Findings

of a

Significant Case Review- J Family

Undertaken on Behalf of

North Ayrshire Child Protection Committee

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Structure of the report

National guidance[1] requires that SCR reports follow a consistent structure, to make it easier for people to read and to read-across to other reports (p.21). The report structure and content is outlined in full in Annex 5 of the guidance and in compliance with these requirements, this report includes:

- A contextual introduction
- A factual summary
- An analysis of the quality of practice, considered in the context of circumstances at the time, highlighting the key areas that impacted upon practice
- Clear learning points, or Findings
- Recommendations and/or considerations for the Child Protection Committee (CPC)

[1] Scottish Government (2015) *National Guidance for Child Protection Committees for Conducting a Significant Case Review*

Introduction

Why this case was chosen to be reviewed

In [redacted] an initial child protection conference took place to consider risks to a sibling group of [redacted] children [redacted].

At this conference it was agreed that the children were at risk of significant harm and all [redacted] children were placed on the child protection register. However, due to the assessed level of risk at that time, it was also agreed that the children should be accommodated away from home. This was immediately achieved with the agreement of their mother; subsequently child protection orders were deemed necessary and these were granted the following day.

Due to these unusual circumstances, senior management within Social Services examined the case more closely.

This examination revealed that there had been some delay within the recent child protection processes and that there had been varying concerns expressed about the children over a number of years. Social Work Services managers commissioned a single agency internal review of practice and also referred the case to North Ayrshire Child Protection Committee. This enabled a timely response to the identified concerns about practice to safeguard the children from a Social Work perspective. This review was informed by a combination of the Social Care Institute for Excellence's (SCIE) Learning Together and LEAN[2] principles and processes. Several system-related themes emerged from this review and included: the effectiveness of the intake/duty process; the impact of organisational change; engagement in reflective practice; the use of national assessment frameworks; the interface between social work teams, particularly in relation to thresholds and transfer; communication; and 'custom and practice'. The conclusion of this review was that these factors had combined to create a number of occasions on which opportunities to intervene to protect these children from significant harm had been missed. The Social Work internal review cited a main limitation to its process as being unauthorised to include other agencies in its purview.

Following submission of the review report, North Ayrshire Child Protection Committee conducted an Initial Case Review, in line with the *Pan Ayrshire Protocol for Conducting An Initial or Significant Case Review.*

The conclusion of the Initial Case Review Panel was that all [redacted] children had experienced significant harm while in the care of their parents and that there were serious concerns about how services had worked together on a multi-agency basis to identify and respond to risk to the children within the household. On this basis, the case met the criteria for proceeding to Significant Case Review (SCR).

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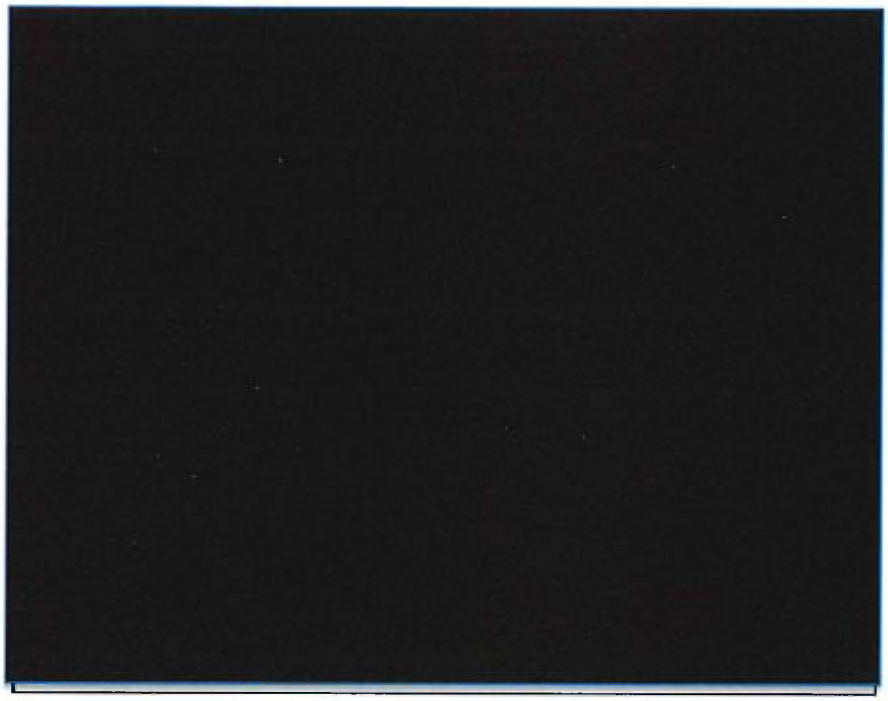
[2] George, M (2003) *Lean Six Sigma for Service* McGraw-Hill

Family Composition



All pseudonyms

Ages given at time of removal of children

Succinct Summary of the Case

NOTE: All names are pseudonyms

This summary gives a very brief overview; there is further detail in the appraisal of practice (p15) and within the findings (p24).

The family are white and Scottish. During this period ( ) they have been dependent upon state benefits and there are indications of problems with debt, fuel poverty and occasional destitution. Money was often a cause for dispute between Sarah and David (children's parents). The family's housing situation varied from sharing William's tenancy (children's maternal grandfather), described as 'full of dampness' ( ) to their own rented accommodation ( ) which, while much improved, became overcrowded when William moved in with them ( ) and with the subsequent birth of their children. David would sometimes present as homeless with no secure living arrangements.

Adult family members were known to services over many years preceding this review, including significant health and social care interventions with Sarah during her childhood and mental health services to her father William, with whom she lived after her parents separated permanently, when she was about . The review concentrates on the period that starts with ( ) Sarah's pregnancy with Jenny in . Sarah had been living between her father's home and her partner David's family home. After giving birth she, David and baby Jenny moved back to William's house and they (and subsequent children) shared a home with William for significant periods over the next seven years.

A particular feature of the period from is the frequent (more than 12 x per year) presentation of William at hospital . He usually declined follow-up and was discharged 'to the care of his daughter and her children'. He was subject to at least two Adult Support and Protection investigations. William's presentations to mental health services ceased abruptly in , by which time had been born. Sarah went on to have between and .

All children were frequently in contact with health services, with an ongoing health visiting service throughout the period. Sarah often took the children to the GP, using 'on the day' appointments and also consulted out of hours GP services as well as taking the children to Accident and Emergency. These were often for minor ailments – coughs/colds, diarrhoea and vomiting. Jenny had long term problems with constipation; most of the children had thrush at some stage. The children also suffered significant health events necessitating hospitalization, including blue light admission for and both Jenny and Jane were admitted for significant dental extractions (4 and 7 teeth respectively). Follow-up appointments however were often missed. Sarah kept all her

own routine maternity appointments with an increasing pattern of emergency appointments and admissions in later pregnancies.

There was a recurring pattern of non-attendance at nursery and school for both Jenny and Jane, the latter having been allocated an 'early' placement following referral from the health visitor, who was concerned about Jane's slowness to walk and talk. The health visitor disagreed with David and Sarah, who felt Jane had ADHD. [redacted].

David and Sarah came regularly to the attention of the police for a variety of 'domestic' incidents. On some occasions they sought advice from police about their relationship as a result of arguments; other events were perceived as more serious. David was often absent from the family home for periods of time and these absences both prompted contact with the police by Sarah and occurred following their attendance at points of dispute.

There is a recurring theme of sexual abuse and violence attached to both adults and children, including intra-familial allegations, which emerges and retreats. The children were referred from different sources more than once to the Scottish Children's Reporter Administration. When these referrals resulted in an assessment by Children and Families Social Work services, a recommendation of no change to current services was made. Help was offered to the family by Social Work Reception Services sporadically and with a focus on presenting issues.

In [redacted] there was a step-change in professional intervention brought about by the increasingly clear distress of [redacted] in particular, alongside a reframing of the family's home circumstances. This culminated in the removal of all [redacted] children in [redacted].

Organisational learning and improvement

National Guidance for Child Protection Committees[3] states that a significant case review (SCR) should seek to:

- Establish the full circumstances of the death/serious harm of the child (where parallel processes like a criminal investigation are in place, it may not be possible to gather and report full information);
- Examine and assess the role of all relevant services, relating to both the child and also, as appropriate, to parents/carers or others who may be connected to the incident or events which led to the need for the review;
- Explore any key practice issues and why they might have arisen;
- Establish whether there are lessons to be learned from the case, or good practice to be shared, about the way in which agencies work individually and collectively to protect children and young people;
- Identify areas for development, how they are to be acted on and what is expected to change as a result;
- Consider whether there are gaps in the system and whether services should be reviewed or developed to address those gaps; and
- Establish findings which will allow the CPC to consider what recommendations need to be made to improve the quality of services (p.13)

It tasks Child Protection Committees (CPCs) with considering how the analysis, findings, recommendations and remedial action can best inform learning and practice as part of an ongoing "learning cycle" (p.25). Among a number of 'good practice principles' is the requirement for

SCRs to have "a clear remit" (p.13).

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[3] Scottish Government (2015) *National Guidance for Child Protection Committees for Conducting a Significant Case Review*

Methodology

National guidance gives CPCs discretion to consider and agree a review methodology and explicitly advocates two evidence-based approaches, the SCIE Learning Together model (see Appendix 3 for excerpt from guidance and detail about this method) and Root Cause Analysis.

The SCR Panel agreed that SCIE's Learning Together[4] methodology should be used for the multi-agency SCR and that this should be centred on a workshop involving staff who had been involved with the family who would comprise the 'case group' (case group described on page 11).

Acronyms and terminology

Writing for multiple audiences is always challenging. We endeavour not to assume knowledge of the processes and language of the work of protecting children in the writing of the report and all acronyms are given only after they have been given in expanded form at least once. Acronyms are also listed in Appendix 4 and, if appropriate, an explanation is also given.

Gender neutral terminology has been used throughout this report in support of anonymisation. This can lead to some clumsiness of expression due to the lack of a gender neutral pronoun. 'He' and 'she' have been replaced by 'they'; 'his' and 'her' have been replaced by 'their'.

Some of the report tackles issues which are complex; attempts have been made to write as clearly as possible but there may be occasions when the reader needs to slow their reading pace, or re-read a passage for it to be clear. It is important that complex issues are not inappropriately simplified.

Research Questions

Learning Together (LT) reviews take their focus from what a CPC wants to learn more about, using a review of a particular case as the vehicle. LT reviews therefore have research questions rather than fixed "terms of reference".

The research questions build on the learning from the Initial Case Review and were agreed as:

1. In the context of Getting it Right for Every Child, how well does the system enable agencies to effectively assess and respond to need and risk?

2. To what extent do professionals and agencies share an understanding of what constitutes an effective wellbeing assessment?

3. To what extent is there a shared understanding and model of collaboration among professionals and agencies?

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[4] Fish, S; Munro E and Bairstow (2008) *Learning Together to safeguard children: developing a multi-agency systems approach for case reviews* London: Social Care Institute for Excellence

The research questions identify the key lines of enquiry for the review and are framed in such a way that make them applicable to casework more generally, as is the nature of systems findings.

Proportionality

Deciding on a proportionate review took into account the already existing review which focussed on Social Work Services' processes and interactions with other agencies for the period between September 2015 and February 2016. A degree of integration of that review with this one was achieved through the significant involvement of the three person team who conducted that review (with the supervision of Bridget Rothwell) as well as the inclusion of all previous members of the case group from that review in the case group of this one.

The SCR Panel were keen to have the review conducted efficiently but without compromise to the integrity of the process and justice in its findings. Group methodology was favoured for its time efficiency and also for its capacity to reproduce elements of the system within the room, creating further opportunities for insights.

Timeframe

The timeframe of the review begins with the birth of the oldest child in [redacted] and ends at the point that the process to remove the children began, in late [redacted]. The Review Team had access to the multi-agency chronology compiled via the Initial Case Review process and this source was used to identify three 'Key Practice Episodes' (KPE) within the seven year time frame. The chronology included information about all family members. The KPEs were selected because they appeared to illustrate missed opportunities to intervene on behalf of the children more effectively. These were not the only possible episodes but were felt to be sufficiently representative and to offer a useful 'window' on wider practice over the longer period.

KPE1 was a one day period in [redacted] taking into account the subsequent professional responses. KPE2 took place in [redacted]. KPE3 was a two month period between [redacted] where there was evidence of increased professional activity with the family. These three episodes offered an opportunity to examine what occurred when, with what intention and to illuminate the understanding agencies had of events as they occurred.

<u>Who participated in this review?</u>

1. Reviewing expertise and independence

The SCR has been led by Bridget Rothwell, who is independent of the case under review. She has been significantly supported by a Review Sub-team, (See Appendix 1) by Jillian Ingram, Lead Officer of NACPC, who has acted as a Champion for this process and also by Phil Hayden, Co-Reviewer and Independent Consultant who is accredited to carry out SCIE reviews.

The Review Sub-team have received group supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

2. The Review Team

The Review Team are managers representing the agencies involved in the case. The detailed composition of the Review Team is given at Appendix 2. It is important to note that the Review Team were active in different ways during the process and this is also indicated.

The role of the Review Team was to provide a source of professional expertise in their fields as well as knowledge of broader trends and strategic level information about their own agencies, particularly in terms of procedural expectation. Some members also gave an interim view on the early appraisal of practice as part of the iterative process.

3. The case group

The third important group taking part in the case review were **36 front-line professionals and managers** who were identified as having had a significant role at some stage during or nearby at least one of three Key Practice Episodes, or others who could represent them if they were not available. They provided a detailed picture of what happened in the case and why. They also brought their wider experience of working within local systems over a period of time and with a range of cases. The majority of Social Work Staff had some experience of Learning Together principles from their involvement in the earlier, single agency review. All case group members were invited to a two hour briefing event to orient them to the process and its methodology. They subsequently participated in a day long workshop to consider the conduct of the KPEs, identified by the Review Team as key moments at which the direction of professional practice could have been altered. The case group also participated in a further half-day workshop to consider and further contribute to the emerging findings, particularly with regard to the question of recognition of the issues raised and their likely/experienced prevalence.

Some case group members were identified by themselves or facilitators as not having had sufficient opportunity to contribute or were unable to attend the workshop. Individual conversations were held with those people.

4. Specialist advice

Those directly involved in implementing GIRFEC in North Ayrshire were consulted twice in the course of the review to clarify the introduction and evidence the use of AYRshare; to share experiences of the transition to use of the Named Person role, and to discuss the use of Partnership Forums as a route of access to resources. This provided the degree of professional expertise required to understand practice in North Ayrshire.

Methodological comment and limitations

Overall the methodology of the review has been felt to have benefits both in terms of its capacity to illuminate practice in the system and its demonstrably participative orientation.

The experience of the workshop was noticeably enhanced by the provision of visual aids. Time-lines demonstrated the environmental conditions and individual experiences of the children; these were extended as each KPE was reached chronologically. Participants were encouraged to add notes to the timeline if they knew of missing information about either the family or the professional system at that point. Genogram and ecomap representation of the family and professional systems illustrated the point in time that each KPE focused upon. Silhouettes of family members were also on view as a reminder of their relative ages and characteristics. In view of the paucity of personal information in the recording, participants were encouraged to annotate the silhouettes with post-it notes. In retrospect, participation of some key professionals may have been enabled by individual conversations prior to, rather than after, the workshop.

The review has, however, been conducted within a very limited time frame and the Review Sub-team have expressed concern that the speed of the process runs the risk of reproducing a number of the system's less enabling characteristics. Review process issues of accessing, understanding and assessing information, consistency of attendance at meetings, role changes and handover between different representatives of agencies are themselves indicators of the difficulties experienced in the wider, time-poor system. Most members of the Review Sub-team have continued in full time posts while making space for contributing significantly to the process. In turn the Findings pose questions for the Committee relating to issues of prioritisation, delegation and operational support for systemic initiatives. Mirroring processes are here considered a source of information which can be used to see the system from different angles.

A relatively small group attended the interim Review Team meeting and it was a mixture of some who had attended the workshop and some who had not. Thus, for some members there was a substantial quantity of information to digest in a very limited time; for others the process felt repetitive, particularly given the post workshop process which the Review Sub-team engaged in. The arrangements for dissemination of material may require to be re-considered for this part of the process. For some, the strictures of pre-set enquiry questions was unhelpful and the fact that the Lead Reviewer was unable to attend may have compromised continuity. For two members of the Review Team, this was their only opportunity to participate in the process, which they did actively but with inevitable constraint.

We have striven to achieve as accurate a representation of events as we can but do not lay claim to having discovered or recovered all that exists. The Review Sub-team nevertheless believe that the process has successfully achieved a 'window on the system' and gained some insight into the ways that the arrangements of the current multi-agency system enables or constrains practitioners in the delivery of a service which focuses on identifying and responding to issues of wellbeing and protection. Where they have been consulted, the case group and Review Team have indicated that they concur with our Findings.

Participation of case group professionals

Most case group members have participated actively and willingly over a total of two days and many have contributed further, by submitting case notes and other sources of evidence as well as participating in follow up conversations. While some anxiety was expressed at various points, informal feedback collected at the end of the workshop was largely positive and thoughtful, reflecting that the process had prompted some deep thinking about roles and some insights. It was felt to have been an illuminating, challenging and emotional process. At both meetings there was clear appreciation for the opportunity to discuss and discover new things about the system they are working in every day. One written comment said it was "pitched at the right level of professional challenge: didn't duck issues but not intimidating". A number of key professionals were courageous in their willingness to share their practice and experiences.

Participation of the Review Team

The attendance of Review Team members is detailed in Appendix 1 and some comments about their participation is given in commentary above regarding the limitations of the methodology. Some members of the wider Review Team have made substantial contributions to enabling the process as well as considering and supplementing the emergent information. The Review Team meeting to consider the draft report and its findings was well attended and active in commenting on both structure and content.

Participation of family members

The invitation to participate in the review via a conversation was limited to David and Sarah, the parents of the children. They met once with Bridget Rothwell Lead Reviewer and Jillian Ingram, Lead Officer for the Child Protection Committee. The purpose of the conversation was clearly explained to both as a wish to understand their experience of professionals and agencies and to learn from that experience.

The couple were living separately immediately prior to the meeting due to ongoing criminal proceedings but on the day of the interview they were able to, and chose to, come together. While Sarah did most of the talking, David was consistently engaged [redacted]

[redacted]. Although there are frequent references to David's intellectual capacity in the records, neither Jillian nor Bridget experienced him as limited in his understanding of the conversation at any point.

Much of what the parents told us reinforced key messages that are discussed in the findings. They experienced some services as helpful and encouraging. Sarah felt she could confide her worries to her Health Visitor, that they were supportive and that the key message she received was to keep doing what she was doing. She recalled turning down offers of support from Social Work Reception Services staff but said she found them to be practically helpful and reassuring in their brief contacts.

She was less positive about other services where her experience was of being passed from 'pillar to post' and being 'fobbed off' particularly with regard to her concern that Jane had ADHD. She felt excluded by nursery and school and did not consider them to have fed back clearly to her about Jane's presentation in particular.

She did not feel there was good co-ordination of health information between the GP and school nurse.

David felt that the family would have benefitted from help from the time of the birth of their first child; he felt responses were too slow and that professionals would take his explanations and 'put it in their own words'.

Both Sarah and David felt there was a significant and negative change in the service they received when Children and Families Social Work staff and a new Health Visitor became involved. Before this, she said, "we didn't know anyone was concerned". From this point Sarah felt that she was "being told one thing and then another" and that key staff were 'unprofessional' and determined to remove the children despite her co-operation.

David, a man considered by professionals to be relatively inarticulate, said at the end of the interview that he 'would have liked a better understanding of what help was available so we could take this forward ourselves'.

The Findings

This section contains five priority findings that have emerged from the SCR. The findings explain why the Review Team consider professional practice was not more effective in protecting the children in this case. Each finding also lays out the evidence identified by the review team that indicates that these are not one-off issues. Evidence is provided to show how each finding creates risks to other children and families in future cases, because they undermine the reliability with which professionals can do their jobs.

First, an overview analysis is provided of what happened in this case. This clarifies the view of the review team about how timely and effective the help was that was given to family members, including where practice was below expected standards.

A transition section reiterates the ways in which features of this particular case are common to the other work that professionals conduct with other families and therefore provides useful organisational learning to underpin improvement.

Appraisal of professional practice in this case: a synopsis

While the Key Practice Episodes provided points of focus for the review, the contextual period of the case is bounded by the birth of the eldest child in [redacted] and the end of [redacted], which was the period prior to the removal of the children. During this period a wide range of professionals had contact with key members of the family for a variety of reasons, as well as a number of other professionals having contact with members of the extended family in relation to issues relevant to the children's wellbeing.

Agency recording relating to the early period of the lives of these children is dominated by services from health along with activity prompted by the problematic contact by William, Sarah and David particularly with police and mental health facilities.

William was known to Acute and Community Mental Health services from [redacted]. In [redacted] he was admitted because he had self harmed under the influence of alcohol citing his trigger as unhappiness at his "[redacted] daughter being pregnant". From that point until [redacted], when he suddenly stopped, he presented to acute mental health services or A&E with an episode of self harm/injury or overdose from prescribed and non-prescribed drugs along with alcohol misuse [redacted] On many of these occasions there was explicit mention of the support of his daughter and presence of her children and he was known to be living with them during some periods. He was frequently referred back to his GP for support, as well as to other mental health and alcohol misuse resources within the wider health service although he rarely accessed these. [redacted] 'Adult Mental Health Services' encompasses a number of distinct services based in a variety of settings and is, itself, a

complex system within the wider system. While the scope of this review does not include a focus on these services, there is some indication that the interface between acute and community, crisis and addictions services did not operate such that William's care (and capacity for self care) could be understood coherently. Under these conditions it was unlikely that the safety and wellbeing of the less visible children would receive appropriate attention.

Overall this review is particularly critical of the failure within some adult mental health services to pro-actively consider the impact of William's presentation and pattern on the safety and wellbeing of the (small) children that he clearly spent time with and often shared a home with. Assumptions about Sarah's capacity to protect her children and care for her father simultaneously were made repeatedly. The review is similarly troubled by the lack of meaningful communication from the GP practice who had long term knowledge of and significant levels of contact with the family but did not consider or connect the various presentations of family members or exercise curiosity about the living conditions of the children and whose methods of sharing information with other health staff were experienced as limited and restrictive. This is contrary to the advice and guidance available to all doctors [5] and to GPs in particular[6].

Adult Social Work services were also periodically involved with William, sometimes through Adult Support and Protection or police concern referrals. There is evidence that there was some concern about the impact of William's mental ill health and alcohol use on the children and strong advice appears to have been given to Sarah and David about his lack of fitness to care for them. In [redacted] Social Work requested that Mental Health staff advise them if there were further incidents because of the presence of the children; David, Sarah and the children moved into their own home not long after and an assumption was made that this resolved the issue. This review considers that a notification of concern should have been made to Children and Families Social Workers about the children's circumstances on more than one occasion. **These issues relate to the tendency in some adult services in North Ayrshire to take insufficient account of and action in respect of the experiences of children connected to their clients is discussed in Finding 4.**

In contrast, the review found that communication from Housing Services, on those occasions when they had contact with family members, was timely, clear and specific about their concerns for the children.

KPE1 related to a domestic incident on [redacted] because it appeared to represent a missed opportunity for multi-agency and Child Protection focused practice and the episode raised questions about a number of aspects of police and Social Work Reception Services practice in particular. The review has concluded that police took appropriate action during this episode. However, information collated by (then Social Work) Out of Hours does not appear to have been made available to Social Work Reception Services in their deliberation of risk. The reasons for this are not clear, but it is recognised that it may have furnished the latter with sufficient information,

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[5] GMC (2012) *Protecting Children and Young People: the responsibilities of all doctors*

[6] RCGP/NSPCC (2014) *Safeguarding Children and Young People: The RCGP/ NSPCC Safeguarding Children Toolkit for General Practice* (Accessed online at www.rcgp.org.uk on 2 May 2017)

alongside the automatic notification from police, to trigger a more thorough investigation of the children's circumstances the following day. At the very least, it would have made information about William's history of self harm and alcohol misuse and the assessment of the police more accessible in the Social Work recording system. Overall the Review considers responses to referrals about this family by Social Work Reception Services to show a tendency towards episode bounded and literal interpretation. Referrals about domestic incidents between David and Sarah, [redacted] (all knowable via this recording from Out of Hours) as well as investigations of sexualised language and behaviour by [redacted] Jenny were all responded to without apparent reference to each other. It is not clear to what extent this relates to difficulties accessing or to analysing the information appropriately. **This relates to some aspects of Finding 2, which explores communication and access to reflective process.** It is acknowledged that at the point of the KPE particular challenges were created by changes of manager and the partial development of the Multi Agency Domestic Abuse Response Team (MADART). However, the pattern of responding continues outwith that time period.

In addition, the review considers it possible from case-group testimony and the patterns of response evident in the multi-agency chronology that the Reception Services processes contained at least some of the 'latent conditions for error' identified by Broadhurst et al (2009)[7].

The family had an on-going health visiting service from the time of Jenny's birth. The home based visiting service was provided by relatively consistent personnel before [redacted], although visits were infrequent and supplemented by clinic based drop in contact with other staff. This level of service was in keeping with standards at that time, with home visits which were additional to a basic minimum were carried out at the professional discretion of the Health Visitor. The opportunity to assess a parent or child's wellbeing is considered by health Review Team members to have been insufficient at this time and there have been significant changes to Health Visiting since the introduction of the Universal Health Visiting Pathway in 2015. This being said, following Jane's [redacted], there is a period of six months in which the children are seen on only one occasion which seems inadequate, even by the earlier standards.

In November [redacted] a referral to the Vulnerable Families Midwife (VFM) was discussed by the incoming Health Visitor and an unidentified social worker, Sarah being pregnant with Judith. This referral was not made. In the meantime Sarah attended maternity appointments on a planned and unplanned basis, experiencing a 'fall downstairs' and 5 admissions with abdominal pain/? early labour; she revealed that she had 'worries at home'. The VFM at the workshop considered there to have been three missed opportunities to refer to their service, by Maternity services and MADART, in this and subsequent pregnancies. The VFM service would have provided Sarah with a dedicated midwife whose remit includes wider health and lifestyle issues and the inclusion of fathers. The VFM felt there were indicators of domestic violence in Sarah's presentations. Judith was born and

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[7]Broadhurst K et al (2009) *Performing Initial Assessment: Identifying the Latent Conditions for Error at the Front Door of Local Authority Children's Services* British Journal of Social Work 1 -19

regular and more frequent health visiting activity is noticeable both in terms of contact with the family and with other services, notably on behalf of Jane. The new Health Visitor identified the family as in need of an 'additional' Health Visiting programme. David and Sarah experienced this staff member as consistently supportive and reassuring, although they disagreed with the assessment of Jane's needs and felt the Speech and Language service they procured for Jane when she was assessed as having a speech delay was too brief.

The Health Visitor secured an early nursery placement for Jane to support her language development and because they felt that David and Sarah were largely 'inactive' and that Jane needed further stimulation.

There was a good deal of activity centred on attempts to effect Jane's access to nursery by remaining in contact with nursery staff, encouraging Sarah, David and William and by referring the attendance issue to Social Work a number of times. There is discernible confusion, however, over the question of the level and nature of concern expressed by the Health Visitor and/or nursery in inter-agency communications, as well as a lack of clarity about what was sought as a response to the referrals. This review has understood these confusions to have arisen from a number of aspects of the operating system. These are to do with the key GIRFEC roles of Named Person and Lead Professional, **discussed in Finding 1** and the patterns of communication evident between professionals which is **highlighted in Finding 2.** There are a number of contradictions and anomalies in the health visitors' assessment of the family: there is inconsistency in their attitude to William and his safety as a carer of the children; they demonstrated some acute insight into dynamics between the parents which compromised their capacity to care but reiterated that they had never seen anything to make them concerned about the children. Working for a period of time with confusing clients whose presentation is difficult to make sense of can cause practitioners to struggle to articulate their assessment. Lone working and a lack of reflective supervisory process exacerbates this possibility and **this is an issue raised through Finding 2.** Practitioner impressions of the family were reinforced by the habitual reactions of other health staff that they were 'hopeless' and that William was 'harmless'.

Confusion about the level and type of concern for the children persisted for some time. During the period of the second KPE ([redacted]) this contributed to the failure to capitalise on an opportunity to escalate intervention to a compulsory form when a domestic incident referral to the Scottish Reporters' Children's Administration resulted in a request for a report from Children and Families Social Work. A report was duly submitted recommending 'No Further Action' on the basis of an understanding that David was no longer living with the family and that neither the education or health agencies considered compulsory measures to be necessary. There are inadequacies in the assessment process and report: assumptions are made about David and he is largely invisible; the children's voices and views are not well enough represented; like others, the report writer is unrealistically optimistic and convinced by the superficial, conversational capabilities of Sarah. **Some of these issues are further discussed in Finding 3.** However, the report once again reveals the extent to which collaborative, integrated process is compromised by a lack of clarity about escalation processes and joint ownership of decisions. Some of this is reinforced by the allocation of responsibility for these reports to Social Workers, with an expectation that they 'consult' others.

This may continue to reinforce the current pattern of a relative failure of agencies to make full use of the Reporter and the Children's Hearing system.

Overall, this review considers the events covered in KPE1 and KPE2 to demonstrate considerably muddled thinking with regard to escalation and the necessity for compulsory measures of supervision; inadequate processes for reaching mutual understanding between different agencies and a consequent failure to appreciate the children's experience. **These issues are discussed in Findings 1 and 3.** It is telling that David and Sarah's comment about services was that "they did ask if we needed help, but didn't make it clear what their concerns were."

The wider health system had a good deal of knowledge about the family but it is not clear to what extent this was available to other health personnel. There was a widespread expectation in the case group that GPs acted as 'gatekeepers' of much available health information but also that they would routinely share such information as was useful with Health Visitors in particular. It was clear that there is no one pattern for this activity and that very little was in fact shared with the Health Visitor at the weekly meetings that took place. The GP who participated in the review painted a picture of a particularly overwhelmed practice, with poor information management systems, impacted by both its long term operating habits and widespread cuts in which the retreat of specialist services means an increase in GP demands as they 'hold' patients in the meantime. Under these conditions they felt it was unlikely that many families with presentations like this one would be noticeable. In addition, the family were 'representative' of a standard of parenting and use of healthcare that was known and tolerated. This was a concerning experience for us since it seemed to have clear implications for the identification of neglect and also indicated that very significant reliance is placed on Health Visitors to raise issues of concern. This conversation exemplifies a frequent discovery in the course of case group and other meetings: that between agencies there is a widespread lack of clarity about each other's conditions of work, functioning and processes, some of them critical to successful multi-agency communication and co-ordination and this is noted as a **cross cutting theme** in that section of the report. The GP gave appropriate support to the newly allocated Health Visitor in [redacted] writing about their concern that the Child Protection process was not sufficiently urgent in relation to what they identified as clear indicators of sexual abuse, but was not able to reassure us that issues of neglect would be identified through everyday practice.

The third KPE focussed on a period of intense multi-agency activity over a two month period [redacted] when a professionals' meeting was held. A change of Health Visiting personnel occurred in [redacted], following the birth of [redacted] had begun school in August. There was a rapid escalation in the level of concern about Jane's behaviour at school, which the school recorded clearly and in detail in pastoral notes. Following their first visit to the family the new Health Visitor detailed their assessment of risks to the children and phoned the 'duty worker' at Social Work Service Access (formerly Reception Services) to make a referral. They were redirected to the school for further discussion and advised to call back 'if concerned'. The health visitor's perception was that they were already communicating a high level of concern and as a demonstration of this believed that they had placed the assessment within a few days on the shared electronic platform, AYRshare, on the basis of having used this facility to communicate effectively in a neighbouring authority. The combination of the muted response from Service Access

and an apparent lack of response to the shared assessment left the practitioner believing that they were not being taken seriously. **This aspect of communication difficulties is explored in Finding 5 relating to AYRshare.** The experience of this professional new to the geographical area, not acclimatised to the way the local system worked and reacted to this family, illuminated some of the confusions of roles, use of tools, assumptions and expectations about communication and by approaching the work in the way that they did, highlighted some of the accommodations that appear to have been made in longer term relationships with the family. Their reframing of the situation at home and recognition that Jane's situation had been understood almost entirely as an issue of access to education (through being physically or emotionally available) allowed the other children to come into view. This is an aspect of practice **discussed briefly in Finding 1.**

The escalation of the children's behaviours and the clearly demonstrated levels of their distress prompted increasing and eventually appropriately urgent action from professionals from all agencies – albeit with some continuing difficulties, many of which have aspects in common with the findings of this report and form the subject of the earlier Social Work Services review – culminating in the accommodation of the children, where they remain.

In what ways does this case provide a useful window on our systems?

While all families and their circumstances, including this one, have aspects of uniqueness about them and can only properly be understood within their particular context, the act of organising services by single and combined agencies is predicated on assumptions of some measure of predictability of demand and response. Case group members recognise that this family and their circumstances have aspects in common with others that they work with and are, in that sense, 'representative'. They also recognise that ***how they have organised themselves*** to carry out the work has recurring characteristics, based on assumptions about what others around them (seem to) expect and through the tools and processes provided for them to do so. GIRFEC, as an idea enacted through a set of principles, processes and legislation has been informing the organisation of such activity for a decade. This case has illuminated some of the ways in which the implementation of GIRFEC - involving a plethora of complex single and multi agency initiatives, some more visible than others, and alongside re-organisations in the context of reduced budgets, has created contradictions, challenges and accommodations at practitioner, single- and multi-agency levels. The hidden and implicit rules for 'how we respond to a family/child like this' have become more visible and explicit in this process. This review has focused on reaching a better understanding of the gaps between the apparent function and actual functioning ('the inner workings') of both individual practice within single agencies (e.g. collecting and transferring information to others) and multi-agency systemic mechanisms (e.g. resource allocation groups). The intention is not to seek problems in the system and find ways 'fix' them, but to help the system as it has currently evolved to function with more insight and so better manage the risks.

Summary of findings

The review team have prioritised five findings for the CPC to consider. In addition there are clear indicators from reflections about the experience at the workshops by practitioners as well as some questions raised when considering the possible reasons for actions not taken and referrals not successfully made that **practitioners do not feel they know enough about each other's agency processes and arrangements** and this is a theme that cuts across all findings.

Finding	*Category*
1. The systemically driven blurring of terms (single agency, universal services, early years) in North Ayrshire results in a loss of clarity about the appointment of a Lead Professional which leads to a lack of co-ordinated overview of children's needs.	*HUMAN-MANAGEMENT SYSTEM OPERATION*
2. In North Ayrshire there seems to be a tendency for professionals across all agencies to assume that giving and receiving information equates to communicating, which can lead to misunderstandings about the current assessment of children's situations. This leaves children without services to address both their wellbeing and their protection longer than necessary.	*COMMUNICATION AND COLLABORATION IN LONG TERM WORK*
3. In North Ayrshire professionals across all agencies are tending to restrict the evidence of children's experience to what they say, which results in both missed cues and the privileging of the voices and views of adults (family and professional).	*FAMILY-PROFESSIONAL INTERACTIONS*
4. In North Ayrshire 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.	*PATTERNS IN HUMAN JUDGEMENT / HUMAN-TOOL OPERATION*
5. The use of AYRshare is inconsistent within and across agencies in North Ayrshire and this creates risks to clear communication about children.	*HUMAN-TOOL OPERATION*

Findings in detail

FINDING 1

The systemically driven blurring of terms (single agency, universal services, early years) in North Ayrshire results in a loss of clarity about the appointment of a Lead Professional which leads to a lack of co-ordinated overview of children's needs.

Introduction

GIRFEC guidance states that "**in all cases**" where there are "two or more agencies working together [to deliver] services to the child and family .... a Lead Professional **will** be needed". (Practice Briefing 2 my emphasis)[8]. However, within Health Visiting there is also a facility to assess families' needs as 'core programme', where needs can be met through routine services, or 'additional programme', under which circumstances Health Visitors may need to request further services from – usually – Speech and Language Therapies (SLT) and Assistant Nurse Practitioners (ANP). These services reasonably qualify as constituting help offered from within the single agency of 'health services' and, in the context of GIRFEC, would be consistent with fulfilling the duties of the Named Person (NP). In addition, however, Health Visitors may request a nursery placement for a child prior to 3 years and universal entitlement. This is a relatively common occurrence, considered to be within everyday practice at the 'additional' level. On these occasions the Health Visitor does not consider 'education' as a separate agency, but as 'part of universal services'. For this activity 'them' (the education agency) is considered 'us' (universal services and part of 'early years' provision). Because they are not conceptualised as "different agencies who act as a team" (Practice Briefing 2), but as different elements of a 'partnership' the step change from single to multi-agency work goes unnoticed and the explicit appointment of a Lead Professional (LP) may not be made.

This matters because the authority vested in each of the roles (NP and LP) is qualitatively different although the activities can look very similar. Critically, the Named Person role is considered in the practice briefing to often not involve doing "**anything more than they normally do in the course of their day-to-day work**" (Practice Briefing 1 bold original[9]) and the consent of parents and children is emphasized, creating an assumption of voluntarism in the uptake of services. Key to the transition to a Lead Professional role is the assessment that additional services are **required** (my emphasis) to meet the child's needs and at this point Named Person becomes Lead Professional. Making this transition requires that Named Persons identifies the need which is currently unmet

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[8] Scottish Government (2010) *GIRFEC Practice Briefing 2: The Lead Professional*

[9] Scottish Government (2010) *GIRFEC Practice Briefing 1: The Named Person*

and requires the services of an additional agency; they are invited to do so in consultation with their colleagues from other agencies but the Lead Professional's role is to "make sure" that services are provided and has a "significant role" in the co-ordination of a multi-agency Child's Plan. Further, the explicit implementation of the LP role carries with it an indication that the processes of a 'team around the child' approach is needed. This naming process is important because it acts as a signal of change to the organisation and nature of multi-agency intervention.

How did the issue manifest in this case?

At the point of procurement of an early nursery placement for two-year-old Jane (August 2012) via a local Multi-Agency Partnership Forum, the format of the Child's Plan allowed for the identification of the Health Visitor as the Named Person and the Assessment Analysis in the Care Plan identified needs under "Active" and "Achieving". Sought outcomes were expressed in general terms (optimum level of health and wellbeing) and were linked to continuing the Health Visiting service and early provision of a nursery placement. There was a considerable period following the allocation of a nursery placement where there was clear communication of concerns about attendance between the health visitor and the nursery staff/head teacher. There were repeated contacts with social work reception services to alert them to this concern but there was no evidence of explicit and authoritative co-ordination of either the messages or the requirement for a particular additional service on behalf of the children. Instead of coming together and explicitly inviting the services of the social work agency in (re)consideration of the children's situation, each single agency acted alone to meet the child(ren)'s needs within their own resources.

Thus, the Health Visiting system, in providing an additional programme, secured the service of SLT and an Assistant Nurse Practitioner. At a later date, the school accessed classroom assistance and referred back to the Partnership Forum to seek access to the education agency's own Nurture Base. In [redacted] Jane's situation was referred to the Resource Allocation Management Group (RAMG), a senior group with cross agency representation whose approval was needed to access more specialist education provision. While both of these forums have the potential to act in consultative ways across professional perspectives, their operation is much more focused on the allocation of resources which are clearly requested and thus their process is much more transactional than reflective. Furthermore, while representatives from other agencies were present, the resources that were sought were entirely within the gift of the department from within which the request came, making it questionable whether with a busy agenda, others would become meaningfully involved.

Crucially this led to single agency scaffolding around the child and the parents separately which masked the need for a wider and more systemic view of the family functioning.

The definitional issue regarding single or multiple agency involvement was further exacerbated by the nursery's direct access to the involvement of Early Years Social Worker (EYSW). This service was considered to 'belong' within the education agency and required no formal referral across agency boundaries. This caused confusion for the new Health Visitor when they were attempting to prompt Child Protection activity and also created difficulties for the EYSW in their attempts to

escalate concerns and seek intervention by Children and Families Social Workers at least in part because their 'belonging' in education as a 'partner' in an Early Years service was misunderstood. Some conflation of terms Early Years and Early Intervention added to this confusion.

Difficulties escalating from early intervention to the next stage persisted for some time and – along with some lack of clarity about what 'the next stage' constituted – no relevant agencies appeared to explicitly make use of the roles of Named Person or Lead Professional to organize their responses or inject authority into their requests. If, for example, social work staff assumed the Health Visitor to be acting in their role as Named Person it might be reasonable to expect them to be consulted about and informed of others' decisions and recommendations regularly. This was not their experience.

How do we know it is an underlying issue and not something unique to this case?

Consultation with senior staff in health has clarified that conceptualising access to early nursery placements as 'additional programme' practice is routine. It is likely that it will not constitute a noticeable shift to 'multi-agency' intervention for some practitioners, particularly those who have used the current systems over a longer period. Referrals (via the Multi-Agency Partnership Forum, now disbanded) for early nursery placements are not unusual and placements appeared relatively easy to procure. Furthermore, the use of the Partnership Forum by education agencies to access its own resources was described as 'bizarre' but not unusual by those managing the Forum's. The view of those with the relevant professional expertise was that the remit of the Forums appeared to have 'morphed' from their original purpose to include acting as a screening for RAMG but also that there was some expectation that the Forums would make more informed decisions because they could provide different perspectives. Information from the case group confirmed that the RAMG is largely concerned with access to resources from within education with the possibility of some 'consultation' from others. However, there was also concern about the capacity of this group to reflect on cases, given their current experience of considering the needs of around 30 children in 3 hours. This group is currently under review.

Case group members confirmed widespread confusion about Named Person and Lead Professional duties. Those with the professional expertise and the responsibility for leading the implementation of GIRFEC in North Ayrshire described the adoption of the Named Person duties and mindset as existing 'in name only' until around 2012 and this observation would need to assume that there were early and late adopters to the change. A subtle transition from one role (e.g. Named Nurse) to another (Named Person) is harder to achieve (and accurately assess as having taken place) than a conscious change of role or significant step change that requires easily observed behaviour changes.

Further changes to the configuration of the early years services (including the line management and supervision of the Early Years Social Workers) makes it difficult to assess the likely future understanding of the boundary around their role and their professional function relative to (Area Team) Children and Families Social Workers but it is likely to require clear explanation which takes

care to identify underlying assumptions and make explicit the expectation of inter-professional role relationships.

How prevalent is it?

This is hard to quantify by its very nature, since evidence would arise out of the recorded use of the terminology and the adaptation of the paperwork might (optimistically) signify use of the concepts where 'change' is limited to adopting terms not behaviours. The language and processes of 'Team Around the Child' are relatively new to North Ayrshire and so mechanisms for demonstrating the process would perhaps be named as 'planning' and 'professionals' meetings. The case group considered this to be a recognisable and representative description of some of their experiences in the wider system.

How widespread might it be?

Since the use of 'additionality' within the key single agencies of health and education occurs nationally it is likely that some of these effects are Scotland wide. The plethora of overlapping terms to describe different aspects of the system is nationwide. As the Child Protective Systems Review[10] observes, 'the system' is both crowded and complex and the term itself may create a sense of more cohesion and coherence than there actually is.

Why does it matter? What are the implications for the reliability of the multiagency child protection system?

The blurring of single and multi-agency activity matters because it a) causes confusion in the wider system where different conceptions of single and multiple agency intervention exist and therefore erroneous assumptions may be made; b) compromises the identification of a need for escalation on a multi-agency basis through the mechanism of the Lead Professional role; and c) may lead to difficulties further down the line because the frame of thinking has been firmly established by the time further agencies are invited to provide a service.

Much of the debate between agencies centres on the question of thresholds and is conducted as if the threshold is 'owned' by one agency (usually Social Work) and the challenge is for others (usually Health and Education) to cross it. In the current system it appears that the 'achievement' of entry to the Child Protection system is understood as a matter of accumulation of events such that the 'pile up' is sufficient to cross the threshold. The achievement of an earlier threshold – the imposition of compulsory (or even voluntary) measures of supervision via the Children's Reporter

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[10] Scottish Government (2017) *Protecting Scotland's Children and Young People: It is Still Everyone's Job* Edinburgh: Scottish Government

and/or Children's Hearing System – does not appear to feature clearly as an escalation mechanism, leaving a 'hole' in the system between Early Intervention (or universal services?) and Child Protection where ownership is a contested issue and, as one case group member put it, 'professional ping pong' ensues. Both Named Person and Lead Professional duties are primarily intended to create opportunities for the pooling of information *and perspectives* such that sense-making can be shared and the achievement of a threshold for action arises out of qualitative and theoretically grounded assessment rather than quantitative accumulation of 'concerns'. Furthermore, since many of the 'early' services are offered in the context of support and compensation for family difficulties or gaps, rather than in the service of change in functioning, this creates the potential for unnecessary (low level) conflict between the existing services and 'new' ones and between the family and services whose focus is on achieving change in the family's functioning.

A safe system, within the context of the common policy of GIRFEC, is one that consistently enacts the role expectations of that policy. This allows for the explicit transition from single to multiple agency intervention and for the transition from Named Person to Lead Professional orientations. The most risky system is one that believes it is following policy while it is not.

The need for single agency responses continues, and is particularly referenced in the '5 key questions' of GIRFEC. It is likely, therefore, that complex and sometimes multi-**disciplinary** activity to contain provision within single agencies will persist. The increasing integration of services under umbrella terms such as 'early years' and 'early intervention' exacerbates the potential difficulty for identifying the moment at which a service is provided by an agency separate from one's own.

FINDING: The systemically driven blurring of terms (single agency, universal, early years) in North Ayrshire results in a loss of opportunity to appoint a Lead Professional which leads to a lack of co-ordinated overview of children's needs.

Multiple and incremental changes in the delivery of services focusing on the wellbeing and protection of children has resulted in overlapping and conceptually indistinct terminology. The problem of how to understand the service practitioners provide exists at individual practitioner level, in the inter-action between practitioners and is sewn into the mechanisms which govern the provision of resources. 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. It is difficult both for those working within an issue and those 'consulting' to it to retrace (and possibly retract) how they have made sense of a

situation such that others can identify their possible contribution.

This case demonstrates that the failure to explicitly notice and enact expectations in relation to the Named Person and Lead Professional roles can lead to a lack of co-ordinated overview of children's situations, authoritative procurement of appropriate services on their behalf and failure to create opportunities to jointly clarify, discuss and own the need for escalation from voluntary to compulsory measures of care.

QUESTIONS FOR THE COMMITTEE

1. Does the Committee recognise this issue?
2. Is there a role for the Committee in seeking to manage or reduce the risks inherent in the current system?
3. What is the Committee's role in supporting the effective use of the Named Person and Lead Professional roles and their respective activities?
4. How might the Committee assure itself a) that its member agencies understand this issue and b) the requirements of GIRFEC are being consistently and properly followed?
5. If this is a national issue, which is likely, how might the Committee raise this as a concern to promote the welfare and protection of children and young people in Scotland?

FINDING 2

In North Ayrshire there seems to be a tendency for professionals across all agencies to assume that giving and receiving information equates to communicating, which can lead to misunderstandings about the current assessment of children's situations. This leaves children without services to address both their wellbeing and their protection longer than necessary.

Introduction

Communication is a complex process, involving as much intra- and inter-personal psychology as practical activity[11]. The environments within which communication takes place contain embedded

[11] Reder, P and S Duncan (2003) *Understanding Communication in Child Protection Networks* Child Abuse Review Vol 12 82 – 100

assumptions which combine to create challenges in even apparently simple exchanges and the probability of miscommunication is high.

One of the key intentions of GIRFEC has been to enable multi-agency communication through the introduction of a common set of terms, tools and concepts. At the heart of this has been the adoption of the Wellbeing Indicators (SHANARRI) as a framework, the use of the National Practice Model and Risk Assessment Toolkit and mechanisms to streamline planning, which includes explicit reference to the need to develop inter-professional trust and respect with regard to each other's assessments.

The cross-professional adoption of terms and tools, however, does not necessarily mean that there is a common and shared understanding of one another's use of those terms because they are constructed from within a single agency mindset which, inevitably, has a bias shaped by the focus and theoretical orientations of that agency. The 'transfer of information' between agencies, even couched in familiar terminology, "has no consequence unless the communicators are able to attribute [accurate, shared] meaning to the messages conveyed" (Reder and Duncan, 2003:86). The familiarity of the terminology may, itself, mask the level of misunderstanding between the parties.

In addition to the issue of content, the purpose of the exchange must be mutually agreed. 'Keeping you updated' may seem very different to 'trying to get you to take action' but these need to be explicitly explored as possible purposes in order that one is not mistaken for another. 'Seeking your help' and 'trying to refer to you' can co-exist for some time before each participant understands the other's orientation as either the same or different. The (resource-stretched) intra- and inter-agency context needs to be explicitly acknowledged as an influence on these exchanges, which often take place in the context of requests for services.

How did this manifest in this case?

1. Misunderstanding at the level of terminology

Police reports relating to the children's experience of domestic incidents recorded them as 'unaffected'. This was understood widely in the case group (and at the point of receipt by social work services) as meaning that the children were not impacted upon by their parents' domestic disputes. However, the police terminology was intended to be more restricted in scope and limited to the current, episode bounded, physical presentation of the child. Inferring that the scope was wider than this gave false reassurance to the recipient about the impact of the event on the children and may have influenced the focus of subsequent action.

There was considerable exchange between the Health Visitor and Social Work staff relating to the former's level of 'concern' and an apparent oscillation between positions of ' being concerned' and

'having no concerns'. This confusion was predicated on the notion that a shared definition of "concern" existed and that the definition remained constant in all contexts. The Health Visitor clarified that they were, indeed, concerned about the children in that they cared about their wellbeing; they were not, however, worried about the children's safety in the care of their parents. The term "concern" has to some extent been appropriated as a term relating to issues of protection and may be heard as a 'referable' Concern or incident. Rather than a more encompassing concept, this 'meaning' has more interventionist implications. This 'appropriation' of the concept was also reflected in the observation that there was no available form for sharing concern relating to attendance and the available (protection focused) form was deemed inappropriate. This resulted in confusion about how to make the referral.

2. Misunderstanding about the meaning/intention of sharing

There were occasions in which an exchange/transfer of (usually descriptive) information was effected but no interpretation of the information appears to have taken place and thus the reason for it being shared was not explored. An assumption about what action was (or more often was not) prompted was made from the perspective, knowledge and within the current working conditions of the recipient.

Sometimes there was no clear action expected, as was the case when the Health Visitor let Social Work know that Grandfather was living in the house when they began work with the family because they were aware that Social Work did not approve of his presence. The Health Visitor had no expectations about what would follow but assumed that Social Workers would make their own assessment of the information received.

Information was conveyed repeatedly, particularly to Social Work Reception Services about the children's non-attendance at nursery and school. For the most part it appears that it was considered self evident as to why this was a cause for concern. However, the recipient contextualized the activity of attendance at nursery within a framework of early, voluntary intervention and considered the matter as resolved because the parent chose (as was their legal right) not to make use of the available early placement. The Health Visitor and Nursery/School continued to 'update' the Reception Services and the recipients accepted the updates without further assessment. For the Health Visitor, repeated referrals were intended to 'accumulate' sufficient concern for a threshold to be achieved. However, because the frame for considering the information did not change, neither did the response. Neither party took responsibility for checking understanding either of content or of intended impact.

3. Failure to co-ordinate and triangulate information: taking information at face value

There are many instances in the communication between professionals and between professionals and the adult carers in which information is transferred and accepted at face value, with little apparent attempt to verify the information through triangulation with other sources. Doing so

would have revealed anomalies and contradictions in both information and opinions which would likely have prompted more meaningful, reflective dialogue between participants.

Where this involved adult family members the combination of the superficially well informed and voluble communication style of the mother, the aggressive stance of the grandfather and the relative silence [redacted] of the father seemed to contribute to a response from professionals that retreated to a simplistic 'assessment' of the situation based on what could be 'evidenced' as having been said. It is noticeable that when corroboration was explicitly sought, from [redacted], understanding of the children's situation began to be reframed in significant ways.

4. Practical problems of transmission, accessibility and attribution

There is a pattern of over-reliance on telephone communication, which often leads to 'telephone tag' and the loss of urgency and clarity. The same is true of the use of email and data entry/transfer, which is not accompanied by other means of contact.

For all agencies there appear to be difficulties in accessing already known information. The issue of accessibility is both practical and psychological. For some the combination of high volumes of information and very restricted time available to sift and organize it in ways pertinent to the current event can mean that an all or nothing approach is taken leading to episodic assessment or overwhelm.

For other practitioners/agencies/incidents the route to the information is either unclear or it is accessible only with considerable effort because of its format or because it is already understood in a particular way and therefore prejudged as not useful/relevant. This latter aspect is particularly true of information held about adults relevant to the children's welfare. For example the [redacted] was not widely known even by those professionals closely connected to the practice. The need to share such information was precluded partially by the conceptualisation of the family's presentations, use of healthcare and low standards of parenting and care as longstanding and typical for the area and therefore not noticeably problematic.

5. The allocation of status to information

Tacit or 'soft' knowledge is held by all agencies. There is (see Finding 3) a hierarchy of 'evidence' in operation in the system, with inappropriate (criminal prosecution) benchmarks applied to the question of 'inclusion' or consideration of what is known. This demotes other kinds of knowledge to the status of rumour, prejudice and hearsay. It also precludes the explicit application of professional, interpretative frameworks where the observable evidence is indicative rather than definitive. This has implications for the identification of neglect, in particular, but also for any situation in which attempts are being made to hide or distort information.

How do we know it is an underlying issue and not something unique to this case?

Practitioners in a number of settings, most notably in community health, did not consider this case to be unusual, or 'the worst' example of its type suggesting widespread issues with the conceptualisation of neglect in particular, but also raising questions about the recognition of indicators of intra familial sexual and emotional abuse.

How prevalent are these issues?

Case group members recognised all aspects of this finding exemplified above.

How widespread are these issues likely to be?

These issues are likely to happen wherever there are humans engaged in relationship based practice in complex situations.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

A safer system is one that recognizes that communication and assessment are complex reciprocal processes. Successful communication relies on a degree of reflective process such that each party is mindful and explicit about the possible influences on their contribution. Sharing information (by whatever means), while necessary, is not in and of itself sufficient to 'inform' assessment; it requires to be processed and given meaning in order to prompt action. In both multi-disciplinary and multi-agency settings shared meaning is acquired through dialogue, as terms are refined, concepts are illustrated, theoretical frameworks made explicit so that practitioners' consequential thinking can be seen, understood and evaluated. This 'mindset' in relation to information inevitably invites difference in professional perspective and sometimes disagreement about the conclusions that can be reached. This is the value of multi-agency work, not an unfortunate by-product. It includes a presumption that collaborative practice is not necessarily comfortable and does not have a predetermined design.

All of these issues may be presumed by practitioners to be already anticipated and managed by the design and provision of the GIRFEC framework and its core components, particularly in the adoption of a 'common language' and common processes/tools/technology. Paradoxically this very 'commonality' itself creates a risk that communication is considered to be effected by making use of them (e.g. "doing an electronic transfer of Sharing of Concerns about an aspect of wellbeing") where, in practice, it may be used to replace the more human processes and cause a rush to 'task' and reaction rather than creating a pause to think things through to a more considered (and more likely collaborative) response. In this way, the work becomes a series of (apparently successful)

reactions to episodes (request carried out/task done) rather than a thoughtful intervention which addresses underlying patterns. This particularly creates a risk that neglect will be missed.

FINDING: In North Ayrshire there seems to be a tendency for professionals across all agencies to assume that giving and receiving information equates to communicating, which can lead to misunderstandings about the current assessment of children's situations and this leaves children without services to address both their wellbeing and their protection longer than necessary.

Lone working and individual casework; complex family dynamics; habituation to low standards and patterns of relating; subconscious orientations to 'support and compensate' or 'intervene and change'; one's own or others' changes of role and remit within a complex system; anxiety about the safety and wellbeing of children; high caseloads in the context of reduced resource (particularly time); worries about data protection responsibilities and the tendency (and need) for practitioners to take shortcuts in their communication create conditions under which the probability of miscommunication, including failures to make information available, is high.

A complex and changing system under conditions of anxiety is always in danger of engaging in defensive practice. Such a system requires predictable opportunities for considering how it employs feeling (reacting based on the experience of being human) and thinking (processing thoughtfully through professional frameworks for understanding) in the service of delivering appropriate responses. The Care Inspectorate's review[12] advocates the provision of regular reflective supervision for **all** staff involved in "Child Protection" work. The question of the same provision for those involved in the wider processes of 'protecting children' may need to be addressed.

Since communication is predominantly a matter of human process, deliberate local mechanisms for maximizing the development of a 'communication mindset'[13](focusing on what needs to be understood by the listener/recipient) at both individual and collective levels need to be created. This depends on the capacity of the system to prioritise time and space for reflective process. This has implications for a system which is experienced as resource

[12] Care Inspectorate (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* Dundee: Care Inspectorate

[13] Reder P and S Duncan (2003) *Understanding Communication in Child Protection Networks* Child Abuse Review Vol 12 82 – 100

stretched in exactly these ways, sometimes to a significant degree.

QUESTIONS FOR THE COMMITTEE

1. Does the Committee recognise these issues?
2. If so, what can the Committee do to encourage and support the development of conditions conducive to both individual and shared reflective process?
3. What can the Committee do to further establish clear principles and expectations for effective collaborative process and inter-professional communication?
4. What role does the Committee have in encouraging the development of reflective supervision in single and multiple agency settings?

FINDING 3

In North Ayrshire professionals across all agencies are tending to restrict the evidence of children's experience to what they say, which results both in missed cues and the privileging of the voices and views of adults (family and professional).

Introduction

A key practice requirement in work with children, enshrined in law, is the inclusion of the 'views' of children. Cognitively, it seems that the most easily accessed interpretation of this requirement is that the views (opinions) of children are sought by asking them what they think and want. This narrow conception demands that children must be able to 'say' what they think or wish for. The limitations of this interpretation are clear, particularly for those children who are pre-verbal and/or those who are, for a multitude of reasons unable to verbalise either their experiences or their wishes. Children are often inarticulate or 'inaccurate' because they have no independent view of what is happening to them, being reliant upon their carers for an interpretation of their experience and dependent upon them for future care and protection. Children's (unconscious) strategic adaptation to their care and (un)safety may compromise their capacity to communicate in

a host of ways. They are unlikely to 'know' and therefore disclose that they are being neglected,[14] and may be waiting to be noticed and asked why they are unhappy[15].

In addition to this, children (like adults) communicate far more through their non-verbal behaviour. The interpretation of this requires close observation and careful consideration. Interpreting what they are expressing requires both the exercise of professional (i.e. theoretically grounded) judgment, and the capacity to engage personally with them as subjects in their own lives. This may involve looking beyond the immediate presentation and demands that we always consider children in context. Their apparently easy engagement with professionals may be as concerning as their difficulties doing so and their relationships with those in positions of authority (that is, responsible for their care and protection) both within and outside the home are particularly key as sources of information about how they view the world and themselves within it.

This latter orientation is the 'second layer' and more literal interpretation of the requirement to 'seek children's views'; it means orienting to their view of the world, understanding what they are experiencing from where they are. What do they, at their height, position in the family, stage of development see, hear and understand is going on? In particular, who can they rely on for care and protection, for the achievement of wellbeing?

Practitioners need to be able to conceptualise children's communication in complex ways and this leads some to feel anxious about their competence particularly in the context of limited opportunity to spend time with children in appropriate environments. This may be heightened when there are identifiable indicators of risk and in the context of Joint Investigative Interviews as a source of evidence for possible criminal prosecution.

How did this manifest in this case?

There was clear sense from the case group that the children's voices (largely but not exclusively direct quotes from pastoral notes) were clearly heard by many for the first time at the workshop and that their 'view' of their world became clearer. Considering the child's perspective and experience is an issue across all agencies.

There is a recurring theme throughout the progress of the case of a failure to both speak to and hear the children and to make best use of their non-verbal communication to address their wellbeing and safety. For some episodes children's words were reinterpreted or replaced by adults' phrasing and framing and the children's voices were lost or their presentations explained away too easily. For other episodes there were at best limited attempts to engage directly with the children and sometimes none, even in the context of concerns that should have triggered professional alarm.

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[14] Action for Children/University of Dundee (2013) *Action on Neglect – A Resource Pack* available online from www.stir.ac.uk and www.actionforchildren.org.uk

[15] Burgess et al (2014) in Scottish Government (2017) *Protecting Scotland's Children and Young People: It is Still Everyone's Job* Edinburgh: Scottish Government

The difficulty hearing the children may have been exacerbated in the home by the communication patterns (both quantity and quality/content) of the adults in the house. Attempts to engage with the children away from that environment sometimes would have been relevant but do not seem to have been made.

As concern about the children's presentation grew, inappropriate assessment of their verbal contributions were made and their testimony was disregarded, for example, on the grounds of 'inconsistency'. Their non-verbal communication at these times was not considered. Widespread anxiety about the evidential value of children's direct speech/disclosure appears to have elevated verbal disclosure in Joint Investigative Interviewing (JII) settings to such an extent as to exclude the relevance of all other sources and forms of communication.

In nursery and school settings, while there was an accurate, vivid record in pastoral notes of the children's voices and behaviours, these were subject to interpretation within the current frame for understanding (as yet unidentified additional support for learning needs) and were not shared outside the agency in their original form. In this sense they too were replaced by adults' re-interpretations, especially when transferred to referral templates and this led to a loss of impact. The opportunity to highlight particular aspects of one of the children's presentations may also have been diluted at the education resource group meetings by second hand representation – in this way, both the child and the practitioner become unseen and unheard[16].

Similarly, aspects of the children's home life gleaned through the Health Visiting service may have been better understood at the Partnership Forum, when an application for early nursery placement was made, had the practitioner presented the case in person, and therefore been able to add to what was written.

How do we know this is an underlying issue and not something unique to this case?

Testimony from participants in the case group workshop suggests that anxiety about communicating with and representing the views of children is both prevalent and widespread, particularly in the context of prospective Court and Children's Hearings proceedings and this is unlikely to be confined to this case. There are particular local concerns and loss of confidence for social workers in the context of recent difficulties in cases taken to court. Anxiety about communicating with children was also expressed by police personnel for whom Joint Investigative Interviewing Training was felt to be necessary before they felt able to approach or assess children confidently.

Assessment reports to SCRA were judged to be representative in terms of the sources (home visits/phone calls) of information and level of contact with the children.

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[16] Howarth J (2011) *See the Child, See the Practitioner: The Framework for Assessment of Children in Need and Their Families Ten Years On* British Journal of Social Work 41 1070 - 1087

There is also evidence of restricted and restricting interpretation across all agencies about what children's communication constitutes, especially with regard to the inclusion of behavioural indicators.

How prevalent is this?

The case group considered this to be a recognised and common issue across much of the system. Review Sub-team members, in the course of their usual practice, reinforce this view, reporting anxiety among participants of learning events about communicating with and interpreting children's behaviour. Audits of initial assessments of needs and risks in Child Protection investigations consistently finds a significantly lower recording of children's views and perspectives than parents' and the former range between 44% and 68% over the past 18m, compared a range of 65% to 96% for parents. Anecdotally, there is a perception by Social Work Managers and Children's Reporters that phrases such as 'not known due to age and stage' continue to be used. Across the recording accessed for the case at the heart of this review there is very little evidence of the children's views being actively sought. The pastoral notes are a very good example of accurate recording and thereby offer a vivid picture of the ways in which the children were behaving. However, even here, this amounts to an adult's observation of their behavioural communication rather than a child's perspective on their experiences.

How widespread might it be?

Given the range of professionals included in the case group and their geographical locations it is likely that this is an issue across North Ayrshire. The Care Inspectorate review of SCRs[17] (2016:24) 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 impact", suggesting that this finding has resonance in other regions.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

The representation of children's views (both spoken opinion and experiential perspective) is a fundamental of safe child protection practice. The question of how children are experiencing their lives is key to an assessment of their care and safety. The (adult) system is prone to minimizing, sanitizing and re-interpreting children and deliberate mechanisms to include their perspective are required to offset this bias. Most fundamental to this is the allocation of sufficient time to get to know children and to communicate with them through their own medium in different contexts in

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[17] Care Inspectorate (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* Dundee: Care Inspectorate

order to collect the relevant information. Mechanisms which maximise the potential for their voices and non verbal communication to be 'heard' clearly and without prior editing will create opportunities for (re)thinking together – from different and collective perspectives - what those voices and behaviours might be trying to communicate. A system that considers 'disclosure' about incidents under Joint Investigative Interview conditions as the only acceptable evidence from children about their wellbeing and safety will fail to intervene effectively before there is a crisis. The implication in particular is that children who are experiencing long term neglect will go unnoticed. A safer system considers explicitly both what children are vocalizing (including an absence of vocalization where one might reasonably expect it) and how they are experiencing their world.

FINDING: In North Ayrshire professionals across all agencies are tending to restrict the evidence of children's experience to what they say, which results both in missed cues and the privileging of the voices and views of adults (family and professional).

The design of the My World Triangle was intended to focus practitioners on the experiences[18] of children within their caring environments. This and other reviews[19] have found that some practice continues to demonstrate difficulties in both seeing and hearing children and in enabling them to participate sufficiently in assessments of their wellbeing and safety. Principles of child focused practice[20] - time, space to see the child alone, adapting communication to suit the child and representing their voices accurately – continue to be difficult to achieve for practitioners across all agencies. There is some evidence also that recording forms and systems of representation at resource meetings lead to the minimisation and sanitisation of what is known. A safe system is one that encourages the amplification of children's voices, predicated on the assumption that theirs are the least likely to be heard.

Questions for the Committee

1. Do the Committee recognise this issue?
2. How can the Committee influence the orientation of practice to include a 'child's eye view' to 'see and hear their needs' beyond those of their parents?
3. How can the Committee influence the representation of children's voices more accurately in assessments of their needs?
4. How can the Committee support improvement in the expertise and confidence of staff that are required to assess children's wellbeing?

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[18] Scottish Government (2010) *GIRFEC Practice Briefing 4 – The My World Triangle*

[19] Care Inspectorate(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* Dundee: Care Inspectorate

Scottish Government (2017) *Protecting Scotland's Children and Young People: It is Still Everyone's Job* Edinburgh: Scottish Government

[20] Archard and Skivnes (2009) in Howarth J (2011) *See the Practitioner, See the Child: The Framework for the Assessment of Children in Need and their Families Ten Years On* British Journal of Social Work 41 1070 -81

FINDING 4

In North Ayrshire 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.

Introduction

Since the national audit of child protection practice in 2002, Scottish policy and guidance has emphasized the responsibility of adult focused services to notice and consider the wellbeing and safety of children connected to adult clients/patients. This is very clearly represented in the National Guidance for Child Protection (Scottish Government, 2014) which is explicit about its scope.

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 behaviours of the client. Where the client is a child, their dependency upon adults inevitably implicates those adults in the assessment of their world. The inherent assumption of aspects of the National Practice Model and National Risk Assessment Framework is that some risks accrue to children because the behaviour of those adults lead to adverse (care-giving) environments. However, these are tools (and theoretical perspectives) made available to children's workers, not those working with adults. The visibility of children in the adult's world – particularly when they are not clearly classified as a carer - varies. Community settings and home based work, where the practitioner has access to information about the adult's living environment in much more immediate ways, provide more concrete cues about the presence of children in client's lives. Where the adult is seen only within particular contexts and conditions (such as inpatient settings and emergencies) it is more difficult to appreciate the wider context.

The expertise of practitioners working with adults is not the expertise of those working with children, although there are many aspects of practice that are common to all practitioners in helping professions. Many staff are understandably reluctant to give a view which feels beyond their competence. The language of (adult-focused risk) assessments presumes a 'professional' view can be given when, perhaps, those practitioners do not feel able to do so. The question "Are there Child Protection concerns?" is predicated on a host of assumptions about the practitioner's knowledge base. Even when practitioners have been exposed to Child Protection training, the assumption that this easily transfers to practice is unsafe.

Thus while adult focused practitioners 'ought', 'are trained to' and 'are given formats which' keep an eye out for children, these do not seem to lead to a reliable focus on children's welfare and protection or appropriate action to prompt further assessment or intervention.

How did this issue manifest in this case?

Adult Mental Health services in both acute and community settings had considerable contact with William over [redacted]. It is clear from records that there was awareness of his contact and sometimes residency with [redacted] and that his discharge from hospital care following an episode of self harm or overdose, usually under the influence of alcohol, was enabled on the basis that he would be cared for by Sarah. Relationships with family members were often cited as triggers for his behaviours. With the exception of one event, in which William gave the reason for his self harm [redacted], no indication of concern about the wellbeing and safety of the children was made and at no other point is there evidence that the children's experience of his behaviour was considered. On that occasion advice was appropriately sought from the Child Protection Advisor. Information was passed to the Health Visitor who raised the issue with Sarah after which no further action was taken. There is no evidence of feedback, follow up or later reference to this episode.

Further failure to identify potential risks to the wellbeing and safety of the children occurs in the context of William's contact with his GP, who was in receipt of repeated notifications of his attendance at hospital. He was frequently referred back to his GP for support; [redacted] In parallel with this and in the context of the same GP practice Sarah was attending regularly with the children [redacted]. She raised concerns with the practice, which were passed on to the Community Mental Health Team, about William's aggression and hallucinations. The 'outcome' of that referral was reiteration of the GP's responsibility to assess William. Jenny began having anoxic seizures and Jane was born into this household.

The police referred a number of concerns about William's wellbeing to Adult Social Work Services. They also referred concerns for Jenny in the context of William's behaviour. While the children's situation prompted concern on the part of the visiting Reception Services Social Work staff, it did not prompt referral from them to Children and Families' Social Work.

A number of referrals about William or David to Social Work Reception Services from Housing Services, Police and Sarah resulted in brief intervention with those adults and subsequent case closure. On each occasion – even when they were highlighted in the referral - the children's on-going experiences of disruption or distressing events remained largely unexplored.

How do we know this is an underlying issue and not something unique to this case?

The relatively restricted opportunity for practitioners from adult settings to participate in this review process means that our 'knowledge' of the wider and systemic influences on this issue remain limited. Case group feedback suggests that staff in Mental Health settings do not routinely consider children in the contexts of their patients unless they feature as the possible target or victim in an 'incident' and more particularly if the patient is a *parent* or clearly identified carer rather than having another familial relationship. The Ayrshire Mental Health Risk Assessment paperwork asks the practitioner to consider impact on others but interestingly creates distance from children in the structure of the questions. Thus, it asks as a headline about 'Risk of harm to others', and guidance prompts the practitioner to think about the type of risk, targets, means and history. Rather than 'Risk of harm to children', consideration of impact on them is headlined 'Child protection concerns' which nominalises the issue and directs thinking towards the system rather than the children themselves.

How prevalent is this issue?

Audit findings (NACPC 2015) demonstrate that communication with mental health services where there is an issue of parental mental ill-health is problematic but it is difficult to be precise about clear numbers of families impacted and, again, the issue is focused on *parents* rather than other adults sharing homes with or caring for children.

How widespread is this issue?

Since Mental Health services are delivered on an Ayrshire wide basis that aspect of this finding is likely to affect the whole of Ayrshire. The issue of communication between practitioners working with adults with mental health issues and those working with children is noted as a feature of other SCRs in Scotland between 2012 and 2015. [21]

Other agencies (Social Work with Adults) may have more restricted geographical relevance.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

A safe system recognises the dependency of children upon adults, within care-giving, wider family and community environments. It also equips practitioners, whatever their practice focus, with the knowledge, skills and opportunities to contribute to identifying situations where children may be in

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[21] Care Inspectorate (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* Dundee: Care Inspectorate

need of help through the provision of services, or protection because they are unsafe. While guidance, assessment templates and training contribute to conditions which support such practice, the ownership of such responsibility (and response – ability) depends on the development of a culture of meaningful engagement with the question of what, exactly, practitioners with a focus on adults can do given the knowledge base they feel competent with.

Conclusions about the underlying causes of this issue would be premature here and will require careful attention to be paid to the detail of practitioners' opportunities to notice children, to consider their likely experience, to work within the limitations of their role and knowledge base and to take appropriate steps to bring them to the attention of others. There are noticeable examples of success in some agencies that may illuminate this issue.

FINDING: In North Ayrshire 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.

While protecting children remains 'everyone's job' the relative invisibility of children in services whose focus is adults creates genuine challenges for practitioners in those settings. A safe system is one that identifies and ameliorates the limitations of human processes and working conditions, understanding the rhythms and cultures of the work and the interfaces between different aspects of complex services. Systemic mechanisms for bringing practitioners from adult and children's services together appear limited and this may restrict the opportunities for mutual understanding of each other's needs. Further enquiry into this issue will be needed to do justice to it and to understand what practitioners need to help them and the system they work in to develop this aspect of practice.

Questions for the Committee

1. Do Committee members recognise this issue?
2. How do Committee members understand the variation in practice across agencies?
3. How can the Committee influence and support the development of practice in services focusing on adults to include a meaningful assessment of likely impact on children?

4. How can the Committee influence and support the inclusion of professionals whose focus is adults in processes to protect children and promote a whole family, whole systems approach?

FINDING 5

The use of AYRshare is inconsistent within and across agencies in North Ayrshire and this creates risks to clear communication about children's wellbeing and safety.

Introduction

AYRshare is an electronic recording system available to a number of agencies in Ayrshire whose client focus is children. Introduced in North Ayrshire in mid 2013, training was provided by AYRshare administrators with priority afforded to Area Team Social Work staff, Health Visiting staff and Depute Head Teachers and some guidance/pastoral staff. By 2015, after support to upload existing records was provided, responsibility for training was passed to individual agencies. Social Work Reception Services staff have had access to training on AYRshare only recently and outwith the period of this review.

A professional's experience of AYRshare depends on where they sit in the system. For Social Workers, the system has been enabled so that uploading to AYRshare is, under many

circumstances, an act that requires no conscious awareness of doing so, if the system's capabilities have been realized. An administrator or Team Manager will have opened the record on the basis of the status of the work (Looked After Child; report requiring multi-agency input; Child Protection process) and thereafter update to the Social Work recording system will include AYRshare as long as the recording indicates that is an entry of significance. Note that this rests on the assumption of a record being opened at an appropriate point. For Health Visitors, no automatic upload takes place. In order to place a significant event within the record Health Visitors initially required to make a conscious decision to go into AYRshare and upload a pdf file with the pertinent information. Since the introduction of uploads from FACE (the electronic Health recording system) they have been able to share recording more easily but this still requires selecting an option to do so. Education staff have a similar experience to Health Visiting in having to upload records and choose to share them as a task additional to their usual recording process. This variation in experience is unlikely to have been noticed by practitioners since each sits within their own process and will likely have resulted in some assumptions being made.

All enabled users have the capacity to create an AYRshare record and invite others to participate; without an invitation, however, no access by others can be safely assumed. The majority of records are created by Social Work Services.

The feedback loop built in to AYRshare was an email to all those connected (including the initiator) to confirm the entry and alert others to an update. However, this was altered to remove the name of the subject when it was discovered that the Education Agency's system was insufficiently secure. The result of this was that the subject of the email was not accessible to the recipient via the 'subject line' of emails, necessitating opening and closing emails to check both content and identity of the initiator. If a practitioner was 'catching up' with recording over a number of clients/period of time this would result in the receipt of multiple identical-looking emails which raised the risk of either failing to notice a significant communication or ignoring them altogether on the assumption that the email related to their own activity. The potential for this mechanism to raise awareness of entries to AYRshare (and so to bear sharing in mind) was thus compromised and it is possible this caused a negative reaction to and lack of engagement with the tool for some practitioners.

AYRshare has not been made accessible to all children's practitioners, potentially excluding important sources of information and limiting their capacity to collaborate effectively.

How did the use of AYRshare manifest in this case?

Accessibility issues were experienced by key practitioners in this case. The EYSW, based in an Education Agency, had practical difficulty accessing the Social Work recording system and is unlikely to have accessed training in the use of AYRshare.

The third sector practitioner had no access to shared recording and relied on the transfer of their own information via a third party to records.

The new Health Visitor believes they uploaded their assessment detailing risks to the children within a few days of their first contact with the family in [redacted]. There is no record on

AYRshare to substantiate this. It is not clear on what basis the Health Visitor would have thought an open AYRshare record existed but it may be that the existence of a Child's Plan, involvement of education services as well as the EYSW led them to believe that the work was already classified as multi-agency. Finding 1 explored the potential for confusion in the system on this basis. Their assumption was that the system would operate across the three Ayrshire authorities in the same way.

How do we know this is an underlying issue and not something unique to this case?

Intelligence gained from the case group workshop suggests that practitioners regularly experience system incompatibilities and there was widespread agreement that there is inconsistency in the use of AYRshare in particular. Case group members felt that IT systems interfere with, rather than enable communication.

Since many parts of complex agencies and whole agencies (third sector organisations, for example) are excluded from the system, wherever those agencies are involved, the issue of access and contribution to recorded information will exist.

Those involved in the implementation of AYRshare expressed that their perception of the implementation process is that it lacked operational support and follow through and that it was unlikely therefore that consistency could be assumed. They cautioned that current integration raises further questions about the relationship between individual agency and shared IT systems and the risk of further confusion.

How prevalent is this issue?

Evidence from auditing reveals that Health Visitors are the most consistent users of AYRshare, but of 215 Social Work users the last audit suggested that 30% of staff have not accessed AYRshare over a 3 month period.

How widespread is this issue?

AYRshare is an Ayrshire-wide resource; comparisons across the three Ayrshire local authorities would need to be carried out to determine whether the challenge extends beyond North Ayrshire.

Why does it matter? What are the implications for the reliability of the multi-agency child protection system?

Shared electronic systems in themselves do not protect children. However, their use and relative importance as a means of communicating and of collating and making information available in accessible form need to be explicitly agreed among potential and current users. If this does not

happen, individual practitioners will operate from within their own preferences and capabilities, which will create greater risk of loss of information under conditions where parties believe it to have been safely transmitted. A safe system uses a variety of means to communicate but requires enough consistency to provide practitioner with a manageable 'menu' of options.

FINDING: The use of AYRshare is inconsistent within and across agencies in North Ayrshire and this creates risks to clear communication about children.

The intention of AYRshare is to enable efficient and meaningful collation of relevant information among practitioners working around a child or family. This finding demonstrates that not only is this not true but that the current inconsistent and confused use of AYRshare may create unintended risks because practitioners believe they have shared information which prompts others to action when they may not have.

There is a review of AYRshare underway and the introduction of Key Performance Indicators in relation to its use are proposed. It is important that the human processes which interrupt the adoption of technologies (including partial recognition and change fatigue) are recognised and operational support is given to those expected to transition from the current position to a preferred future.

QUESTIONS FOR THE COMMITTEE

1. Do the Committee recognise this issue?
2. What role and priority do the Committee consider the consistent use of AYRshare to have in supporting multi-agency collaboration?
3. If AYRshare is a significant resource for sharing information in the multi-agency system how can the Committee support member agencies to use it appropriately and consistently?

APPENDIX 1

SCR Panel Membership (14)

Designation	
Independent Chair, NACPC	
Lead Officer, NACPC	*
Reporter Manager, SCRA	
Associate Nurse Director, NHS Ayrshire & Arran	*
Head of Service, Children & Families & Criminal Justice, NAHSCP	*
Senior Manager, Children & Families Fieldwork, NAHSCP	
Senior Manager, Universal Early Years, NAHSCP	
Nurse Consultant, NHS Ayrshire and Arran	*
Senior Manager, Housing, NAC	
Director of Education and Youth Employment	
Superintendent, Police Scotland	
Clinical Director	
Head of Service, Mental Health Services, NAHSCP	*
L&D Coordinator, NACPC	*

* Also Review Team member

Review Team Membership (14)

Review Team invited to:

26th January – scope setting with SCR Panel

9th March – SCR workshop

24th March – Reviewing workshop output

20th April – Sharing findings with Case Group meeting

Designation	
Lead Reviewer, External Consultant	
Co-Reviewer, SCIE	
Team Manager, Kinship, NAHSCP	
Quality Improvement Lead, NAHSCP	
Information Systems Officer, NAHSCP	
L&D Coordinator, NACPC	
Lead Officer, NACPC	
Head of Service, Children & Families & Criminal Justice, NAHSCP Attended 26th January, SCR workshop (part), 24th March Unable to attend 20th April due to change of role, new Interim Head of Service attended	
Nurse Consultant, NHS Ayrshire and Arran Attended 26th January, SCR Workshop, 24th March	
Associate Nurse Director, NHS Ayrshire & Arran Did not attend any meetings	
Head of Service, Mental Health Services, NAHSCP Attended 26th January only	
Head of Service, Education & Youth Employment, NAC Attended 24th March only	
Reporter Manager, SCRA Attended 26th January, 9th March, 24th March, unable to attend 20th April	
DCI, Police Scotland Attended 26th January, 9th March and 20th April. Superintendent attended 24th March meeting	

Review Sub Team (6)

Name	Designation	
Bridget Rothwell	Lead Reviewer, External Consultant	
Phil Hayden	Co-Reviewer, SCIE	
Fiona Campbell	Team Manager, Kinship, NAHSCP	
Ruth Davies	Quality Improvement Lead, NAHSCP	
Kirsteen Lee	Information Systems Officer, NAHSCP	
Louise Henry	Child Protection L&D Coordinator, NACPC	

APPENDIX 2

North Ayrshire SCR Case Group

	Sector/agency	Designation	
1	Police Scotland	Detective Sargent	Replacement attended
2	Police Scotland	Detective Constable	Replacement attended
3	Health & Social Care Partnership	Health Visitor	Attended + individual conversation
4	Health & Social Care Partnership	Assistant Nurse Practitioner	Attended
5	Health & Social Care Partnership	Health Visitor Staff Nurse	Did not attend
6	Health & Social Care Partnership	Health Visitor	Attended +individual conversation
7	Health & Social Care Partnership	Social Worker	Attended
8	Health & Social Care Partnership	Team Manager	Attended
9	Health & Social Care Partnership	Social Work Assistant	Attended
10	Health & Social Care Partnership	Social Work assistant	Attended
11	Health & Social Care Partnership	Social Worker	Did not attend
12	Health & Social Care Partnership	Social Worker	Attended
13	Health & Social Care Partnership	Social Worker	Attended

14	Health & Social Care Partnership	Social worker	Attended
15	Health & Social Care Partnership	Team Manager	Did not attend
16	Health & Social Care Partnership	Team Manager	Attended
17	Health & Social Care Partnership	Team Manager	Attended
18	Health & Social Care Partnership	Team Manager	Attended + individual conversation
19	Health & Social Care Partnership	Social Worker	Replacement attended
20	Health & Social Care Partnership	School Nurse	Attended
21	Health	Child Protection Advisor	Attended
22	Health & Social Care Partnership	General Practitioner	Individual conversation
23	Health	Midwife Manager	Attended
24	Health	Community Midwife	Attended
25	Education	Education Psychologist	Replacement attended
26	Education	Senior Manager	Attended
27	Education	Head Teacher	Did not attend
28	Education	Head Teacher	Attended
29	Education	Head Teacher	Attended
30	Education	Senior Manager	Attended
31	Education	Classroom Assistant	Attended
32	Education	Senior Early Years	Attended
33	Education	Teacher	Attended

			+individual conversation
34	Education	Pupil Support	Attended
35	Health & Social Care Partnership	Care At Home	Attended
36	Scottish Children's Reporters Administration	Reporter	Attended
37	Third Sector Organisation	Family Support Worker	Attended
38	Health & Social Care Partnership	Clinical Team Leader	Replacement attended
39	Health & Social Care Partnership	Advance Nurse Practitioner	Replacement attended
40	Health & Social Care Partnership	Service Manager	Attended

APPENDIX 3

Excerpt From: The Scottish Government. (2015) "National Guidance for Child Protection Committees for Conducting a Significant Case Review."

The SCIE Learning Together model

The Social Care Institute for Excellence (SCIE) Learning Together approach has been designed specifically to be relevant to cases involving multi-agency working by

- using systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture
- building internal capacity by having staff trained and accredited in the Learning Together approach to reviewing
- undertaking rigorous case reviews and audits using a core set of principles and analytical tools
- accessing a pool of accredited independent reviewers as required
- building on the experience and findings of previous reviews as part of the Learning Together community.

For those conducting an SCR using this methodology, there will be no specific recommendations. Instead, the CPC will have findings and issues to consider.

The Learning Together model was developed by SCIE, based on evidence from research literature and investigation methods used in engineering, health and social care.

A SCIE training programme familiarises reviewers with the Learning Together process and analytic tools. An accreditation process for lead reviewers assures basic competence. Thereafter, lead reviewer expertise is supported through supervision and regular participation in the Learning Together community of practice.

The model has three key principles:

1. Avoid hindsight bias by understanding how the case unfolded from the viewpoint of those involved. This is done by reviewers being open-minded and empathetic and having no preconceived assessment of the case beforehand. The source of information, or data, comes primarily from conversations with the practitioners and family involved and details are supported from documented evidence. The information is collated into a narrative reconstruction of events as they took place using the perceptions " "and understanding of people who were there at the time. Although the events taken together run chronologically this is very different from a dated chronology taken from case records alone. It forms the local 'rationality'.

2. Provide adequate explanations by appraising practice and explaining decisions and actions taken. This is done by using a specific analytical tool, called 'key practice episodes' (KPE) that helps us

understand and explain why the case unfolded as it did. It gives an explicit appraisal of practice, from the perspective of what was known or knowable at the time and identifies the various factors that may have contributed to that. It is a process that holds people to account for their professional responsibilities but which can also point to the kind of things that make those responsibilities very difficult to carry out at times.

3. Move from individual instance to general significance. This allows the case to provide a 'window on the system' (Vincent 2004) and tease out issues that replicate more widely rather than just being relevant to a single case. This includes the opportunity to expose those hard-to-articulate practices such as cultures and values within organisations that impact on effective working. These are written as evidenced 'findings', which then give rise to issues for the CPC to consider.

The review process aims to include the views of the case group (practitioners directly involved in the case) and the review team (members include managers from the relevant agencies), as well as family members. The model also includes the role of a champion who ensures open communication lines between the CPC and the review process. This role is commonly taken by the lead officer if they are not part of the review team."

APPENDIX 4

ACRONYMS

ADHD	Attention Deficit Hyperactivity Disorder	
ANP	Assistant Nurse Practitioner	
CPC	Child Protection Committee	
EYSW	Early Years Social Worker	
GIRFEC	Getting it Right for Every Child	
KPE	Key Practice Episode	These are brief periods within the longer time frame, selected for more intense scrutiny.
KPI	Key Performance Indicator	

MADART	Multi Agency Domestic Abuse Response Team	
NACPC	North Ayrshire Child Protection Committee	
RAMG	Resource Allocation Management Group	A senior management group with cross agency representation which enabled access to specialist education provision
SCIE	Social Care Institute for Excellence	
SCRA	Scottish Children's Reporter Administration	
SLT	Speech and Language Therapies	
VFM	Vulnerable Families Midwife	