

# South Ayrshire Child Protection Committee

## Learning Review Report

Re: Child B

### 1. Introduction

#### 1.1 Child / Young Person

B [REDACTED] enrolled in a South Ayrshire Secondary School.

#### 1.2 The precipitating incident

A child protection concern was received into South Ayrshire Social Work Department on the 7<sup>th</sup> September 2022 from a 1st Tier Judge who attended B's family home, [REDACTED]. The purpose of this visit was to execute a warrant to enter the property in order to perform required electrical safety checks. A warrant was granted following six unsuccessful attempts [REDACTED] to gain access to the property. On entry, concerns were raised in relation to the condition of the home which was said to be unhygienic, and unsafe for a child to reside in. B was present in the home during this visit, but could not be seen due to the volume of belongings or refuse within the home which restricted the view into any of the rooms.

In response to this concern, Social Work staff carried out a home visit later that day. On arrival at the family home, Social Workers in attendance were unable to enter or move around the property due to items restricting the doorways. The Social Work practitioner present expressed concerns that mum was under the influence of alcohol during the visit. On attending, B was no longer present in the family home and was seen by a Social Worker at their maternal grandfather's home later the same day.

Principal Teacher of Guidance at B's school was made aware of the circumstances of the home visit on 8<sup>th</sup> September 2022. An IRD took place on 9<sup>th</sup> September 2022 where a Child Protection Investigation commenced.

#### 1.3 Criteria for a Learning Review

The National Guidance for Child Protection Committees Undertaking Learning Reviews (2021) sets out the requirement for CPCs to proceed with a Learning Review in specified circumstances. Namely,

**When a child has died or has sustained significant harm or risk of significant harm** as defined in the National Guidance for Child Protection in Scotland (2021)

**And** there is additional learning to be gained from a Review that may inform how we improve protection of children and young people.

**And** one or more of the following apply:

- abuse or neglect is known or suspected to be a factor in the child's death or the sustaining of or risk of significant harm
- the child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR or was a care experienced child (i.e. looked after, or receiving aftercare or continuing care from the local authority). This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death or sustaining of significant harm, unless it is absolutely clear to the Child Protection Committee that the child having been on the CPR or being care experienced has no bearing on the case
- the child's death is suicide, alleged murder, culpable homicide, reckless conduct, or an act of violence

On 12<sup>th</sup> October 2022, South Ayrshire Child Protection Committee decided that circumstances surrounding B met the criteria to undertake a Learning Review. This report will consider the circumstances surrounding the concern raised and the role of services involved with B's and their family, with an aim to identify strengths and areas for improvements to systems/practice across the South Ayrshire locality.

## 2. The Process of the Review

### 2.1 Terms of reference

At the Extraordinary CPC meeting held on 12<sup>th</sup> October 2022 the following terms of reference were agreed:

- Review circumstances of Child Protection registration and rationale for de-registration\*
- Consider the ethos of intervention thresholds between last school attendance date and date of vulnerability risks discovered\*\*
- How well did South Ayrshire processes recognise and respond to risks of neglect around B\*\*\*
- Produce (if relevant) an improvement action plan to address process or training gaps to mitigate the possibility of similar episodes.

\* Since the terms were set the review understands that B's name has not been placed on the Child Protection Register, nor has it been previously.

\*\* This incorporates the review of communication and information sharing across departments and agencies.

\*\*\*This incorporates:

- 1) Support & engagement with mum and B from all agencies.
- 2) Quality of assessments and decision making undertaken regarding planning for B welfare and development.
- 3) Adherence to practice guidance

Following consideration of the ethos of intervention thresholds regarding B, the recommendations noted below take into consideration that further work with practitioners is required to understand the reasons that underpin a child's non-attendance at school. The gathering of B's views or appropriate sharing of wellbeing information between professionals, particularly at the point of school transition, could have led to earlier identification of the circumstances that the pupil was residing in and support could have been in place earlier.

The report recommends actions in relation to the findings noted, which should contribute to timeous responses in relation to a child who is at risk of neglect. In this case, there were opportunities to identify and respond to the risk of neglect for B. The recommendations within this report are suggested to services to minimise the risk of a similar situation arising in future.

An Action Plan has been created to sit alongside this report. Services are requested to review this and implement recommendations.

## 2.2 Approach

In accordance with the guidance this Learning Review adopted a systemic approach. Such an approach goes beyond individual or professional practice to explore underlying systemic elements, the links with organisational factors and the wider context. A key feature of this approach is to bring together agencies and practitioners in a collective endeavour to reflect and learn from what has happened in order to improve practice for the future. The focus is on accountability not culpability, on learning and not blame.

## 2.3 The Review Team Composition

A Review Team was convened to steer the process. At Extraordinary CPC held on 12<sup>th</sup> October 2022 it was agreed that [REDACTED] would undertake the role of Chair and [REDACTED] the role of Lead Reviewer.

Review Team membership was agreed as follows:

[REDACTED]	Child Protection & Wellbeing Officer	SAC
[REDACTED]	Child Protection & Wellbeing Officer, Education	SAC
[REDACTED]	Senior Manager for Children's Health	HSCP
[REDACTED]	Detective Inspector, PPU	Police Scotland
[REDACTED]	ADP Lead Officer	ADP
[REDACTED]	Service Manager, Children and Families Social Work Services	HSCP
[REDACTED]	Team Manager, Family Resource Service	Barnardos
[REDACTED]	Corporate Parenting Lead Officer	SAC
[REDACTED]	Trauma Informed Practice Officer, Housing Policy & Strategy	SAC
[REDACTED]	Private Sector & Landlord Registration Officer	SAC
[REDACTED]	Inclusion Co-Ordinator, Education	SAC
[REDACTED]	Planning & Performance Officer, Communications	HSCP
[REDACTED]	Co-ordinator, Legal and Licensing	SAC

## 2.4 Review Team Planning Process

The Review Team began the learning process by identifying significant issues and areas to explore. Each service also identified participants to be invited to practitioner/first-line manager events and consulted with Senior Managers. Participants were asked to reflect on their services or agencies involvement with B and mum considering specifically:

- Assessments
- Decision making
- Actions
- Interactions with other professionals and services
- Areas of effective practice
- Areas where there could have been some improvements

## **2.5 Gathering of information to identify themes, good practice and key learning**

On notification of the concern surrounding B and to support identification of themes for learning, a Chronology of B's time in Education was compiled from pre-school to present. This document evolved into a Multi-Agency Chronology as the process continued and services shared their supports for B and mum. Significant information was gathered from B's school files; Pre-school file, Pupil Progress Record, Confidential file, and Pupil Support File. Further information to support learning was gleaned from records available to Social Work, the GP, Carepartner, Education Management Information System SEEMiS and entries held within the electronic information sharing system, AYRshare.

[REDACTED] To gain further insight into these events, and the response from Education, a learning meeting was held with the Head and Depute Head Teacher at the Primary School. Both came into post when B was age seven therefore held important knowledge of the family circumstances and B's needs.

A learning event involving Secondary school practitioners was undertaken through conversations reflecting on and exploring; themes, assessments, decision making, good practice and key learning. Suggestions for development or improvement to systems or practice were also encouraged. These conversations took place individually within the school on 29<sup>th</sup> September 2022, followed by a further reflection session as a group on 25<sup>th</sup> October 2022. The group had opportunity to reflect on initial learning points and offer their voice to the process at the meeting or via another method if this would be more comfortable. Further discussions were facilitated with practitioners from Health, in particular the School Nurses. All practitioners who were identified to attend the learning events did so and their valued input will be reflected within this report.

The Review Team met virtually on 1<sup>st</sup> November 2022. Members of the Review Team from Health, Social Work, Police Scotland, and Barnardos conducted an information gathering process within their own service to allow opportunity for learning and reflection. Participants identified emerging themes; looked at what worked well and why; explored challenges and missed opportunities and considered any changes that were needed as a result of the learning from this review. On 2<sup>nd</sup> November the Chair and Lead Reviewer met with B's mum to ascertain her view.

To aid the compilation of this report, themes for learning and report recommendations were discussed during a Workshop, held on 21<sup>st</sup> November 2022. A final review team meeting was held on 14<sup>th</sup> December 2022 with a focus on agreeing the findings of the initial report.

[Redacted]

### 3. The Circumstances that Led to the Learning Review

#### 3.1 Family Composition

Relationship	Date of Birth	Ethnicity
[Redacted]	[Redacted]	[Redacted]

#### Background

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

#### Involvement with Professionals and Services

##### 3.7 2016/17

During 2016/17 when in Primary Four B began displaying behaviours linked with difficulties managing emotions, which were manifesting in aggressive behaviours towards others. Mum was invited into school to discuss these concerns. [REDACTED]

[REDACTED]. B's mum also reported that similar distressed behaviours were emerging at home. Discussion focussed around how adults in B's life could provide support. It was agreed that a referral to the Educational Psychology Team would be helpful, with further support to be gained for B through the local Hospice counselling team arranged by mum.

In January 2017 concerns were raised to the Children and Families Social Work team by a staff member from the team who facilitated counselling sessions with B. [REDACTED]

[REDACTED] The result of this investigation was Education staff would continue to be the responsible professionals for B as no further action was planned to be taken by Social Work. Feedback from Social Work for the purpose of the review was that an Initial Referral Discussion (IRD) was not deemed necessary at the time. It is important to note that this incident of maltreatment took place prior to the passing of the Equal Protection from Assault (Scotland) Act 2020. Today, a similar situation may have resulted in a different outcome. It is acknowledged by the review with hindsight, that an IRD might have been helpful at this stage.

There is evidence of consistent contact between school and mum in the months following this disclosure. Education staff raised concerns with mum in relation to B's hygiene. This contact led to further support being provided through the Staged Intervention Plan (Stage 2) in June 2017, where desired outcomes were linked with helping B with challenging emotions which could impact on behaviour.

In May 2017, B's GP raised concerns to the School Nurse as mum reported struggling with B's behaviour to which a health assessment was requested. This staff member has since left post and the review found no record of contact being made. It is unclear if the assessment took place and therefore may have been a missed opportunity for earlier support.

B's attendance at the end of Primary Four was 95%, so despite the trauma, attendance remained high.

### **3.8 2017/18**

In September 2017, when in Primary Five Education staff requested assistance from Social Work due to mum being uncontactable during the school day. Concerns arose that there would be no-one home for B on return from school. This concern was heightened as B reported that mum was not always home at the end of the school day. A visit by the Social Worker to the family home in response found the family home to be in a cluttered, unsafe, and unhygienic condition, reflecting mum's difficulty in coping and the neglect experienced by B. A voluntary agreement was made between mum and the Social Worker for B to reside with a female family member, and a Child Protection Investigation was commenced.

At the preceding IRD regarding the concern, it was agreed from a tripartite discussion between health, police and social work that a health assessment should be undertaken by the school nurse.

[REDACTED] A home visit to complete the health assessment visit was promptly undertaken

by the school nurse where significant concerns regarding living conditions that led to the IRD were acknowledged.

A referral to the family-support service Barnardo's was received into the service via Social Work in September 2017, and as such the family are placed on the waiting list. This referral requested supports for grief, loss and emotional regulation. Whilst B is awaiting allocation of individual support, they attend all eight group sessions of the grief programme Seasons for Growth. During this time mum also attends a parenting group to develop strategies to support her to provide therapeutic care for B when distressed.

At Initial Case Conference held on 26<sup>th</sup> October 2017 there was a unanimous decision not to place B's name on the Child Protection Register. This decision is noted in documentation to be based on improved home conditions and agreement that the Locality Social Work Team would provide continuing support and assessment of the circumstances. B returned to live with mum.

During this time B continued to be supported at school through a Staged Intervention Plan, with a continuing focus on emotional wellbeing. Education Psychology support was requested in November 2017 for assistance in supporting school and B with strategies for coping in class. This led to a classroom-based assessment which identified that no further work from the Educational Psychology team was deemed necessary.

In January 2018 B received an allocated person to provide support from Barnardo's. This appears to be a whole family support as mum is offered support in de-cluttering the family home, indicating that the home was not fully cleared following the Child Protection Investigation in 2017. Mum declines this support and appears to disengage from the service.

There is limited information around continuing support for the family. At a Team Around the Child meeting in March 2018, Social Work closed B's case. B continues to attend groups run by Barnardo's but as mum's engagement ceases, as does B's and by July 2018 they no longer access the service.

B concluded Primary 5 with 97% attendance.

### **3.9.1 2018-19**

In July 2018, just prior to entering Primary six, B was referred to Child and Adolescent Mental Health Service (CAMHS) by their Social Worker. The referral requested supports with low mood, grief and nightmares. Contact was made promptly with the family and an initial appointment was attended by B in August 2018. A plan was made for a follow up appointment four weeks later which B attended. Health records reflect the agreement between the service, mum and B that no further input from CAMHS was required as B's mood had improved therefore B was discharged from the service.

At this time there were no other significant agency supports around the family. Education staff reported that there were no concerns raised by services or otherwise identified with regards to B's home circumstances during the final two years of B's attendance at Primary school.

### **3.9.2 Transition to Secondary Education 2019-20**

In line with Education standards, all pupils undergo a transition period between Primary and Secondary school Education. B's transition took place in 2020, in the midst of the Covid 19 pandemic which impacted usual processes and supports. Information was shared regarding B between

Primary Depute Head Teacher and the Secondary Principal Teacher of Pupil Support, who was very newly into post. This conversation was held over the phone, and it is unclear if B's previous vulnerabilities were shared. B's final months in Primary Seven were spent at home due to lockdown, where free school meals were offered due to previously recognised vulnerabilities. Mum declined this support as she did not feel this was required. Telephone calls continued to be made by Education staff for support and to provide opportunity for B to remain engaged with Education during this time. In June 2020 B was observed by the class teacher, depute and head teacher during a socially distanced leavers event with no concerns.

**3.9.3** Primary Six attendance: 96%, Primary Seven attendance: 87% (Primary Seven impacted by Covid)

### **3.10 2020/21**

There were no initial concerns for B in S1, and school attendance was within an acceptable level. Mum contacted school at the start of S1 to enquire as to why B was placed in a class with no peers from Primary school, reasons for this are not clear from the Pupil Support paperwork and practitioners from each establishment cannot evidence who requested this, if at all. Mum identifies this as a significant factor in B's reluctance to attend school, and contributed to feelings of isolation. The school facilitate a group to support pupils to make new peer relationships and B was approached to join this friendship group, but following discussion with B the teacher did not feel it was necessary. Whilst B's attendance at the end of S1 was 81%, it is recognised that Covid absence coding could have impacted this percentage in a positive way. Covid rules also impacted what was deemed acceptable levels of attendance during this year.

### **3.11 2021/22**

When in S2 B attended school for two days in August 2021, then was absent until October 2021. The last day B was present in school prior to the child protection concern being raised was 4<sup>th</sup> November 2021. During this time B's support from school was impacted by the absence of the Principal Teacher Guidance (PTG) with whom a relationship was formed in S1, and from August 2021 to March 2022 B was supported by an Acting PTG.

On 23<sup>RD</sup> December 2021 Police Scotland received an anonymous call regarding the welfare of B, this was risk assessed and following enquiry at address and police contact with mum, the incident closed.

Monthly House Group meetings involving school staff were held where attendance was discussed and concerns were highlighted on lists generated for the purpose of this meeting, however no Actions are noted for B until PTG returns in March 2022. Prior to this B is discussed at the meetings but there is no record of the outcome.

During S2 attempts by school to meet mum are recorded, twice in school terms one and two. Further attempts are made in sessions three and four where mum rescheduled two meetings before attending a Team Around the Child meeting in March 2022. In attendance was the PTG, and mum. B did not attend and continued to be unseen.



Supports from other services such as the Home Link team were offered to mum during the Team Around the Child meeting, but she did not wish to consent to these. Mum offered instead to take B to the GP for support with underlying issues to positively impact attendance which was viewed as a positive step. [REDACTED]

B's attendance at the end of S2 was 13%. On return to school for S3 in August 2022, another meeting is rescheduled by mum before a Team Around the Child meeting takes place on 12<sup>th</sup> September 2022 following the initiation of the child protection investigation.

In attendance are B, mum, grandfather, PTG, and B's Social Worker.

## 4. Strengths and Effective Practice

Over the course of the review, there were many areas of positive practice identified and highlighted.

Primary School practitioners had a holistic understanding of B's need and experience. This is evident where the staff have recognised distressed behaviours as communication, and the supports sought at those times where they observed difficulty in coping or managing emotions. It was the Depute Head Teacher's response to a concern in relation to B's welfare that initiated the Child Protection Investigation in September 2017. Primary staff communicated well with B, mum and other services which led to timely responses of supports. B's voice is clear during these years and is evidenced through responses on wellbeing paper work. B had opportunity to identify the individual in school with whom they had the best relationship and this person took forward the role as relationship-focused support for B.

Guidance staff in Secondary School made many attempts to forge and maintain a relationship with mum, although efforts were impacted by staff sickness. It is acknowledged that the Principal Teacher of Guidance is a positive support.

Fortnightly meetings to discuss pupil attendance is an effective practice. Guidance staff attend prepared with a list of pupils who require discussion, generated from SEEMiS attendance data. Despite acknowledgement of issues with SEEMiS recording, this process appears to have worked well in this case as B's name was on the list at each meeting. The apparent lack of action from these meetings has been incorporated into recommendation 2 below, which should increase their effectiveness.

Support sought from Barnardos was noted by mum to be particularly significant to the family [REDACTED]. Group sessions were offered to B and mum whilst they remained on the waiting list for an allocated member of the team to provide specific supports. Alongside this, CAMHS are acknowledged within the review for their timely input, as B was provided with an initial appointment within two weeks of the service receiving the referral. There is also evidence of strong communication from CAMHS with the team around the child, and also the GP.

Children and Families Social Work were alerted to circumstances that led to the Child Protection Investigation [REDACTED]. It is acknowledged that [REDACTED] in this circumstance conducted their duties appropriately and their actions highlighted B's living conditions to all the relevant services. The most recent Child Protection Investigation was noted by mum during the course of the review to be a positive experience, with praise for the Young People's Support and Transition Team for their care and assistance.

The review acknowledges Police Scotland's process that states when a child concern incident is recorded by Police Scotland, a daily report is submitted to Campus officers detailing the details of the child, the incident and the school attended. This process should mean that appropriate engagement can be made if necessary.

## 5. Practice and Organisational Learning

Due to circumstances of this review presenting a similar experience of neglect as previously experienced by B in 2017, it is probable there were missed opportunities to identify difficulties and intervene earlier to support the family. It should be acknowledged that this learning review took place with the benefit of hindsight, which can conclude with a different perspective of the circumstances. The following analysis considers the learning found within response or actions of services within the context of the time.

It is important to mention that Covid lockdowns or associated guidance impacted all pupil's attendance during this period. This period of time was also compounded by staff absences and all schools were under massive strain.

Professionals involved in the care of B communicated frequently with mum. Communication and relationship building with parents is an important factor in supporting the child, however an optimistic approach with parents should be balanced with the role of protecting the child. Working with parents where there is partial or limited engagement is challenging for practitioners. Persistence, curiosity and professional rigour are required to meet the needs of the child.

### ***Learning Point 1 - Child's Voice to Inform Planning***

The review identified that direct views were not gained from B S1 and particularly during S2 in relation to wellbeing, despite opportunity from Education and Police Scotland to gain this. The child's voice is central when determining the service to provide or action to be taken, considering the age and stage of the child. All professionals involved in safeguarding or supporting a child should pursue practice that embeds the child at the heart of their work. This includes ensuring the child is seen. Children and young people should be recognised as individuals with rights, in particular with the right to participation in decisions that affect them.

### ***Recommendation to Address Learning Point 1***

South Ayrshire Council Education Services should review Child Missing in Education (CME) guidance in light of the Learning Review.

Educational Services should create a training package directed at aspiring, new or experienced Guidance Teachers and imbed effective use of the CME Guidance into the training. Suggested inputs within Guidance Staff Training; Attendance, Health and Wellbeing, Information Sharing, Relationship Building with Parents, GIRFEC principles, Team Around the Child processes, named person role and responsibilities, SEEMiS training including appropriate recording of wellbeing information or absence recording, and knowledge of outside agencies. Further to this, Child Protection Co-ordinator Training should be updated to place emphasis on CME and Annual Child Protection Training undertaken by all school staff should be reviewed to include Children Missing in Education; responsibilities of all staff, and processes

While it is a priority to ensure that the child starts or is re-engaged into learning, the possibility that the child is experiencing neglect should also be considered for non-attending pupils. Continuing a trauma-informed focus to training should remind staff of the complex and pervasive impact that trauma can have on a child's view of the world and relationships. Non-attendance at school or disengagement from learning is noted in literature as a potential symptom of trauma.

All updated training should place emphasis on professional curiosity from the Team Around the Child and link non-attendance with potential neglect or trauma and shared understanding that disengagement with Education increases vulnerability of the child.

### ***Learning Point 2 - Importance of Meaningful Actions and Accountability Within School Attendance Meetings***

Attendance meetings provide an opportunity for holistic discussion and creative thinking to consider next steps to engage or re-engage a pupil into learning. Child's voice and their experience should inform next steps, where wider services support can be sought where appropriate. Communication with parents via letter, email and telephone call to promote attendance are acknowledged as required however meetings should create meaningful actions which impact the underlying concern, with clarity of role and outcome recorded. Education Practitioners involved in this review identified meaningful improvements to strengthen outcomes from attendance meetings which will be incorporated within the action plan. Ensuring wellbeing checks are prioritised and should minimise likelihood of a similar situation arising.

The review recognises current work being undertaken with a local Secondary school led by the Educational Psychology team. This on-going improvement work collaborates with staff, parents, carers and pupils to inform an evidence-based protocol to support attendance, with a focus on supporting pupils who present with Emotionally Based School Avoidance. It is also important to note that following this review, a Depute Head Teacher focus group has commenced led by a Senior Education Officer, where attendance improvement is a key action.

### ***Recommendations to Address Learning Point 2***

South Ayrshire Council should consider Actions from attendance meetings be recorded on the pupil's Pastoral notes on SEEMiS. An entry should include Actions for pupil, timescales and member of staff who is responsible for taking the action forward. Standing Agenda Item 'Previous Meeting Actions' suggested, to satisfy Chair of progress and inform discussion at current meeting. Actions are encouraged to be meaningful and proportionate to the circumstances of the individual child's experience.

Staff should be reminded of existing guidance which explains when it is appropriate to convene a TAC meeting, reflecting a commitment to a co-ordinated approach for pupils who are not currently in receipt of Statutory supports. GIRFEC principles should underpin these meetings.

Attendance data is reviewed by a senior education officer termly. The data focusses on learners whose attendance is less than 70% and less than 50%. Moving forwards this exercise could be combined with actions above to strengthen each schools overview on problematic attendance.

### ***Learning Point 3 – Getting it Right for Every Child (GIRFEC) Processes***

In B's case, wider agency support may have been beneficial in assisting school to ensure wellbeing. The Team Around the Child processes support sharing of information between services, with GIRFEC principles being effective in providing a framework to maintain safety and wellbeing around the young person.

Practitioners are reminded that informal routes of communication between professionals is equally as important as formal processes for the best outcome for the child and optimum service delivery. Informal routes require relationships between services and shared understanding of the child. All professionals, particularly school-based staff should be aware that disengagement from Education or other professionals increases vulnerability for some children and young people. Professionals should consider pupil absence as a warning indicator of wider concerns and the need to triangulate this information with other agencies within the Team Around the Child.

It is recommended that GPs, as with all practitioners, consider GIRFEC processes in light of the review and consider best routes of wellbeing information sharing where there are concerns about a child. It is considered that information sharing processes would have been strengthened if the GP liaised directly with the named person in school in 2017. In line with a relationship-based approach, the named person is then able to identify the staff member which the best relationship with the child to support. In 2017 the school nurse had limited relationship with B and mum in contrast to school staff.

Work is currently on-going on a Pan-Ayrshire basis to update GIRFEC processes in line with the Refreshed GIRFEC Guidance. This work is acknowledged by the review and it is understood that messaging for children, young people and families will form part of the communication strategy. The review acknowledged children and young people should understand what GIRFEC means for them.

### ***Recommendations to Address Learning Point 3***

When schools have concerns that a child is not in education, there needs to be timely information sharing and consideration of the child's lived experience, which includes the child being seen. Professionals are encouraged to ensure wellbeing of the pupil, and as per GIRFEC principles and CME Guidelines ensure they see the child to gain their views and voice to inform future planning.

Encouragement to seek to engage wider services in the support and follow the Request for Assistance process to gain support from services such as the School Nurse, Home Link, Learning and Inclusion, Education Psychology, or school based Social Work Teams such as the Family First team or Small Steps to Wellbeing.

Relationships between GPs and Education staff could be strengthened through the inclusion of education staff in joint learning sessions currently facilitated by the School Nursing service with

regards to GIRFEC practice, and encourage direct information sharing with the child's named person.

#### ***Learning Point 4 - The Importance of Transitions and Information Sharing***

The review recognises that B's transition from a Primary to a Secondary setting took place during a period of national lockdown where schools were dealing with an unprecedented range of issues, in order to continue to provide education and transition support to pupils. The impact of lockdown on the functioning of a school's usual processes cannot be underestimated.

Learning events with Secondary school staff determined that they did not have knowledge of the previous vulnerabilities around B. This may highlight missed opportunities to identify concerns through the Confidential File system, transition information sharing, transition processes and SEEMiS functions.

Education are encouraged to utilise further opportunities for wellbeing information sharing within their Enhanced Transition plans for pupils as recommended below. The involvement of the school nurse is critical in multiagency workings in both early interventions, within the Team Around the Child meeting process and transition meetings. This review process has highlighted the importance of including health and the sharing of information.

#### ***Recommendations to Address Learning Point 4***

South Ayrshire Council Education Services should review Management Guidance for Transitions to incorporate the recent Enhanced Transitions Guidance document created by Psychological Services.

Focus on creating opportunity for trauma informed information sharing, for example pupils who have been subject to Child Protection Investigation with no further action, or pupils who have experienced a significant bereavement or other adverse experiences that might impact supports required. Education plans should seek to involve the School Nurse service and Guidance staff in enhanced transition work from an early stage. Consideration should be given to promoting the importance of these relationships within the updated Management Guidance for Transitions. This should allow increased opportunity for sharing of wellbeing information and additional supports for the pupil.

The updated Guidance should be shared via the training packages for relevant staff.

#### ***Learning Point 5 - Continuation of Supports and a Whole Family Approach***

Staying with families whilst they resolve or manage difficulties, develop new skills or maintain existing skills is central to a whole family approach. The review team considered the need for consideration of on-going supports following the Child Protection Investigation in 2017. Continuing support may have assisted in reducing maternal difficulties and as such minimised their impact on B's wellbeing. An unmet need for continuing holistic support for B and mum could assist understanding as to why B was found to be living in similar unsafe and unhygienic conditions five years later.

#### ***Recommendation to Address Learning Point 5***

Consideration of ongoing supports for a child/family where a Child Protection Investigation concludes without placement on CPR or with a referral to SCRA. This should be part of a Team around the Child discussion, which may then result in a Child Plan to support any identified risks which don't meet the threshold for Child Protection Registration or referral to the Children' Reporter. South Ayrshire as a locality has decreasing numbers of children on the Child Protection Register and Looked after Children, which is considered to be as a result of the implementation of the Signs of Safety and the implementation of The Promise.

Whilst this has been discussed at the Child Protection Committee (November 2022) as potentially being a positive reflection in embracing Early Intervention and Prevention approaches, there is a need for partners to remain vigilant to situations such as B's, where reoccurring neglect has arisen in the years following case closure to Social Work. Literature informs that neglect is more likely to reoccur than any other form of maltreatment.

As such, where appropriate, the Team Around the Child should consider if there is a requirement for continued family support at a lower level of intensity following removal from the Child Protection Register, termination of a Compulsory Supervision Order or withdrawal of Social Work as the lead professional in building on strengths and supporting resilience to minimise risk of future concerns. Professionals should understand when it is appropriate to re-engage with Social Work if further appropriate supports are declined by a parent, or welfare concerns emerge despite supports.

This is also the case with hoarding, where on-going support is essential to avoid re-occurrence.

#### ***Learning Point 6 - Practitioner Knowledge of Referral Pathways and Appropriate Services***

Referral pathways for professionals working with families who may require supports are not clear across the authority.

The Team Around the Child should be reminded of the importance of the role of services across Thriving Communities in enabling a Signs of Safety early intervention approach, alongside the voluntary sector. A robust collaborative service alongside community-based support should assist in early intervention for children and their families.

#### ***Recommendation to Address Learning Point 6***

In South Ayrshire there are a number of statutory and third sector organisations offering support individual and family support for alcohol or substance use. It is recommended to support the Alcohol and Drug Partnership with their actions in relation to embedding a Whole Family Approach, including awareness raising and training activities which may allow for earlier interventions and better supports for potential service users

The Private Rented Sector within South Ayrshire Council should ensure Landlords are kept informed of their obligations in relation to those who reside in the property, whilst remaining informed of relevant support networks and routes to share information if they have a concern regarding a tenant or a child within the property.

#### ***Learning Point 7 - Importance of Relationship-Based Practice***

Trauma informed systems acknowledge that relationships are at the heart of supports and that every interaction has the potential to be impactful within trusting, safe relationships. The journey to becoming trauma informed begins with being trauma sensitive and aware.

***Recommendation to Address Learning Point 7***

Recommendations above for the team around the child, should assist in supporting the ability to recognise when a child may be communicating via behaviours linked with trauma (for example, non-attendance). Professionals should respond by taking account of the ways that a child can be impacted with a focus on utilising relationship-based practices.

<b>Reviewer(s):</b>	██████████
<b>Review Chair:</b>	██████████
<b>Date:</b>	20 <sup>th</sup> December 2022