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Executive Summary:
Learning review: Taking forward findings from Initial and Significant Case Reviews

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Part 1: Introduction

1. Why were the cases chosen to be reviewed?

1.1 Between 2018-2021, two children from different families came to the attention of West Lothian Child Protection Committee. Child C (Case 1) was removed into foster care following attendance at Accident and Emergency with a fractured skull. The details of the second, older child, Child D (Case 2), cannot be shared due to ongoing legal processes.

1.2 The Significant Case Review subcommittee of the Child Protection Committee agreed that each met the criteria for a Significant Case Review in line with the national guidance[1] at that time:

> '*When a child has not died but has sustained significant harm or risk of significant harm as defined in the National Guidance for Child Protection Scotland , and in addition to this, the incident or accumulation of incidents (a case) gives rise to serious concerns about professional and/or service involvement or lack of involvement*'
>
> (Scottish Government 2015, p.8)

1.3 The SCR subcommittee also considered findings from three previous significant case reviews in West Lothian, which included a themed review of two families with a focus on neglect, and identified that several findings were common across all. This led to wider discussions including to what extent the learning from reviews had been embedded in practice, what were the obstacles and what might be needed to support the implementation of learning into wider practice. Embedding learning into practice is an issue which has been discussed both at the local Child Protection Committee and also nationally at Child Protection Committees Scotland.

1.4 Significant case reviews and learning reviews are an important way of helping to understand the challenges for practice and provide important learning for multi-agency partnerships. West Lothian Child Protection Committee decided to undertake a Learning Together Significant Case Review for each case as well as undertake a wider consultation with staff from across services to understand the obstacles and what might be needed to support the implementation of learning into wider practice. This combined review applies aspects of the *Learning Together* methodology and blends a more in-depth review of two cases with wider staff consultation to incorporate a breadth of views.

2. Methodology

2.1 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.

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

[1] Scottish Government (2015) *National Guidance for Child Protection Committees Conducting a Significant Case Review*. Edinburgh: Scottish Government. During the course of the review, updated national child protection guidance was published in August 2020. Revised guidance was issued in September 2021 after the review had started.

- *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.

2.3 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.

2.4 The review was undertaken by two Lead Reviewers, both of whom are accredited and experienced in using the SCIE's Learning Together methodology and, while they had no connection to agencies in West Lothian, both had undertaken previous significant case reviews in West Lothian. The Reviewers were supported by a Champion, who is the Lead Officer for the Child Protection Committee. Ownership of the final report lies with the West Lothian Child Protection Committee as commissioner of the learning review.

Research questions

2.5 As mentioned, the approach to this case review was broader than the two individual significant case reviews and, therefore, the overall research question was:

- Why have messages from Significant Case Reviews and associated actions not resulted in practice change?

2.6 The time frame under review for Child C was November 2018 – January 2020.

Data collection

2.7 In order to gain a wider perspective on the aim of this learning review, there were additional activities as part of the process of data collection. A survey was developed and distributed to all agencies working with children and families to gather their views of how learning is embedded into practice. These broader findings were then explored in three discussion groups. Two groups were also held with practitioners most closely involved in each to explore events in more detail. Three additional conversations were held with professionals to clarify particular issues which had emerged through the group discussions for Case 1.

Survey

2.8 A survey was developed by the reviewers in partnership with the champion and chair of the Child Protection Committee's Quality Assurance subgroup and sent out to all agencies working with children and families including social work, education, Police Scotland, housing and local third sector organisations. The broad areas explored in the survey were:

- How do you hear about changes to practice or the learning from ICRs and SCRs?
- How is learning implemented?
- What supports the implementation of learning and what are the obstacles?
- What is needed to overcome the obstacles?

2.9 A total of 128 surveys were completed by social work (28%), education (23%), health (32%), housing (8%) and Police Scotland (Public Protection Unit) (2%). Other colleagues (7%) who contributed included those working in social policy, drug and alcohol services, and third sector. Sixty per cent of respondents worked directly with children and families, 21% worked in a management role, two per cent work in policy and practice development or had a strategic role and nine per cent had a combination of roles. The remaining colleagues worked in tenancy management, chaired looked after and child protection reviews or were involved in Inter-agency Referral Discussions.

Discussion groups

2.10 Three virtual discussion groups were held with frontline staff, frontline managers and middle managers from health, education, police, social work, third sector and housing. The four key questions identified above were explored in each discussion group as well as discussing the emerging themes from the survey. A total of 29 individuals took part.

Case groups

2.11 The SCIE model involves gathering and making sense of information about a case through conversations with the practitioners directly involved in each case who form the Case Group. Each group was involved in virtual discussions about the specific case, possible wider systemic findings and also what hinders and helps embed learning into practice. In each group there were nine participants and attendance at meetings is noted in Appendix A. Three further individual conversations also contributed to the review for Case 1.

Methodological comment and limitations

2.12 For this review to be completed within the identified timescales, a workshop approach was taken for each significant case review. There were no individual conversations with all staff. Instead, the independent reviewers together with the champion identified the areas of practice to explore with each case group. This was informed by multi agency chronologies and relevant paperwork. The areas of practice – or key practice episodes – were explored with participants in each case group to clarify points of accuracy and to identify what had contributed to decision-making. Timescales did not allow for further meetings with both case group to agree systemic findings. Findings have been identified in areas where the case group was clear that the practice issue was not unique to the case, was underlying and widespread. Where this was less clear, practice issues identified have been reported as learning points.

2.13 Due to the passage of time, some individuals were no longer in post. The social worker in Case 1 had moved to another local authority and did not take part in discussions and the FNP supervisor in post during the time period for the review was also not available although there was representation from the FNP at the Case Group. Three health professionals involved were unable to participate in the case group discussion, so conversations took place individually.

3. Perspectives of family members

3.1 A decision was taken by the SCR subcommittee not to involve either family in this learning review as both cases were sub judice at the time of the review.

4. Context of a global pandemic

4.1 The impact of a global pandemic has been considerable for services delivered to children, young people and their families already facing challenge. From March 2020, the situation was changing quickly and there was immense pressure on the whole system. This severely restricted the normal access to services as processes were displaced by necessity and many public sector staff were redeployed or duties re-assigned. The response to the pandemic is likely to have impacted on collaborative working and decision-making during this time for all working in social work, education and health with staff working from home and experiencing significant additional pressures.

5. Acronyms and terminology

5.1 There is a challenge in writing a report which protects, as far as possible, the privacy of all individuals concerned but provides sufficient evidence to support the findings. Where possible, gender neutral terminology has been used throughout this report, but can lead to some clumsiness of expression. Every effort has been made to write as clearly as possible to disentangle the elements of the system and how practitioners work in it. There may also be some repetition so that each finding and learning point is fully contextualised.

6. Structure of the report

6.1 Scottish Government guidance for undertaking a learning review was updated and published in September 2021. The guidance followed for producing this SCR report is the previous guidance published by Scottish Government in 2015 as this learning review was commissioned prior to publication of the new guidance. The approach to this review was systemic and proportionate as identified in the new guidance and involved all relevant staff (Scottish Government 2021c).

6.2 The structure for this report is as follows:

Part 1 Introduction
Part 2 Findings from two significant case reviews
Part 3 Feedback from survey and all groups
Part 4 Summary and conclusion

Part 2: Findings from two significant case reviews

7. Introduction

7.1 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).

7.2 In Learning Together, case review findings address the reliability of the Child Protection Committee area or about agencies and their 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.

7.3 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

7.4 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:

a. How the issue manifests in the particular case
b. In what way it is an underlying issue
c. Any information about how widespread an issue this is perceived to be locally, or data about its prevalence nationally

8. Summary and appraisal of professional practice

Details of the Case 1 has been summarised to prevent identification of the family involved

Case 1 Child C

8.1 The mother and her siblings were well known to services and a significant amount of information was available to agencies. As a child, the mother's name had been on the child protection register because of concerns of neglect, domestic abuse and parental alcohol misuse. Child C's name was placed on the child protection register pre-birth because of concerns about the mother's ability to meet the child's needs. Despite multi-agency involvement the child's situation did not improve to any great extent and concerns

remained. Child C was removed from the mother's care when they attended hospital with a fractured skull.

Case 2: Child D

8.2 Due to ongoing legal proceedings details of this case cannot be published.

9. Findings from two Significant Case Reviews

9.1 As mentioned previously, the two Significant Case Reviews discussed in this report are part of a wider learning review on what prevents learning being embedded into practice. In this context, the review identified one systems finding for each case. There were, however, further learning points discussed in each case group and those are set out in paragraph 10 as it was felt important to bring them to the attention of the Child Protection Committee.

9.2 This Significant Case Reviews identified the following three findings:

Finding 1 (case 1) In situations where parents have a mental disorder[2], there is insufficient understanding among children's services about the process of assessment, diagnosis and access to adult services which may leave some children living with vulnerable parents and in harmful situations for too long [Professional norms and cultures - longer-term work]

Finding 2 (case 1) Practitioners can sometimes be too dependent on the outcome of formal assessment of parents' capacity rather than responding to a child's current experiences which impacts on timely interventions to meet children's needs [Professional norms and cultures - longer-term work]

Finding 3 (case 2) There is tendency that professional interventions in adolescence focus on the presenting behaviours as problematic rather than seeing the child as in need of protection which means that children's needs are not fully addressed impacting on later development [Professional norms and cultures - longer-term work]

9.3 **Finding 1**

In situations where parents have a mental disorder, there is insufficient understanding among children's services about the process of assessment, diagnosis and access to adult services which may leave some children living with vulnerable parents and in harmful situations for too long [Professional norms and cultures - longer-term work]

A mental disorder such as depression or learning disability can inhibit a parent's ability to respond to their child's emotional cues and offer consistent care. All practitioners in children's services need to recognise and understand how child protection may overlap and interact with adult services and that sometimes investigations about risk to children may also indicate the need for adult support and protection.

[2] As defined in the *Mental Health (Care and Treatment) (Scotland) Act 2003*, the term mental disorder includes mental illness, learning disability and personality disorder.

How do we know it's an underlying issue?

9.3.1 The Case Group identified that this was not unique to this case and expressed a lack of joined up working between children and adult services, particularly with parents who have mental health issues including learning disability. The term 'mental health problems or learning disability' is often referred to by professionals without a clear analysis of how this manifests and the impact on children. Participants also discussed the difficulty of accessing services if there is no formal diagnosis and how this becomes a barrier to services and care.

How prevalent and widespread is the issue?

9.3.2 The Case Group agreed that in their experience the impact of parental mental health on their capacity to parent and the interventions most likely to be successful are not understood by professionals whose main focus is the child.

9.3.3 For the 2,654 children on the child protection register at 31 July 2020, there were 7,315 concerns at the case conferences at which they were registered, parental mental health problems accounted for over 1,034 of these recorded concerns; an increase of 17% from the previous year (Scottish Government 2021a). As previous reviews have identified, children were affected by parental mental health in 43% of SCRs analysed in 2007-2012 (Vincent and Petch 2012), 65% analysed between 2012-2015 (Care Inspectorate 2016) and in 36% analysed 2015-2018 (Care Inspectorate 2019). Mental health also featured in the Care Inspectorate triennial review:

> "*Our analysis of SCR recommendations highlighted that the majority were multi-agency and focused on the need to have coordinated and informed approaches across services to impact on a child's safety, health and wellbeing. Recommendations had implications for a wide range of different partners and services including adult services, housing services, mental health and wellbeing services, drugs and alcohol services as well as children's services*."
>
> (Care Inspectorate 2021, p.22)

Why does it matter?

9.3.4 From other reviews including a significant case review in West Lothian (West Lothian 2019), there is little understanding amongst professionals across children's services, about the impact of mental health on parenting capacity and the interventions most likely to be successful. Mental health covers a vast spectrum of conditions, each of which may require a different type of intervention at different times and have a potentially different impact on parenting capacity. As has been mentioned, there will be times when children's and adults services need to consider both the risks to children and the need for adult support and protection, so:

> *To ensure that individuals do not fall between eligibility and service criteria, co-ordination and collaboration is necessary between child and adult services at an operational and strategic level*
>
> (Scottish Government 2021b, p69).

Questions for the CPC

9.3.5 This finding raised the following questions for the Child Protection Committee:

a) Is the CPC confident that staff working in children's services have sufficient training to help them identify and act on parental mental disorder, and adult support and protection issues?

9.4 Finding 2

Practitioners can sometimes be too dependent on the outcome of formal assessment of parents' capacity rather than responding to a child's current experiences which impacts on timely interventions to meet children's needs [Professional norms and cultures - longer-term work]

Working with parents to change their parenting behaviour has to be carefully balanced against a young child's stages of growth and development. While parents need to be given the opportunity to make the changes and be supported to do so, the child's best interests must remain at the core of any planning or decision-making.

How do we know it's an underlying issue?

9.4.1 While not discussed directly with the Case Group, this issue is likely to be underlying as it manifested in other cases in terms of practitioners awaiting formal assessments of parents to inform decision-making in relation to children. In a previous significant case review (West Lothian 2019) a picture emerged of a lack of a multi-agency assessment of the needs of each family at a stage when concerns were identified or known by the Named Person. There was sufficient known historical information about the parents' childhoods and family circumstances to inform an assessment of the current situation.

How prevalent and widespread is the issue?

9.4.2 Vincent and Petch (2012) identified in their audit of 99 SCRs and ICRs conducted in Scotland since 2007 that in cases involving infants the focus of practice was sometimes unduly weighted towards the needs of the parents as opposed to the safety of the child. This was particularly likely in cases where parents were known to adult services due to substance misuse, mental health or domestic abuse and interventions focused on the needs of the adult. The impact of this on the health and welfare of children was not always fully considered.

Why does it matter?

9.4.3 In relation to babies and very young children, it is particularly important that assessments are timely as there is rapid developments in the early weeks of a child's life. It is also necessary to look to the future and assess what help will be needed as the child grows. This needs to be supported by effective planning and review processes, which monitors the parents' pace of change and the child's development, providing challenge where necessary.

9.4.4 Babies are particularly vulnerable because they are unable to communicate verbally and so practitioners need to be alert to their current lived experience. As the national risk framework (Scottish Government 2012) states:

> '*In child welfare there may be greater time and opportunity for working with parents/carers through the cycle of change. In a child protection scenario this will obviously be more boundaried by the character and severity of the risk (actual and potential) and time limited by the mandate to keep the child safe and protected*.'
>
> (Scottish Government 2012, p.83)

9.4.5 The National Practice Model (Scottish Government 2016) also identifies that assessment is required of the parent or caregiver's capacity to meet evolving needs at the different developmental stages. Answering the question *What do I (the child) need from people who look after me?* requires practitioners to think carefully about how to assess the parent's ability to change sufficiently or quickly enough when they are unable to meet the child's full range of fundamental needs and observing actual behavioural change is central to fair and accurate assessments of change.

Questions for the CPC

9.4.6 This finding raised the following questions for the Child Protection Committee:

a) Is the CPC confident that the quality assurance role of Reviewing Officers is understood?
b) Is the CPC confident that Reviewing Officers appropriately recognise escalating concerns and have the confidence to raise issues with senior managers where elements of a child protection plan are not being progressed?

9.5 Finding 3

There is tendency that professional interventions in adolescence focus on the presenting behaviours as problematic rather than seeing the child as in need of protection which means that children's needs are not fully addressed impacting on later development
[Professional norms and cultures - longer-term work]

Research (Brandon et al. 2020) has identified that risks of harm to adolescents may be hidden and harder to recognise and adolescents living in situations of neglect and abuse may be particularly vulnerable to having their needs, and the risks they face, overlooked:

> "*When confronted with adolescents who engage in risky behaviour, practitioners need to look beyond the immediate issues to consider how the young people might be vulnerable from neglect or other harm, rather than simply seeing them as putting themselves at risk*."
>
> (Department for Education 2021, p.89)

How do we know it's an underlying issue?

9.5.1 The Case Group identified that this is a challenging group of young people to work with.

How prevalent and widespread is the issue?

9.5.2 Research (Research in Practice 2011) indicates that risks experienced in adolescence may be particularly harmful and that adolescent-focused interventions can be very effective. A large longitudinal study of 907 participants concluded that adolescent maltreatment had a more pervasive negative impact on outcomes

in early adulthood (up to age 31) than childhood-limited abuse (Thornberry et al. 2010 as cited by Hanson and Holmes 2014). More recently, the Department for Education's (Brandon et al. 2020) recent triennial analysis of serious case reviews noted that younger children form the largest group of children who are the subject of a review, but there was an increase in the number of adolescent cases.

Why does it matter?

9.5.3 Children who suffer from traumatic stress are those who have been exposed to one or more traumas over the course of their lives. Potentially traumatic events may include: abuse (physical, sexual, or emotional); neglect; effects of living with poverty; witnessing harm to an individual or pet; and unpredictable parental behaviour due to addiction or mental illness. A key protective factor is their caregivers response and how they react to the child's needs.

9.5.4 The combination of those events and few protective factors can mean that children's reactions can include intense and ongoing emotional upset, depressive symptoms or anxiety, behavioural changes, difficulties with self-regulation, problems relating to others or forming attachments, regression or loss of previously acquired skills, and attention and academic difficulties. In older children and young people, this may develop into unhealthy drug or alcohol use and risky behaviours including unhealthy sexual activity. Challenging behaviours in children and young people may likely be a learned response to stress.

9.5.5 Some research has identified that children in their late childhood years who are cruel to animals may have witnessed domestic abuse or experienced childhood physical or sexual abuse. The relationship between child abuse and neglect, and childhood animal cruelty is complex and approaches to understanding this behaviour needs to be in the context of other behaviour and broader social environment (McEwen, Moffitt and Arseneault 2014). Left unaddressed, however, children as adults often find relationships difficult, struggle with mental health and regulating emotions, and struggle with addictions. Not all children with challenging behaviour will have experienced abuse and neglect, but it is important that professionals view children through the protective lens as much as the lens of youth justice. Shifting the focus from child protection and to youth offending can mean that abuse, neglect and children traumatic stress are not fully addressed.

Questions for the CPC

9.5.6 This finding raised the following questions for the Child Protection Committee:

a) How can the Child Protection Committee support practitioners to think about young people in the context of their wider family and community rather than presenting behaviour?
b) Is the Child Protection Committee confident that assessments include all members of the household, including biological fathers, new partners or ex-partners who are still involved with the family?

10. Learning points from two significant case reviews

10.1 In addition to the specific findings, several learning points emerged from the two significant case reviews.

Learning point 1 : Lack of focus on male carers

10.2 In both cases, much focus or engagement with professionals was with the mother and little information appeared to be recorded about the male caregivers or males living with the family home.

Learning point 2: Historical Information

10.3 In both cases, there was known and relevant historical information which was not given sufficient consideration.

10.4 This learning point about historical Information has emerged from several West Lothian ICRs and SCRs. Assessing what historical information is relevant and within what timescales is challenging. The lack of careful consideration of historical information impacts on effective planning. Past behaviours are often a good indicator of future behaviours. Practitioners reported, however, on the perception that written assessments for legal proceedings should focus on current evidence.

Learning point 3: Engaging with families

10.5 In both cases, there were concerns about aspects of the family that influenced professional thinking.

10.6 Engaging with families was another learning point which has emerged from several reviews across West Lothian. It was previously identified that professionals could be overly-optimistic with parents who were adept at keeping them at arm's length resulting in the assessment of risk to children being compromised. It was also apparent that there needed to be greater awareness when a child's wellbeing became a child protection concern. This was further compromised when the impact of parental mental ill-health or a possible learning disability on parenting capacity was not consistently recognised or understood across all child or adult focused services leaving some children living in risky situations.

Learning point 4: Lack of multi-agency planning

10.7 In Child's D cases, there was no multi-agency planning process or child's plan.

10.8 From previous ICRs and SCRs, the lack of multi-agency planning and a lack of clarity about the interface of children's planning process with other planning processes also featured. The lack of clarity about who undertakes the role of lead professional when social work is not involved can result in an absence of multi-agency planning, no multi-agency scrutiny or planned involvement.

Learning point 5: Multiple referrals to screening groups

10.9 In both cases, the families were subject to multiple referral to screening groups or other services for support.

10.10 From previous ICRs and SCRs, parents and children had been referred to screening groups for allocation of resources and interventions. Similar to the cases discussed in this review, there was no oversight or review of whether previous interventions had been successful and resulted in sustained improvements in the child's circumstances. The supports and interventions will be of benefit to many families, but for some

families repeated referrals were likely to have limited impact and the potential to be confusing for families.

Part 3: Feedback from survey and all groups

11. Findings from previous Initial and Significant Case Reviews in West Lothian

11.1 As mentioned, the findings and learning points identified from the two significant case reviews resonate with the findings from three previous Significant Case Reviews, which included a themed review of neglect involving two cases (see Appendix C).

12. Reflections from all groups and survey

12.1 The questions asked in the survey and three discussion groups were also asked of the case group members. The questions asked of the groups and survey included:

a) How do you hear about changes to practice or the learning from ICRs and SCRs?
b) How is learning implemented?
c) What supports the implementation of learning and what are the obstacles?
d) What is needed to overcome the obstacles?

12.2 The findings from previous significant case reviews were shared with all discussion groups and there was recognition of the issues raised in terms of wider practice across West Lothian. All the discussion groups and case groups recognised the issues previously identified through initial and significant case reviews. In particular, the balance with professional optimism and parental engagement, increased complexity of family situations, multi-agency referrals to screening groups without follow-up and lack of consistent standardised assessment tools, assessment and planning through the *GIRFEC* approach.

How do you hear about changes to practice or the learning from ICRs and SCRs?

Survey

12.3 From 128 survey respondents, people heard about changes to practice through different routes. Sixty six heard about changes to practice through either training and information sessions (52%) and 55 through team meetings whether face to face or virtual (43%). Thirty-eight respondents (30%) heard about changes direct from the CPC Lead Officer and 31 from the practice briefings including the 7-minute briefings (24%). Twenty-three responded they received newsletters (18%) and 13 accessed information from the CPC website (10%). Of the 32 respondents who said '*other*', nine heard from email circulation, mainly from managers or the CPC Lead Officer. Four were members of the CPC or attended a CPC subgroup. Education staff heard either directly from their Child Protection Officer or from Deputy Headteacher support meetings. Four respondents actively sought information on SCRs either through general websites, BASW Scotland or the media. Four responded that they did not receive information and one heard by chance.

Discussion groups

12.4 The middle managers who participated reflected that Information was shared to frontline staff in different ways across agencies. Information and changes to practice was usually cascaded from managers and shared with teams more widely along with any available executive summaries. There are multi-agency discussions within the Child Protection Committee and quality assurance subgroup. 7-minute briefings are developed and shared with teams. Information was also sent out through the Lead Officer for the Child Protection Committee.

12.5 Social work frontline staff and team managers agreed that changes to practice were highlighted through emails, team meetings and updates from managers. Team managers had previously provided briefings and extensive feedback to senior managers, but it was unclear what had happened with this feedback. The child protection lead officer in education provides annual updates for headteachers at the beginning of each session and also feeds information through the designated child protection roles in each school. Within Police Scotland, learning from all significant case reviews was identified at a strategic level and then cascaded out through email to inspectors and sergeants who decide if this information is shared via email locally or through face-to-face briefings and online training courses. Information was shared through health via multi-agency feedback sessions from significant case reviews, monthly health visitor team meetings and the intranet. Information shared by email was helpful, but there was recognition that numerous emails received daily meant important updates could get lost.

12.6 One issue to emerge through the discussions was about which staff groups were included in dissemination of practice changes. Some reflected that staff, who may not be as closely involved with child protection, but are involved and work with children at risk, do not always get the same information. This also included colleagues in adult services such as mental health, addictions and criminal justice; there was concern that a focus on the issues – such as offending - would fail to see the offender also as a parent and within a family.

12.7 Social work and health were more aware than education and police colleagues of the 7-minute briefings which were issued with key messages following the publication of reports from significant case reviews. Participants mentioned that previously West Lothian had held multi-agency study days which had been effective in sharing updates and bringing staff together. There had been no study days for several years which was thought to be because of resources and capacity. Single agency training had also been put on hold.

12.8 Finally, some participants reflected that there are areas of business where participation in training events or online course is mandatory in terms of data protection, for example. There are not the same expectations of compliance for child protection in terms of learning, briefings and training.

How do you get feedback on how learning is embedded?

Survey

12.9 Those who completed the survey were asked if changes been made to practice since 2018 arising from ICRs and SCRs. From 127 responses, only 3% replied that there had been lots of change, 32% replied that there had been some change, but slightly more replied they were not sure (35.5%), 25.5% replied there were not aware of any change and four per cent said there had been no change.

12.10 Survey respondents were then asked if the changes made had been embedded in practice. From 125 responses, 55 respondents said no, they did not know or were unaware of learning which had been embedded in practice (57.5%). Of the remaining respondents, 53 replied that changes had been embedded fully (11%) or partially (32%). Those who had answered yes fully, were asked to describe how this was done and what supported implementation. Responses ranged from the CPC being extremely vigilant in sharing up to date changes, training taking account of national and local changes, a relentless approach to GIRFEC and child protection procedures, training and advice and reviews on record keeping.

Discussion groups

12.11 Participants in the discussion groups identified there was no clear mechanism for feedback on how learning is embedded. Participants commented that they were aware learning was embedded, but were not always aware of where the learning had come from i.e. from significant case reviews, practice reviews or research, for example. Embedding learning also depended on good relationships between colleagues and across agencies. There were suggestions that a process for regular peer review and learning across all agencies would be helpful.

12.12 Some participants thought that learning was embedded through regular audit and review. The middle managers commented that health visiting was subject to an annual child protection audit across NHS Lothian. Recently social work had re-introduced an audit in child protection practice around risk analysis. Issues identified in relation to individual practice were addressed through supervision and wider patterns were fed back to senior managers for discussion within teams. Within Police Scotland, significant findings for the police would be reflected in amended standard operating procedures. Learning was also identified through the quality assurance subgroup which reviewed child protection registrations, Inter-agency Referral Discussions and repeat referrals.

What are the obstacles to embedding learning into practice?

Survey

12.13 A total of 38 respondents identified a range of obstacles which prevented embedding learning into practice. Four mentioned the impact of the pandemic on increased workloads, reduced face-to-face and joint learning, limited opportunity for team reflection and discussion, and the pressure of competing priorities. Six talked about the challenges including a lack of key partner awareness or learning, shared understanding, and a consistent and shared approach to embed learning across the partnership.

12.14 One detailed response was in respect of GIRFEC and the interface between the Named Person and Lead Professional roles. The respondent identified that although the roles are clear in a protective context, it is less clear at an earlier point in the intervention. Also, there is no shared assessment or plan format between agencies with variations of the Child's Plan and different information systems which are not connected. Chronologies and risk assessments were also identified as 'tricky' especially when there are accumulating concerns as opposed to one key event and that the "*ability to evidence and meet thresholds can always be difficult*" There were also a few responses about thresholds being dependent on individuals, ease of referrals and the difficulty in contacting social work to report concerns.

12.15 Time constraints, bureaucracy, poor funding, staffing levels and increased workload pressures were also identified as obstacles. Three responses commented on the limited opportunities involving schools and while improvements were being incorporated, understanding of lessons from ICRs and SCRs could be formalised. As one respondent observed:

> "*..as usual, it is time restraints. Chronologies are a great idea, but very time consuming and our workload is greater now than ever so it is difficult to fit it all in*."

Discussion groups

12.16 Some participants in the discussion groups reflected that perhaps there was a need to reassess the extent to which agencies shared the vision for children and young people, and priorities in relation to Getting it Right for Every Child and the culture for working together across agencies. Sometimes, the collaborative commitment to children feels inconsistent and this needs to be challenged by senior management:

> "*I think fundamentally we need to question just how joined up we are. We need to go right back to basics about GIRFEC into getting it right for every child and have discussions around what is our culture for working together? How do we get that one vision for young people? We need a joint vision from the top. The commitment to children feels inconsistent as is the collaborative commitment around young people, which goes back to our culture. Challenging this needs to come from the top*."
>
> (Frontline staff)

12.17 More practically, frontline staff reflected that opportunities for training, for example, on practice developments and tools to support practice were needed for a whole range of staff and reinforced through regular updates to help keep changes at the forefront of practitioners' minds until embedded firmly in practice. It was highlighted that developments can get lost when staff have busy caseloads and there are changes in staff. Middle managers commented that a high turnover of staff and managers meant the retention of learning was an ongoing challenge. Some teams had many newly qualified staff and teams can feel overwhelmed. Organisational change impacted on roles and this combined with national policy and practice initiatives such as The Promise and training for joint investigative interviewing meant there are various pressures on practice.

12.18 Frontline staff also commented that training needs to be good quality and informative, and available to a wider range of staff. There were perceptions that training around issues of child protection were not always available to staff not directly involved in children, but it was important that those staff felt included. Prior to the pandemic, there had been few opportunities for attending training and with even less opportunity during the pandemic. The impact had been that some staff no longer prioritised training or thought it was not part of their professional development. Staff talked of induction training, but there was little follow-up training and limited capacity to provide new staff with mentoring or tutoring.

12.19 Middle managers also commented that it was unrealistic to expect staff across different roles and in different agencies to embed learning at the same pace; for example, the findings from a significant case review will mean different things to different people. Also not all staff were aware why changes were being implemented. Participants commented that updates and briefings sometimes lagged behind publication of the significant case review.

12.20 Frontline managers observed that much communication across agencies was through email. Staff can feel that by sending an email they have taken action and shared concerns and risks. As participants reflected "*The power of a phone call should not be underestimated*" and "*a culture of email has replaced conversation*." This has become particularly apparent during the pandemic where the loss of informal discussions has meant a loss of sharing information and opportunities to challenge thinking about practice informally. Some frontline staff were also experiencing a loss in confidence. Frontline managers also commented they have a service development role, but increased workloads, reduced capacity and reduced budgets had impacted on their ability to deliver this aspect of their role.

12.21 Middle managers reflected that the message from research or reviews did not easily translate into practice which had been made more difficult with fewer training opportunities, reduced in person inter-agency working and the pressures of work during the pandemic. Participants also commented that the channel of communication can often be through one individual or one group. For example, the one child protection lead officer in education covers 60 primary schools and 11 secondary schools.

What supports embedding new ways of working or learning into practice?

Survey

12.22 The survey asked respondents for their views on what supports embedding new ways of working or learning into practice. A total of 74 responses reflected on the need for good leadership, ongoing training, regular and effective communication, and meaningful partnership working. A few respondents identified the need to discuss a shared vision, create a strong learning culture and encourage staff to actively engage with learning and development initiatives. Several commented this could be achieved through "*top-down approaches to ensure consistency and continuity of local and strategic practice*".

12.23 The majority identified training as one of the best ways to embed learning. They specified, training of team managers to cascade learning, mandatory training for frontline staff with protected time and not relying totally on online training but sessions which encourage discussion, providing examples and direct information behind new learning or policies. Respondents also stated they would welcome the opportunity of more discussion to understand the rationale for change with clear procedures disseminated to all staff. It was acknowledged that learning from significant case reviews is hard for staff and often there is a delay between the event and the learning, so frontline staff need to be supported in discussions about the changes needed. Commenting on the 7-minute briefings, one respondent reflected:

> "*… it is unlikely that a 7-minute briefing will change culture and practice as so much gets in the way day-to-day…but when robust multi-agency work is working it is really transformative for children and families' lives*."
>
> (Survey respondent)

12.24 Communication was also highlighted as a key factor; communication throughout the organisation to ensure consistent practice, between different agencies to share practice strengths and weaknesses, strengthen collaborative working and realising there is a common goal in improving outcomes.

Discussion groups

12.25 Similar to discussions about obstacles to embedding practice, participants reflected that all agencies would benefit from a shared strategic vision for services to children and families. Briefings needed to be part of a wider package of training and development. More practically, frontline staff suggested that a support network for peers would be helpful to seek advice and support, and to access information, and frontline managers thought more experienced staff should be given time to support and mentor younger or less experienced staff. Some thought a multi-agency resource where reports and practice learning were located would be helpful.

12.26 In order to address the loss of informal relationships, participants suggested making people more visible and highlighted that photographs could be attached to emails to help make people feel more connected. Co-location of teams would also support this. Regular smaller training events would support learning and encourage all staff to engage and participate, and help develop the confidence of staff and support decision-making. Participants reflected that:

> "*there is also something about real time learning at the right time for you and how change is really embedded when it is the right time for you. So how can we give opportunities for both protected learning and for people to revisit learning when it is relevant to them when our case demands it?*"
>
> (Frontline manager)

12.27 Participants thought that digital resources could be used more effectively and one example given was to have a digital dashboard for training to allow people to access, and re-visit training and learning through the process of embedding change into practice. Leadership was important and all managers have a responsibility for the dissemination. Induction training should be at several levels including corporate, service and team induction and people given the time to reflect and learn. Most agencies have continuous professional development so there should be an expectation of developing the workforce.

12.28 This needs to be supported with clear guidelines, particularly for those children "*bubbling under*"; for example, to help think through at what point agencies come together to consider wellbeing concerns, to help understand the criteria of each agency and identify what services and support can be offered if a child does not meet the criteria for a service from social work. Training and learning resources should also be made available more flexibly. Guidance was also discussed in relation to Getting it Right for Every Child. Frontline managers commented that GIRFEC guidance needed to be revised, there was a need for more training in the approach and a standardised approach across West Lothian, particularly in terms of the child's planning process.

12.29 Some agencies, such as health, commented that case supervision in addition to clinical supervision should be more frequent than six months. Facilitated peer supervision was also identified as a support to embedding learning into practice and developing the confidence of practitioners. More time for multi-agency case review and training opportunities with access to resources and peer learning would all be beneficial. Cases for multi-agency review could be identified through audit to help staff understand where learning comes. It would be important to create space to review and share good practice: "…*would be good to know what works now so that we can build on that*." Some had experienced multi-agency practice improvement sessions in another local authority and commented that this had helped staff understand the procedures, practice and processes of partner agencies.

Part 4: Summary and conclusion

13. Summary

13.1 There were several messages to emerge from case reviews, feedback and the survey about the key barriers to embedding learning into practice. To summarise these were identified as:

- Extent to which agencies share the vision for children and young people, the priorities in relation to Getting it Right for Every Child and the culture for working together across agencies;
- Translation of ICR and SCR findings or recommendations into practice can be difficult. This is particularly when they are seen as relevant to one agency, but not to others and learning, therefore, may not be given the same priority;
- Uncertainty in undertaking the Named Person or Lead Professional role in cases that have not reached the child protection threshold;
- Significant national policy initiatives and developments across services combined with local organisational change adds pressure on staff capacity and a sense of competing demands;
- Size of caseloads within health and social work were mentioned as a barrier due to volume of work and reduced time available for professional development;
- Increased workloads, reduced capacity and reduced budgets had impacted on the ability of frontline managers to deliver the service development aspect of their role.
- Lack of learning opportunities which includes multi-agency training, access to books and resources and multi-agency peer learning through discussion groups;
- Updates and briefings sometimes lag behind publication of significant case reviews meaning that staff were not always aware of the reasons for the practice chance and how it emanated;
- Learning can be lost over time through turnover of staff and managers, and change is not always at the forefront of a busy practitioner's mind. Learning needs to be regularly refreshed and reinforced and available in different formats including virtual, written and face to face.

13.2 The supports to enable learning to be embedded were identified as:

- Communication of a shared vision for children: this is relevant to all staff working across children and families and should be accompanied by clear statements for practice;
- Leadership at all levels: leadership is needed at all levels to promote a learning culture. Staff need protected time and frontline managers have a key role in supervising staff, championing culture change and embedding practice change;
- Opportunities need to be available to staff virtually, in person and through access to written material to develop their own learning. This includes mentoring, peer supervision, practice learning opportunities at team level and across agencies, access to formal training events alongside managers delivering 7-minute briefings, arranging events, and team discussion and inputs.

14. Conclusion

14.1 The overarching question of this report was to explore why messages from Significant Case Reviews and associated actions had not resulted in practice change. As discussed earlier, the barriers to embedding change and the supports required emerged from the case reviews, discussion groups and feedback from

surveys. In taking things forward, sustainable change requires leadership and ownership across all partners at organisational, team and individual levels. This requires a shared vision, shared priorities and a commitment of all partners in terms of support, supervision and training. Timely dissemination needs to present lessons learned and propose change in a way that all understand where the learning has originated and why change is necessary. All should have access to training and peer learning, and to ensure that change is sustained, the learning from ICRs and SCRs should be refreshed, reinforced and monitored through processes of quality assurance.

14.2 The complexity of using ICRs and SCRs as catalysts for change has also been recognised as reported by the Care Inspectorate:

> "*We were told by CPCs that changing culture and practice is complex and the ever-changing landscapes of children's services and child protection means that improvements and better outcomes for children and young people do not always happen quickly or in a linear fashion*."
>
> (Care Inspectorate 2021, p.19)

14.3 Similar to the findings of this learning review, the Care Inspectorate also identified the factors that support and learning and changes in practice including the importance of leadership which is supportive and challenging, strategies to support the roll-out learning with multi- and single agency training, promoting a culture of learning and reflection across all partnerships with the Child Protection Committee as the driver for change.

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Appendix A

Membership of Case Groups

Case 1 Child C

Associate Specialist, Community Paediatrician	NHS Lothian
Associate Specialist, Learning Disability Psychiatrist	NHS Lothian
Child Protection Nurse Advisor	NHS Lothian
Family Nurse	Family Nurse Partnership (FNP)
Family Nurse Supervisor	Family Nurse Partnership (FNP)
Social Work Team Manager	Health and Social Care Partnership
Sure Start Worker	Health and Social Care Partnership
Sure Start Manager	Health and Social Care Partnership

Appendix B

Findings from previous Significant Case Reviews in West Lothian

Consistency of record keeping

Findings

In West Lothian Health and Social Care Partnership the existence of different information systems across agencies for recording Inter-agency Referral Discussions decreases the likelihood that records will be consistent resulting in decisions about child protection being made on inaccurate data [Child A]

Across agencies, the lack of chronologies of children and families affects practitioners' ability to identify patterns of concerns, the accumulation of neglect and to respond appropriately which means that children may be living in circumstances detrimental to their health, wellbeing and development [Neglect SCR]

General feedback from SCR

- It was noted that case recording was not always up-to-date and sometimes incomplete. The Review Team commented that cases which are no longer active can remain open until practitioners update the case recordings. Team Managers have a role in the quality assurance of case notes and ensuring work is completed. It is important that this quality assurance role is undertaken consistently [Child B]

Frameworks and tools

Findings

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 [Neglect SCR]

In Children and Families social work, there is a lack of validated risk assessment tools, training and guidance in assessing risk of allegations of sexual harm which impacts on the quality of assessment and the analysis of risk [Child B]

Assessment and analysis

Findings

When key decisions are being made in cases of physical injury to babies and young children, there is a tendency for the medical contribution to be given prominence by other professionals, but parental and environmental factors must be considered and failure to do so can impact on the multi-agency analysis of risk [Child A]

Professional attitudes, confidence and skills in dealing with allegations of non-recent sexual abuse, where the perpetrator and victim are both children, hinders speedy allocation and robust, timely assessment which is likely to impact on the safety and wellbeing of some children [Child B]

General feedback from SCR

- Analysis of risk is not embedded within practice in all agencies; for example, the ICPCC pro forma is not consistent across all agencies and nor is it used consistently by all professionals. The reports varied in terms of the quality of analysis presented at this ICPCC. Generally, the report format used for ICPCCs supports information gathering but not analysis. Different organisational priorities and cultures may impact on the expectations given to the preparation and analysis of information contained within reports. In some, this is a summary of the information rather than a full analysis of risks and protective factors in relation to Baby S; for example, analysing the information in terms of low/high strengths and low/high concerns in the resilience vulnerability matrix (National Risk Framework 2012) [Child A].

Planning processes

Findings

Across West Lothian Health and Social Care Partnership, there is a lack of shared organisational and professional clarity about the interface of the Discharge Planning Meeting with the formal child protection system, which can compromise the safety and wellbeing of children [Child A]

Across West Lothian Health and Social Care Partnership, there is a lack of shared organisational and professional clarity about children's planning processes and their interface with the Inter-agency Referral Discussion, which can compromise the safety and wellbeing of children [Child B]

General feedback from SCRs

- 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 [Neglect SCR]

Historical information

Finding

In child protection decision-making fora in West Lothian, there is a clear focus on the importance of evidence, but not enough credence given to 'grey areas', which increases the likelihood of assumptions being made about the safety of parents' behaviour in the future [Child A]

Use of language

Findings

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 [Neglect SCR]

There is a tendency for professionals to assume meaning rather than verify language that is open to interpretation and this can lead to assumptions and misunderstandings about the nature of services involved in protecting children [Child A]

There is a tendency for professionals to assume the meaning of language that is open to interpretation which can lead to misunderstandings about the level of risk impacting on keeping children safe [Child B]

Engaging with families

Findings

The impact of parental mental ill-health on parenting capacity is not consistently recognised or understood across all child or adult focused services which can leave children living in situations which may put them at risk [Baby S]

Professionals' inclination towards optimism with parents who are adept at keeping them at arm's length can result in the assessment of risk to children being compromised [Child A]

Screening groups

Finding

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 [Neglect SCR]

Supervision and support

Finding

Professionals in universal services are increasingly managing complex situations without adequate challenge, support or oversee their practice or decision-making leading to some children being at risk of significant harm for longer periods than necessary [Neglect SCR]

Role of named person and lead professional

Finding

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 [Neglect SCR]

Managing gaps in service delivery

General feedback from SCR

- All organisations, at times, experience staff absences, lack of capacity, challenges in allocating cases and competing demands on resources. It is important that during such times there is consistency to continue to prioritise the agreed work underway [Child B]

Informing professionals of a child's death

General feedback from SCRs

- It was raised on several occasions that professionals who had worked or continued to work with the family had not always been made aware that a child had died and that some consideration be given to how information is shared appropriately [Neglect SCR]