful if staff across all partner agencies, highlighted and discussed these concerns with parents and families and having done so, ensured this was recorded in case notes and proportionately shared between partner agencies.

7.6 A Learning from Adverse Events Review (LAER) was carried out into the circumstances surrounding Child G which identified learning and made recommendations for improvement.

NHS Tayside Learning from Adverse Events Review (LAER) was undertaken following these events, jointly led by NHS Tayside Health Visiting and Midwifery Services. A number of recommendations were made and shared with multi-disciplinary health practitioners.

Effective Practice – Child D

8.1 There were examples of effective professional challenge that enhanced safety planning for Child D.

At the IRD it was advised / assessed that Child D could be discharged home. Police representative challenged this effectively, advising concern about the lack of additional safety measures. This led to a more robust safety plan being implemented.

8.2 The triaging Out-of-Hours Doctor clearly understood that a torn labial frenulum was a child protection concern and appropriately arranged urgent face-to-face review.

The GP who spoke to Child D's mother documented that Child D was not on the Child Protection Register (CPR), and that infants of this age do not sustain frenulum tears spontaneously. They arranged for Child D to be seen face-to-face. From this documentation and action it is concluded that this Doctor clearly grasped the child protection issues. Although the GP went on to examine Child D, they did not consider child protection concerns, but they did refer Child D to Paediatrics for further assessment.

8.3 Once significant concerns were identified within Primary Care, Child D was timeously referred for further assessment and Social Work were informed quickly.

The second Out-of-Hours GP recognised bleeding from the mouth as a significant concern and referred Child D immediately for Paediatric assessment. The Doctors (the Registrar and the Consultant) in Ninewells Hospital, Dundee, contacted Social Work quickly to raise child protection concerns and arranged appropriate investigations (CT head scan and skeletal survey).

8.4 Housing Service professionals supported the family regularly through telephone contact and made significant efforts to rehouse them.

The Housing Service were in contact with Child D's mother and had made efforts to find appropriate accommodation, once the family were homeless. Child D was born whilst this process was underway and they remained in contact over this time, endeavouring to have a home for the family, once Child D and mother were discharged. They had undertaken detailed assessments of risk and were aware of the parental past vulnerabilities, such as the breakdown between Child D's mother and her own mother.

Suggested Strategies for Improving Practice and Systems – Child G (Including Recommendations)

8.1 Within NHS Tayside, there is a wide range of child protection policies, procedures and guidance, to support and empower staff, across all health disciplines and services. This includes guidance on children and young people who are on the Child Protection Register (CPR) who are admitted to a hospital setting. How widely available, accessible and understood this is by staff can be a challenge, given the volume of guidance and their busy roles. Whilst it is important that these publications are regularly reviewed, refreshed and quality assured, it is equally important that staff are aware of them, know where and when to access them and comply with them.

Recommendation 1

NHS Tayside should review their current wide range of child protection policies, procedures and guidance and where possible, rationalise them, to ensure that it is readily available, accessible and is understood by all staff across all NHS Tayside disciplines and services, including primary and acute services. Regular quality assurance exercises,

including staff surveys and audit reports should be carried out to ensure both understanding and compliance.

Recommendation 2

NHS Tayside should ensure that they have in place guidance on the Child Protection Register (CPR), which should include guidance on the areas of concern / risk coming into place on 1 August 2023 and they should ensure this information is made readily available, accessible and understood by all staff, particularly when babies, children and young people are admitted to primary, acute and / or hospital settings.

8.2 In circumstances where there is a "suspicion of poisoning", particularly from controlled substances, guidance should be developed, or included in current guidance, which requires health practitioners to share and discuss these concerns quickly with the NHS Tayside Child Protection Team and when appropriate, with the Police Scotland.

Recommendation 3

NHS Tayside should develop or include guidance on "Suspicion of Poisoning" for all health practitioners which ensures that such a concern is shared quickly with the NHS Tayside Child Protection Team and when appropriate, with Police Scotland.

8.3 Parental substance use was a feature in Child G's critical illness. A Public Health Basic Awareness and Understanding Campaign on such risks should be considered by NHS Scotland and / or NHS Tayside.

Recommendation 4

NHS Scotland and / or NHS Tayside should develop a public health basic awareness and understanding campaign of the dangers and risks of parental substance use to babies, children and young people.

8.4 There is a need to ensure the robust use of Out-of-Area Guidance when transferring a baby, child or young person to another Health Board area, particularly where there are child protection concerns. This should include the need for consideration of a Single-Point-of-Contact when the baby, child or young person is transferred out of area to keep all services and agencies involved up to date with clinical and child protection progress.

Recommendation 5

NHS Tayside should ensure they have in place robust guidance when a baby, child or young person is transferred to another Health Board area where there are child protection concerns and should consider appointing a Single-Point-of-Contact to ensure good information sharing between all relevant partner services and agencies involved with the baby, child or young person.

8.5 There is a need to ensure that disguised compliance is fully understood across all services and agencies, including health services and that this is included as a theme in all single and multi-agency child protection learning and development opportunities.

Recommendation 6

NHS Tayside should ensure that all staff are alert to disguised compliance, that it is included in key child protection guidance and supported by staff learning and development opportunities.

Recommendation 7

Perth and Kinross CPC should ensure that disguised compliance is included in key inter-agency child protection staff learning and development opportunities.

8.6 Learning from single agency and multi-agency Review processes, including NHS LAERs, is an effective part of a developing and improving child protection service. Such Reviews, not only need to be coordinated, but the findings and recommendations need to be shared with all health disciplines and services, with relevant Health Boards and more importantly, with partner services, agencies and CPCs, if lessons are to be learned and practice is to be improved.

Recommendation 8

Perth and Kinross CPC and partners, working together with key services and agencies, in particular with NHS Tayside, should ensure that all single service and agency Review processes are coordinated and that the findings and recommendations are shared timeously with CPC partners and relevant others, to ensure learning and practice improvement.

Suggested Strategies for Improving Practice and Systems – Child D (Including Recommendations)

9.1 There is a need to ensure that the NHS Tayside Unborn Baby Protocol and the Tayside Multi-Agency Practitioner Guide: Concern for Unborn Babies are embedded into day-to-day practice.

Recommendation 9

NHS Tayside and Partners should consider multi-agency training to ensure that understanding of the NHS Tayside Unborn Baby Protocol Protocols and other single agency protocols are clear and robust.

Recommendation 10

Perth and Kinross CPC should ensure that the Tayside Multi-Agency Practitioner Guide: Concern for Unborn Babies is disseminated widely and understood across all services and agencies.

9.2 All Clinicians (including GPs) who are working with young children should have undertaken Level 3 Child Protection Training, in accordance with the Intercollegiate Document 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff'. This is available in NHS Tayside via Learnpro. There is also an NHS Tayside Child Protection Training Programme, but individual Clinicians working for the Health Board are not fully aware of this and robust appraisal of staff's skills and competencies is lacking. At present, there is no statutory mechanism to ensure staff groups are adequately trained.

Recommendation 11

NHS Tayside should review their Child Protection Training Programme, alongside consideration of available NHS Education Scotland resources, and ensure regular robust assurance and audit processes to monitor compliance.

Recommendation 12

NHS Tayside and Primary Care should take the opportunity to explore how existing resources within NHS Tayside Child Protection Team to support Primary Care and their Child Protection Training Programmes, disseminate key messages and 5 or 7 minute briefings (for example) and provide professional support for child protection issues to GP colleagues.

Recommendation 13

NHS Tayside Primary Care Services should develop a Strategy to promote Child Protection Training and embed training within all Tayside GP Practices and the Out of Hours Service. This strategy should include a reporting mechanism to assure the Health Board that all GPs have the recommended level of training.

Recommendation 14

NHS Education Scotland should integrate Child Safeguarding Training Recommendations into the Scottish Online Appraisal Resource (SOAR) for GPs and all relevant Appraisal processes.

Recommendation 15

NHS Tayside Medical (All Paediatric Specialties) and Nursing staff should be adequately trained in recognition and response of Physical Abuse and other aspects of Child Abuse and Neglect. Service Leads should have processes in place to ensure their staff have undertaken the relevant training and be able to report on this.

9.3 All NHS Tayside disciplines and services need to ensure there are effective, robust processes of information sharing.

Recommendation 16

NHS Tayside should ensure that all referrals made within antenatal services should be passed to Family Nurse Partnership / Health Visiting Services to allow follow up of outcomes. Services not taken up should have systems to clearly communicate back to the referrer.

Recommendation 17

NHS Tayside Out-of-Hours Services (hosted by Angus Integration Joint Board) should review their information sharing processes and consider alerting systems for infants / non ambulant babies presenting with injury. It is suggested that NHS Tayside Out-of-Hours Services (hosted by Angus Integration Joint Board) highlight any injury in a non-mobile infant (regardless of assessment outcome) to the NHS Tayside Child Protection Team the following day – this could be achieved through a Reporting Proforma.

9.4 There is a need for Professional Curiosity, with an additional focus on fathers to be embedded in al Child Protection Training, particularly inter-agency child protection training.

Recommendation 18

Perth and Kinross CPC should ensure that current inter-agency training programmes are reviewed to ensure inclusion of the Professional Curiosity themes. Post-course evaluation should be undertaken to ensure the specific learning is effective and successful.

Recommendation 19

Perth and Kinross CPC and partner agencies should ensure 5 or 7 Minute Briefings on Professional Curiosity are made available as a part of agency Induction Programmes to introduce this concept to new employees.

9.5 There is a need for robust supervision of children in Hospital settings who are subject to Child Protection Investigations.

Recommendation 20

Perth and Kinross CPC should ensure that there are clear protocols in place for the supervision of babies and children in hospital settings who may have been abused or

neglected. A multi-agency policy on the Supervision of Children / Babies admitted to Hospital for Child Protection Investigations is strongly recommended.

9.6 Early referral to the Child Protection Medical Team / Paediatrician of children on the Ward would support General Paediatricians working in child protection and add expertise to multi-agency discussions, including Inter-Agency Referral Discussions (IRDs).

Recommendation 21

NHS Tayside should consider revision of their existing protocols to include early discussion with the Medical Child Protection Team, when there is a baby or child admitted to hospital and where there are child protection concerns. Such discussions could include advice for attending IRD.

9.7 There is a need for better understanding on the role of medical investigations such as skeletal surveys for non-medical colleagues who are involved in child protection investigations.

Recommendation 22

NHS Tayside, in partnership with Perth and Kinross CPC, should develop Guidance on Skeletal Surveys for Multi-Agency Teams, to augment understanding of the role of Skeletal Survey in planning processes.