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 4

Introduction

Why this case was chosen to be reviewed 5

Family Composition 6

Succinct Summary of the Case 7

Organisational Learning and Development 9

Methodology 10

Research Questions 10

Proportionality 11

Timeframe 11

Reviewing expertise and independence 12

The Review Team 12

The case group 12

Specialist advice 12

Methodological comment and limitations 12

Participation of case group professionals 13

Participation of the Review Team 14

Participation of family members 14

The Findings

Appraisal of professional practice in this case: a synopsis 16

In what ways does this case provide a useful window on our systems? 21

Summary of findings 22

Findings in detail (1 to 5) 23

Appendices 44

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)

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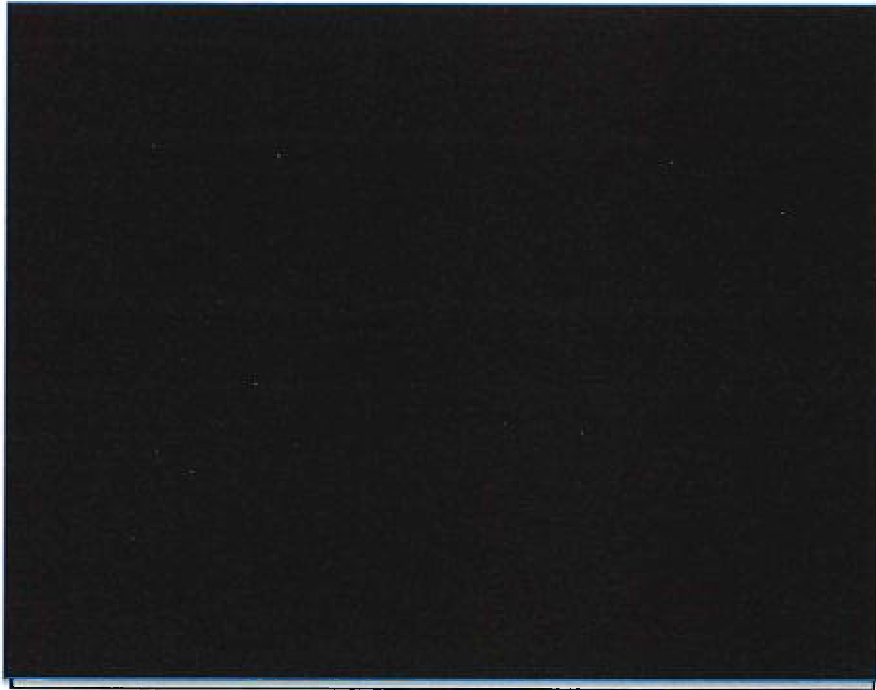
[2] George, M (2003) *Lean Six Sigma for Service* McGraw-Hill

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. .

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

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).

[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 ████ and ends at the point that the process to remove the children began, in late ████. 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 ████ ████ taking into account the subsequent professional responses. KPE2 took place in ████ ████. KPE3 was a two month period between ████ ████ 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.