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Executive Summary Significant Case Review: Neglect Themed Review

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1. Why was a themed review chosen?

Two babies from different families came to the attention of West Lothian Child Protection Committee after experiencing significant harm in the first six months of their lives. Baby 1 was accommodated, but later returned to their mother. Baby 2 died. In both cases, there was significant neglect.

In 2018, West Lothian surveyed workers across social work, education, health and police about recognising and responding to neglect of the children and young people they work with. From a total of 563 responses it emerged that, while professionals generally recognised neglect in children and young people, many reported a lack of confidence and an uncertainty in how to respond.

Child neglect was recognised in West Lothian as an issue that emerged in Initial Case Reviews and multi-agency audit activity. Recognising and responding to neglect continues to be challenging for professionals across agencies. The decision was taken by West Lothian Chief Officers' Group to undertake a Learning Together themed review to support better identification of systemic barriers to (and enablers of) good practice in supporting and working with families and children experiencing neglect. A themed review applies the *Learning Together* methodology and blends scoping a wider number of cases where neglect features and a more in-depth review of two or more cases to incorporate the breadth and depth of learning.

2. Summary of each case

Baby 1

The baby's mother met the criteria for services offered by the Family Nurse Partnership due to her age and as it was her first child. She was offered and agreed for involvement of the FNP. The mother was previously homeless, but had moved to live with her partner in his tenancy. During the pregnancy, the mother disclosed that as a child she had been on a supervision order for neglect, shared her worries about looking after a baby and that Baby 1's Father had social work involvement as a child. The parents were referred to Sure Start parenting group work for expectant families.

The parents engaged to some extent with the Family Nurse during the pregnancy and following the birth the Community Midwife reported concerns about the parents' lack of priority in terms of feeding and buying milk for the baby. The Family Nurse involved Action for Children to support the family in managing their finances including debt. During November and December, the Family Nurse continued to address the importance of feeding the baby, and helping the parents respond appropriately to the baby's health and emotional needs.

During the next 6 months the Family Nurse had concerns about the baby's development, parents' routines, feeding and sleeping routines, increasing non-engagement with their service and poor interaction between the baby and parents.

At a paediatric review the Consultant Paediatrician recorded significant delay in all areas of the baby's development and dirt in the folds of the baby's skin. An Inter-agency Referral Discussion (IRD) was initiated with social work, health and the police and the baby was accommodated under s.25 of the Children (Scotland) Act 1995 two days later.

Baby 2

Considerable information was held by the GP, adult mental health services, CAMHS, Social Work and the Police about both parents and the children. There were indicators of neglect including lack of routines and boundaries, lack of supervision and developmental delay in all children. The mother was concerned about her ability to cope with parenting her children and she had been in care due to chronic neglect. In the two months before and two months after the baby's birth there were four incidents where agencies were made aware of or observed that the children were unsupervised or in the care of the eldest sibling. The eldest child's name had previously been on the Child Protection Register and the case was identified as a cause for concern by the health visiting service.

When the baby was 4 months old there were increasing indicators of neglect with concerns raised about the physical presentation of the older children, and the mother's admissions of not taking her prescribed medication and struggling to cope with the older children's behaviour. Although there was multi-agency involvement there were no planning meetings to share information and develop a plan. An arranged planning meeting was postponed. At the age of 6 months the baby was found unresponsive, transferred to hospital, never recovered and subsequently died two days later. A full investigation into the circumstances of the death was carried out and no criminality was identified.

3. Methodology

The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case and changing them will contribute to improving practice more widely.

At the analytic heart of the Learning Together model are three key questions:

- *What happened?* Reconstructing the case and surrounding context as experienced by the professionals involved. The aim is to avoid the temptation to form judgements with the benefit of hindsight;
- *Why did it happen?* Analysing practice in detail appraising individual practice and looking at individual, local and national influences on practice. This uses information provided by practitioners – both directly and through case records – to appraise the quality of practice and to explain why something happened given what was known and knowable at that particular time; and
- *What are the implications for wider practice?* Exploring whether issues identified in the case apply more widely in consultation with staff and managers and their relevance to achieving better safeguarding.

Using this approach for studying a system in which people and the context interact requires the use of qualitative research methods to improve transparency and rigour. The key tasks are data collection and analysis. Data comes from semi-structured conversations with involved professionals, case files and contextual documentation from organisations.

4. Research questions

The research questions identified for the review were:

a. How well do practitioners across agencies in West Lothian recognise and respond to the neglect of children under two years?
b. What helps or hinders practice in responding to children?
c. What helps or hinders agencies working together in recognising and responding to neglect?

5. Review Team and Case Groups

The review was undertaken by two Lead Reviewers: one who is accredited and experienced in using the SCIE's Learning Together methodology and has no connection to agencies in West Lothian; and a second reviewer working in West Lothian and a trainee SCIE accredited reviewer. The Reviewers were supported by a Champion, Critical Friend and Review Team whose membership was drawn from across agencies involved in each case and had not held any decision-making responsibility in relation to either case. Collectively, their role was to contribute to the analysis of data and inform the final report. SCIE's Deputy Head of Learning Together provided methodological oversight and quality assurance. Ownership of the final report lies with the West Lothian Child Protection Committee as commissioner of the case review.

The SCIE model involves gathering and making sense of information about a case through meetings with the Review Team and two Case Groups of practitioners directly involved in each case. Both groups were involved in the analysis of practice of the specific case and in discussions to identify the wider systemic findings. Attendance at all meetings was requested but not always possible.

6. Process of a Learning Together themed review

There were four stages to this Learning Together themed review.

Stage 1: identifying area to explore and cases to review
The choice of neglect as the theme was linked to concerns identified in the two cases which met the criteria for a Significant Case Review (SCR) and it emerged as a continuing challenge across professionals as identified through West Lothian's Neglect Survey 2018.

Stage 2: scoping activity
The purpose of scoping a range of cases was to provide a snapshot appraisal of practice across agencies about how staff recognise and respond to neglect in children under two. Nine cases were selected from the three area teams in West Lothian and the criteria for selection was that from birth to 24 months, the child had been on the child protection register at some point during the two years, neglect was a recorded concern and there was multi-agency involvement or neglect had been identified through an internal audit process within West Lothian. The reviewers and SCIE developed a short scoping framework which considered the information known or knowable and professional responses when the case was referred to social work through an Inter-agency Referral Discussion (IRD), single or multi-agency assessment or multi-agency planning and review. Descriptors were developed for the assessment of practice as weak, adequate or good. Multi-agency information from nine cases was examined and eight were included in the final scoping review. One case was excluded because the child was under two over ten years previously so practice was subject to different legislation and policy, and the information would have been difficult to source from the agency's archived information systems.

Stage 3: multi-agency workshops
Preparation: The Lead Reviewers met with the Champion and Review Team to consider the Initial Case Review (ICR) reports and multi-agency chronologies for Baby 1 and Baby 2, and identify the 'Key Practice Episodes' (KPEs; periods or instances that appeared significant to the direction that the case developed) from the integrated chronology and ICR reports. Following this, work was undertaken by the Lead Reviewers and the Champion to produce a timeline of key events and agency involvement to work through with each Case Group.

Workshops: the systems approach requires the reviewers to approach a case from the viewpoint of the practitioners who were involved at the time in order to avoid the risk of reaching conclusions with the benefit of hindsight. This includes an exploration of the contributory factors within their working environment that may have influenced their thinking or actions. The workshop day was structured to facilitate the gathering of this information from a multi-agency group through:

- Briefing the group on the principles that underpin the Learning Together model and the ultimate aim of identifying possible underlying systemic strengths and vulnerabilities through the information generated on the day; and
- Exploring the visual timeline of the case

In order to help focus on what was happening at the time, practitioners were asked to consider: the role of their agency; their own role; their impression of each family member; and to reflect on what might have affected the practice of the team, service or organisation during the period under review. Each group was asked to reflect on the aspects of the case which had some commonality with other cases in their experience and where there may therefore be underlying issues that were wider than this one example.

Stage 4: Case Group and Review Team feedback
A further half-day session was held with each Case Group to explore the preliminary findings. Each Case Group was asked for their views on the finding presented, on how widespread and prevalent the finding and asked for their views about the questions this raised for their organisations and West Lothian CPC.

During the course of the review, the Lead Reviewers met with the GP Lead for Child Protection in West Lothian to provide background information about GP practice in relation to child protection. As mentioned, a range of paperwork also informed the review.

7. Methodological comment and limitations

It was not possible that all members of the Case Group and Review Team could meet together on all occasions; however, every effort was made to seek the views of colleagues. There were also limitations to the scoping activity: the quality of information contained in case records was often not clear enough about the rationale for decisions; and as the criteria was to examine cases of children under two, this meant that the period examined spanned 2012 to 2018 where practice would have been subject to different policies and procedures and a developing knowledge and understanding of neglect.

There were a couple of issues, which emerged from the review but were not presented as Findings because the issues related to practice out with the scope of the SCR, nevertheless, the Review Team considered it important to highlight these:

- **Professionals' meetings**: during the review it emerged that the Family Nurse had arranged a Professional Concerns Meeting at the time when West Lothian had moved to Child's Planning Meetings, which also include family members. This raised questions about where within multi-agency processes professionals could discuss concerns on a multi-agency basis before involving the family.
- **Informing professionals of a child's death**: it was raised on several occasions that professionals who had worked or continued to work with the family were not always made aware that a child had died and that some consideration be given to how information is shared appropriately.

Current issues
In 2014, Scottish Government introduced the Children and Young People (Scotland) Act 2014, which included Part 4 outlining the role of the Named Person Service and Part 5, introduced the requirement for a child's plan when a child has wellbeing needs requiring targeted intervention. Both parts were subject to a Supreme Court judgement and the Children and Young People Information Sharing (Scotland) Bill was introduced in 2017 to propose changes to the information sharing provisions in Parts 4 and 5. Government set up the GIRFEC Practice Development Panel to undertake this work.

The Government accepted the Panel's recommendation that Ministers should not pursue the information sharing bill and withdrew legislation and stated its continued commitment to GIRFEC to be reflected: '*in the upcoming refresh of the Getting it right for every child practice and policy guidance*.' (Scottish Government 2019b, p10).

There remains confusion about Scottish Government's commitment to the Named Person, but in addition there is also confusion where more than one Named Person is involved with a family and the identification of a Lead Professional to coordinate services when more targeted support is required, but there is no social work intervention.

Introduction

A Case Review plays an important part in efforts to achieve a safer child protection system, one that is more effective in its efforts to safeguard and protect children. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this

reveals about the child protection system. The particular case acts as 'a window on the system' (Vincent 2004, p.13).

In Learning Together, Case Review findings address the reliability of the Child Protection Committee area or agencies' usual patterns of working. They exist in the present and potentially impact in the future. It makes sense to prioritise the findings to pinpoint those that most urgently need tackling for the benefit of children and families; these may not be the issues that appeared most critical in the context of a particular case, however they may present the most risk to the system if left unaddressed. In this review, the prioritisation of findings is a matter for the Child Protection Committee.

In order to help with the identification and prioritisation of findings, the systems model that SCIE has developed includes six broad categories of underlying patterns, each of which relates to different aspects of multi-agency child protection work:

1. Tools
2. Management system issues
3. Professional norms and culture – incidents
4. Professional norms and culture – longer term work
5. Patterns of interaction with families
6. Identification of cognitive and emotional biases

Not all categories are relevant in each case and the task is to identify those which are. In order to establish if the patterns suggested are systemic, it is necessary to answer the following questions:

- How the issue manifests in the particular case
- In what way it is an underlying issue
- Any information about how widespread an issue this is perceived to be locally, or data about its prevalence nationally
- How the issue is usefully framed for the CPC (or its delegated sub-committee) to consider relative to their aims and responsibilities

8. In what ways do these cases provide a useful window on our systems?

These cases provide a useful window on the system precisely because the learning is in relation to families where children may be experiencing neglect with whom practitioners work regularly. In the 2018 neglect survey, the majority of staff in universal services, Education and Health, estimated that between 0 - 20% of the children they dealt with were experiencing neglect. The balance between identifying and responding to patterns of needs and risks is part of everyday decision-making for professionals working with children and families, but it can be challenging for professionals to identify a possible accumulation of risk indicators for many families as these may not be fully understood until information is brought together by all involved. How information is shared and understood helps inform assessment and planning for children and their families.

9. Findings

Finding 1

Without consistent use of assessment framework and tools, practitioners struggle to identify or respond to children who may be experiencing neglect leaving some inadvertently at risk of significant harm [Professional cultures and norms – longer term work]

Professionals can struggle to identify indicators of neglect and, once neglect is identified, put in place an appropriate plan to meet children's needs. Some practitioners lack confidence in their ability to analyse the data collected, others find it hard to define and assess neglect which can lead to preventable delays in acting. The use of assessment frameworks and tools can provide a structure for professionals to collate and analyse information and intervene more effectively.

How do we know it's an underlying issue?

The use of available assessment tools is inconsistent across agencies (i.e. Assessment of Wellbeing, National Practice Model, Risk Assessment Framework, Graded Care Profile[1]). While the National Practice Model is used within the Health Visiting Pathway, there is not a clear assessment pathway available to practitioners across all agencies to help identify when assessments should be completed out with formal circumstances such as child protection case conference or assessments requested by the Reporter. Both Case Groups and Review Team agreed that in West Lothian the lack of assessments can hinder the recognition of neglect and, in cases where there are concerns of neglect, the scoping of eight case files identified that the Graded Care Profile was rarely used.

Both Case Groups raised anxieties about when information can be shared in relation to children's wellbeing which hinders undertaking comprehensive assessments. Staff reported that they lack confidence in situations where they can or cannot share information in light of the new requirements of the General Data Protection Regulation 2016 and the confusion in relation to Part 4 and 5 of the Children and Young People (Scotland) Act 2014 in sharing information in relation to wellbeing concerns.

How prevalent and widespread is the issue?

The Case Groups and Review Team agreed that that this was an issue across agencies and teams in West Lothian.

This was also a recurring theme to emerge from the recently published review by the Care Inspectorate (2019) of 25 Significant Care Reviews (SCRs) in Scotland from 2015-2018. The Care Inspectorate review identified that in half the SCRs reviewed, children often remained unnoticed in neglectful or harmful situations until a threshold for child protection was reached: '*neglect had not been sufficiently recognised or adequately responded to before risks escalated and children were seriously or fatally harmed. In almost all these cases, families were already known to services and were being supported on a non-statutory basis by a range of universal and statutory services*.' (p2).

Why does it matter?

To experience neglect is one of the most profoundly damaging childhood experiences. There is now an overwhelming body of research that evidences just how harmful neglect can be to emotional, behavioural and cognitive development in the short and long term (Daniel, Taylor and Scott 2009). These affect life chances and contribute significantly to widening social, economic and health inequalities. Evidence suggests that one in ten children in the UK experience neglect and that it is the most prevalent form of child maltreatment (Radford et al. 2011). Assessing and reducing the effects of neglect within families is complex and challenging. Neglect is multi-faceted and often the greatest uncertainty is in deciding the seriousness of a situation and identifying ways in which to intervene in order to improve outcomes for children. Professionals in all agencies need to be mindful that their information is only one piece of the jigsaw and that others may have more information to help build a clearer picture; this is particularly true in cases where the evidence for neglect is not obvious and likely to fluctuate over time.

Frameworks and tools are available which are designed to help professionals assess a child's current circumstances, but also to help identify when a child is at risk of neglect. They can assist professionals to measure the quality of care being given to a child in respect of physical care, safety and a nurturing environment. Frameworks and tools can provide clear structures in which to record information, but is not a substitute for the skills needed to ensure the quality of information collected and quality of subsequent analysis to inform interventions.

[1] The Graded Care Profile was created by consultant paediatricians - Drs Polnay and Srivastava - and was developed to help professionals measure the quality of care being given to children, where there are concerns that they might be being neglected. The tool 'grades' aspects of family life on a scale of 1 to 5 and the assessment aims to help identify the support needed to improve the level of care children receive.

Questions for CPC to consider:

- How can the CPC satisfy itself that workers are aware of the National Practice Model and the Risk Assessment Framework?
- How can the CPC support staff in their assessment, analysis and planning for children, young people and their families?
- How satisfied is the CPC that the Graded Care Profile is the most appropriate tool and, if not, what should be used?

Finding 2

The impact of parental mental ill-health on parenting capacity is not consistently recognised or understood across all child or adult focused agencies which can leave children living in situations which may put them at risk and agencies providing inappropriate interventions. [Professional cultures and norms – longer term work]

Practitioners working with children and families rarely have specialist knowledge of mental illness and personality disorders and how this may impact on a person's parenting capacity or the child's day to day life living with a parent who has mental ill health. There is little understanding about which interventions are most or least likely to be effective with parents experiencing mental ill health. Those professionals whose focus is on supporting adults with mental health difficulties may not consider the impact of parental mental ill health on parenting capacity and the day to day lived experience of children in households where there is parental mental ill health.

How do we know it's an underlying issue?

The Case Groups and Review Team agreed that there is little understanding amongst professionals, whose main focus is the child, about the impact of mental ill health on parenting capacity or the interventions most likely to be successful or an understanding of when adults' non-compliance with medication may heighten concerns or should lead to Adult Protection interventions. Mental ill-health covers a vast spectrum of disorders, each of which may require a different type of intervention at different times and have a potentially different impact on parenting capacity. The term 'mental health problems/difficulties' is often referred to by professionals without a clear analysis of how this manifests and the impact on children.

How prevalent and widespread is the issue?

Both Case Groups and Review Team agreed that in their experience of potential child abuse and neglect the mental ill-health of parents is an established risk factor, but that the impact of mental ill-health on parenting capacity and the interventions most likely to be successful are not understood by professionals whose main focus is the child.

For the estimated 2,668 children on the child protection register at 31 July 2018 (Scotland), there were 6,830 concerns noted at the case conferences at which they were registered, parental mental health problems accounted for over 800 of these recorded concerns (Scottish Government 2019). During the period 26% of children placed on the Child Protection Register in West Lothian were from families where there was a concern about parental mental health. Children were affected by parental mental health in 43% of SCRs analysed 2007-2012 (Vincent and Petch 2012), in 65% of SCRs produced between 2012-2015 (Care Inspectorate 2016) and in 36% of SCRs analysed 2015-2018 (Care Inspectorate 2019).

Biehal and colleagues (2019) reported on a survey undertaken with social workers and carers to gather detailed information on the histories of 433 children drawn from 19 participating local authorities and who were under five and either looked after away from home or adopted/placed for adoption at the time the data was collected. For the majority of these 433 children the most common reported reasons for placement were abuse and neglect. Nine out of ten of the children had directly experienced abuse or neglect (in some cases pre-birth including maternal substance misuse during pregnancy) and for 71% of these children the maltreatment was severe. The most common additional reasons contributing to decisions to place children away from home were parental drug or alcohol misuse and mental health

problems (each reported for just over 70% of parents) and domestic violence (reported for just over 60% of parents) (Biehal et al. 2019, p51)

Why does it matter?

Living in a household where parents or carers have mental health problems does not mean that a child will experience abuse or be affected negatively, but alongside other stressors such as poverty, domestic abuse, a parent's own childhood experiences of neglect or abuse can impact on their capacity to parent. Without a comprehensive assessment of a child's circumstances this impact may be unknown or misunderstood (see also Finding 1). Confusion about information sharing undermines professionals' confidence in approaching mental health specialists if concerns have not yet been identified as child protection:

> *'Timely and appropriate sharing of information and effective communication remains a challenging area, suggesting ongoing ambiguity and understanding of what and when to share information, and in what circumstances. This is particularly evident at the lower threshold of child protection where concerns relate to wellbeing. Despite local information-sharing protocols and guidance (to facilitate closer working and information sharing) and greater integrated working across partnerships, professional cultures at play within the system are impacting on information sharing behaviour and attitudes within and across organisations. Likewise, legal and ethical tensions persist between maintaining confidentiality and sharing information. These dynamics influence and impact on professional judgement, inter-professional communication and effective information sharing.'*
>
> (Care Inspectorate 2019, p3)

Questions for CPC to consider:

- How can the CPC be assured that child care practitioners and adult mental health staff understand the impact of parental mental ill-health on parenting?
- How can the CPC be assured that children and adults services are sharing information appropriately around the impact of parental mental health on parenting?

Finding 3

Across agencies, the lack or limited use of chronologies for children and families affects practitioners' ability to identify patterns of concerns to inform an analysis of neglect and respond appropriately, which means that children may be living in circumstances detrimental to their health and wellbeing. [Tools]

Case recording in most agencies is attributed to an individual family member's electronic case record making it difficult to identify emerging patterns or themes in families. Where chronologies are available they are not consistently used as a tool to inform ongoing risk assessments and are rarely multi-agency.

How do we know it's an underlying issue?

This is an underlying issue as chronologies are not consistently used in practice across agencies. Guidance and procedures exist in individual agencies for completing chronologies, but there is little consistency across agencies on how they are produced. Furthermore, the guidance was developed when chronologies were developed from the information held on paper case files and not electronic systems. From the scoping activity of eight cases, it was clear that once a family was subject to a child protection case conference each agency produced its own chronology, however, there was no multi-agency chronology and nor was there evidence that chronologies informed ongoing analysis of risk. Chronologies are produced for formal meetings or for reviews; they are used less consistently to identify patterns or an accumulation of concerns and inform actions and interventions with children and families.

How prevalent and widespread is the issue?

Both Case Groups agreed this was an issue for all agencies in West Lothian and the Care Inspectorate (2019) commented that a lack of and poor chronologies continues to hinder the assessment process to support practitioners to make a properly informed assessment of risk, particularly in instances of cumulative harm and neglect.

Why does it matter?

For two decades, UK and Scottish Governments have stressed the importance of seeing children as individuals. Children within sibling groups and families should be seen as individuals with different experiences and needs. Policies, procedures, structures and IT systems delivering both universal and targeted services to children and families have been developed to reflect this. The unintended consequence perhaps has been that it has become increasingly difficult to see the child within their sibling groups and wider family. The structure of IT systems has made it more difficult to see the child's story and to understand the patterns and trends of a family's history over time.

Families in which children are experiencing neglect are characterised by multiple interlinked difficulties such as poverty, parental childhood maltreatment and large families, an absence of protective factors and either an unwillingness or inability to access support, social isolation and enduring parental difficulties such as mental health, domestic violence or substance misuse (Gillingham, Blomfield and Higgins 2007). It is also known that where more than four factors are present, the potential for neglect increases significantly (Brown et al. 1998) and many families known to services in West Lothian are living in such circumstances. Chronologies could effectively bring this information together.

The Care Inspectorate's (2019) review of SCRs noted that the absence of a multi-agency chronology hindered the ability of professionals to identify the re-emergence of historical behaviours relating to avoidance and non- compliance. It is crucial in situations where children are living with neglect that patterns are identified and their significance recognised. Neglect is rarely a single event, but a persistent failure to meet a child's needs. The unremitting daily impact of these experiences on the child can be profound and reduce a child's sense of safety, stability and wellbeing. To be an effective tool, chronologies have to be regularly updated and reviewed.

Questions for CPC to consider:

- How will the CPC ensure that staff understand the importance of chronologies?
- How will the CPC be assured that staff have the skills to analyse information?
- How will the CPC ensure that staff use chronologies as a tool to inform assessment?

Finding 4

There is no formal oversight or review of the outcomes of intervention provided via the Screening Groups meaning that the impact on some parents is likely to be less beneficial with children experiencing little change [Management systems]

Parents and children had been referred to screening groups for allocation of resources. For some agencies this activity appeared to be regarded as an outcome. There was no oversight or review of whether previous interventions had been successful and resulted in sustained improvements in the child's circumstances.

How do we know it's an underlying issue?

This is likely to be an underlying issue because West Lothian provides numerous early interventions including parenting groups via screening groups or direct referral, often without a comprehensive assessment of the child's and family's needs. Some groups have a review process, but others do not and in some instances, there is feedback to the referrer, but not for others. Group work is a valuable resource for many parents but is not suitable for all.

Engagement in group work can mean different things to different agencies. For the most vulnerable parents, if there is no ongoing involvement, it is difficult to tell whether the learning from the practical group work is sustained in their family life when there may be less support available and more competing demands on parents.

An internal West Lothian Social Policy review of residential child care (2017) reported that:

> *'The lack of a comprehensive assessment prior to referral for a variety of Social Policy services may result in young people and their families receiving services that do not meet their needs. Re-referrals for the same type of services indicate that these interventions have not been successful but that thinking has either become 'fixed' about what a family needs or workers feel that a problem has been resolved because a service, however inappropriate, is being provided.'*
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> (West Lothian Social Policy 2017, p16)

How prevalent and widespread is the issue?

Both Case Groups and Review Team agreed that there is no shared understanding of the content delivered by parenting groups, who is likely to benefit most and in what circumstances. Screening groups provide no oversight or review of the outcomes of interventions meaning that the impact on some parents is likely to be less beneficial with children experiencing little change.

Why does it matter?

Screening Groups appear to operate in isolation of each other, lacking in oversight of previous interventions and their success or otherwise. Screening groups are often allocating resources without a comprehensive assessment of not only an individual child's needs but the needs of the family as a whole (Finding 1). Had there been an understanding of the Mother's mental ill health, its impact on herself and parenting (Finding 3) group work would not have been considered an appropriate intervention. There is a danger of parents being labelled non-compliant when in fact the interventions provided are either not suitable for parents because of their particular diagnoses of mental ill health or because parents cannot understand the content of courses due to learning difficulties or disabilities.

Questions for CPC to consider:

- How will the CPC ensure a more effective approach to screening referrals and allocation of resources?
- How will the CPC ensure that screening groups have oversight of the impact of resources on children?

Finding 5
Professionals in universal services are increasingly managing complex situations without adequate challenge, support or oversight of their practice and decision-making leading to children being at risk of significant harm for longer periods than necessary
[Management systems]

Supervision is a crucial part of reflective practice. It provides the opportunity and space for workers to critically analyse their knowledge, values and skills and their understanding of the work they are undertaking. It should also provide a safe place for professionals to reflect on their practice, decisions and interventions, and receive feedback and support. Many of the issues and difficulties presented by the families that professionals in universal services are working with are often long term and complex. Without supervision or the space to reflect and receive feedback, practitioners may be making significant decisions in isolation.

How do we know it's an underlying issue?

Both Case Groups agreed that this is an underlying issue as the supervision and oversight of decision-making is different across agencies, particularly in those organisations which have a responsibility to children and young people as their Named Person.

How prevalent and widespread is the issue?

It is prevalent and widespread as only Social Work Services and the Family Nurse Partnership offer regular supervision. The lack of constructive supervision was also identified in the Care Inspectorate (2019) review:

> '*Practitioners require structures that provide the opportunity for robust and regular consultation, constructive challenge and reflective supervision. Our previous review of SCRs 2012 -2015 found that child protection work presents huge challenges and the many complexities of child protection work can have a significant impact on staff.*
>
> *Just under half of the SCRs we reviewed identified that a lack of proactive and effective management oversight, support and scrutiny of practice was an identified contributory factor to helping staff make sound, professional judgements in their work to support and sufficiently safeguard children and young people, as this example demonstrates.*'
>
> (Care Inspectorate 2019, p22)

Why does it matter?

It is important that services remain alert to the possibility that practitioners working in areas of high deprivation, unemployment and poverty begin to view the children's circumstances relative to those in the wider community. They may not recognise neglect or make decisions about **not** contacting social work about families for whom they may have some concerns as they perceive that these are not child protection and would not be sufficient to warrant social work intervention. A system that challenges staff through supportive oversight is important in recognising and responding to neglect.

Supervision is a different activity across different agencies, but usually includes elements of educational supervision (developing knowledge and skills), supportive supervision (supporting practical and emotional elements of a practitioner's role) and administrative supervision (maintenance of standards and adherence to policies). Whatever, the focus of supervision, it is important that this activity supports the work of the practitioner. For example, while the Family Nurse identified cases to bring to weekly supervision, cases may only be discussed every 8 weeks resulting in some cases not having sufficient oversight during the important very early weeks and months of a baby's development. Similarly, cases identified as a cause for concern or child protection by Health Visitors will be subject to supervision either every three or six months, which again may not provide sufficient oversight during a period of rapid change for a young child.

Questions for CPC to consider:

- How will the CPC ensure that staff in universal services are appropriately supported and challenged in their assessment and decision-making?
- How will the CPC ensure that supervision and support of other staff is adequate?

Finding 6

A lack of clarity about the role and expectations of the Named Person can lead to agencies working with a family in isolation and patterns of behaviour and accumulation of concerns going unnoticed [Professional cultures and norms – longer term work]

Getting it Right for Every Child is Scottish Government's approach to ensuring that children, young people and families get the right help at the right time. As part of the approach, all children should have an identified Named Person who is responsible for helping them get the support they need if and when

they need it. A named person will be a clear point of contact if a child, young person or their parents want information or advice, or if they want to talk about any worries and seek support.

How do we know it's an underlying issue?

Both Case Groups agreed this is an underlying issue. There is confusion about the role of the Named Person nationally, but both Case Groups were unclear about West Lothian's policy in relation to *Getting it Right for Every Child* generally and to the Named Person in particular.

How prevalent and widespread is the issue?

The confusion expressed by Case Group members was from a range of agencies and not one agency in particular. This is also a finding found across SCRs nationally. In ten of the 25 SCRs reviewed by the Care Inspectorate (2019), there was professional confusion about the roles of the named person and lead professional, with findings identifying that they were not always well understood by practitioners or that practitioners lacked confidence in the role. These uncertainties impacted on the lack of a coordinated overview of children's needs. This confusion has been compounded by the Supreme Court in relation to implementation of Parts 4 (role of Named Person) and Section 5 (Child's Plan) of the Children and Young People (Scotland) Act 2014 and compatibility with Article 8 of ECHR and information sharing in relation to wellbeing.

Why does it matter?

It is crucial that all professionals working with a child and their family share information effectively and at a time which is important for a child's development. Professionals have different knowledge and perceptions about the strengths and susceptibilities of families and multi-agency discussions should identify what is needed to support families and the planned outcomes for children and their family. The Named Person needs a clear of understanding of when to arrange a Child's Planning Meeting and that all relevant agencies are invited to share information, identify needs and risks, and make appropriate plans. Importantly, and particularly for young children, this should ensure that planned actions and their intended outcomes are monitored and reviewed.

It is unclear who should take the responsibility for pre-birth planning for families where there may be concerns about potential neglect. It is also evident that there will be families for whom there are two and, potentially three, Named Persons if there is a child at secondary school (Head teacher), primary school (Head teacher) and a child under five (Health Visitor).

Questions for CPC to consider:
How can the CPC ensure that all practitioners in West Lothian understand the role of the Named Person, Lead Professional and the GIRFEC Practice Model?

Finding 7
Verbal referrals to social work can result in miscommunication and misunderstanding resulting in different expectations about the purpose of the discussion leading to an inappropriate response for children who may be at risk of significant harm
[Management systems]

At times, professionals believe they have made child protection referrals to social work, however, this has not been the understanding of those receiving referrals. This is an important time for making decisions about children who may be experiencing neglect, therefore, a written follow-up will help practitioners articulate their concerns and the purpose of the verbal referral more clearly. It also provides a clearer picture if concerns then need to be escalated. Sometimes professionals are frustrated by what they perceive to be a difference in thresholds between themselves and social work and a lack of respect for their professional assessment.

How do we know it's an underlying issue?

There is no expectation in West Lothian that verbal referrals to Social Work are followed up in writing. Both Case Groups and the Review Team agreed that it was not standard practice to provide written follow ups to referrals in West Lothian, there is no shared record of agreed actions and a reluctance to escalate concerns. It would appear that making a referral is seen by many professionals as an outcome.

How prevalent and widespread is the issue?

The Case Groups and Review Team were clear of the need for written follow-up to help clarify communication across agencies.

Communication and assumptions made by professionals was highlighted in a previous SCR conducted in West Lothian. This issue was also identified in the Care Inspectorate's (2019) review of SCRs: *'How professionals communicate, including the assumptions that are made about language and the nuances of terms that are used, can lead to misinterpretation or misunderstanding.'*(p12).

Why does it matter?

Different interpretations of information imparted verbally by the speaker and those receiving the information can lead to an over or under reaction in cases: *'Reviews of fatal child abuse cases regularly identify communication problems between the professionals. Understanding their origins requires an analysis of the psychology of communication as well as its technology, since it is a complex process in which interpersonal factors impact on the meaning that each person attributes to the messages given and received. The contexts within which the communications occur also colour how the messages are comprehended.'* (Reder and Duncan 2003, p82*)*.

Questions for CPC to consider:

- How can the CPC be reassured that verbal referrals are not misinterpreted leading to an inappropriate response or preventable delay for a child who may be experiencing neglect?
- How can the CPC be reassured that all professionals are aware of the processes of escalating concerns?
- How can the CPC be assured that those receiving referrals have the skills to help professionals articulate their concerns, gather appropriate information from the referrer and analyse that information?

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