care inspectorate

Learning from
Significant Case Reviews

March 2015 to April 2018

Contents

Introduction

Scottish Ministers asked the Care Inspectorate to become the central collation point and undertake qualitative evaluation on all significant case reviews (SCRs) from 1st April 2012. The Care Inspectorate is required to report publicly on these findings to provide independent public assurance on the quality of services for children and young people; to share any learning and good practice; and to support improvements to child protection practices and policy across Scotland (National Guidance for Child Protection Committees Conducting a Significant Case Review, 2015).

This report presents the findings from our analyses of 25 significant case reviews that concerned 44 children and young people, carried out by child protection committees in Scotland between 1 April 2015 and 31 March 2018. Twenty-two out of the 25 SCRs related to incidences of child abuse and/or neglect, of which 19 related specifically to children under 5 years old. Three of these SCRs were also affected by Sudden and Unexplained Death in Infancy (SUDI)[1]. A further three concerned teenage suicide. Appendix 1 provides a table of case type.

This report builds on our previous triennial review published in 2016 Learning from Significant Case Reviews in Scotland: A retrospective review of relevant reports completed in the period between 1 April 2012 and 31 March 2015.

Methodology

The method we adopted for this report is the same as that taken in our preceding report. We studied individual case reports to extract key sets of information, which we used to populate a bespoke database. This enabled us to analyse on a case-by-case basis as well as a cross-case basis to identify relevant themes for the context of learning. Anonymised case illustrations are used to emphasise key learning points.

[1]Sudden and Unexplained Death in Infancy (SUDI) is deemed to have occurred where there is no known pre-existing condition which would make the death predictable. Infant deaths which happen suddenly, and which there is no apparent reason, are unexpected. https://www.sudiscotland.org.uk/about-sudi/

Executive summary

This report presents the findings of a retrospective review by the Care Inspectorate of 25 significant case reviews (SCR) conducted in Scotland over the three years from April 2015 to March 2018. It follows our previous report Learning from Significant Case Reviews in Scotland: A retrospective review of relevant reports completed in the period between 1 April 2012 and 31 March 2015.

A significant case review is a multi-agency process for establishing the facts of, and learning lessons from, a situation where a child has died or been significantly harmed. Significant case reviews should focus on learning and reflect on day-to-day practices and the systems within which those practices operate.

The overarching objectives of significant case reviews are outlined in National Guidance for Child Protection Committees Conducting a Significant Case Review, published by the Scottish Government in 2015. They are fundamentally to establish whether there are lessons to be learned about how better to protect children and young people and help ensure they get the help they need when they need it in the future.

This review of significant case review reports reflects a number of familiar themes from earlier reviews that remain areas for learning and development for child protection committees and children's service staff across agencies. These include information sharing, thresholds for intervening with families, particularly in relation to neglect, and working with resistance and disguised compliance.

We also found a degree of uncertainty about the operation of named person and lead professional roles. This uncertainty was particularly evident following the Supreme Court judgement in July 2016 on the provisions for the sharing of information by named persons.

The importance of well-managed, interagency collaborative working was evident in supporting planning and decision making alongside timely and appropriate sharing of information. In 12 of the reports we reviewed, there was a need to strengthen processes for effective development and review of the child's plan with multi-agency input.

A further recurring theme was that of children remaining unnoticed in neglectful or harmful situations until a threshold for child protection was reached. This was a factor in just over half of the SCRs we reviewed. As in our previous review of SCRs 2012-2015, 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.

Findings from this review also highlight the importance of children's service staff being well supported to be confident and competent in their assessments and making good use of chronologies. Linked to this was the importance of seeing and listening to the child. This has been a recurring theme and in this review, nine of the 25 reports found a lack of focus on the child's or young person's experiences and perspective in considering their wellbeing and safety.

The second part of this report considers the quality and consistency of SCR process and reports. Regardless of the methodology used, we found some reports to be overly descriptive with too much of a focus on what happened and not keeping the child as the focus of the review. The more analytical reviews provided deeper insight, reflection and consideration of what went wrong and why, made effective use of research and presented clear findings.

Summary of key learning points

- Uncertainty within the system around underlying assumptions, expectations and understanding of the named person service and lead professional role is undermining professional confidence. This is resulting in a lack of a coordinated overview of children's and young people's needs. The effectiveness and implementation of GIRFEC is dependent on professionals working in partnership so that children, young people and their families get consistent support and the right help at the right time. The roles and interface of the named person and lead professional are crucial to coordinating early intervention and integrated support across the continuum of children's wellbeing needs, particularly given the majority of the children were all known to universal services and not subject to care or protection measures.

- Where there are many agencies involved, the use and effectiveness of the team around the child process strengthens inter-agency working, multi-agency planning and decision making. The process ensures clear lines of responsibility and that the actions of the different agencies and professionals are well coordinated and reviewed through the single child's plan. To be effective requires a multi-agency, collaborative approach that is dependent on inter-professional working in coproduction with families. This discourages silo practice and promotes a greater understanding of everyone's roles and responsibilities in keeping children and young people safe and protected.

- 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.

- The vulnerability of children remaining in neglectful or harmful situations until a threshold for child protection is reached highlights a need within the system to clearly articulate a shared understanding of thresholds. This is compounded by variability in how definitions of neglect are understood, interpreted and applied. This is particularly so when wellbeing concerns are perceived to be below the threshold for child protection. Likewise, the assumptions that are made about the meaning of language that is being used such as 'wellbeing concerns', 'thresholds' and 'neglect' are not commonly shared and collectively understood and these concepts merit further consideration.

- Identifying and addressing need at the earliest opportunity to prevent problems escalating is dependent upon practitioners understanding and recognising neglect and putting in place effective responses to prevent wellbeing concerns worsening. This brings inherent tensions and challenges for practitioners where the multi-faceted nature of neglect presents systemic challenges, bias and a predisposition in how neglect is recognised and responded to. A systemic shift is needed from focusing on addressing the symptoms to addressing the core cause. However, this requires an understanding of the wider social, economic and cultural factors that impact on neglect and other adverse childhood experiences (ACEs).

- Across the SCRs we reviewed there was little or no reference to the investment and impact of early intervention and preventative services. There was little about the programmes of parenting work or preventative initiatives being undertaken with children and families that specifically targeted the impact of multiple adverse childhood experiences such as neglect, domestic abuse or parental substance misuse at the child, family, community or societal level. Nineteen out of the 25 SCRs concerned children under five years old, and prevalence of adverse childhood experiences (ACEs) was present in most of these cases. Increased awareness and understanding of the impact of ACEs and adopting trauma-informed principles and practice would support the development of a common language and shared approach towards addressing the cause and treatment of ACEs. Research identifies the need for a tiered level of prevention measures being required in directing efforts and focus.

- Good mental health and wellbeing is fundamental in helping children and young people succeed and reach their potential. The review identified three teenagers, all female, who had died as a result of suicide. Ensuring that responsive, trauma-informed treatment and prevention services are readily available to support vulnerable young people within their local communities is crucial in ensuring that they and their families get the appropriate help and support they need, when they need it.

- We identified the need for improved rigour and effectiveness of the assessment and decision-making process in almost all the 25 SCRs we reviewed. While a range of factors acted as barriers to effective assessment, the use of the GIRFEC National Practice Model and Risk Assessment Framework when applied consistently and comprehensively, supported an evidence-informed approach to reaching decisions about children's and young people's care planning. Lack of and poor chronologies continue to hinder the assessment process to support practitioners to make a properly informed assessment of risk, particularly in instances of cumulative harm and neglect. Likewise, an incident-focused or crisis-orientated response to concerns hampered effective analysis of risk and needs.

- A lack of a comprehensive and evidence-informed assessment can impact on decision-making about whether grounds for compulsory supervision of the child have been met. Understanding what information the children's hearing requires in order to make a fully informed decision that is in the best interest of the child is central to this process, and in making timely referrals.

- Maintaining a focus on and understanding the child's or young person's experiences and perspective in considering their wellbeing and safety is reliant on practitioners seeing, listening and being attuned to the non-verbal behaviour the child is displaying.

- To safeguard and be effective, practitioners need to be confident and competent, and properly supported in their role. This means having strong structures in place that provide the opportunity for robust and regular supervision that enables constructive challenge and time to reflect on practice and develop skills.

- This review notes that the barriers to learning that could improve the quality, consistency and use of SCRs are the same as those identified in our previous review of SCRs 2012-2015. This review has also identified the high number of ICRs that do not progress to a SCR and a need to analyse the decision making where there has been a decision not to initiate an SCR, and to identify key themes and learning arising from ICRs and SCRs.

- Across the child protection landscape there is a wide range of work being undertaken to strengthen and improve multi-agency working and improve child protection practice at local and national level. This includes the revision of the 2014 National Child Protection Guidance and implementing the recommendations for improvement from the Child Protection Systems Review which is being overseen by the National Child Protection Leadership Group.

Part One: Key themes influencing practice

Findings

In common with previous studies[2], which remain very relevant, the findings identified in this report reflect familiar themes. These include issues around effective information sharing; intervention thresholds, particularly within the context of neglect; inter-agency and multi-agency working; professional curiosity and challenge; dealing with resistance and disguised compliance; engaging directly with children; and effective supervision and management oversight.

A recurring theme emerging from this report relates to the role of the named person and lead professional within the Getting it right for every child (GIRFEC) approach in inter-agency practice to promote the wellbeing and protection of children and young people. This was a prominent feature in half of the SCRs we reviewed. The effective use of the 'team around the child' process was also highlighted in over half of the SCRs we reviewed. We have explored these specific findings to draw attention to important issues and the potential for wider learning.

Lack of clarity of the named person and lead professional roles in interagency working

Getting it right for every child (GIRFEC) is the national approach in Scotland that puts the rights and wellbeing of children and young people at the heart of services. It provides a framework within which universal or specific services can offer the right help, at the right time, from the right people. The GIRFEC approach has been a landmark children's policy in Scotland since 2010. GIRFEC makes a clear point of contact available for children, young people and parents - the named person. However, the provision of the named person does not detract from all practitioners having responsibility to promote, support and safeguard the wellbeing of children and young people within the context of partnership working. Where support is asked for or offered and it is established that a child has wellbeing needs that require support from a range of services, or from more specialist services, the planning and delivery of that support needs to be well organised and coordinated. GIRFEC helps provide a consistent approach to planning this support through a single planning framework, called a child's plan. Where it has been agreed that a child's plan should be prepared, it is the lead professional's role to ensure the multi-agency plan is coordinated. Depending on the situation, including consideration of the child's needs, the lead professional and named person may be the same person. Overall responsibility for delivering a child's plan sits with an organisation such as a health board, local authority or independent school (Scottish Government policy update, July 2017).

The provision of a named person has been the subject of debate following the Supreme Court judgement[3] issued in July 2016. Statutory implementation is on hold so that Scottish Government can

[2]Rose and Barnes 2008; Brandon et al 2008; Vincent 2010; Vincent & Petch 2012; Care Inspectorate 2015 and most recently, Sidebotham et al 2016.

[3]The particular concern of the Supreme Court has been 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 along with providing greater clarity around the Act's information sharing provisions. .

review what changes would be required to meet the Supreme Court judgement requirements. Findings from just under half of the SCRs we reviewed show there is perhaps a degree of confusion and uncertainty within the system that is undermining the professional confidence and role of the named person and lead professional.

Ten of the 25 SCRs we reviewed made specific reference to the named person and lead professional role, eight of which predated the Supreme Court judgement. In these SCRs, there was an element of 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 is illustrated in the following SCR learning point.

"One issue continues to headline in this review and that is the named person process. It is impossible from this review alone to assess how widespread the issue is but what is all too obvious in this case is the gaps both in practitioner knowledge of their role as named person in terms of gathering information, sharing information and progressing concerns towards solutions in a joint approach with other agencies when necessary and in particular, the use of the meeting structure that is clearly laid out within guidance."

National guidelines on GIRFEC from Scottish Government state that "Where those working with the child and family in the universal services of health and education have concerns about a child and think that a co-ordinated plan involving two or more agencies will be necessary, then a lead professional will be needed to coordinate the actions of the different agencies and draw up a multi-agency child's plan. The need for a coordinated plan may have arisen out of a growing concern over time, or it may be have been triggered by a particular change in the child, or an event, or behaviour of the child or family, or because the child and family, in working with the Named Person, have identified that extra help is needed"[4].

However, the underlying contextual issues influencing practice are summed up in this particular SCR finding on the role and interface of the named person and lead professional role, which concluded that:

"There is no shared organisational and professional clarity in children's services about the role of the named person, lead professional and child's plan, particularly in the context of health and early years education". In this particular case, the SCR identified that both health visiting and early years staff had their own single-agency plan and determined that "The absence of a multi-agency plan set the tone for a lack of coordinated approach, resulting in several single-agency plans. In line with the GIRFEC approach, when two or more agencies are involved, a lead professional should have been considered to take on a coordinating role."

The following finding raises a relevant point about inter-professional practice and clarity of role for practitioners working within a single- and multi-agency context.

[4]Practice Briefing 2 The role of the Lead Professional

"Many practitioners are, at any moment, potentially working from within a single discipline or agency identity; as part of an early years initiative; delivering within universal provision and/or under the auspices of early intervention. How, then, are they to be helped to achieve clarity about the moment that they move beyond their single-agency remit to a multi-agency arrangement such that the question of appointing a lead professional to co-ordinate activity becomes relevant? This is made even more challenging by the issue of 'additionality' within single agencies which reinforces a particular framework for understanding the situation being worked with, from within a single professional orientation."

Other SCRs identified that there was inadequate knowledge of the roles and responsibilities of other agencies amongst those professionals involved with the family. One review concluded that:

"The role of the named person under the principles of GIRFEC policy was relatively new at the time and not always fully understood by professionals and may have contributed to confusion as to who was co-ordinating support for the family."

One SCR identified hesitancy by some staff to assume the lead professional role:

"We heard that there had been previous difficulties around joint working as some health professionals were reluctant to take on the role of lead professional. We were not confident this had been fully resolved".

Another SCR cited cultural issues that had presented barriers to successful implementation:

"Getting it right for every child is followed in principal across the partnership, but culturally there are issues with the shared ownership of case responsibility and establishing the lead agency."

These findings highlight a level of confusion, locally and nationally, around underlying assumptions, expectations and understanding of the named person and lead professional role in coordinating integrated support across the continuum of a child or young person's wellbeing needs. The importance of having clarity, coherence, consistency and conformity of approach in delivering and implementing the national GIRFEC policy successfully is captured in the finding below from one SCR.

"There is not sufficient clarity about the role of the named person and lead professional as set out within GIRFEC guidance particularly for children and families for whom there are wellbeing concerns or when two or more agencies are involved. There is confusion nationally, which has been exacerbated by the recent delays in implementation of Getting it Right for Every Child in relation to information sharing and wellbeing concerns. Nevertheless, it is important for the child protection committee to be clear about how this will operate locally, otherwise the variability will continue and important information about individual children may not be identified and shared at an early enough stage in order to support and help families."

This mirrors the message arising from our report The joint strategic inspection of services for children and young people: Review of findings from the inspection programme 2012-2017. While the majority of frontline staff reported in our staff surveys that they understood their named person or lead professional role and responsibilities, a degree of uncertainty surrounding the implementation of the named person service was apparent on the part of some staff that could serve to undermine confidence in carrying out these important roles and responsibilities. This was particularly evident following the Supreme Court judgement after July 2016 in respect of the named person's information-sharing provisions, where the threshold for professionals to share information about children and young people had the potential to breach children's and families' rights to privacy[5].

The 2017 programme of improvement to address neglect and enhance wellbeing undertaken by the Centre for Excellence for Looked After Children in Scotland (CELCIS) highlighted several key themes, challenges and insights arising from parents, practitioners and managers that emerged as potential areas which, if strengthened, would improve local partnerships' ability to address neglect and enhance children's wellbeing. This included strengthening the role of the named person and the pathways for families to access timely, proportionate and appropriate support at times of stress or strain; and high-fidelity implementation of GIRFEC across and between local authority and health board boundaries. In this work, practitioners shared the challenges and different skills of occupying the role of the named person and its connection with team-around-the-child meetings and lead professional roles alongside their primary roles as health visitors or teachers.

Use of the 'team around the child' approach

Getting it right for every child (GIRFEC) introduces the principle of a single plan that coordinates and records support, no matter what the child's needs, to be used by a single agency or several agencies working together to support the child. The child's plan is generally discussed and reviewed in a single forum: the child's plan meeting. The format and attendees of the child's plan meeting will reflect the complexity of the child's needs and circumstances[6].

This process, also referred to as the team around the child meeting was a theme identified in 12 of the 25 SCRs where opportunities to strengthen multi-agency planning around the child through the child's plan was highlighted as an important learning point, as these SCRs emphasise.

"Though a named person and lead professional were identified, the communication and sharing of information never led to a team around the child meeting or formal review of all aspects of the case."

"There were missed opportunities to convene a meeting around the child. There was a lack of clarity about who the lead professional was and whose responsibility it was to

[5]Coles et al (2016) in their analysis and findings of GIRFEC development and implementation found that there was 'considerable scope for interpretation within the GIRFEC legislation and guidance, most notably around assessment of wellbeing and the role and remit of those charged with implementation. Tensions have arisen around issues such as professional roles; intrusion, data sharing, and confidentiality; and the balance between supporting wellbeing and protecting children' (Coles et al 2016, in Milbank Q. 2016 Jun; 94(2): 334–365).
[6]Practice Briefing 6, Scottish Government, 2010.

convene a meeting. The clear and agreed identification of a lead professional might have helped the agencies to share information better."

Equally, in other SCRs, the team around the child meeting lacked enough rigour in reviewing the child's plan and monitoring its effectiveness. In some cases, the child's plan was not individual to each child where it was a sibling family, was too generic to provide sufficient clarity regarding expected actions and outcomes, or had not been updated, or continued without any tangible improvement or progress being made.

"The child's plan section of the assessment, agreed and monitored through the team around the child meeting, remained unchanged from approximately a year previously and was too generic to provide sufficient clarity for the family and professionals involved regarding expected actions, change, impact and contingency plans."

Ensuring relevant professionals are invited to contribute and attend the team around the child meeting and be included in the development and implementation of the child's plan is crucial to effective multi-agency working. Sidebothom et al (2016) highlights the important role of multi-agency meetings with professionals involved in a child's case 'encourages information to be shared and roles to be clarified, improving multi-agency working and allowing professionals to gain a holistic view of the case' (Sidebothom et al 2016, p 116).

A few SCR reviews acknowledged the good practice of practitioners involved in the team around the child process in meeting regularly to share information and review the child's circumstances. Other aspects of good practice involved child-centred planning that ensured the child's plan focused on addressing the child's individual needs across all aspects of their wellbeing.

Other reviews highlighted the importance of ensuring that the outcomes from meetings and child's plans are shared with all the relevant professionals involved with the child in order to provide the right support to support children's identified needs. One SCR identified the barriers that hindered such effective practice.

"It is normal practice within [this area] for head teachers to attend child protection core groups and case conferences. As such, teachers were not invited to attend either conferences or core groups nor were they given comprehensive feedback around the outcomes of the meetings. Teacher's non-attendance at case conferences and core groups as well as the poor feedback to them about the detail of child protection plans created gaps in their knowledge about what was impacting on the children's ability to focus and learn at school day-to-day. It prevented them from recognising the adversities they were facing and from taking different approaches to the children around their behaviours."

These findings stress the importance of effective information sharing and meaningful communication between professionals in relation to child's planning in order to ensure that children's wellbeing and concerns are fully recognised, understood and are appropriately supported and coordinated across the GIRFEC continuum.

Sharing information effectively and inter-professional communication

Barriers to information sharing and communication were findings highlighted in our previous review of SCRs 2012-2015. This included sharing of relevant information or failing to appreciate the significance of the information that was shared, and making assumptions about the wellbeing of children from the information shared. These themes remain highly relevant and common to this review.

Of the 25 SCRs we reviewed, 20 specifically highlighted difficulties that had impacted on effective information sharing and inter-professional communication. A few SCRs cited issues relating to information management systems hampering effective inter-agency working. These included differing IT systems that did not facilitate sharing of information by professionals in the same organisation, for example between GPs and health visitors. Most findings identified that information-sharing protocols and guidance were in place and a few attributed individual professional errors to protocols and guidance not being consistently applied or effectively followed in practice in their findings.

A common response or recommendation from such findings was the need to improve or increase understanding, compliance and conformity or to reinforce the importance and consistency of use of already existing guidance or protocols by staff, as this SCR recommendation highlights.

"The adult protection committee, child protection committee and senior managers within the health and social care partnership should re-issue the current procedures for information sharing and ensure that all staff are aware of and understand their role and responsibility in sharing information."

Guidelines and procedures are helpful tools to support professionals in their role. However, to be effective not only do they need to be appropriately disseminated, accessible and consistently applied, they also need to be regularly promoted through "appropriate training, ensuring that protocols and guidelines are up-to-date, relevant and reflect good practice, and their implementation monitored through audit and governance arrangements" (Sidebothom et al, 2016, p 226). Such an approach shifts the narrative away from an ethos of blame at the individual case level to one that encourages continual improvement within the wider context of organisational learning. However, in their analysis of serious case reviews that spanned more than 10 years, they purported "that, despite national guidance and legislation, there are deep cultural barriers to effective information sharing among professionals" (Sidebothom et al, 2016 p 164).

Other SCR findings that are defined as barriers to effective information sharing and communication are related to:

- the quality and robustness of the information being shared
- uncertainty between practitioners about how much, with who, when and what information to share
- limited or restrictive information sharing within and between services and with families
- information sharing at the threshold below that of child protection, relating to wellbeing concerns
- information sharing at key points of transition and cross-boundary issues
- miscommunication, misunderstanding and misinterpretation of information being shared or sought

- corroborating and triangulating information from different sources
- insufficient attention to existing available information and prominence
- routinely seeking information from other professionals when assessing risks
- accessing past (known) history.

The National Guidance for Child Protection in Scotland (Scottish Government 2014) states that 'to secure best outcomes for children, practitioners need to understand when it is appropriate to share information, how much information to share and what to do with that information. Practitioners also need to consider from and with whom information can and should be sought and/or shared' (p 26).

Despite national guidance[7] and local information sharing protocols and agreements, our findings show the uncertainty within the system about data protection issues that are impacting on practitioner's understanding of what information to share and when. This has perhaps been exacerbated by the Supreme Court ruling[8] and legislative amendments as this SCR finding reveals.

"Nationally there is variability in local implementation of the Getting it right for every child policy not helped by the current review of legislation and policy in relation to information sharing and wellbeing concerns. It is important that the understanding of the process for a coordinated approach to multi-agency planning and delivery of services is supported by all agencies from senior leaders to individual practitioners. Otherwise the variability will continue and important information about individual children may be lost."

Another SCR identified that an inconsistent approach to the named person role and lack of information sharing had failed to link concerns relating to the children's wellbeing and safety.

"Once the named person process had been introduced and was embedded across agencies this did nothing to prompt professionals to share information with named persons for either child. Had information been available to the relevant personnel this would have better informed professionals regarding the risk to the children."

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, as this learning point highlights.

"In their communication with each other, practitioners used general terms or euphemistic language around describing the potential indicators for neglect within the household such as describing the home circumstances as a poor house and family were considered to be 'doing fine for a struggling family'. Terms such as 'high-risk', 'additional

[7]Information Commissioner's Office (ICO) Letter of Advice 2016 - Information Sharing. http://www.gov.scot/Topics/People/Young-People/gettingitright/information-sharing

[8]Following a legal challenge, the Supreme Court judgement ruled that changes are required to the information sharing provisions in Part 4 of the Children and Young People (Scotland) Act 2014 and to make those provisions compatible with Article 8 of the ECHR. The Scottish Government sought to clarify information sharing requirements through the introduction of the Children and Young People (Information Sharing) (Scotland) Bill. The Bill is at Stage 1 in Parliament, with further consideration to follow publication of a draft Code of Practice.

needs', 'support' and 'failed visit' were not necessarily understood in the same way by other agencies. The term 'support' was itself ambiguous and did not specifically identify to other practitioners what support was being offered."

Sharing of information with parents and carers and balancing child safety and protection responsibilities with a duty of care while respecting a young person's right to confidentiality were findings specifically highlighted in the three SCRs of young people who had died through suicide. This included the role of child and adolescent mental health services, where confidentiality issues hindered good communication and effective information sharing practices with parents or carers.

"The need to consider the balance of maintaining confidentiality regarding the young person while ensuring that families and carers have enough relevant information to make informed decisions about safety."

"Partner agencies tasked with supporting the mental and emotional health of vulnerable children and young people need to improve the way they communicate and share information both with each other and with those adults within the family who care for the child/young person."

"If there is any doubt about the wellbeing of the child and the decision is to share, the Data Protection Act should not be viewed as a barrier to proportionate sharing."

These findings show that despite agreed principles and guidance in place about sharing personal or confidential information, ambiguity still prevails for some professionals around the legal and ethical tensions between maintaining confidentiality and the sharing of information confidently. Information sharing agreements that help set out the processes and principles for sharing of information between organisations are commonplace across all local community planning partnerships in supporting effective governance and were referred to within some of the SCRs we reviewed. However, the balance between the need to share information and protect confidentiality would appear to remain challenging within and across structures and organisational systems.

It is unclear if, in preparation of the new General Data Protection Regulations (GDPR) legislation, there has been any implication in its use and compliance that may have impacted or undermined professional confidence or caused over-cautiousness. Given the timeframe of the SCRs in this period of review, the implementation of GDPR had not been put into effect however, organisations would have been preparing for this legislative change.

As well as navigating within these complexities, practitioners need to be confident about exercising their professional judgement. The findings reveal the tensions that remain around information sharing at the threshold of low-level wellbeing concerns and where there is perceived risk of harm, which in turn influences the level and type of response and action taken. Richardson et al (2006) identified ways in which professional cultures can shape information sharing behaviour and attitudes between collaborating agencies: "professional culture can influence information-sharing behaviour in two important ways, through the characteristics associated with individual professional backgrounds and through the ways in which professionals from different backgrounds interact" (p 661). They also

highlight that attention needs to be given to original training and professional development in order to create professional values that are more outward looking and that strengthen levels of inter-professional trust (p 666).

The SCR extract below demonstrates an example of the inherent challenges between the duties of care and the duty to share where children are deemed to be vulnerable but the child protection threshold may not be met or fully assessed.

"The reviewers found that a potential barrier to effective information sharing was a concern amongst specialist mental health services about balancing their duty to protect children from harm and their general duty towards their patient or service compounded by child protection guidance which was not universally applied. The tension between confidentiality/consent, duty to care versus duty to share, is far easier to overcome when a case is very clearly at the level requiring child protection intervention. It is far less straightforward when the risk of harm has not been clearly assessed."

One SCR identified that legal issues had impacted on treatment and support because of staff uncertainty about the legal framework that underpinned their work and where better use could have been made of adult support and protection legislation.

Silo practice and insufficient joint working was a feature identified in eight of the 25 SCRs we reviewed where disparate information sharing by practitioners within and across agencies had hindered effective information sharing. In one case, this had resulted in important information relevant to keeping children safe being overlooked as a result of not involving other relevant professionals sufficiently.

"Third sector agencies were perceived as the least professional partners in some areas of care and unable to be trusted with some confidential information due to others being wrongly bound to their interpretation of the rules on confidentiality. This caused a pattern of silo working that failed to draw on the full strength of the multi-agency partnership in identifying and meeting the children's needs causing the children to suffer as a consequence."

The importance of effective information sharing, and inter-professional communication is highlighted as a central learning point in the following SCR.

"A culture of pro-active information sharing by all practitioners is a critical element of a safe and reliable child protection system. All practitioners involved have a professional responsibility to pro-actively share relevant information, within the framework of data protection and human rights legislation, with other practitioners who need to know in order to protect the child. Good decision cannot be reached without good information."

Equally, one SCR identified good practice in that when corroboration was explicitly sought an understanding of the child's situation began to be reframed in significant ways. Despite recurrent issues identified in communication, a few SCRs highlighted examples of effective information sharing practice and good collaboration taking place across the partnership.

"There was evidence of health visiting services, midwifery services and social work services working together. Within records there was evidence of joint visits, information sharing and discussions about ways in which the parents could be supported. Individual workers were persistent in maintaining contact with the parents despite levels of avoidance. They linked with other services such as housing to resolve difficulties in relation to accommodation."

A few SCR findings also identified examples of effective sharing of information across organisational boundaries relating to children's wellbeing including the use of multi-agency forums in assessing and responding to low-level difficulties or concerns. These local forums enabled good working relationships to form, building trust and communication between practitioners and the effective coordination of support to children, young people and families.

Lack of shared understanding and clarity of thresholds

The issue of thresholds, particularly what constitutes a child protection case, and lack of shared understanding and clarity between children deemed to be in need of protection and children considered to be in need of additional support has previously been highlighted by Vincent & Petch (2012) and more recently by Sidebothom et al, 2016.

Half of the 25 SCRs we reviewed identified issues around thresholds for intervention. Most of the children subject of these SCRs had not been identified or assessed as a child in need of protection prior to the significant event leading to the SCR but they had been known to services and were receiving support as children in need within the context of GIRFEC to support their wellbeing. These SCRs deemed all these children to be vulnerable and that they had been let down in one way or another; either that their needs had not being sufficiently assessed, or effectively addressed or supported to prevent concerns escalating. The importance of appropriate help and support to promote wellbeing of children who are identified as vulnerable but assessed as not meeting a child protection threshold is reinforced in this SCR.

"The family entered the multi-agency system at a threshold below that of child protection and at the heart, this case concerns issues relating to information sharing at this threshold; that is, children deemed to be vulnerable but who are assessed not to meet the need for protection."

Sidebothom et al (2016) affirms that only a small minority of SCRs come wholly out of the blue and specifies that "more needs to be done to support children and families with these known vulnerabilities and especially to be on the alert for vulnerability slipping into the need for child protection. This raises issues about long-term planning and support and how known vulnerabilities are responded to at a strategic as well as an individual case level" (Sidebotham et al, 2016, p 241).

The SCR finding below identifies such vulnerabilities, particularly where unborn and newborn babies are assessed as needing additional support but are below the threshold for child protection and where practitioners are not being sufficiently well supported within the system.

"The number of babies in the system (born and unborn) identified as having additional needs is far greater than those assessed as being at high risk, who 'qualify' for structured multi-agency support due to falling within the high-risk threshold. Often, it is community midwives who are tasked with management of such cases. Additional needs can very quickly become higher level needs but for a professional acting alone and under pressure, without a supporting structure within which to triangulate information with other professionals and without access to regular supervision, this shift can be more difficult to detect."

Likewise, the vulnerability of children remaining unnoticed in neglectful or harmful situations until a threshold for child protection was reached when harm had been caused to the child was a specific factor in just over half of the SCRs we reviewed, as this SCR highlights.

"This finding is most particular to the large numbers of families where children are subject to consistent levels of neglectful parenting but where no single incident easily meets the high-risk threshold of a child protection referral. It is only in understanding the signs and the cumulative impact of neglect that the right kind of assessment can be made, and referrals can be framed in a way that points appropriately to the behaviour that puts children at greatest risk."

Platt et al (2014) found that a range of factors can affect thresholds. This included the nature of the welfare concerns for the child, the policy and organisational circumstances and the role of collaborative practice amongst professionals. The finding from the SCR below demonstrates this ambiguity in the system to clearly articulate a shared understanding of thresholds and threshold decisions.

"Criteria for information sharing needs to be well understood where the concern triggers child protection procedures and also where the concern is less than that required to trigger child protection procedures."

The consequences of not having a shared understanding of thresholds, particularly in relation to neglect, are highlighted from this SCR finding.

"There were instances when professionals became desensitised to the risks inherent in this case. Thresholds became blurred and professionals did not always see the extent of the deterioration in the home circumstances. This resulted in the child remaining in a neglectful situation for longer than necessary."

Munro (2011) highlights the major challenge and dilemma that exists for practitioners 'of deciding when to escalate the level of professional involvement and the risks to, and potential harm that can come to children who are being supported in community services when they are in fact being neglected and hurt and should be referred to statutory child protection services' (Munro, 2011, p 80). Munro further emphasised the significant role of 'designated and named leads working in early years, education and health who have an important role to play in responding to the challenges involved in assessing whether children's presenting needs means they are suffering, or are likely to suffer, significant harm' (Munro, 2011, p 81).

The Getting it right for every child (GIRFEC) approach provides the contextual framework for the Scottish Government's aim of ensuring a shared, consistent and child-centred approach to supporting the wellbeing of all children and young people. It is within this coordinated planning framework that universal services, are best placed to provide support and to identify and address need at the earliest opportunity to prevent problems escalating or raise a concern about a child's wellbeing needs. However, this is dependent upon practitioners recognising and responding appropriately when wellbeing needs are worsening.

"The absence of a shared understanding of thresholds led to problems with decision-making throughout the period under review. Periods of deterioration were not always recognised and sometimes minimised by professionals. Even when evidence pointed to a significant decline there was a failure to act."

This was a common finding in most of the SCRs we reviewed where children's and young people's difficulties had either been missed or their needs had gone largely unrecognised.

One SCR in which the young person's circumstances did meet child protection thresholds was the subject of an inter-agency referral discussion (IRD) process. However, the case finding identified that a failure to follow up with a debrief meeting[9] meant that the ongoing harm and risk to the young person was not fully assessed, including whether there was a need for statutory intervention to keep them safe.

"There were opportunities to share information in a multi-agency partnership way; however, the IRD debrief, which should have been held after the conclusion of the police investigation, did not take place. This meant that the decision taken at the IRD, not to do a joint interview with the young person was not reviewed and the opportunity to consider any additional supports within a multi-agency forum was not available."

Differences in professionals' perceptions and responses to neglect

Neglect is the primary maltreatment issue faced by Scotland's children and there are known weaknesses in the current assessment of, and response to, the problem (Scottish Government, 2017). However, it can be difficult for professionals to identify neglect and to evidence whether the threshold for statutory social work intervention or court action has been reached (Wilkinson and Bower, 2017, p 15). The Scottish Government's Child Neglect in Scotland follow-up survey in 2016 asked child protection committees if a formal definition of neglect was used by practitioners to identify children experiencing neglect. While most reflected the definition provided in the Scottish Government's 2014 National Guidance for Child Protection in Scotland, it was less clear as to how local definitions were interpreted, applied and consistently used across both statutory and universal services. Consequently, these differences in perception lead to inconsistencies and variations in the way neglect is assessed and in differences of judgement about what constitutes 'good enough parenting', even among professionals within the same team (Horwath, 2005).

[9]The purpose of a debrief IRD meeting is to ascertain what information has been obtained to date, to identify and/or assess on-going risk, to make a decision on how to proceed with the investigation and to make a plan to support and protect the child or young person, which will include the allocation of further tasks to individuals and agencies, and the setting of timescales.

Of the 25 SCRs we reviewed, neglect was a prominent and contributory feature in over half of them. All these SCRs alluded to missed opportunities to intervene or to recognise signs or patterns early enough. As in our previous review of SCRs 2012-2015, 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 from a range of universal and statutory services, in some cases for several years within the context of the GIRFEC approach.

We highlight in this report several factors and challenges that act as barriers to professionals recognising neglect and intervening early and effectively enough to protect these children and young people from significant risk or harm. This includes a focus on addressing the symptoms rather than the root cause and understanding the social, economic, and cultural factors and the inequalities that impact on neglect.

As well the issue of thresholds, including the need for statutory intervention, other factors related to an underlying culture or ideology where professionals were, or had become, desensitised to neglect. This had acted as a barrier to recognising and responding effectively. In a few of the SCRs we reviewed, the issue of inter-generational neglect and of deteriorating conditions over time influenced how practitioners addressed and responded, as the following findings illustrate.

"If due to the familiarity of dealing with 'run of the mill' cases practitioners have become desensitised to the impact on children of domestic abuse, one aspect of which may be neglect, then there is an increased likelihood that more children, living in these circumstances will be left vulnerable and suffer neglect."

"There was a view shared across professionals that the issues affecting this family were faced by many in the community. Mother and her wider family had been known to both universal and targeted services for several years and their lives included a combination of poverty, domestic abuse, low moods experienced by the mother and the adverse childhood experiences of both parents."

"In the many and varied contacts that different agencies had with this family, no consistent view of the home environment was developed. It appears that at some stages different staff saw different areas of the house, but the wide variety of views expressed, suggest that this is a complex area where staff at times appeared reluctant to make, what may be seen to be, judgemental statements or condemn a 'lifestyle choice'."

The SCR finding below cites the particular social and environmental factors that are associated with neglect and related assumptions, predispositions and beliefs, and the implications this has for professionals to identify and intervene early in making decisions about children's wellbeing.

"The scale of poverty and deprivation in some areas is making it more difficult for practitioners to recognise potential risk indicators within common behaviour, with particular implications for cumulative patterns of child neglect. The importance of early

intervention to support child wellbeing is widely recognised, but the contexts within which some families live make it arguably more difficult for practitioners to recognise when they need to intervene. The danger then is that they wait for behaviour that is abusive in its impact to become more obvious. Earlier acknowledgement of child neglect is more likely to result in a coordinated professional plan for a child and their family."

Other barriers influencing practitioners' practice to intervene more effectively included having an over-optimistic view about parents' capacity for change or parenting ability even when there was evidence to the contrary. The 'rule of optimism' has been a recurring theme of significant case review analysis and was a feature highlighted in our preceding review. This was a specific finding in seven of the SCRs we reviewed, where over-optimism can dominate as this SCR highlights.

"Staff adopted the rule of optimism. They believed that in providing a number of different agencies, their services and staff to provide support, something would eventually work."

Other SCR findings referred to how the need to balance the professional focus on facilitating change with maintaining a positive relationship had been a barrier to respond in an appropriately authoritative way when the risk of harm was escalating.

"A strong commitment to an asset-based approach to working with children and families are an important aspect of a safe and reliable child protection system. However, issues of resistance can be missed where practitioners are over-focused on maintaining positive relationships with families and are not supported to recognise the need to make an objective assessment of progress and the impact on the child. Taking an authoritative approach can be challenging for even the most experienced practitioners, however persisting with positive practice in the face of resistance, whilst easier for the practitioner and parent/carer, risks leaving children without the help and support they need for longer than is necessary."

Sidebothom (2017) contends that 'authoritative practice enables professionals to adopt a stance of professional curiosity and challenge from a supportive base, rather than relying on undue optimism' (Sidebothom, 2017, p 201). A lack of effective and proactive challenge, not recognising or responding appropriately to behaviour of non-engagement, ambivalence or disguised compliance was a feature identified in 10 of the 25 SCRs, as this SCR finding illustrates.

"Throughout the period of the review there was little evidence of meaningful cooperation by the parents and evidence of disguised compliance. The absence of improvement and lack of meaningful engagement was not robustly challenged by professionals. Failure to recognise disguised compliance led to the children living in neglectful circumstances for longer than was necessary."

Other obstacles cited in reports that had impacted on practitioners' ability to confidently challenge and exercise professional curiosity and authority with difficult to engage families included:

- appropriate staff development and supervision to support practitioners' confidence and skills to have difficult or authoritative conversations
- clarity about how to record issues of resistance in an ethical and defensible way
- a shared understanding about how to assess resistance and the threshold for an authoritative response
- managing the tension between relationship building and the need to work authoritatively where change is not being achieved or sustained.

The West of Scotland Practitioner Portfolio Working with Resistance (2016) was a tool identified in one review as a positive framework in supporting practitioners to recognise, understand and manage resistance, non-engagement and non-compliance.

A key finding from our report **The joint strategic inspection of services for children and young people: Review of findings from the inspection programme 2012-2017** found that "the complexities of recognising the point at which wellbeing concerns require to be escalated should not be underestimated and there remain challenges for staff and managers in practice, however, this is a critical area for improvement as the negative and long-term effects of neglect on a child's behaviour, educational achievement, emotional wellbeing and physical development are profound" (Care Inspectorate, 2018, p 25).

Wilkinson (2017), draws on research by Brandon et al (2013; 2014) to highlight the challenges and range of factors that can act as potential obstacles for professionals in sufficiently recognising and responding to neglect and determining whether statutory thresholds for action has been reached.

These included the following.

- The chronic nature of this form of maltreatment can mean that professionals become habituated to how a child is presenting and fail to question a lack of progress.
- Unlike physical abuse, for example, the experience of neglect rarely produces a crisis that demands immediate, proactive and authoritative action, making it difficult to evidence that the threshold is met at a specific point in time.
- Neglect can in some cases be challenging to identify because of the need to look beyond individual parenting episodes and consider the persistence, frequency or pervasiveness of parenting behaviours, which may make them harmful and abusive.
- Practitioners may be reluctant or lack confidence to make judgements about patterns of parental behaviour, particularly when these are deemed to be culturally embedded or associated with social disadvantages such as poverty or when the parent is a victim.
- The child may not experience neglect in isolation, but alongside other forms of abuse. (Wilkinson, 2017, p 23)

Of the 13 SCRs we reviewed where cumulative or chronic neglect was a specific feature in the case, only two considered and made specific reference to evidence-based assessment tools that helped practitioners identify and assess when a child could be at risk of neglect or potential harm. This related to the use of the Graded Care Profile tool[10], designed to help professionals measure the quality of care being given to a child to help in identifying neglect.

"The partnership has introduced an evidenced based framework for practitioners working with cases of neglect. Implementation has been supported by training and a series of staff briefings."

One case identified that there had been no agreed tools or assessment frameworks available to assist staff on cases of neglect and that specific training was limited. This finding demonstrates the need for improved systems to support the early recognition and response to assessing neglect.

"The apparent difficulties that staff face in defining and discussing neglect in relation to a home environment suggests that additional training in this area would be helpful in supporting staff to move from considering such issues as subjective and potentially judgemental to acknowledging them as core to the assessment of a family's situation."

The Neglect Review (Scottish Government, 2012) highlighted the confusion on whether the focus should be on the severity of the neglect and the associated harm to the child or the likelihood of the parents being able to accept help and make changes without the need for compulsory measures. Consideration and use of statutory measures to protect the child appropriately where there was evidence of cumulative concerns of neglect, were findings that featured in eight of the 25 SCRs we reviewed. This related to not escalating intervention for children who may be in need of compulsory measures of care to the children's reporter timeously or delaying making a referral until there was an accumulation of concerns or, the impact on the child became more obvious or, not referring at all.

Factors influencing this related to professionals persevering with families to maintain positive engagement, perceived co-operation and giving opportunities to achieve change (the rule of optimism). Another aspect arising from these SCRs related to practitioners' perceptions of thresholds in relation to neglect. There was a notion that a referral to the reporter would not sufficiently meet the criteria or grounds for compulsory measures, particularly where the family was perceived to be engaging with agencies voluntarily. One SCR identified that practitioners' experience had led them to believe that a more detailed level of evidence of the impact of neglect was expected compared to physical abuse before the children's hearings would consider compulsory measures of care. These SCR findings raise a pertinent point regarding the need to provide strong, evidence-based assessments and having a clear understanding of process and impact as these findings highlight.

"Hearings rely on information from all key stakeholders to inform decision making about whether grounds for compulsory supervision of the child have been met. It is in the interest of all referrers to fully understand what information the children's

[10]The Graded Care Profile is an assessment tool that assesses the care of children and helps in the identification of neglect https://www.nspcc.org.uk

hearing requires in order to make a fully informed decision that is in the best interest of the child. It is also in the interests of the child for referrers not to pre-determine the outcome of the process and delay referring the case. Equally, it is important for panel members to be fully trained and undertake regular development activities to ensure they fully understand the impact that particular forms of abuse in particular neglect, can have on children."

"A lack of understanding by social work with respect to regulations governing the children's hearing system may aide tensions concerning the decisions being made by the Hearing. Conversely hearing members require a good understanding of the impact of trauma, poor attachment and violence as a consequence of parental dysfunction."

The no order principle[11], also referred to as the minimum intervention principle is the responsibility of a children's hearing to decide that an order should only be made if it is considered better for the child than if no order was made. The findings raise the question as to whether this is a misperception or common premise within the system that is driving practitioners' practice.

"If practitioners are not presenting information through a referral to the Reporter on the perception that the referral will not be accepted or a hearing will not impose compulsory measures, then children may be left in situations of risk for too long and practitioners create a new standard/threshold that is not in line with legislation, with the result that children can become inadequately protected in family placements."

Conversely, one SCR describes a case in which children had been referred to the local authority for voluntary support[12] from the children's reporter, as a compulsory supervision order was not deemed necessary, but this support had not been put into effect. A lack of effective quality assurance and management oversight led to drift in this case, which resulted in the children's wellbeing and safety being severely compromised.

The findings discussed in this section demonstrate the multi-faceted nature and challenges for practitioners in recognising and responding effectively to neglect concerns that are enduring and complex. 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.

[11]Section 28 of the Children's Hearings (Scotland) Act 2011
[12]Section 68(5) (a) of the Children's Hearings (Scotland) Act 2011

"There is a shortfall in practitioners' ability to recognise, understand and address neglectful behaviour that is not being picked up in supervision, which leads to an ineffective response to the cumulative impact of neglect on a child's development and wellbeing."

Brandon et al's (2013) thematic analysis of neglect found that strong leadership and management support is needed to help practitioners manage, monitor and think systematically about a case where neglect is, or might be an issue (Brandon et al, 2013, p 78).

Rigour and effectiveness in assessment and decision making

Opportunities for improvement in the rigour and effectiveness of the assessment and decision-making processes were identified in almost all the 25 SCRs reviewed. Themes included the quality and timeliness of assessments; analysis of the impact and cumulative risk of harm on children's wellbeing and safety; an over-reliance on single sources of information; assessments being undertaken as one-off events rather than a continuous process, and the use and effectiveness of tools and frameworks to explore risks and vulnerability in the assessment process. Similar themes in relation to assessment and decision making were identified in our previous review of SCRs 2012-2015 and have also been discussed in previous studies (Vincent and Petch 2012).

One SCR we reviewed for this report identified a pattern in which assessments appeared not to have been undertaken thoroughly enough, driven by the need to meet prescribed timescales.

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

Other SCR findings identified a lack of a coordinated approach relating to pre- and post-birth planning and transitions. The absence of a pre-birth assessment or not fully assessing the needs and risks to vulnerable newborn babies meant that possible opportunities for early intervention and support were not offered or were missed. This was a feature in six of the 25 SCRs we reviewed, where there was a lack of clarity in undertaking a pre-birth or post-birth assessment, particularly where vulnerabilities and wellbeing concerns were deemed to be below the threshold for child protection.

"Some information existed in health records regarding the mother's exposure to previous domestic abuse and to having had a previous change of partner during the term of her pregnancy. This information which may have been relevant to inform post natal assessment of risk, was not considered effectively in assessing risk."

The SCR finding below emphasises the clear need for a collective, joined up response to pre-birth and post-birth planning and transitions, particularly where services cross geographical boundaries.

"There was no co-ordinated approach to the mother's ante natal care; she was not linked to the local midwife and no home visits were made as antenatal visits were not routinely carried out by health visitors in the local area."

A third of SCR findings highlighted the relative invisibility of children to adult care services for which the focus is primarily on the adult as the client or patientas this finding below describes.

"Some services for adults take insufficient account of children connected to their clients and thereby fail to identify risks to their wellbeing and safety or alert relevant others to do so. The challenge of systems that are organised to deliver services separately to adults and to children is to retain sufficient focus on all parties and relationships which may be impacted by the behaviour of the client. Where the client is the child, their dependency upon adults inevitably implicates those adults in the assessment of their world."

Opportunities for improvement noted in eight of the 25 SCRs related to the lack of a holistic assessment in considering relevant risks across family groups and reflecting these within the child's assessment and child's plan. This absence had left some children within family groups less well protected.

"The practitioners involved in this case, in implementing the principles of GIRFEC often operated in a culture that focused on the individual children; with a lack of focus on working with the whole family. A number of opportunities were missed at key decision-making points, to consider the issues for the family as a whole."

"Although an acknowledgement of historical factors and history was recorded, there was no review or bringing together of information held which viewed the whole family unit and assessed the risk and needs of all the children."

Our report **Alcohol and Drug Partnerships: The use and impact of the Quality Principles – a validated self-assessment (2017)** found that while a number of alcohol and drug partnerships were embedding a whole-family approach within their key processes to support a parent's or care giver's recovery, the needs and wellbeing of the children were not always fully considered in the assessment. The report identified that inter-agency working between alcohol and drug services and children's services could be improved by strengthening the GIRFEC process.

The lack of rigour in undertaking an assessment of parenting capacity was highlighted in seven SCRs, four of which attributed to the needs of learning-disabled parents. A lack of formal assessment to better understand parental needs and tailor the appropriate interventions and support impacted adversely on the child's development, basic care and emotional needs, which had resulted in chronic neglectful care or significant harm. One SCR made the following recommendation.

"That an assessment, directed to understanding the needs of parents with learning disabilities, in the context of child protection and child development concerns, should be undertaken at an early stage. Such an assessment would inform practitioners whether

any special arrangements need to be put in place when working with learning disabled parents."

Another SCR identified that an over-reliance on process had constrained or compelled practitioners to work in a very prescriptive and inflexible way in exercising their professional judgement to provide the appropriate support to a parent with perceived learning difficulties.

"There was a lack of confidence by practitioners to act on their own initiative and shape interventions that met the mother's learning needs, rather they remained bound by procedure that demanded a formal diagnosis of learning disability before additional steps would be taken to support her."

Sidebothom et al (2016) found that "bureaucratic processes are implemented with the intention of forming a robust and replicable mechanism around professionals and families to ensure best practices are upheld". However, they also acknowledged that "rigid processes may at times be incompatible with the realities of how services operate and are accessed" (Sidebothom, 2016, p 193).

The GIRFEC National Practice Model and Risk Assessment Framework[13] provides a common and standardised approach and tool for practitioners and agencies to assess information and analyse risk and need in an informed, structured and evidence-based way. However, the use and application of these tools to aid professionals' thinking and inform interventions was variable and inconsistently applied, as the findings from these SCRs highlight.

"At critical points in the management of this case the assessment processes, including professional practice, were not consistently effective. In particular, tools which assist with assessment, analysis, care planning, risk assessment and risk management were not always deployed."

"The assessment provided in this case presents a wealth of historical and chronological information but with no analysis of what that information may mean in relation to the impact on their parenting capacity or wellbeing outcomes for the child. In effect, the tools used have become a 'checklist' for information gathering rather than an effective means of assessing that information."

Our review of findings from the joint strategic inspection programme of services for children and young people 2012-2017 found that around six out of ten assessments of both need and risk were evaluated as good or better. However, a persistent proportion, around one in ten, remained weak or unsatisfactory. While some partnerships performed better than others, our review found a clear relationship between quality assurance processes and better performance in relation to assessment.

In looking across the 25 SCRs we reviewed, nine referred in their findings to an incident-focused or crisis-orientated response having been given to concerns. Rather than looking more broadly at

[13]National Practice Model and Risk Assessment Framework is a toolkit to support the assessment of children and young people in identifying and acting on child protection risks. https://www.gov.scot/publications/national-risk-framework-support-assessment-children-young-people/pages/2/

underlying issues and taking a holistic view of existing historical information to inform risk, incidents had been dealt with in isolation.

"There were numerous occasions when incidents occurred which in turn generated opportunities for assessments to be undertaken and for decisions to be made about the need for professional interventions. Most incidents were dealt with sequentially but in isolation, individually and without aggregating them into a picture of wider concern."

Sidebotham (2017) emphasises the dangers of working within an incident-focused model that "carries the risk of harm to children continuing unabated for long periods of time, and ignores the huge damage that will already have been done to the victims by the time any action is taken" (Sidebotham 2017, p 80). This is typified by the SCR finding below.

"The incident driven approach is inconsistent with understanding, at a sufficiently deep level, the needs of the young person as a whole. We did not see much evidence of professionals revising judgements in the light of new information, continued or changed behaviour or discussions with young people as their concerns and priorities changed. Once a causal hypothesis or assessment had been formed, this rarely changed and once the identified problem, as understood by the professional, had been dealt with, the professional closed the incident/case leaving problems addressed only in part or superficially."

Effective use of compiling and using chronologies

The absence, quality and effective use of chronologies, both single- and multi-agency, to help practitioners understand and appraise the nature and level of risk and impact of significant events on the child was a recurrent finding in 11 of the SCRs we reviewed. This was a specific theme arising from our previous review of SCRs 2012-2015 where a multi-agency chronology might have helped clarify case history information and identify patterns or accumulations of concern.

Subsequently, our report **The joint strategic inspection of services for children and young people: Review of findings from the inspection programme 2012-2017** also found the quality and standard of chronologies remains a continuing and challenging area of practice. We concluded in it that chronologies were not being used sufficiently well to enable staff across agencies to analyse shared information, identify patterns and determine and review the right course of action to keep children and young people safe.

Sidebothom et al (2016) asserts that 'the use of chronologies and systematic review of the history and development of a case can facilitate recognition of the accumulation of concerns' (Sidebothom et al, 2016, p 198). We found the lack of shared analysis was a specific feature in all the 11 SCRs reviewed in compiling and using chronologies to help practitioners understand analyse and appraise the nature and level of risk and impact of critical points on a child's wellbeing outcomes.

The following SCR findings highlight the barriers when chronologies are either absent or not of sufficient quality to support practitioners to make a properly informed assessment of risk, particularly in instances of cumulative harm and neglect.

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

"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".

Identifying and responding appropriately to adverse childhood experiences (ACES)

Adverse childhood experiences (ACEs) are stressful or traumatic experiences occurring in childhood that can have a huge impact on children and young people throughout their lives. The term adverse childhood experiences was originally developed in the US in the context of the Adverse Childhood Experiences (ACE) Study[14]. It has since been the subject of study in numerous other countries and has been accepted to mean:

"Intra-familial events or conditions causing chronic stress responses in the child's immediate environment. These include notions of maltreatment and deviation from societal norms." (Kelly-Irving et al 2016 in Couper & Mackie, 2016, p 6).

ACEs include domestic abuse, parental abandonment through separation or divorce, a parent with a mental health condition, being the victim of abuse (physical, sexual and emotional) being the victim of neglect (physical and emotional) a member of the household being in prison, or growing up in a household in which there are adults experiencing alcohol and drug use problems (NHS Health Scotland). There are a range of other types of childhood adversity that can have similar negative long-term effects. These include bereavement, bullying, poverty and community adversities such as living in a deprived area including neighbourhood violence (Scottish Government, 2018). Prolonged exposure or accumulation of multiple adverse experiences in a child's life can create toxic stress[15] and increase the risk for negative outcomes.

Identifying and responding appropriately to parental needs and risks while retaining the focus on the child in the ongoing assessment process was a recurring theme in most of the SCRs we reviewed. Adverse parental risk factors were evident in most of the 25 SCRs and had contributed to the maltreatment, neglect or abuse of children. Parental mental ill health issues were prevalent in nine of the SCRs, parental alcohol or substance misuse was identified in 10 of the SCRs and domestic abuse featured in 10 of the SCRs we reviewed. Seven of the SCRs included adults who had spent

[14] http://www.cdc.gov/violenceprevention/acestudy/about.html

[15] Toxic Stress happens when a child experiences severe and ongoing stress - like extreme poverty, abuse, or neglect - without any support. Toxic Stress can damage the way that a child's brain develops and can lead to lifelong problems in physical and mental health (Fond, M., Haydon, A., & Kendall-Taylor, N.2015, p12).

time in prison or had a history of criminality or anti-social behaviour. Eight of the SCRs contained a combination of those risk factors. In the majority of the cases, the adults were identified as the primary care givers and had direct caring responsibilities for their children. Fourteen of the SCRs identified the parents or carers as having experienced adverse childhood issues. These included bullying, sexual exploitation and mental health issues.

Findings from these SCRs identified that the likely impact of parental vulnerabilities or behaviours (including the social conditions affecting parenting capacity and impact of cumulative risk of harm and neglect on children) was not always adequately explored or fully considered in the assessment process. Conversely, effective examples of preventative and early intervention initiatives or evidence-informed programmes to build resilience in children, their caregivers and within communities were not well highlighted within SCR findings.

The deaths of very young children as result of sudden and unexpected death in infancy (SUDI) featured in three SCRs we reviewed. These children tragically died during sleep with no warning signs or clear reason but their death was not found to be a direct consequence of injury or severe neglect. However, all the infants presented with pre-existing concerns, including neglectful care to warrant a significant case review being undertaken. These related to poor-quality parenting and supervision, poor living conditions within the family home and parental non-engagement with services. All these very young and vulnerable children had been exposed to adverse childhood experiences from birth, with emotional and physical neglect a prominent feature. Environmental risk factors included issues of substance misuse, parental mental ill health and domestic abuse. One child was the subject of child protection registration and child protection plan. Concerns in relation to unsafe sleeping environments such as co-sleeping was a feature in two SCRs with one SCR identifying the need to raise greater awareness and understanding, as this risk reduction finding highlights.

"Assessment and education re SUDI given the noted historical issues re co-sleeping and what would appear to have been known risk factors i.e. ongoing addiction, smoking and leather couches. Failure to subsequently gain access meant this was not addressed or explored. Safe sleeping requires to be highlighted within and across agencies".

Brandon et al (2008, 2013) emphasised the importance of an 'interacting risk perspective' in SUDI cases where environmental risk factors such as parental smoking, alcohol misuse, deprivation and co-sleeping can elevate the risk to infants. The SUDI cases occurred in families where the child's immediate environment was deemed to be chaotic, hazardous and unsafe.

These SCR findings clearly demonstrate the need to maintain a focus on the wellbeing and safety of children while supporting parents and carers; particularly within a context of multiple adverse childhood experiences (ACEs).

"The circumstances of this case are familiar to practitioners from all agencies that deal on a regular basis with the cocktail of social issues highlighted in the case. Domestic abuse, alcohol misuse, a transient family, high numbers of practitioners serving the family over a relatively short period of time, poor continuity of care, developmental delay in the children, neglect by the parents in many ways that cumulatively leave the

children at risk of real harm. The practitioners saw what was before them, but they regularly failed to act in concert to assess the risk and provide effective interventions that would change the inevitable outcomes in this case".

"Assessments gave too much weight to parental assurances without investigation being undertaken of the impact on the children living with domestic abuse. There is broad based, well-documented evidence showing the poor outcomes for children living with domestic violence, and of the physical dangers to children by some abusers who persistently offend in this way. The closure of the case by social work when the perceived danger had temporarily been removed minimised the opportunity to break into the abuse cycle and to reduce the impact of violence on the children involved".

The complexity of domestic abuse within families was identified in just under half of SCRs we reviewed. Our report **The joint strategic inspection of services for children and young people: Review of findings from the inspection programme 2012-2017** also identified that many children and young people continued to be at risk of harm from the behaviour of adults. In this report, we found partnerships responding proactively to tackling domestic abuse with many partnerships continuing to develop strategic approaches to addressing domestic abuse, including programmes that identify families in which women and children may be at risk. These approaches were addressing the causes and behaviour change, reducing repeat incidents and working with perpetrators. These multi-layered approaches were having a positive impact on children and young people.

The Scottish Government has been progressing a range of initiatives to tackle and address ACEs in its Programme for Government 2018–19[16], which is rooted in the Getting it Right for Every Child approach and the Children and Young People (Scotland) Act (2014) to support the resilience of children and adults to overcome life adversity. Within the GIRFEC approach, the My World Triangle[17] provides an evidence-based framework to support practitioners in assessing children's experiences and circumstances within the context of their wider world. One SCR highlighted the effective use and application of this tool and the GIRFEC Wellbeing (SHANNARI) indicators[18] in terms of taking all aspects of the family and child's wellbeing into account. Conversely, other SCRs found the My World Triangle tool had not been used effectively to inform the basis of the assessment for the child in identifying wellbeing needs and support. Shared tools such as the My World Triangle and Resilience Matrix, when used together, support practitioners to structure and analyse information consistently around wellbeing needs.

These findings emphasise the impact of ACEs and toxic stress on children's wellbeing and outcomes. This demonstrates the need for effective preventative, community-based strategies and universal and targeted interventions to address the risk factors and alleviate the negative impact of ACEs within families and communities as a whole. Likewise, Oral et al (2016) advocates that integrating trauma-

[16] Scottish Government (2018) Delivering for Today, Investing for Tomorrow: the Government's Programme for Scotland 2018–2019, Edinburgh, Scottish Government.
[17] Scottish Government (2010) GIRFEC Practice Briefing 4 – The My World Triangle
https://www2.gov.scot/resource/doc/1141/0109332.pdf
[18] Getting it Right for Every Child (GIRFEC)Wellbeing indicators – Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included https://www.gov.scot/policies/girfec/wellbeing-indicators-shanarri/

informed care and practice into educational, health, justice and child welfare services supports the development of a common purpose and shared understanding among professional groups and service providers. Furthermore, Oral et al. (2016, in Spratt et al, 2019) identified that 'in ACE interventions, the complexity of the interaction between factors at the individual, family, community and larger societal structural level makes the socioecological model a suitable conceptual framework to provide guidance, with strategies required at every level' (Spratt et al. 2019, p 12). The original ACE study and subsequent research has built new urgency around strengthening prevention and treatment of the trauma related to childhood adversity across all sectors and at the primary, secondary, and tertiary prevention levels (Cortex-Neavel, 2019, p5).

Listening to the voice and behaviour of the child

The importance of seeing and listening to the child has been a common and recurring theme in previous studies relating to learning lessons from serious case reviews undertaken in the UK. In our review, nine of the 25 SCRs highlighted a lack of focus on the child or young person's experiences and perspective in considering their wellbeing and safety as a finding. In these cases, professionals did not always observe the non-verbal behaviour of the child or young person and fundamentally missed vital signs of abuse or neglect, as this SCR finding highlights.

"A safer system considers explicitly both what children are vocalising, including an absence of vocalisation where one might reasonably expect it, and how they are experiencing their world."

In our previous review of SCRs 2012-2015, we found that the emphasis of children's own words (and sometimes the words of parents themselves) could be subtly but fundamentally changed in the retelling by adults and lose their relevance and impact.

One SCR finding in this latest review highlighted the need for professionals to listen and pay close attention to children's experiences and respond to their needs as understood by them, rather than focusing on modifying their behaviour.

"Professionals from all disciplines were insufficiently inquisitive about the source of the girls' distress, challenging behaviour or symptoms of sexual abuse/exploitation and they were also insufficiently informed by knowledge of barriers to disclosure and how offenders groom children and their environment."

Other SCRs identified that the assessment process had overlooked the direct experience of the pre-school child.

"Although the child in this case was young, it should have been possible to form an empathetic view of what life must have been like for him had visits taken place on a more regular basis and had he been seen alone, both in and outside the home."

"It is been clearly evidenced that the child's life experiences were not fully assessed however, of paramount concern is the absence of his voice and views in the work that

was happening around him. He was never spoken to about life at home or given an opportunity to speak to a worker about any worries he may have had."

Changes in workers were cited in eight of the SCRs we reviewed as having impacted on the continuity of relationships to supporting consistent involvement, particularly during periods of transition. For the three young people who died through suicide, despite many services being involved, it had been difficult for them to develop and build meaningful, trusting relationships with a specific person.

"No individual professional managed to establish a relationship or a level of trust that might have enabled them to help them manage their distress, reduce their harmful behaviour, create meaningful connections and set boundaries".

The need for effective multi-agency coordination, single planning process and importance of a designated lead professional when there are numerous professionals involved in a single case has already been outlined earlier in this report. However, difficulties in transitions from children's to adults' mental health services suggests the need for greater continuity and clearer expectations of each service's role and responsibility in the team around the child process towards supporting young people's transition plans, as this SCR finding highlights.

"It is acknowledged that the transition to adult services for young people is often marked by a series of discontinuities in terms of personnel, treatment approach and often a failure to recognise and adapt treatment to developmental stage… It is also recognised that the choice of lead professional will be dependent on the needs of the young person at the time and who is the most appropriate person to take on the role. Whilst the lead professional may be drawn from any of the services or agencies who are partners to the child's plan, staff need to be clear about who has the role of the lead professional in different circumstances to enable them to offer ongoing support and protection as needed, via continuous single planning for the young person."

Another finding from those SCRs of the young people who died through suicide is the dilemma for professionals in balancing their duty of care with the rights of young people to be self-determining and judging a young person's capacity to make their own decisions about treatment and intervention. However, in doing so, professionals also need to be familiar with the various legal frameworks that apply to young people with mental health diagnosis in addressing and supporting risks and needs of young people who are in transition from children's services to adults' services.

"Capacity should not be assumed in cases of complex, self-defeating and high-risk taking behavior."

Part two: The process for significant case reviews and the quality of reports

Proportion of cases proceeding to a significant case review

The Care Inspectorate has been the central collation point for all SCRs carried out by child protection committees in Scotland since 2012. In 2017, the Child Protection Systems Review Group published Protecting Scotland's children and young people: it is still everyone's job. The report made several recommendations to improving approaches to Initial (ICRs) and Significant Case Reviews (SCRs) with a focus on how learning from these reviews is shared and implemented. This included extending the Care Inspectorate's role so that it became the central repository for all ICRs as well as SCRs. An ICR precedes a SCR and is the process through which child protection committees consider relevant information, determine the course of action and recommend whether an SCR or other response is required. Since June 2017, all ICR reports undertaken are required to be shared with the Care Inspectorate for analysis and review in order to understand more about the rationales being applied across the country in determining whether SCRs are carried out and to support better sharing of learning from ICRs. Before this date, the Care Inspectorate received a notification from child protection committees on their decisions on whether to proceed to a SCR.

Within the timeframe of this review (1 April 2015 - 31 March 2018) we were notified by child protection committees about a total of 73 ICRs having been undertaken, of which 48 did not proceed to an SCR. This shows that only a third of these ICRs progressed to a SCR. In most of these cases the rationale recorded for not undertaking a SCR was that the criteria as set out in the National Guidance for Conducting Significant Case Reviews in Scotland (2015) had not been met, in that "an SCR should only be undertaken when the criteria are met; where there is potential for significant corporate learning; and where a SCR is in the public interest and in the best interests of children and young people and their family" (2015, p 8). These notifications had recorded that the ICR process had established the key learning points and that in taking a proportionate and timely response, further inquiries would not lead to significant new evidence, findings or learning. In the majority of ICR notifications action points were noted to have been identified in respect of taking forward local learning. A few child protection committees identified undertaking another type of case review such as an inter-agency practice review, a reflective or learning review or holding multi-agency workshops in order to expedite the learning identified from the ICR process where the decision had been made not to conduct an SCR. Given that most ICRs do not proceed to a SCR and are not published means there is limited wider sharing of learning. We will carry out further work to review and analyse the findings and any learning arising from ICRs. In addition, the National Child Protection Leadership Group may wish to consider if the issue of decision making on ICRs would benefit from further exploration.

Methodologies used in significant case reviews

In our previous review of SCRs 2012-2015 we reported on the different methodologies used to conduct SCRs and ICRs and shared concerns over the quality of analysis and consistency, and the range of terminology that was being used for different reviews. The National Guidance for Child Protection Committees for Conducting a Significant Case Review states that child protection committees should always consider and agree the methodology to be used in undertaking the SCR however, it does not

prescribe or propose a particular model allowing flexibility in the approach used. Of the 25 SCRs we reviewed, four indicated they had followed a systems methodology while seven SCRs were undertaken using the Social Care Institute for Excellence (SCIE) Learning Together model. The SCIE model uses systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture (SCIE, 2012). Five reports used a 'hybrid' model drawing on elements adapted from the SCIE model and systems approach. Nine of the 25 SCRs did not specify the methodology they had used in conducting the SCR however, they had drawn on components of systems theory in reviewing key processes.

While the Significant Case Review guidance (2015) seeks to support a consistent approach nationally and improve the dissemination and application of learning both at a local and national level, the 2017 Child Protection Systems Review recommended that the Scottish Government should explore a "new tiered approach to, and methodology for, ICR and SCRs, based on the 'Child Practice Review' model used in Wales". It anticipates that learning from other models developed in other parts of the UK will offer a more flexible and proportionate approach to reviewing and learning. It will ensure reviews are more succinct and timelier in such a way that enables learning to be taken into the system faster. This recommendation is currently being progressed and overseen through the National Child Protection Leadership Group.

Recommendations, findings and learning points arising from the significant case review process

The SCRs we reviewed referred to either recommendations, findings or learning points, or used a combination of these to pull together key conclusions arising from the review. These focused predominantly on implementing change at a local level, directed at both single- and multi-agencies. These related mainly to developing, improving or reviewing existing policies, procedures and systemic processes as a result of latent failures, gaps or inadequacies identified in the system. This included the effectiveness of quality assurance processes and implementing thematic audits to monitor and improve practice.

Other recommendations or findings were targeted at strengthening and reinforcing governance and case management arrangements through professional challenge and reflective supervision, training and workforce development to improve practitioners' knowledge, increase effective working and enhance staff skills. Those reviews using the SCIE approach presented questions to the child protection committee to address. Recommendations also varied in number from six up to 47. Where findings or learning points were presented, these ranged in number from four to 15. Collectively across the 25 SCRs, there were more than 250 recommendations and findings. Seven of the SCRs presented them as themes. Likewise, the length of the SCRs varied, ranging from 19 pages up to 76 pages. Three SCRs, including appendices, ranged between 100 to 150 pages long.

Those SCRs that had framed clear and concise learning points for chief officers and child protection committee members to consider as the bodies responsible for implementing and embedding the lessons learned, were the most helpful. Sidebotham et al 2016 in their triennial review of serious case reviews in England found that "the least helpful were recommendations that were generally aimed at a range of professionals, with no indication as to how those professionals were to be informed of the expectations, or how their response would be measured" (p 231). Our analysis of SCRs mirrors this finding as this SCR recommendation highlights.

"Staff within all disciplines should be reminded of their duties and responsibilities towards children and their families and be empowered to use the appropriate escalation processes to refer their concerns about any practice issue."

The following recommendation, directed at the child protection committee is more specific about what should be done to improve child protection systems.

"Senior managers across services should implement systems which allow them to take a closer look at cases where children who are subject to an initial child protection case conference are not subsequently placed on the child protection register."

Iriss (2014, p 7) cites evidence from Walshe and Higgins (2002) that suggests "although we are good at writing reports and commissioning inquiries about our failures in the sector we are not as good at acting on these recommendations". They suggest that "often these failures are organisational and cultural, and the necessary changes are not likely to happen simply because they are prescribed in a report" (p 895). Likewise, the 2017 evaluation of the learning into practice project (LiPP) identified ongoing challenges in ensuring that the time and investment in SCRs produces reports that are accessible and consistent. They emphasised that "it is still too often the case that the findings and recommendations are lost in reports, and do not lead to changes in practice beyond the local context; shape services or lead to better outcomes for children" (2017, p 47).

Where recommendations were made, more focus on how these would be taken forward and addressed could be better emphasised and captured through identified, specific and measurable outcomes. Several SCRs helpfully referred to drawing up an action plan to take forward the recommendations or findings from the review which would then be incorporated into local CPCs' improvement plans although were not clear in translating or distilling the learning outcomes and how these would be taken forward, disseminated and shared beyond the SCR. This was a finding from our previous review of SCRs 2012-2015, which found that SCRs were not always clear on what needed to improve and how learning would be taken forward by child protection committees (Care Inspectorate, 2016).

Most SCRs presented several recommendations directed at individual agencies and services to act upon, review or to ensure compliance.

"Social work children and families should ensure robust arrangements are in place to review the quality of assessments, risk assessments and the child plans. This will help ensure risks continue to be accurately identified and plans reflect clear actions linked to the management and reduction of risk."

In contrast, those SCRs that had been undertaken using the SCIE method prioritised a few key findings or learning points directed at the child protection committee to consider. As an example, the learning point below was identified by one SCR in response to specialist mental health services' interaction with the child protection system.

"The impact of parental mental health on children is not always sufficiently recognised either by specialist mental health services or the wider professional network, with the

result that adult clients are treated in isolation from the context in which they live and the risks they may present to others."

This question was put to the child protection committee (CPC) to consider:

"Is the CPC satisfied that social work and health professionals, including mental health communicate effectively when they have concerns about the wellbeing of a child and his/her parent(s) and factor the need for this into any assessment?"

Time taken to complete a significant case review from conclusion of the initial case review

We found there had been notable delays in the completion of SCRs, mainly attributed to court proceedings taking precedence, resulting in the SCR process either being placed on hold until after criminal proceedings had been completed or being completed in two stages following consultation with the local Crown Office procurator fiscal service. This was the situation for nine out of the 25 SCRs we reviewed. An initial phase had involved an examination of records and then a second phase involved interviewing relevant people once the criminal proceedings had concluded.

"In order not to prejudice the criminal investigation or trial, the SCR team did not commence any interviews until after their conclusion. The SCR has been completed and reported on in two phases."

"The Review was commissioned and commenced prior to the conclusion of criminal proceedings and, despite there being in place a "Memorandum of Understanding" relevant to access to Crown documents this was not permitted in this case. It is of note that there is a mixed picture across Scotland of decisions by Crown Office whether to permit access to documents before the conclusion of criminal proceedings. In essence this meant that this SCR was progressed over a period of 2 years."

Timescales from the conclusion of the initial case review to completion of the SCR showed wide ranging variations from eight months up to three years. Those cases that involved criminal proceedings took the longest to complete ranging from two to three years from the decision to undertake the SCR. The average period taken to complete an SCR was 18 months. This has an impact on the length of time it takes to get the learning from the SCR process into the system, with the result that the significance for local and wider learning in real time is lost. A few SCRs had demonstrated how they had taken forward the lessons learnt identified from the initial case review process and the changes and developments that had taken place in parallel to the SCR being underway or being completed.

"Key to the learning from this review is the changes which have been made since the child's death and the improvements currently in progress to ensure that findings take cognisance of the work already underway."

"This section of the report identifies key learning points which should be considered by the partnership. A number of areas have been identified where the reviewer is aware that work has already commenced and, in some instances, significant progress has

been made. A programme of change and improvement, led by the Children's Services Executive Group, pre-dated the completion of this SCR. Consequently, the detail contained in this section should take account of those key developments."

The 2017 Child Protection Systems Review identified a lack of clarity about whether SCRs could be conducted when fatalities investigations, fatal accident inquiries or criminal proceedings were ongoing (2017, p 22). A protocol developed in 2014 between the Crown Office, Police Scotland and child protection committees on SCRs and criminal proceedings to avoid any unnecessary delays to SCRs where potential court proceedings were being considered is currently being reviewed. Better understanding is needed of the obstacles that impact on undertaking a SCR or publishing and sharing the learning when legal proceedings are ongoing.

Quality and consistency of significant case reviews

In our previous review of SCRs 2012-2015, we found the variable quality and consistency of SCRs was a potential barrier to learning. Regardless of the methodology used, we found similar issues during this latest review, including overly descriptive detail and lengthy narrative of agency involvement, too much of a focus on 'what happened' and not keeping the child the focus within the review. The more analytical reviews were those that provided deeper insight, reflection and consideration of both active and latent errors, and causes in the system. In essence, what went wrong and why, effective use of evidence-based research and clear, defined findings that linked well to the SCRs terms of reference. The national panel of independent experts in their first report, published in July 2014 (DfE, 2014a) made recommendations for improving the quality of serious case reviews. The panel identified several features that they would expect to see in an effective review.

- A sharp focus on what caused something to happen and how it can be prevented from happening again.
- A concise account of critical points in the management of a case (rather than a lengthy chronology of undifferentiated events).
- A detailed analysis of what went wrong and why, including individual errors and system failures.
- Clear learning points and recommendations addressed to named people or organisations locally and nationally, including adult services where appropriate.
- Measures should be included to follow up and see whether these recommendations have been accepted and implemented.
- A focus on what the lessons should be for the services concerned, rather than a blow-by-blow account of what happened to a child.
- Proportionate to the case being considered when applying the points above. This is far more important than a blind adherence to a specific methodology. LSCBs should be looking at a 'sliding scale' of SCRs, from those which result in very quick outcomes and a short report, to those which by the nature of the incident require a greater level of investigation.
- Prepared to highlight relevant failings and good practice and policy at all levels, not just those at lower levels (DfE, 2014a, p.8).

Sidebotham et al (2016) contend that good quality SCRs should incorporate particular characteristics. These include: "lessons learned which are clearly linked to the findings of the review; findings and

questions for the [Local Safeguarding Children Board] to promote deeper reflection on the lessons of the review, and leading to a response and action plan developed by the Board to address that learning; specific recommendations where there is a clear case for change, with a response and action plan developed by the Board; and a strategy for dissemination and learning of the lessons that will reach relevant practitioners and managers within the Board's constituent agencies" (p 19).

The 2017 Child Protection Systems Review also identified the need for "greater coordination to strengthen and support practice across the country, such as provision of nationally developed training materials, access to expert reviewers who have the competencies required to deliver high quality Significant Case Reviews" (2017, p 15). The review recommended "developing national standards to develop an understanding of the skills, competencies and experience required by those reviewers undertaking ICR/SCRs with the aim of improving quality, consistency and learning from these reviews". This recommendation is being progressed and overseen through the National Child Protection Leadership Group.

Opportunities for national learning

Opportunities for learning lessons nationally and informing wider policy, practice and service development and improvements were limited to a few SCRs as a result of the differing approaches towards their publication. As there is no statutory requirement on child protection committees to report publicly on SCRs undertaken in Scotland this limits national learning opportunities arising from these reviews. This was a specific finding of the 2017 Child Protection Systems Review, which considered this to be a missed opportunity in providing a valuable understanding of child protection practice. Furthermore, the review also commented that "the level of redaction required to comply with data protection principles in SCRs not only delayed any publication of a summary of findings, but could severely limit learning opportunities" (2017, p 30). This is in contrast to the child protection landscape in England, Wales and Northern Ireland, where there is a requirement to publish serious case reviews, case management reviews and child practice reviews. This improves transparency and public confidence in the child protection system and allows for practice improvements to be identified and good practice to be disseminated at a national level. To enable the sharing of wider learning across all professionals involved in child protection work, a recommendation arising from the 2017 Child Protection Systems Review is to develop a community of practice portal. A SCR reference group chaired by the Care Inspectorate is working through the many challenges and complexities involved to achieve this recommendation.

Of the 25 SCRs undertaken between 1 April 2015 and 31 March 2018, 11 were either published in full with redactions or as an executive or learning summary on child protection committees' websites. Fourteen SCRs were not published at all. There is a need to have a better understanding of the barriers that inhibit meaningful publication and in identifying opportunities that would better support the process including public and media perception around SCRs as a tool for learning. One SCR that was not published stated how it would promote national learning.

"In order to promote national learning, the findings and recommendations from the SCR, in accordance with National Guidance will be shared with the Care Inspectorate, and through Child Protection Committee Scotland or by specially convened meetings or seminars."

The 2016 Wood Review identified a need for fundamental change in how local multi-agency arrangements for safeguarding children were operating and improvement in practice at a local and national level. An essential component of the new framework includes:

- bringing greater consistency to public reviews of child protection failures
- improving the speed and quality of reviews, at local and national levels, including through accrediting authors
- making sure commissioned reviews are proportionate to the circumstances of the case they are investigating
- capturing and disseminating lessons more effectively, at local and national levels; and
- making sure lessons inform practice (Dept for Education, 2016, p 7).

Four SCRs made national recommendations that considered key changes in national policy. The mechanism for communicating any national recommendations is stated in the SCR national guidance as "any national implications should be shared directly with the relevant organisation and with the Scottish Government" (2017).

Learning from good practice

The SCR process is not just a process for improvement but also a means of recognising and disseminating learning as a result of what has worked well and to embed effective practice. In most SCRs we reviewed, good practice was either highlighted throughout the report or as findings in the conclusion although a few SCRs did not identify or feature any good practice. These mainly focused on performance and practice within the multi-agency child protection system that was uncovered by the review.

"Pre-birth processes had been established to ensure a multi-agency approach was adopted following notification of pregnancy. The process ensured that police, health and social work were aware of the pregnancy from a very early stage. Information was shared in relation to both current and historical factors. A pre-birth assessment was completed to inform decision making at an initial child protection case conference. A Childs Plan was produced, and core groups met on a regular basis to track progress in relation to the child. This approach meant that key agencies and services met regularly to oversee a protection plan."

"The child protection investigation involved all the relevant partners who contributed well to a process that was thorough and effective in providing the initial Child Protection Case Conference with the quality of information it required to reach outcomes that safeguarded the children."

Some SCRs highlighted good practice that was happening at both a multi-agency as well as at a service or department level that was worthy of attention.

"There is a pattern of children being admitted to emergency departments and the Children's Hospital receiving excellent care and comprehensive medical examinations from experienced and competent medical teams."

"The quality of the multi-agency response to the domestic abuse referral triggered by NHS 24."

A few SCRs highlighted improvements made during the review process that reflected good practice.

"Since the events leading to the review enhanced supervision for midwives has been put in place to ensure that pre- birth information is reviewed, and pre-birth assessment happens."

We found in a few SCRs good practice being highlighted that could be deemed as merely reflecting expected standards of practice from professionals, particularly in terms of following local protocols and procedures but that were being consistently and diligently applied. For example:

"SCRA conducted Hearings timeously and within required timescales."

"When child protection concerns were raised interagency referral discussions were held which led to child protection investigations."

Identifying and promoting good practice within the system encourages strong and effectual multi-agency practice and behaviours to be embedded and built upon, which enables higher standards of practice to be fostered.

Conclusion

This review of findings from SCRs has identified specific practice themes in systems and structures and the cultural factors that both influence and impede professionals from intervening effectively to safeguard, promote and support children's and young people's safety and wellbeing. An important practice theme arising is uncertainty in the expectations and shared understanding of the named person and lead professional role in inter-agency working and coordinating integrated support across the continuum of a child's or young person's wellbeing needs. There is also a continuing need for practitioners across all agencies to be alert to and understand the impact of neglect. This issue is an ongoing priority for further practice development and improvement. Likewise, the findings reveal a need within the system for a shared understanding of thresholds particularly in recognising and responding to neglect. Equally important is maintaining a focus on the wellbeing and safety of children while supporting parents and carers including a greater understanding of the negative impacts from adverse childhood experiences on children's wellbeing and outcomes.

Initial case reviews (ICRs) and SCRs were closely considered by the 2017 Child Protection Systems Review. Its recommendations mirror the themes arising from this, our latest review, and our previous review of SCRs 2012-2015 and are already being taking forward to support continuous improvement. This includes the decision-making process in undertaking a SCR and towards publication or not; the quality and consistency of SCRs; and the differing methodologies and types of case reviews adopted throughout Scotland.

Fundamental to the ICR and SCR process is improving how the key themes and learning they identify can be shared and expedited at a local and national level to be both meaningful and timely. We have identified that the time taken to decide on, conduct and finalise a SCR can take years from the incident occurring to the finalised SCR being sent to us, more so where criminal proceedings have not yet concluded. These lengthy processes and delays impact negatively on sharing the learning from SCRs and embedding the systems, structures and cultural changes required for improvement. This means the quality and speed of SCRs need to improve so that we capture and disseminate the lessons in a more timely way and embed the learning. Central to this are the skills and competencies of reviewers undertaking ICRs and SCRs. This is a specific recommendation from the Child Protection Systems Review and work is underway to develop national guidance for reviewers.

Tables

Our findings from the 25 SCRs we reviewed: characteristics of the children and young people

Twenty-five SCRs were submitted by child protection committees between 1 April 2015 and 31 March 2018 and concerned 44 children and young people. Six SCRs concerned more than one subject child or young person. Of the 44 children, more than half (26) were female. Their ages ranged from a few weeks to 19 years but most were of pre-school age.

Fourteen cases involved significant harm or risk of harm, and 11 cases involved death, one being the death of a looked after young person. Seven deaths were infants and pre-school aged children, four were teenagers aged 13 – 19 years. The four teenagers who died were female and had received support from child and adolescent mental health services. All of the 44 children and young people were known to a range of services, including universal and statutory services.

Table 1: Breakdown of non-fatal cases

Type of harm	Number of children/ young people
Neglect	13
Sexual abuse	6
Physical abuse / Non accidental injury	5
Combination of physical/sexual abuse and neglect	5
Near drowning	1
Physical injury/emotional abuse	3
Total	33

Table 2: Breakdown of deaths

Type of death	Number of children/ young people
Drowning	1
Physical injuries	3
Suicide	3
Murder	1
Sudden unexplained death in infancy	3
Total	11

Table 3: Living circumstances of child or young person at time of harm or death

Living circumstances	Number of children/ young people
Living at home	34
Living with relatives or friends	3
Residential unit or hospital	7
Total	44

Child disability

Most of the SCRs did not record whether or not the child had a disability. In two cases, three children were noted to be disabled. In one case, two were recorded as being on the autistic spectrum with one of them having additional complex needs and in the other the child was recorded as having complex needs.

Our findings from the 25 SCRs we reviewed: characteristics of child's parents/carers

Key themes in relation to parents/carers

The following table gives an overview of particular aspects in relation to the parents or carers that were identified in the audit of SCRs 2007-2012 (Vincent & Petch 2012), key themes from our previous review of SCRs 2012-2015 and from this, our latest review. Under half (11) of the children (8 SCRs) lived with parents/carers who had a number of these issues presenting simultaneously.

Table 4

Theme	Number of SCRs with % in brackets		
	2007 – 2012 from 56 SCRs	2012 – 2015 from 20 SCRs	1 April 2015 – 31 March 2018 from 25 SCRs
Mental health problems	24 (43%)	13 (65%)	9 (36%)
Domestic abuse	30 (54%)	13 (65%)	10 (40%)
Parental substance misuse	36 (64%)	11 (55%)	10 (40%)
Criminality	31 (55%)	7 (35%)	7 (28%)
Parents' own childhood issues	22 (39%)	4 (20%)	14 (56%)
Learning disability	4 (7%)	0	5 (20%)

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