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SIGNIFICANT CASE REVIEW, FAMILY Z

EXECUTIVE SUMMARY

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FOREWORD

The Significant Case Review (SCR) report for Family Z was accepted by the Child Protection Committee (CPC) and Chief Officers Group (COG) in October 2016. As well as presenting the findings from the case review, this executive summary provides information about the progress that has been made in addressing these findings and about ongoing work between partners to embed excellent practice which identifies concerns early; responds timeously and proportionately; and always promotes the health, wellbeing and safety of all children and young people.

As well as identifying several areas of good practice, such staff persistence in establishing positive relationships with the family and attempting to identify supports in order to achieve best outcomes for all of the children, the SCR also highlighted 10 areas of concern for both the CPC and Getting It Right for Every Child (GIRFEC) partners. These findings were reflective of areas for improvement which had been identified within the Joint Inspection of Services for Children and Young People, published in March 2016. Each finding was supported by a number of more detailed questions for the CPC to consider in responding to the review. The CPC and COG recognised that strong leadership support and challenge would be critical in supporting the development and implementation of the improvement actions associated with the SCR findings and GIRFEC in general. Members of both committees approved the final action plan in April 2017 and have maintained oversight of developments on a routine basis. The Children and Families Executive Board has also provided consistent leadership.

Over the last 3 years significant progress has been made in addressing the findings from the review. In the same period there have been a range of changes to models of service delivery and investment in target improvement activities. In partnership with the Centre of Excellence for Looked After Children (CELCIS), partners are implementing an Addressing Neglect Enhancing Wellbeing (ANEW) programme which aims to build capacity, competence and confidence amongst Named Person. In 2018 the COG established a Transforming Public Protection Programme, supported by the Care Inspectorate, to provide renewed emphasis, leadership and support for a range of practice, leadership and service improvements across the Protecting People agenda. All of these developments provide assurance that the findings from the review have been, and continue to be addressed, by multi-agency partners.

This executive summary contains the findings of the Significant Case Review in relation to Family Z. This executive summary has not been published previously as the case was subject the subject of criminal proceedings. In the interests of transparency every effort has been made to disclose as much of the SCR as is lawfully possible. However, all personal information which is disclosed must be shared lawfully and in accordance with the General Data Protection Regulations (GDPR) and the Data Protection Act 2018 (DPA). Although there has been media coverage of this case, and consequently a certain amount of personal data and special category personal data is publicly available, disclosure of personal data contained within this report must still comply with data protection legislation. For this reason details such as names, dates of birth and other personal identifiers have not been included in this executive summary. In addition other personal information has been redacted as disclosure of this information cannot be justified in law. This means that even though some of the withheld information may already be publicly available, or it may be considered to be in the public interest to disclose, it cannot be disclosed because the relevant conditions under data protection legislation have not been met.

The process of redacting the SCR has involved careful consideration of:

- The need for transparency and the overall purpose of the SCR in identifying learning.
- The provisions of the GDPR and the DPA and the statutory bases for sharing information.
- The public interest in disclosure, and in particular the public interesting in ensuring that the relevant agencies work together effectively in assessing risks and taking action where necessary to manage those risk and protect children.
- Whether information is sensitive personal data (for example, because it is information about a person's physical or mental health) and whether inclusion in the SCR complies with data protection legislation.

The executive summary of the SCR follows but with certain text redacted for the reasons set out above. Any redactions are clearly marked. Some minor grammatical changes have been made (unflagged) to maintain consistency of language following some redactions.

Norma Ritchie

Independent Chair, Dundee Child Protection Committee

1 INTRODUCTION

1.1 SUCCINCT SUMMARY OF THE CASE

1.1.1 Family Z had been involved with child wellbeing and protection systems for a period of just over 5 years. The children within the family were cared for by a number of adult family members across multiple households. Two of the children within the family have complex additional support needs. From early 2014 there were increasing concerns about the welfare of the eldest child in the family due to historic patterns of neglect and non-engagement with services re-occurring. The children were allocated within Social Work during 2014, with the Social Work Team Manager describing the case as one of 'chronic neglect'.

1.1.2 In [redacted] 2014 a new child was born into the family. The involvement of the child's father, along with support from social work, school and health services, was considered adequate to keep the child safe. Concerns regarding neglect and non-engagement for the eldest child continued to increase in frequency and severity into the summer of 2015. As a result, a decision was made to refer this child to the Scottish Children's Reporter Administration (SCRA), which subsequently led to the child being accommodated.

1.1.3 In the summer of 2015, a breakdown in family relationships led to a period of significant deterioration in the care of the children who had remained with their family and in their adult carer's ability and willingness to engage with support being offered by a range of services. Later that year, a decision was made to refer these children to SCRA due to ongoing neglect and non-engagement. Within a day of this decision, the youngest child had been admitted to hospital with a significant [redacted]-injury and Child Protection Orders were granted for the child and their siblings.

1.2 WHY WAS THIS CASE CHOSEN TO BE REVIEWED?

1.2.1 The [redacted]-injury to the youngest child prompted the consideration of the case under local Significant Case Review (SCR) procedures. The process of undertaking the Initial Case Review Report uncovered a range of information regarding a pattern of chronic neglect within the family over a number of years. The decision to proceed to an SCR was therefore made in relation to the significant harm sustained by the children in relation to neglect which led up to the incident in late 2015, rather than in relation to circumstances surrounding the injury itself.

1.2.2 Dundee Child Protection Committee (CPC) agreed to conduct a Significant Case Review (SCR) in relation to Family Z in January 2016. This was endorsed by the Chief Officer Group (COG) in February 2016.

1.2.3 Permission was secured from the Senior Investigating Officer (SIO) and latterly the Crown Office and Procurator Fiscals Service (COPFS) for the SCR to proceed on the basis that there would be no family involvement in the process other than to inform them that the SCR was to take place.

1.3 METHODOLOGY

1.3.1 Learning Together reviews take a systems approach to understanding the current practice realities for agencies as they work together to protect children and to identifying learning about what is working well and where there are difficulties. The aim of such reviews is to use the review and analysis of practice in a single case (i.e. what happened and why) to gain insight into underlying patterns that either support good practice or make poor practice more likely. Learning Together reviews therefore aim to produce generic or generalisable findings or lessons that will support learning and improvement across the multi-agency child protection system as a whole. Further detail regarding the approach can be accessed at: http://www.scie.org.uk/children/learningtogether/

1.3.2 The Lead Reviewers were supported by a Review Team comprising of 8 senior managers from the agencies that had been involved with the children and their family. None of the review team members had decision making or line management / supervision responsibilities in relation to the case being reviewed.

1.3.3 The individual practitioners who were directly involved in working with the children and their family at the time played a vital role in providing qualitative data for the review through individual conversations and facilitated group discussions.

1.3.4 The fact that family members were unable to participate in the review process was a significant limitation on this review. The absence of the perspectives of a range of family members regarding their experience of working with services, what they had found helpful and what they found created barriers and challenges to working together with agencies to keep the children safe, has made it difficult to address questions focused on whole family approaches to assessment and service delivery (see 1.4.2).

1.4 REVIEW SCOPE AND RESEARCH QUESTIONS

1.4.1 The period covered by the SCR begins in February 2014 and ends in late 2015. Learning Together Reviews focus on recent time periods in order to support the aim that systems findings and learning are relevant in the present day. In this review the CPC agreed two broad research questions with the Lead Reviewers. These were:

1. How easily do staff recognise and respond to neglect within families?

2. How well do practitioners apply a whole family approach when assessing needs and providing services to children and families?

2 REVIEW FINDINGS

2.1 WHAT IS IT ABOUT THIS CASE THAT MAKES IT ACT AS A WINDOW ON PRACTICE MORE WIDELY?

2.1.1 The review process explored the unique interactions that took place between practitioners and the family, and within the group of practitioners involved, at the time. However, there are some elements of this that are likely to be common to other cases within local child wellbeing and protection processes.

2.1.2 In undertaking this review the review team were left with a strong sense of the commitment the group of practitioners involved had to working with the family, despite the significant complexities and challenges this involved, to maintain engagement, improve outcomes for the children and attempt to support them to stay within their family setting. Whilst there are important areas of learning, described in the findings section of this report, there were also numerous examples of good practice by the practitioners involved. These included:

- Evidence of good communication and collaboration between some of the practitioners involved, which enabled very good information sharing.
- There was evidence of a supportive working relationship between some staff and their managers.
- Efforts made by staff to mitigate against the impact of changing staff in order that the positive relationship between the service and the family were not lost.
- A range of practitioners demonstrated significant persistence in establishing and maintaining positive relationships with the family despite very challenging circumstances.
- Practitioners were persistent in their attempt to identify supports for the family in order to achieve the best outcomes for all the children.
- The Multi-agency Screening Hub (MASH) set-up allowed for quick and easy access to key information from across core agencies involved with the family, which supported appropriate assessment of levels of risk and concern.

2.1.3 This case is interesting because it identified the ways in which management systems can struggle to adequately support practitioners as they strive to meet the significant challenge of identifying and responding to the complex issue of neglect. It also provides an insight into the way in which communication and collaboration between practitioners, working together over extended periods of time, can act to support or prevent effective interventions with children and their wider families.

2.1.4 This case also demonstrates that, where a single sibling group have differing underlying support needs and are being cared for through complex family arrangements, child protection and wellbeing systems can operate in a way that leads practitioners to focus on the child considered to be at the greatest risk of harm, leaving others in the family group less visible and less well protected.

FINDING 1

In Dundee there is not yet an embedded culture of multi-agency responsibility and professional challenge within child wellbeing and protection processes, this has led to an over reliance on case holding Social Workers to lead and direct multi-agency processes.

How did the issue manifest in this case?

During the course of the review, the review team were struck by the continuing dominance of social work in leading and directing decision making and a lack of robust professional challenge from other agencies, as well as a reliance on the case holding Social Worker to take responsibility for almost all aspects of communication, information sharing and practical tasks.

What are the implications for the reliability of the multi-agency child protection system?

Collaborative working, within a wider framework of different professional responsibilities and competencies, is a crucial element of a reliable child wellbeing and protection system. Equally, a culture of pro-active information sharing by all practitioners, within the framework of data protection and human rights legislation, is critical. In a context of reducing resources it is imperative that each practitioner involved is enabled to contribute to the fullest extent possible in order to maximise the positive impact on children and families. Where this does not happen the burden of responsibility and activity will fall too heavily on specific practitioners, and critically can act as a distraction from their professional duties and responsibilities.

A safe child protection system is more likely to develop from a culture of ongoing professional debate and challenge. Where there is a dominant agency within multi-agency child protection processes and insufficient opportunity / willingness for critical thinking and challenge, there is a significant risk that their view about the right course of action to take will persist despite dissent amongst others involved. In this context it is imperative that all practitioners recognise that it is part of their professional responsibility to challenge, and have access to appropriate, transparent mechanisms through which to do so.

What has changed since October 2016?

Multi-agency partners have developed and rolled out an extensive programme of staff training which covers issues associated with identifying, assessing and responding to concerns, including where parents or carers are unwilling or unable to cooperate. An initial programme of workshops ran between March and June 2018, with 550 places available across the multi-agency workforce. An open education learning resources was launched in February 2018 and during 2018/19 there were over 1,200 completions of child protection e-learning modules. In addition, a specific course has been developed for people who volunteer across public and third sector services to enable them to better understand their child protection responsibilities and participate in child protection processes. The full range of multi-agency training continues to be available to teams via the Protecting People website.

A Child Protection Practitioner Forum was established in November 2016 and has convened regularly to engage with the multi-agency workforce in relation to the development of practice, procedures and strategy. Subjects covered include the interface with SCRA (Scottish Children's Reporters Administration) and core responsibilities and expectations relating to the child protection process. Most

recently, the focus of the forum has been on the development of inter-agency child protection instructions and the roll out of these across the city.

An audit of 14 child protection and Looked After Children cases completed in May 2018 found that areas of particular strength included both the speed and effectiveness of responses, involving the appropriate agencies, multi-agency working and communication, and involving family members. In 13 cases, readers located plans providing direction to staff to address the needs of the child / young person. 11 of the 13 cases were assessed as containing an appropriate level of collaborative partnership working in implementing the plan for the child.

In addition, the revision of the multi-agency Child Protection instructions has included specific content relating to the escalation of dissent. A range of activities have been undertaken to promote the revised instructions to the multi-agency workforce.

FINDING 2

In Dundee there is a lack of clarity across the Children's Services Partnership regarding the nature of risk in neglect cases, which results in the application of higher thresholds for referral compared to other forms of abuse.

How did the issue manifest in this case?

The Team Around The Child (TATC) meetings for the children involved a number of practitioners who should have considered the increasing risk and escalated the children, in particular the eldest child, into child protection procedures. Escalation into child protection processes as an interim step would have provided a structured / formal opportunity to ensure that a clear multi-agency plan and expectations were in place, fully understood by the family, and supported by agencies. It was also known / knowable that involvement in child protection processes had proven to be effective historically in significantly improving the situation for the children. In conversations with practitioners, they expressed the view that escalation into child protection processes was not taken forward because they considered that there was no immediate risk of physical harm to the children. Some practitioners felt that escalation into child protection procedures would not change anything as the type and intensity of intervention would not change, whilst others expressed doubt around their judgement about the level of risk the children were at.

What are the implications for the reliability of the multi-agency child protection system?

If there is a problem around the recognition of the true nature of risk in neglect cases across the range of multi-agency partners, including those who have the greatest level of contact with children and their families, such as health visitors, schools, nurseries, support services etc, children who are living in chronic and neglectful situations may continue to live in these circumstances for longer than is necessary.

What has changed since October 2016?

In partnership with the Centre of Excellence for Looked After Children (CELCIS), partners are implementing the Addressing Neglect and Enhancing Wellbeing (ANEW) programme, which has three strands: support for named persons, family engagement through the buddy system and more effective access to services through a Fast Online Referral Tracking (FORT) system. The approach is receiving positive responses from professionals and families, particularly in one primary school where the work has reached the stage where all children who were part of the ANEW style of Team Around the Child meeting maintained or reduced their level of need.

ANEW focuses on early intervention and has developed an early concerns sheet to be filled in periodically to track what kinds of concerns arise in a typical week. The form has been tested over two weeks in one primary school, where it immediately led to improved information sharing between senior school staff and an increase in recording on central systems of concerns which may have otherwise been left unrecorded. School staff reflected that the daily end of day conversation was more focused and that joint reflection about the needs of children allowed clearer understanding and agreement of what was to be recorded where so that it could be referred to in future if need be. They further said that it brought attention to a larger number of children where early intervention may prove effective but where the lack of urgency for intervention, such as in ongoing neglect cases, may have led to them

being overlooked otherwise. Following this success, the form will be used for two weeks per term across school and nursery ANEW sites and a slightly amended form will be tested by health visitors after the 2019 summer holidays to allow a similar level of reflection and recording following home visits.

The audit of child protection and Looked After Children cases completed in May 2018 found that overall, services were rated positively in relation to recognising when children / young people and their families needed to receive additional support at an early stage to prevent difficulties arising or escalating. 7 out of 8 cases were rated as 'good' or better and 1 as 'adequate'. The timeliness and effectiveness of early support provided by services was also rated very positively, with 7 out of 8 cases being rated as 'good' or better and 1 as 'adequate'. The audit also found that all cases contained an assessment of risk for the child / young person. Overall the quality of these assessments were rated positively, with 9 cases being rated 'good or better'. All 14 files also contained as assessment of needs for the child / young person, with 10 of these being rated as 'good or better'.

FINDING 3

The way in which Dundee's Children's Services Partnership has interpreted the proposed statutory duties under the Children & Young People (Scotland) Act has inadvertently created a culture amongst practitioners to focus on individual children outwith their family context, which is not being consistently picked up in quality assurance and supervision processes.

How did the issue manifest in this case?

The practitioners involved in this case, in implementing the principles of GIRFEC often operated in a culture that focused on the individual children, with a lack of focus on working with the whole family. The situation was compounded by the complexities surrounding the family. Practitioners focused on the eldest child, for whom there was the most significant level of concern, and therefore consideration was not given to inviting practitioners primarily involved with their siblings to TATC meetings or asking them to provide relevant written input. A number of opportunities were missed at key decision making points, to consider the issues for the family as a whole.

What are the implications for the reliability of the multi-agency child protection system?

Cases that are complex in nature often involve a considerable number of professionals involved with the whole family. If risks associated with one child within the family are not shared with professionals involved with the whole family, then there is the potential that decision making will be compromised as well as child protection risks not being recognised and acted upon. Different practitioners may be involved with other children in the same family, particular for those families where there are complex living arrangements. It is important that this information is shared with all professionals involved with all children in the family in order to ensure that all assessments and child's plans are reflective of the current circumstances and potential risk factors. It is not necessary that all professionals involved with all children in the family are invited to the TATC meetings, but the Named Person (and in some cases Lead Professional) must ensure that appropriate information is shared with the relevant professionals connected to other children. The TATC should also consider how relevant information from professionals involved with other children in the family can be obtained.

What has changed since October 2016?

The programme of multi-agency staff training, described in more detail at finding 1, has also included a focus on assessing and responding to the risks and needs of individual children within their wider family context. The Introduction to Child Protection course was also revised to reinforce that where concerns are identified for a one child within a family attention must also be given to any potential risks to other children within the family.

Partners considered re-framing Team Around the Child processes to Team Around the Family within the wider context of the legislative requirement in UK law and the UNCRC to view the needs of children and young people as paramount. On this basis, TATC remains in place but with an emphasis on the needs of parents/carers as being a key part of assessments and support. This is also consistent with the approach of the ANEW programme, which pro-actively engages with parents through the buddy system and their full involvement in meetings on their child. In good examples of practice, Team Around the Child meetings for sibling groups are held consecutively. This means that family and professionals only need to attend one appointment but different buddies can support children to voice their views and each child receives their own child's plan. In one example this was observed for a family with twins where different

buddies and professionals were involved resulting in separate and quite different plans for the two children, reflecting their very different needs.

TATC procedures have been updated to reflect the learning from the significant case review relating to assessing children and young people within a family context. Revised multi-agency child protection instructions were approved in August 2018; these instructions also incorporate learning from this case review. In addition, guidance has been issued across the multi-agency workforce to support enhanced understanding and practice in relation to information sharing about children and young people, within the context of recent changes to data protection legislation. This is currently being updated to also provide guidance regarding information sharing relating to adults at risk.

FINDING 4

Chronologies to help practitioners understand and appraise the nature and level of risk are not being used well enough, or at all, which is of particular concern in neglect cases where abuse often occurs over periods of time.

How did the issue manifest in this case?

In the course of reviewing the case the review team identified that at no point had a single or multi-agency chronology of sufficient quality been compiled to support practitioners to understand and appraise the developing nature and level of risk to the children. This was particularly critical in relation to helping the practitioners involved during the review period understand the historic involvement of multiple agencies with the family since 2010.

The absence of any chronology of a sufficient quality in this case was a significant barrier to all of the practitioners involved being able to make a properly informed assessment of the nature and level of risk to all of the children in the case. Whilst the detail of concerns and interventions were recorded on agency IT systems these had never been compiled into single or multi agency chronologies of a sufficient quality and level of detail that would allow practitioners involved to see the current concerns within their historical context and identify recurring patterns. The task of compiling such chronologies was not prioritised by any practitioner within the case group within the wider context of the multiple demands placed on them and the resources available.

What are the implications for the reliability of the multi-agency child protection system?

Good quality single and multi-agency chronologies are critical in helping practitioners to understand and assess the nature and level of risk to children and young people. They are a vital first step in the assessment and planning process within safe and reliable child protection systems. This is particularly important in relation to neglect, where risks and concerns are related to ongoing patterns rather than individual incidents of abuse. Chronologies are also a critical tool for enabling communication of key information about significant events in a child's, and their wider family's life, within and between agencies. This is particularly important at points of transition. This can include helping practitioners to identify patterns across family groups that affect more than one child (see finding 3).

What has changed since October 2016?

A Tayside assessment and chronology group has developed a consistent framework and guidance for the use of chronologies. This has now been disseminated across the three local authority areas in Tayside and has been well received by practitioners. Work is ongoing to monitor the impact of this guidance on practice through audit activity.

The May 2018 audit of child protection and Looked After Children cases found that further work is required to improve practice in relation to chronologies; both in relation to their completion and also their quality. The findings of the audit were reported to the CPC Meeting in February 2019 and an action plan to address key areas for improvement has been developed by Operational Managers. This includes a focused improvement programme designed to ensure that appropriate chronologies are in place in at least 90% of cases. It is leading to significant improvements in the rates of chronology completion. This includes chronologies for children who are "looked after" and/or children whose names are on the Child

Protection Register, but also children who are at the earlier stages of intervention via GIRFEC procedures.

Additional work is being undertaken to improve the quality of chronologies as part of the Transforming Public Protection Programme. An operational team from the Children and Families Service is working, with support from the Care Inspectorate and Improvement Service, to achieve the aim of 95% of chronologies started for new current cases being rated as good or better using an agreed audit tool. As part of this work the team are developing exemplar chronologies to supplement existing templates and guidance. Learning from the team will be rolled out to practice teams across Children and Families, Health and Social Care and other partner agencies as part of the Transformation Programme.

FINDING 5

Supervision and management systems across the Children's Services Partnership are struggling to balance quality of practice with process, which risks making the child's journey speedy rather than appropriately considered.

How did the issue manifest in this case?

Throughout this case, assessments and visits were undertaken as required and generally within the specified timescales. However, given the high volumes of case work, they were frequently of an insufficient quality, missing out on key risk factors and opportunities to intervene. This suggested that the emphasis on timeliness of the assessment was the main focus with the quality falling below the expected level of assessment and analysis.

What are the implications for the reliability of the multi-agency child protection system?

Effective and proactive decision making and case management in complex cases of neglect is clearly associated with improved outcomes for children (Farmer and Lutman, 2012). Research demonstrates that the majority of cases are consistently not well managed and can result in children suffering repeated neglect despite ongoing child protection work (Davies and Ward, 2012). Ensuring effective case management relies on effective assessment and the development of quality plans.

Although a degree of focus needs to be placed on timescales as cases could drift within the system, the focus needs to be balanced with the quality of the assessment. Some assessments may require more time for their completion, particularly where information relevant to the assessment is hard to come by. However, where limited consideration is placed on the quality of the assessment, in order to ensure timescales are met, this can be detrimental to the standard of the assessment. This could result in vulnerable families not getting the level of support they require, with children suffering repeated abuse. Supervision should support practitioners through this process.

What has changed since October 2016?

NHS Tayside has embedded processes to ensure that Health Visitors, Family Nurses and School Nurses receive supervision at least 4 times per annum. In Social Work supervision encourages reflective discussion and challenge to support decision making and identify areas for learning and development. This approach is now being extended to Support Workers located within Education Services.

Support to Named Persons is one strand of the ANEW programme and is now embedded with the GIRFEC Delivery Group. A Named Person Practice Profile (to be finalised in time for August 2019 school start) has been developed which allows named persons to understand what good practice looks like and for colleagues to be able to train, coach and mentor named persons to that standard. Appropriate roles for coaches and mentors have to be identified but small tests including peer observation and supportive feedback have been shown to be effective in a first pilot site.

As part of the Transforming Public Protection Programme a group of operational managers drawn from Children and Families Service and the Health and Social Care Partnership are working together with the aim of ensuring that all supervisions take place as agreed within individual supervision agreements and follow a consistent good practice format. Learning from this work will be shared across all partner

agencies as part of the Transforming Public Protection Programme.

The audit of child protection and Looked After Children cases completed in May 2018 found that in 12 out of the 14 case files there was evidence that the lead professional / named person had opportunities to discuss their work with a supervisor, manager or other appropriate staff member.

The audit also found that all cases contained an assessment of risk for the child / young person. Overall the quality of these assessments were rated positively, with 9 cases being rated 'good or better'. All 14 files also contained as assessment of needs for the child / young person, with 10 of these being rated as 'good or better'. However, outstanding areas for improvement were identified in relation to the quality of children's plans, including ensuring plans are SMART (specific, measurable, achievable, realistic and time-bound). The action plan in response to the audit contains actions targeted to ensure that 90% of audited child's plans meet Care Inspectorate standards, including reviewing planning formats and guidance, ensuring IT systems reflect these and enhancing regular quality assurance mechanisms and reporting for children's plans.

FINDING 6

There is a tendency in Dundee for practitioners to assume the outcome of Children's Hearings in neglect cases, rather than follow procedures, with the result that children can become inadequately protected in family placements.

How did the issue manifest in this case?

There were a number of opportunities within this case where concerns were not escalated through a referral to the Reporter because practitioners involved perceived that the referral would not be further investigated by the Reporter or a Hearing would not impose compulsory measures. There were a variety of factors that influenced the fact that escalation was not considered, in particular the perception amongst practitioners that the evidence they had available would not be sufficient to meet the criteria they perceive is applied by the Reporter and the Children's Panel. Specifically, there was a perception that a referral would not be further investigated due to the level of engagement the family had demonstrated on a voluntary basis. Practitioners' experience also led them to believe that a more detailed level of evidence of the impact of neglect is expected compared to physical abuse before the Panel at the Children's Hearings will consider compulsory measures.

What are the implications for the reliability of the multi-agency child protection system?

There are numerous grounds on which a child may have to be referred to a Children's Hearing, which are set out in 67(2) of the Children's Hearing, (Scotland) Act 2011. If practitioners are not presenting information through a referral to the Reporter on the perception that the referral will not be accepted or a Hearing will not impose compulsory measures, then children may be left in situations of risk for too long and practitioners create a new standard / threshold that is not in line with legislation.

What has changed since October 2016?

In July 2018 the Independent Chair of the Child Protection Committee and Area Convenor of Children's Hearings Scotland (CHS) progressed discussions which provided assurance regarding the initial and thereafter ongoing training offered to Panel members on the issue of neglect. Assurance was also provided regarding the performance monitoring and quality assurance activities undertaken by CHS that contribute to their understanding of how Panel's respond to neglect cases.

Dundee Children and Families service has actively collaborated with SCRA and with panel members on a number of initiatives. These include:

- The Better Hearings agenda where the current focus is on a review of Hearing reports.
- Regular meetings between Children and Families Service senior management and the Locality Reporter Manager are now embedded into the culture of communication between the two organisations.
- A Senior Manager from Children and Families now regularly attends the Children's Panel Dundee Area Group. Similarly, the Locality Reporter Manager regularly attends Children and Families management meetings to discuss matters of common interest and ensure up to date information sharing.

- The use of specific case discussions has been promoted to encourage learning opportunities alongside a regular training program offered to panel members by Dundee Children and Families service, with an emphasis in recent years on the impact of neglect on children. In addition social work teams have offered regular shadowing opportunities for Panel members and there has been a very healthy uptake this.

Other more recent developments include a Panel member joining the membership of the Dundee Child Protection Committee and a Panel member joining the Dundee Permanence Group.

Feedback from practitioners within the Children and Families Service indicates that this range of developments has led to more collaborative working between SCRA and themselves in individual cases. This includes professional conversations between reporters and social workers about the type and quality of evidence and information required to frame grounds within the Hearings process.

FINDING 7

Close working relationships between disability services in Dundee are a positive, but risk creating a culture of informal working that conflicts with local procedures.

How did the issue manifest in this case?

The review team identified very strong working relationships, at both service and individual practitioner level, between the core group of services who have a specific focus on children with disabilities. These relationships could be powerful in ensuring good information sharing, communication and a co-ordinated response to the children and family. There were numerous examples throughout the review period of close working relationships between disability services leading to good communication between the practitioners involved and quick responses to emerging concerns. However, at times these close working relationships led to informal practices that did not reflect expected practice under agreed multi-agency policies and procedures and led to delays in the children receiving an appropriate response from services.

What are the implications for the reliability of the multi-agency child protection system?

This case highlights the important role that close working relationships between practitioners and the services they work within have in securing the safety and wellbeing of children and young people. Strong and trusting relationships between practitioners support good communication and a co-ordinated response to the needs of children and families. They are an important feature of any reliable multi-agency child protection system.

However, close working relationships are dependent on individuals. Whilst shared professional backgrounds, skills and experiences engender strong relationships, factors such as an individual's personal wellbeing at any given point in time and the quality of the management support they receive are also important influences. So, whilst it is desirable to promote a working environment which enables professional trust, unless policies and procedures are also adhered to, or the rationale for not doing so clearly evidenced and recorded, there is an inherent risk of errors of judgement and / or drift into informal routines of practice becoming embedded for all cases/situations. A child wellbeing and protection system that affords practitioners no discretion is not safe, however one that leaves discretion unchecked is also problematic.

What has changed since October 2016?

The Assessment and Resource Pathway for Children with Disabilities / Additional Support Needs has been developed by partners to demonstrate:

- that a child with a disability or Complex Additional Support Needs is supported by the Named Person, the Team Around the Child and MASH processes (where appropriate) in the same way as any other child in need or at risk;
- how Dundee City Council responds to a request to assess the needs of a child and family affected by a disability either in accordance with Section 23 of the Children (Scotland) Act 1995); or where there is a wellbeing concern or child protection concern for the child;
- the processes that support resource allocation; and,

- which children have a Named Person, a Lead Professional or an allocated social worker.

The Pathway has been promoted and disseminated through workshops, team meetings and meetings with individual professionals to consolidate understanding and implementation.

This pathway and the involvement of the Senior Officer (Children with Complex and Additional Support Needs) in the allocation of Section 23 assessments reduces the number of children who are recorded as 'active' to the Children with Disabilities (social work) team – listing only the children who have a Social Worker in the Children with Disabilities Team. The consequence of this is that the Team Manager of the team is less likely to be consulted where other professionals have queries about a child who is not active to the team (this is also relevant to Finding 1).

Decisions to allocate a social worker from the Children with Disabilities Team to a child follow assessment. The child will normally have been involved in the TATC process with a Child's plan and minute of a meeting; in most cases there will have been a full initial assessment of the child and family.

FINDING 8

Are there effective enough support systems locally to help Lead Professionals, and the wider Team Around the Child, to work authoritatively with parents and carers, particularly when there is resistance to statutory interventions?

How did the issue manifest in this case?

In the course of reviewing the case, the review team were struck by the persistence and commitment of a range of practitioners, particularly the Social Worker, in building and maintaining positive relationships with family members. However, this ultimately became a barrier to more authoritative work with family members when risk to the children was escalating and sufficient progress in implementing planned actions and achieving improved outcomes for the children was not being achieved.

There were numerous examples across the period being reviewed of where practitioners from a range of different agencies should have been more authoritative in their interactions with the family. The practitioners involved did not effectively identify the behaviour of these adults as disguised compliance at an early enough stage and respond in an appropriately authoritative way. A professional focus on facilitating change through positive relationships left the children at risk for a longer period than was necessary.

What are the implications for the reliability of the multi-agency child protection system?

An underlying professional commitment to engage with children and families through an asset, rather than deficit, based approach is an important principle of practice across child wellbeing and protection systems. This approach is critical in positively engaging with parents / carers and supporting opportunities for change that improve outcomes for children and young people. An asset based approach is therefore an important part of a reliable multi-agency child protection system. However, a commitment to an asset based approach also needs to include safeguards for the relatively small but significant proportion of parents / carers who are resistant to help, engagement, and / or change. Without these safeguards it is likely that children and young people will be left in situations of risk for longer than is necessary. A reliable child protection input must therefore include the right tools, resources and management support to enable practitioners to recognise resistance and to respond appropriately and proportionately.

What has changed since October 2016?

The programme of multi-agency staff training, described in more detail at finding 1, has included a focus on working authoritatively with parents / carers in circumstances where this is required. The Tayside Child Protection Group has developed a new Non-Engaging Families course. This has been piloted through two sessions delivered jointly by Dundee City Council and NHS Tayside and plans are currently being progressed to deliver further sessions as part of ongoing child protection staff development activity.

The child protection and Looked After Children case file audit completed in May 2018 found that overall cases were rated positively in relation to effectively involving parents, carers and families in key processes; with 10 cases rated as ‘very good’ or ‘excellent’.

Within the ANEW test site creative approaches have been used to the co-production of action plans during Team Around the Child meetings to improve engagement and ownership by families. While the scribe is usually a professional (though in one case was a parent), all participants contribute to the actions and the chair and/or scribe frequently checks with everyone that they are happy with the wording. This balance of power and ownership creates shorter and clearer plans which are actionable by all involved and form the basis of review meetings. Since copies can be taken home immediately families can write and comment on them. There has been an example where the child, not present at the meeting but meeting their buddy afterwards, added post-it comments to each action, which could then be discussed as child's views in the review meeting. In another example the parent fed back it was the first piece of meaningful paper they had ever received from a meeting.

Buddy-time to support children and parents before, during and after meetings is truly embedded for children in one school, and buddies are also offered to parents, although uptake has been low. Buddy-time allows dedicated time for relationship building and better communication of child's views to the professionals involved but also to parents who sometimes hear the views of their children for the first time. This can lead to emotional insights about the impact their own actions are having on their children and can strengthen the relationships to their children and lead to more immediate improvements as some of these actions are within their own power to change.

FINDING 9

Are there adequate resources available within the Dundee health visiting service to provide sufficient assurance that risk to children and families is effectively identified and managed?

How did the issue manifest in this case?

NHS Tayside were aware that, during this period, the level of qualified staff Health Visiting staff was insufficient to manage the complexity of cases known to their Health Visiting service. This challenge was particularly apparent in the Health Visiting team aligned to the GP practice to which this family was registered. Given this challenge, a management directive by the local Operational Management Team was put in place directing that health visiting staff were to prioritise those cases assessed as having an 'additional' level of need, which require a different level of intervention from families deemed as 'core'. Given the resource levels, the Health Visitors carried a significantly larger case load than deemed normal practice and there was insufficient monitoring of the directive to assess how well it was being implemented and level of impact. A further impact of the Health Visiting service's circumstances at the time was that there were lower levels of supervision and support to staff in managing cases of such complexity. As a result assessment and decision making was compromised alongside child protection risks not being recognised and acted upon.

What are the implications for the reliability of the multi-agency child protection system?

Health Visitors make a significant contribution to the health and wellbeing of families across Scotland (and the rest of the UK). The availability of Health Visiting expertise is essential if the health and wellbeing needs of families across Scotland are to be realised for children to be kept protected. The commitment to recruit adequate Health Visitor numbers must continue and the clinical accountability for Health Visiting caseloads and supervision of the Health Visiting workforce must be provided by appropriate practitioners with the required skills and experience. Health Visitors are in the prime position to recognise and support families who are the most vulnerable and at risk, but require the ongoing training and supervision to provide this service, not least because of the high volume of cases that they carry and the difficulty sometimes in this context of seeing the 'wood for the trees'.

What has changed since October 2016?

The national transformation programme for Health Visiting services, which commenced in 2015, has progressed as planned over a 4-year period. Within NHS Tayside, strong progress was made in the first 2-3 years of the programme, resulting in the workforce trajectory (based on application of the developed national caseload weighting tool) for the Tayside Health Visiting service being achieved in January 2018.

As a result of the above NHS Tayside's Health Visiting service is in the position to offer the new national Universal Health Visiting Pathway to all families, and caseload sizes are within the nationally recommended range.

In addition to the above, NHS Tayside has further developed its models of Management Supervision and (Child Protection) Case Supervision for Health Visiting staff, and reviewed and updated Child Protection, and other relevant, policy and guidance documents.

The national GIRFEC Practice Framework has also been increasingly embedded within Health Visiting

practice through training and development, improvements to the electronic record keeping system used by Health Visitors, development of guidance for practitioners on, for example, 'Team Around the Child'/Planning meetings and through increased levels of multi-agency work e.g. involvement in the 'Addressing Neglect Enhancing Wellbeing' (CELCIS) programme of work.

The management and leadership structure within NHS Tayside for Health Visiting service has also changed, with the service now sitting within a wider women, children and families services structure within the organisation.

FINDING 10

The absence of clarity as to the role and remit of MASH for cases below the child protection threshold is creating confusion within and across agencies as to what action they are required to take.

How did the issue manifest in this case?

In the process of reviewing the case the review team identified that there was not a consistent understanding across the group of practitioners involved of the role and remit of MASH for cases below the child protection threshold (TATC Level 3 and below). In particular there were multiple understandings of whether or not MASH has the authority to instruct practitioners to take specific actions in such cases.

What are the implications for the reliability of the multi-agency child protection system?

MASH is the single point of referral for all child care and welfare concerns for children and young people (aged under 16) who are not (or have not within the last 6 months been) open cases to social work. As such it is the gateway through which child protection responses and social work resources are accessed, as well as applying a triage process that is designed to ensure that cases take the most appropriate pathway through the TATC process. If there is confusion about the role, remit and authority of MASH this triage process is likely to work less well and, in some cases, fail. This will result in risk of children being left too long in situations without the help and support they need or duplication of effort, wasted resources and children and families experiencing an un-coordinated response.

What has changed since October 2016?

In March 2017 the Child Protection Committee endorsed a proposal regarding the future role and remit of MASH. Subsequent to this information on the role and remit of MASH was distributed across partner agencies, including through meetings with all designated Child Protection Officers within Dundee schools and a presentation to Child and Adolescent Mental Health Services. Information has been shared with a range of third sector organisations through attendance at team meetings. Focused discussions were also held by the Children and Families Service Senior Management Team to support enhanced understand of the interface between MASH and schools.

A permanent team manager and permanent multi-agency team members are now in place, supported by a MASH Strategic Oversight Group. The MASH Team Manager regularly liaises with key stakeholders in Police, Health and Education services to ensure clarity of role and remit is provided. The team works closely with 2 Locality Officers (for East and West Dundee) and senior Health staff to ensure support and guidance is provided to named persons in respect of child protection and GIRFEC processes.

An inter-agency audit of cases considered by MASH has been undertaken and was considered by the Child Protection Committee in May 2018. This identified a range of improvement actions, including the need to develop a standardised MASH referral format and process followed by all referrers / agencies and the need to ensure consistent recording of outcomes from MASH within relevant IT systems. Since this time a single referral form has been develop for use across all agencies (with the exception of health who utilise a pan-Tayside format) and work has been progressed on a multi-agency basis to strengthen referral pathways for unborn babies. From August 2019 a new process will be implemented

in all schools which enables staff to record referrals to MASH and the subsequent response from them, enhancing the ability of professionals working within schools to track repeat referrals overtime in neglect cases.

The audit of child protection and Looked After Children cases completed in May 2018 found that overall, services were rated positively in relation to recognising when children / young people and their families needed to receive additional support at an early stage to prevent difficulties arising or escalating. 7 out of 8 cases were rated as 'good' or better and 1 as 'adequate'. The timeliness and effectiveness of early support provided by services was also rated very positively, with 7 out of 8 cases being rated as 'good' or better and 1 as 'adequate'.

APPENDIX 1 - GLOSSARY OF TERMS

Glossary

COG	Chief Officers Group
CPC	Child Protection Committee
COPFS	Crown Office and Procurator Fiscal Service
GIRFEC	'Getting it Right for Every Child'
MASH	Multi-Agency Screening Hub
NHS	National Health Service
PBRA	Pre-birth Risk Assessment
SCR	Significant Case Review
SCRA	Scottish Children's Reporter Administration
SIO	Senior Investigating Officer
TATC	Team around the Child
UBB	Unborn Baby

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