Child Protection
Significant Case Learning Review

Child H

Chairperson Significant Case Learning Review Team:

Professor Paul Martin CBE

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Contents

Appendices

1. Executive summary

This Significant Case Learning Review (SCLR) sets out the considerations of the multi-agency review team established by the Chief Officers Groups of South and East Ayrshire to establish the learning opportunities from the experiences of Child H and his family.

The purpose of this review is laid out in the overarching improvement questions outlined below:

- What can we learn about barriers and aids to effective communication and information sharing both within and between agencies?
- What can this case tell us about professional understanding of 'risk' and risk indicators (including assessment, decision making and planning) – what works well and where improvement is needed?
- What can we learn and improve on in respect of the transfer of a child from one local authority area to another?
- What can this tell us about: leadership; case management; review processes; use of supervision for children looked after away from home; and permanency planning?

The incident involving Child H occurred on [redacted]. The Child was taken to hospital, having been found [redacted] East Ayrshire. Child H was taken to the local emergency department where the doctor's assessment led to the conclusion that Child H had experienced neglect and potential harm.

Child H was thereafter accommodated and the Initial Case Review (ICR) notification was accepted by East Ayrshire Child Protection Committee (EACPC) with a request being circulated to partners seeking their respective information.

South Ayrshire Council was the responsible Local Authority for Child H from April 2014 to August 2018.This responsibility transferred at a Children's Hearing to East Ayrshire Council on 30 August 2018.

On receipt of agency reports, an integrated chronology was prepared. The ICR Panel, made up of representatives from both South and East Ayrshire agencies/services, met for the first time on 4 February 2019. Given the complexity of the case it was agreed to jointly progress the ICR, with the lead authority at that time being East Ayrshire Child Protection Committee (EACPC) as Child H and his family were living in East Ayrshire at the time of the incident.

On 19 February 2019, a special meeting of the EACOG considered the circumstances of the ICR, and given the significant involvement of services in South Ayrshire agreed a joint process.

On 25 March 2019, a full ICR report was prepared for the EACOG, with a recommendation to proceed with a joint Significant Case Learning Review. The SACOG also received notification from their respective CPC and on 8 April 2019 similarly endorsed this recommendation.

The SCLR was led by a team representative of the different agencies and professions involved in the case. The review team was chaired by Professor Paul Martin Independent Chair CPC South Ayrshire.

An open, challenging and reflective approach was taken. The approach to the SCLR was impacted at first by considerations relevant [redacted] and then by the Covid 19 pandemic. This meant that there was longer than would normally be the case between the commissioning of the SCLR and its completion.

The Root Cause Analysis approach facilitated robust desk top analysis of the available records. This alongside cross sector learning workshops in both South and East Ayrshire enabled key learning opportunities to be defined.

Family summary

[redacted]

The review

An integrated multi-agency chronology was created from information supplied by the agencies involved, along with a timeline of relevant and significant events in the life of Child H.

From the review of the chronology it would appear that the return of child H to his mother's care was the key consideration when examining the family dynamics, pressures and stressors. The SCLR therefore focusses on this and how organisations and services responded.

This SCLR considers the case from the point that a decision was made to pursue legal permanence for Child H away from home in November 2014 to the date of the incident on .

The chronology and detailed considerations of this information are set out in the full report, however, in summary the circumstances surrounding this case are complex and multi-faceted.
Child H has experienced services and responses to his needs that, at times, have lacked focus, purpose and urgency.

Although the SCLR identifies examples of good practice and positive intent the needs of Child H were lost in the application of systems and approaches that did not necessarily, focus on his specific needs or wants. It was not child centred.

It is also clear that good communication, supervision, staff support and training are a key organisational and professional requirement. Some social work staff involved from South Ayrshire, at the time, did not feel that this was always the case. Staff require to feel supported in all that they do whilst recognising the scope and importance of professional autonomy and responsibility. The detailed findings, recommendations and actions noted below set out the rationale for the Review Team coming to this conclusion.

In setting out the improvement requirements the Review Team recognise the efforts of organisations to act timeously to address emerging findings as part of the review process. Examples of this are the Transfer Protocol, developed by East and adopted by South, and implementation of the programme for Signs of Safety in South Ayrshire.

This review has identified a number of procedural and practice issues, from which multi-agency learning can be drawn and many of the issues identified have featured in other SCLRs across Scotland.

The renewed focus on the ambitions of UNCRC,GIRFEC and anticipated publication of the refreshed National Child Protection Guidance for Scotland alongside the commitment to the outcomes of the Independent Care Review and the Promise create opportunities both locally and nationally for review of current cultures, approaches, policies and practice.

Practice and organisational learning- focus for improvement

It has been recognised by the Review Team that individual agencies have already reflected on practices highlighted within the report and have instigated significant changes in relation to process and practice in order to address some of the concerns raised.

The summarised findings set out in this section are informed by the case review process and discussions with staff. The key recommendations and suggested improvement actions are informed by the "why" approach.

DRIFT AND DELAY IN PERMANENCE PLANNING;

Summary

- Staff in South Ayrshire did not have the opportunity for appropriate training in permanence planning for children and young people to ensure that they were confident and equipped with the necessary skills to undertake these tasks.
- Social work supervision, in South Ayrshire, did not adequately identify knowledge gaps for practitioners and therefore appropriate action could not be taken to ensure staff had the necessary skills, knowledge and training to take the child's plan and permanence planning forward.
- Managers should consider the level of complexity of cases when allocating to newly qualified staff.
- The Substantive Review set up in South Ayrshire, to consider substantive permanence decisions, was not properly utilised.
- There was a lack of organisational oversight as to why Child H's permanence plan continued to drift.

1. Recommendation

Permanence Planning guidance, systems and practice in South Ayrshire, have been reviewed since 2017. However, there is further need of systemic refinement and improvement to ensure children's permanence plans are subject to the correct oversight to prevent unnecessary drift and delay.

Suggested improvement Actions

South Ayrshire

- Planned audits are established in respect of: 1) are permanence decisions made, within the preceding 24 months, in the correct forum and within agreed organisational timescales, and 2) that practitioners have the appropriate supervision, support and training to undertake permanence work.
- No approval for permanence should be made without a Parenting Capacity Assessment (PCA) that clearly evidences the parent's abilities to meet the needs of the child through childhood.
- Staff including newly qualified Social Workers, who are not already trained, should complete the 5-day permanency training course in the next twelve months and that local guidance in respect of newly qualified Social Workers completing this training in their first year, post qualification, should be updated.

THE VOICE OF THE CHILD, MOTHER AND CARERS IN THE DECISION-MAKING PROCESS.

Summary

- Despite there being a number of non-verbal cues as to how Child H was communicating his feelings, there was limited evidence that Child H's views were being sought directly from him, documented or acted upon.
- There was a lack of evidence of a joined-up approach across agencies to consider the Child's and families holistic needs.
- There was a lack of evidence of a trauma informed approach to supporting the family and a lack of training and awareness.
- Information sharing between services was clunky, which limited effective decision making.
- There was insufficient evidence that joint visits from the Family Placement Team and Locality worker in South Ayrshire to the Foster Carers and Child H, were taking place as directed on a 6 to 8 week basis. More regular meetings/visits may have allowed the Foster Carers to feel more supported, heard and included.

Recommendations

2. Children's views should be actively sought in an age appropriate manner. These views, in conjunction with those of the parents and Carers, must be considered in all decision-making forums about the child. (This aligns with the values as outlined in the Independent Care Review's, 'The Promise'.)

3. Practitioners should adopt a Trauma Informed approach when forming meaningful relationships with both children and adults.

Suggested Improvement Actions:

South Ayrshire

- That annual file/assessment audits are utilised in South Ayrshire to evidence that staff are aware of when, how and why to seek the views of children, confirming those views are thereafter incorporated in the child's care planning arrangements.
- South Ayrshire CPC should ensure that front line staff are provided with the necessary training and awareness of Trauma Informed practice, specific to their role.
- When a vulnerable parent and child(ren) seek refuge, an adequate risk assessment or investigation of reasons for homelessness is undertaken by Housing services, with a view to having more permanent and suitable housing options identified, at initial presentation.

East and South Ayrshire

- As a reflection of best practice services should ensure that the views and wishes of the child are clearly recorded reflecting a rights-based approach linked to the national and local implementation of UNCRC. Due consideration should also be given in relation to advocacy provision for parents [redacted]

TRANSITION OF CASE OWNERSHIP BETWEEN AND WITHIN AUTHORITIES;

Summary

- There was no Case Management Transfer Protocol available (anywhere in Scotland) at the time.
- The child's transition to the care of his mother and her partner should have been managed in a more child centred way, at the child's pace, and with greater joint decision making with partners and Foster Carers.
- The Foster Carers' views were not reasonably considered or incorporated. They were not kept appropriately updated with regard to the changing landscape of Child H's plan, particularly in relation to Permanence arrangements.
- Poor communication was noted between South Ayrshire and other agencies in respect of the plan to return Child H back to the care of his mother and following his return home from South Ayrshire to his parents who were living in East Ayrshire.
- Prior to 26 July 2018, which was the first transfer Hearing, there was little evidence of joint working or communication from South Ayrshire to East Ayrshire Social Work. It is incumbent on the authority transferring to initiate

contact as early as possible as transitions are notoriously difficult for children.

- Following the transfer to East Ayrshire, the case was satisfactorily picked up initially but due to a further transfer to a newly allocated Social Worker, who then went on annual leave, the case did not receive the attention it required, relevant to the identified vulnerabilities

Recommendations

South Ayrshire

4. There should be local guidance in respect of transition planning for children returning home or moving care placements.

East and South Ayrshire

5. The Transfer Protocol should be reviewed at agreed intervals to ensure effective implementation

Suggested Improvement Actions:

South Ayrshire

- Up to date local guidance for social workers should be implemented which supports transition planning for children returning home or moving care placements.

East and South Ayrshire

- The Case Management Transfer Protocol in Children & Families Social Work, developed and implemented in East and South Ayrshire, is considered for national implementation.

ORGANISATIONAL AND PROFESSIONAL FRAMEWORKS FOR DECISION MAKING;

Summary

- There was an over-emphasis, in this case, from South Ayrshire on achieving successful rehabilitation home at the expense of the actual impact of this return home on the child.
- There were four cancelled TAC meetings (3 in South Ayrshire and 1 in East Ayrshire) which led to reduced multi-agency sharing of information and the opportunity for joint decision making. Had these meetings taken place they could

have recognised the regular missed appointments and disguised/false/non-compliance issues, which appear not to have been effectively addressed.

- Child H did not attend school regularly which was a condition of his CSO. This was not followed through by the implementing authority and Reporter was not advised accordingly that conditions of the order were not being followed.
- There were periods of time when the child was not seen by professionals, even when on Statutory Hearing Order.
- The importance of the chronology as a tool to provide clarity and oversight of the support available to the family and the effectiveness of this was not recognised.

Recommendations

6. **South Ayrshire should complete its review of Child Protection policies and procedures as soon as practicable. This should link to the national review of the Child Protection Guidance**
7. **All organisations should use the implementation of the new national guidance as an opportunity to refresh staff awareness.**

Suggested Improvement Actions:

South Ayrshire

- Decisions not following current guidance and procedures require to be documented accurately, shared with partners timeously and where there are associated actions, clearly outline who is expected to implement them, what is hoped to be achieved within what timescale and when the arrangements will be for review.
- Effective review, updating, governance and dissemination to staff in South Ayrshire of Child Protection and Looked After Review policy and procedures to be completed timeously.
- Social work supervision policies should clearly outline the need for managers to ensure that workers have the necessary knowledge and skills to undertake complex case work. A refresh of supervision policies should be undertaken.
- Standards of record keeping and the tools to support this should be reviewed. Regular audit and refresh training should be available to staff across the agencies

East and South Ayrshire

- All services should be reminded of the importance of interdisciplinary and cross organisation communication with the timeous sharing of appropriated information to assist the management of risk.
- Multi-agency training on engagement with the Children's Hearing /panel system should be refreshed

2. CORE INFORMATION	
Child's information/factors	
Child's Identifier	Child H
Age of child	7
Gender	Male
Nature of injury/cause of death	Child H, when 4 years of age, . There was a history of complex support for Child H that included significant multiagency involvement.

3. INTRODUCTION

<u>Note</u>: This Significant Case Learning Review (SCLR) was initiated using the current Scottish Government National Guidance for Child Protection Committees – Conducting a Significant Case Review (2015). The structure of the report has been adapted from the draft National Guidance for Child Protection Committees - Undertaking (Child Protection) Learning Reviews. This approach was adopted to encourage a learning focused approach to the review and its conclusions. The Review Team also explored the Welsh model of safeguarding reviews.

From incident to Significant Case Learning Review

The incident involving Child H occurred on [redacted] in his home town in East Ayrshire. The Child was taken to hospital, following which the receiving doctor raised a Datix concern, recording a near-miss incident (Note: **DATIX** is a risk management system used by the NHS to record concerns, complaints and incidents/near misses involving staff, patients and others). The Doctor's assessment led to the conclusion that Child H had experienced neglect and potential harm.

Child H was thereafter accommodated and the Initial Case Review (ICR) notification was accepted by East Ayrshire Child Protection Committee (EACPC) with a request being circulated to partners seeking their respective information.

South Ayrshire Council was the responsible Local Authority for Child H from April 2014 to August 2018.This responsibility transferred at a Children's Hearing to East Ayrshire Council on 30 August 2018.

On receipt of agency reports, an integrated chronology was prepared. The ICR Panel, made up of representatives from both South and East Ayrshire agencies/services, met for the first time on 4 February 2019. Given the complexity of the case it was agreed to jointly progress the ICR, with the lead authority at that time being East Ayrshire Child Protection Committee (EACPC) as Child H and his family were living in East Ayrshire at the time of the incident.

On 19 February 2019, a special meeting of the EACOG considered the circumstances of the ICR, and given the significant involvement of services in South Ayrshire agreed a joint process.

On 25 March 2019, a full ICR report was prepared for the EACOG, with a recommendation to proceed with a joint Significant Case Learning Review. The SACOG also received notification from their respective CPC and on 8 April 2019 similarly endorsed the recommendation.

The COGs endorsed this recommendation, noting that the circumstances of the case met the criteria for progression to a Significant Case Learning Review in that: -

- Child H had sustained significant harm;
- [redacted]

required further exploration and to ensure a clear understanding of agencies assessment of risk and actions taken to mitigate those risks.

In December 2019, both COGs were updated on the progress of the review, noting the time elapsed and the concerns this raised. It was confirmed, that with certain limitations on who could be involved, COPFS was now content for the review to progress.

Both COGs were advised and the options to progress using an Independent Chair or, given the time lapse, utilise the knowledge and skills of the existing Review Team to conduct the review. The later was agreed and the Independent Chair of South Ayrshire CPC agreed to chair the process.

The Review Team (see Appendix 1) met on 11 February 2020. Actions identified were to critically review the integrated chronology, ICR report and Annex 2 agency reports, to help identify the main learning points the SCLR report should address.

In April 2020 due to the COVID - 19 pandemic, the Review Team Chair, on behalf of the Review Team, sought and received agreement from both COGs to put the SCLR into abeyance.

Following the first lockdown work to progress the SCLR recommenced in October 2020. This was conducted in the main using video and teleconferencing platforms.

In taking forward the SACOG and EACOG review requirements, learning forums took place in both East and South Ayrshire during November/December 2020. The learning forums brought together partners to reflect on Child H's experiences of all services and how he and his family were supported prior to the above incident and to identify organisational learning both within a local and national context.

Purpose of the review

The purpose of this review is laid out in the overarching improvement questions outlined below:

- What can we learn about barriers and aids to effective communication and information sharing both within and between agencies?
- What can this case tell us about professional understanding of 'risk' and risk indicators (including assessment, decision making and planning) – what works well and where improvement is needed?
- What can we learn and improve on in respect of the transfer of a child from one local authority area to another?
- What can this tell us about: leadership; case management; review processes; use of supervision for children looked after away from home; and permanency planning?

In undertaking the SCLR a collegiate and mutually supportive approach was adopted, which included constructive professional challenge.

Time period covered

The time period covered by the review is from 5th November 2014 when the decision was made in respect of permanent care for Child H away from home to [redacted] the date of the incident.

4.THE APPROACH TO THE SIGNIFICANT CASE LEARNING REVIEW

Methodology

Root Cause Analysis based approach

This review used a Root Cause Analysis (RCA) based approach. RCA is an approach that through the 5 "Whys" seeks to identify problems, their cause and develop, based on the analysis, improvement actions to address issues identified. It takes a "deep dive" approach, seeking to clearly understand circumstances, influencers and drivers for why something has happened. Through this, mapping improvement opportunities and actions. It is an engaging process that is both systematic and systemic.

The Review Team assessed and contributed to the ongoing challenge dialogue as issues emerged and understanding of what may have contributed became clearer.

Both East and South Ayrshire areas supported multi agency learning review workshops. These were attended by representatives and participants from across the areas.

The flow of activity:

- A Review Team was established with membership from both East Ayrshire and South Ayrshire CPCs,
- Lead for Review identified (Independent Chair – EACPC then SACPC, due to EACPC Chair standing down)
- Full multi-agency chronology developed and critically assessed for learning
- A timeline of significant events was developed for Child H
- Each agency reviewed case files and records
- Consideration was given to related policies/procedures and guidance (in each area)
- Multi-agency cross area review exercises convened in both areas
- Engagement with practitioners and partners
- Review Report produced with key learning points and findings
- Review Team met to finalise report

- Action plan to be developed from findings
- Review Report presented to Chief Officers (in both areas)
- Submission to Care Inspectorate
- Feedback to family/carers [redacted]
- Publication of report

Engagement with staff

Given the desk top nature of the assessment and analysis of the information in the chronology it was felt important that there was direct engagement with staff involved in delivering the range of services to Child H and his family. This allowed for the "why" questions to be pursued further. Given the time lapse it was not considered appropriate to approach staff who had moved on from the organisations. However, the staff that were engaged in the learning process did so with maturity and self- reflection.

East Ayrshire held a multi-agency learning review exercise on 5 November 2020, to identify and provide further commentary around the summarised learning points and to identify any addition learning. South Ayrshire held two similar exercises, both on the 2 December 2020. The learning review exercises were structured on agreed principles to ensure consistency and were attended by representatives from each area and organisations that are common to both.

[redacted]

Family involvement

As noted above throughout the SCLR process there has been a[redacted] as such it has not been possible to include family or Child H's Foster Carers.

Impact of Covid 19 pandemic

As highlighted earlier, the pandemic impacted directly on the ability to timeously conduct the review and on the approach to engagement with the learning process. The use of video platforms was helpful; however, it is not a substitute for direct engagement with colleagues in these exercises. That said, the findings of the learning review are robust and identify clear improvement requirements as noted in Section 9

5. THE CIRCUMSTANCES THAT LED TO THE SIGNIFICANT CASE LEARNING REVIEW

Background

[redacted]

[redacted]

[redacted]

Incident

On [redacted] Child H (then aged 4 years) was found [redacted] East Ayrshire [redacted]

Police Officers attended the nearby Primary school, whereby the Head Teacher identified Child H as a pupil at that school. He was taken to the hospital Emergency Department [redacted]

On attending the home address, Police Officers found Child H's mother was not aware that he was missing. On inspecting the house, the Police had significant concerns regarding the health, safety and wellbeing of another two young children [redacted] All three children were removed from their parents care and placed in emergency foster care.

History of agency involvement with the family

From the review of the chronology it would appear that the return of Child H to his mother's care was the key consideration when examining the family dynamics, pressures and stressors. The SCLR therefore focusses on this and how organisations and services responded.

The integrated multi-agency chronology was created from information supplied by the agencies involved, along with a time line (Appendix 2) of relevant and significant events in the life of Child H. The agency involvement with the child and his family is outlined below. This SCLR considers the case from the point that a decision was made to pursue legal permanence for Child H away from home in November 2014 to the date of the incident on [redacted]

Summary background from pre-birth to November 2014

Child H had been placed on the Child Protection Register in Dumfries and Galloway prior to his birth [redacted] Child H And his mother [redacted] were accommodated in [redacted] in South Ayrshire. A short time later they were allocated temporary accommodation before securing a permanent tenancy in Ayr in April 2014.

The case transferred to South Ayrshire from Dumfries and Galloway in April 2014 following a Child Protection Transfer Case Conference as Child H remained subject to Child Protection Registration in Dumfries and Galloway.

[redacted]

[redacted] Child H was temporarily accommodated with Foster Carers, but later returned to his mother's care following successful appeal of a Child Protection Order.

Child H remained on the Child Protection Register in South Ayrshire and the family were supported by a number of agencies. Initially, there was positive engagement with services and progress was being made.

In July 2014 Child H's mother was noted to disengage from supports. In September 2014 there was a further incident

[redacted] Child H was found in his pushchair in the close area of a local address [redacted]

Child H was conveyed to Hospital with bruising on his face and body. A Child Protection Order was sought and granted on15 September 2014 and Child H was placed in Foster care.

South Ayrshire involvement with Child H and his family from November 2014- (*the beginning of the SCLR timeline*).

On 5 November 2014 a Child Protection Case Conference and Looked After and Accommodated Review (LAC) took place in respect of Child H. This meeting made the decision to remove Child H's name from the Child Protection Register and that there should be no rehabilitation of Child H to the care of his mother and permanence plans were to be progressed. It was recorded that Child H was safe and well cared for by his foster family.

A further Permanency Planning meeting took place on the 25 November 2014. The minutes of this meeting report that Legal advice was sought and it was noted that grounds for permanence did exist, with the recommended route to permanence being adoption.

On 28 November 2014, the new grounds of referral put forward by the Scottish Children's Reporter Administration (SCRA) were established at Court. Child H's mother was noted to have willfully ill-treated and willfully abandoned Child H. [redacted] she was advised of the Local Authority's intent to pursue permanent care for Child H.

On the 15 December 2014, the Children's Hearing considered the established Grounds and decided that the Compulsory Supervision Order should continue with a Condition of Residence directing Child H should reside with his Foster Carers and have no contact with his mother or father.

Reflections

- Due process was applied with appropriate, timeous decision-making that had the needs of Child H at the centre.
- The permanency decision was made following a period of support for the family focussed on rehabilitation.
- Insufficient recognition of mother's [redacted] when she became known to South Ayrshire.

2015

[redacted]

A Children's Hearing on 1 June 2015 decided that Child H's mother should now have letterbox contact with her son.

[redacted]

On the 23 October 2015, almost one year following the decision for permanent care to be pursued for Child H, seven prospective adopters were identified. There was follow-up with one prospective adopter but this proved unsuccessful and no further progress was made regarding adoption. As a result of this delay all of the adopters who came forward had subsequently been matched with other children.

On 26 November 2015, a Children's Hearing took place, however, no substantive decision was made due to unavailability of Safeguarder's report.

Reflections

[redacted]

- There was now a delay of one year since the initial permanence decision with no clear rational.
- There was insufficient follow-up with the seven potential adopters.
- The approaches to permanency arrangements in this case did not function well.
- There is no clear decision-making trail regarding family being resident in East Ayrshire and case being retained by South Ayrshire social work services in respect of mother's pregnancy.

2016

On 8 February 2016, a Children's Hearing varied Child H's Compulsory Supervision

Order (CSO) to allow Child H to have supervised contact with his mother and her partner once every two weeks for one hour.

On 21 March 2016, Child H's family moved to East Ayrshire

On the 4 May 2016, a (LAC) Review took place for Child H. The Health Visitor noted that Child H had now had four contacts with his mother and her partner and he was observed to be distressed during two of these contacts. It was a recommendation of this meeting that rehabilitation to Mother's care should not be pursued and that permanency planning was to continue. This was now 18 months after the first LAC Review endorsed the recommendation to terminate rehabilitation and pursue permanent care.

[redacted]

On 1 July 2016, Foster Carers continue to report that Child H is very distressed following contact. At a Children's Hearing on 4 July 2016, Child H's CSO is varied and contact with his mother returns to being letterbox contact only, in recognition of Child H's distress during contacts.

[redacted]

On 10 August 2016 a further LAC Review took place in respect of Child H in South Ayrshire. [redacted]

On 30 September 2016, there was an allocation of a new Social Worker

On 21 October 2016, a referral was made by the Health Visitor for Child H to be seen by the Community Paediatrician, [redacted]

On 21 November 2016, a Children's Hearing varied the conditions of Child H's CSO and reinstated face to face contact between Child H, his mother and her partner, despite this not being the recommendation of Social Work.

On 22 November 2016, a Looked After Review took place for Child H. This meeting directed that a parenting capacity assessment should be undertaken. This is the first time there is indication that a parenting capacity assessment should be formally introduced for Child H's formal assessment and plan.

A Health Visiting [redacted] routine.r[redacted] following the earlier decision of the Children's Hearing on 21 November 2016, reinstating contact between Child H and his mother and her partner.

Reflections

- Children's Panel made the decision to reinstate contact with mother and her partner despite challenges from Social Work representative and the Safeguarder
- Was sufficient regard taken of the existing permanency arrangements in the decision of the Panel?
- Social work did not request a review hearing to challenge the Panel's decision.
- There is no evidence of formal notification from South Ayrshire's Keeper of the Register that a child was living in East Ayrshire and on SA CPR.

2017

On 20 January 2017, the Health Visitor for Child H completed a Health needs assessment, [redacted] He was reported to have a close bond with his Foster Carers, [redacted] concerns to Health and Social Work professionals about the impact of contact with Child H's mother and noted these in writing to Social Work Services in South Ayrshire. (16 February 2017)

[redacted]

[redacted]

[redacted]

On 3 May 2017, a LAC Review notes improvement in family circumstances, however, requests the need for a parenting capacity assessment and directs that plans for permanence continue to be progressed. The LAC Review noted that a Review Children's Hearing should consider contact being increase from once every two weeks to once per week to more effectively inform the parenting capacity assessment

On 25 May 2017, a Children's Hearing continued to direct supervised contact between Child H and his mother and her partner, increasing the level of contact to once per week in line with the Social Work recommendation.

[redacted]

[redacted]

On the 8 August 2017, a meeting involving only Social Work staff took place in South Ayrshire to consider a bridging placement to help manage Child H's possible transition home. This was considered as Foster Carers continued to state to the allocated Social Worker that they were unable to support any plan for Child H to return home, as they did not consider that a permanent return home was the appropriate outcome for the child.

On 10 August 2017, a LAC Review again requested an updated parenting capacity assessment and the need for permanence planning to continue. At this Review a date was provided for a Substantive Looked After Review (January 2018) to consider the parenting assessment and recommendation for permanence, including if previous legal advice was still applicable.

[redacted]

[redacted] the Health Visitor notes she was not gaining access to the family home in East Ayrshire. [redacted] Child Protection concerns were raised by the Health Visitor with Social Work in South Ayrshire.

On the 31 August 2017, a Fostering and Adoption panel endorsed the recommendation from South Ayrshire Social Work that the most likely route to permanence would be rehabilitation for Child H to the care of his mother and her partner. The panel noted that positive changes within the family had been reported over a sustained period and the couple were parenting another child, with another baby just born. It was noted in this meeting that the Family Placement Team should support Foster Carers.

[redacted]

On 13 October 2017, a positive home visit was recorded by the allocated Social Worker in South Ayrshire, with Child H's mother and partner advising that they wished overnights with Child H to progress. Foster Carers were advised by Social Work that they should make every effort to support Child H to return home and that they would be supported to do this. There is little evidence of the Family Placement Team in South Ayrshire providing regular supervision and support to the Foster Carers.

Child H's Foster Carers continued to state to Health and Social Work professionals

that they were not in agreement with the plan and they telephoned Child H's Health Visitor on the 17 November 2017

[redacted]

At the Children's Hearing on the 23 November 2017, the panel made the decision to vary the CSO and allow Child H to remain at home with his mother and partner in East Ayrshire. Child H had a period of contact on the days prior to the Hearing on 23 November. This decision to speed up the transition process and recommend an immediate return home is noted to have been made by a Senior Manager within South Ayrshire Social Work Services. This decision was reportedly made to avoid further disruption to Child H by using a bridging placement to allow a longer transition home. The Children's Hearing noted some concerns in respect of this decision and the quickness of the move from Foster Carers, however as Child H had been returned to his mother's care prior to the Hearing they felt on balance that despite their reservations it would be difficult to return Child H back to his Foster Carers only to potentially have to return him home at a later date.

Following his return home on 23 November 2017, Child H was enrolled at the local Early Childhood Centre at the end November 2017.

In December 2017, [redacted] Assistant Nurse Practitioner support was considered and discussed with the family before any referral was made, however, the family declined support from this service.

[redacted] On 8 December 2017, the Health Visitor noted at the initial Health visiting appointment the requirement for a social and emotional developmental needs assessment to be undertaken.

On 19 December 2017, the Health Visitor referred Child H to the Community Paediatrician.

[redacted]

Reflections

- There appears to be little effort made to listen to or understand the voice of Child H.
- There were clear indicators of stress, upset and distress from Child H and his mother with no collective clarity on how these were recognised in a way that positively impacted on the outcomes for Child H.
- It is unclear why responsibility for the family beyond Child H remained with South Ayrshire.
- The approach to the decision on 23rd November 2017 to return Child H home raises questions around protocols for such circumstances.
- The Foster Carers' views were not reasonably considered or incorporated.

- The Foster Carers were not kept appropriately updated with regard to the changing landscape of Child H's plan. Particularly in relation to Permanence arrangements.
- Insufficient support provided to Foster Carers, with little information on how to progress their interest in adopting Child H.
- There is evidence of a lack of a joined-up approach across agencies/services to consider the Child's and family's needs holistically.
- No advocate was appointed for the child or for his vulnerable mother.
- The child's transition to the care of his mother and her partner could have been managed in a more child centred way, at the child's pace, and with greater evidence of joint decision making with partners.
- The transition plan was rushed with no sense of cohesion or of the impact the move would have on the child, family and carers.
- There was insufficient evidence that Placement Management meetings were taking place as directed on a 6 to 8-week basis in the Child's plan. More regular meetings may have allowed the Foster Carers to feel more supported, heard and included.
- SAC returned Child H to the care of his mother before the decision of the change to the CSO had been agreed by the Children's Hearing.
- It would not be standard procedure in SAC to have a Permanence Panel to consider and endorse a recommendation of a child's return home. The reasons why the Permanence Panel was held on 31 August 2017 are unclear and did the panel consider the team Around the Child assessment.

2018

[redacted]

On 9 January 2018, during a home visit by the Health Visitor, Child H's mother advised that she knew he was unhappy and did not want to be there. [redacted]

In January 2018, staff at Child H's nursery advised that he had been in attendance for only one day since Christmas and they had continued to attempt to contact the family. This was reported to South Ayrshire Social Work as per Education Standard Circular 05 *Attendance and Absence in Educational Establishments* to be followed up by allocated Social Worker.

Also in January 2018, a LAC Review took place and a directive from that meeting was that South Ayrshire Social Work Service was to liaise with East Ayrshire Social Work Services in respect of case transfer. During January 2018, there was concern noted by Social Work, Health Visitor and [redacted] that Child H's mother

[redacted] and this was having an impact on Child H.

In February 2018, the Social Work Team Leader in South Ayrshire asked the family Placement Team in South Ayrshire to consider the availability of Foster Carers within the service who could provide care for Child H, should he need accommodated. The allocated Social Worker was visiting frequently and responding to concerns, however, there was no change in caring arrangements. The placement was not progressed by South Ayrshire Locality Social Work. There is no clear reason why.

On the 5 March 2018, extensive support was offered to the family by South Ayrshire Social Work Services. This included: transport to nursery for Child H, play therapy, Life Story work, Scottish Adoption Support Services, Assistant Nurse Practitioner Support and the purchase of items such as baby gates. The allocated Social Worker noted that if the family were unable to engage with these supports then there was a risk of Child H being removed from the care of his mother and family. The case notes highlight the family did not engage.

On 14 March 2018, Social Work records highlight that mother's partner advised the family were travelling to England and noted [redacted]

On 21 March 2018, a Social Worker from South Ayrshire visited the family but they were not at home. Contact was made with the family by telephone to remind them of the conditions of Child H's CSO.

On 26 March 2018, the Health Visitor reported that Child H did not attend a Community Paediatric appointment at Rainbow House. Child H had now missed two appointments at Rainbow House and was still not registered with a GP.

On 28 March 2018, the Health Visitor noted the family were in England, viewing property with a plan to move there on a permanent basis. [redacted]

On 4 April 2018, Social Work records note Child H had not been seen in four weeks, as the family were in England.

On 5 April 2018, the allocated Social Worker undertook a visit and saw Child H and his family. The family were encouraged to take Child H to nursery and the benefits of nursery attendance were explained. The family were advised that a Family Support worker would be introduced to assist with transport and that the allocated Social Worker would commence life story work.

On 27 April 2018, the Health Visitor tried to contact the family, with no success. Health Visiting records note that Child H had not been seen by the Heath Visitor since 9 January 2018.

On 1 May 2018, Child H did not attend a further appointment at Rainbow House. Health sent a letter to Social Work to request assistance to support Child H and his mother in attending future appointments. A further appointment was made to attend

Rainbow House on 25th May 2018, however, there are no details available as to whether Child H attended or not.

On 24 May 2018, an unannounced Social Work visit took place at Child H's home whereupon the family were advised that as a result of an accumulation of concerns and non-engagement, a child protection assessment may be initiated.

On 25 May 2018, a Team Around the Child (TAC) Meeting was arranged. There is no evidence of this meeting having taken place and no evidence of follow-up. Concerns continued to be noted by the Health Visitor and Social Worker in respect of lack of engagement and the family being unwilling to accept support.

On 8 June 2018, a joint home visit took place between the Health Visitor and Social Worker, Child H was not at home and a further appointment was arranged.

[redacted]

On 19 June 2018, Child H's step-father enrolled him in school, within East Ayrshire.

[redacted]

On 2 July 2018, the same Health Visitor is recorded as reporting these concerns to the GP who advised her that an urgent medical assessment would be required. The Health Visitor then took guidance from the Child Protection Health Advisor, who advised her to make a child protection referral in order to initiate an Initial Referral Discussion (IRD), where a medical examination could be considered.

An IRD was then raised by Social Work Services in South Ayrshire on 3 July 2018. It is noted in the records that an IRD took place between the Child Protection Health Advisor and the Social Work Team Leader. However, a service manager in South Ayrshire Social Work services advised that a CP alert was not necessary in this instance. Case records do not clearly set out the rationale for this decision.

On the 3rd July, it was agreed that an emergency LAC would be convened and a medical examination would be pursued in the absence of a CP alert. To ensure the medical could take place, Child H's allocated Social Worker discussed with Legal Services in South Ayrshire, the possibility of applying for an Assessment Order at Court, if Child H's mother did not give consent for the medical examination. Legal

Services advised there was sufficient evidence to make this application.

On the 4 July 2018, the Social Worker from South Ayrshire and the Health Visitor from East Ayrshire undertook a joint home visit. The Social Worker agreed with the Health Visitor that there was a recent deterioration in Child H's presentation. His mother agreed to Child H having a comprehensive medical assessment.

A Consultant Paediatrician undertook a comprehensive medical assessment on the 10 July 2018. The assessment recorded that Child H failed to attend a number of clinic appointments since returning to his mother's care. Child H's mother advised that her main concern was [redacted] Child H's mother noted that as this had improved, she did not pursue further medical appointments. [redacted] The doctor also reported concerns about the rapid separation from his Foster Carers' family and the impact this was likely to have had [redacted] Review Assessment was to be arranged The comprehensive medical report was shared in writing with Child H's allocated Social Worker, in a letter dated 10 July 2018.

On 13 July 2018, a TAC Meeting took place in South Ayrshire and it was agreed by the Chair that transfer to East Ayrshire Council should be requested. It was discussed at the meeting that Child H's case should transfer at the next Children's Hearing scheduled for 26 July 2018. This Hearing was deferred because of Child H's mother's non-attendance.

Reflections

- Record keeping tracking and explaining key decisions is less than satisfactory.
- There are periods where Child H is not seen either by individual or collective services.
- Limited contact if any, from South to East Ayrshire Social Work in respect of identifying and managing risk prior to case transfer.
- There was a lack of clarity and information sharing in respect of responsibility for undertaking home visits when the child moved from South to East Ayrshire.
- Poor communication was noted between South Ayrshire and other agencies in respect of the plan to return Child H back to the care of his mother and following his return home to East Ayrshire.
- A risk assessment was completed by Health Visiting Services to ensure the safety of practitioners - this information was not shared with the TAC.
- Unreasonable delay in family registering the child with a GP was not shared with TAC.
- Limited contact between implementing authority and the Children's Reporter concerning school
- Three appointed Safeguarders did not progress their report timeously resulting

in delays in the decision-making process.

- Failure of child to attend school regularly, a condition on the CSO, was not followed through by implementing authority and Reporter not advised accordingly that conditions of order were not being followed. A direct referral to the Reporter could have been made.

Beginning of implementation authority transfer to East Ayrshire

On 26 July 2018, a Team Leader at South Ayrshire Social Work contacted a Service Manager at East Ayrshire via email requesting the transfer of Child H to East Ayrshire.

The Team Leader at South indicated that the allocated worker for the Child H had now left South Ayrshire Council, and that a Children's Hearing was scheduled to take place on 26 July 2018, however, his parents failed to attend.

For this reason, the Hearing was deferred until 30 August 2018. At that time South Ayrshire Council remained the implementing authority and the Team Leader asked for a transfer meeting wishing introductions to be made for the family and Child H, as this would aid transition to any new worker. The Service Manager at East Ayrshire Council delegated the request to the Team Manager to action given Child H was subject to a CSO, his family were living in East Ayrshire and Child H was attending education in East Ayrshire.

On 7 August 2018, a transfer of information meeting was held between South and East Ayrshire Social Work services, which was attended by Team Managers from both services and case files were handed over. At this meeting it was agreed that Child H would not transfer to East Ayrshire until after the children's Hearing on 30 August 2018. [redacted]

Following the above meeting it was agreed to allocate Child H to a specific Social Worker after their return from annual leave on 17 August 2018.

On 20 August 2018, there was a hand over of Health concerns and history to the school Nursing Service. That day Child H presented for P1 at the local Primary school and Education's SEMiS system was updated accordingly. Also that day, mother reported to her [redacted] This information was not passed to Social Work colleagues.

On 21 August 2018, East Ayrshire appointed a named Social Worker, as Lead Professional for Child H.

The East Ayrshire Social Worker attempted to arrange an initial contact with family on 22 August 2018 and then again on 28 August via telephone, however, there was no answer or voicemail facility to leave a message. This Social Worker then contacted the Family Support Worker at South Ayrshire, as there was no Social Worker re-allocated at this time. This was due to the allocated Social Worker in South Ayrshire leaving her post. The Social Worker from East Ayrshire advised South Ayrshire staff

that he had not been able to contact the family prior to the hearing despite attempts. This meant he would have to introduce himself to the family for the first time prior to the children's Hearing on 30 August 2018.

On 30 August 2018, at a Children's Hearing, the implementing authority was transferred from South Ayrshire to East Ayrshire. This reflected the return home of Child H to his mother's care in East Ayrshire in November 2017. The Children's Hearing determined to continue and vary the CSO with the child required to attend school regularly and have no contact with his father.

After the Children's Hearing on 30 August 2018, the EAC Lead Professional had an introductory session with the family, establishing a connection and the parents did not offer any concerns about their ability to manage the care needs or any behavioural issues for any of the children. The Lead Professional did, however, note the parents' views about [redacted] and that support would be required for family. A TAC meeting was to be arranged and poor school attendance was also noted for Child H. [redacted]

The family raised concerns with the Lead Professional about the transition plan with South Ayrshire and the difficulties this had created for the family. The family were advised of a number of potential supports, including the Family Support Team, [redacted]. The Lead Professional's assessment was there were attachment concerns and possibly the parents were prioritising [redacted] needs above Child H's.

Both parents were happy to accept support and the Lead Professional arranged a home visit for 10 September 2018 for further assessment and to discuss specific supports.

Case notes record the Lead Professional's Assessment –

'*The family are struggling to meet the* [redacted] *needs of Child H at present. It would appear that this is placing stress on family relationships as there are concerns that there are risks to* [redacted] *due to Child H's needs* [redacted]*. Child H transitioned from his Foster Carers back to his mum and her partner's care and it is acknowledged that this may not have been adequately supported in order to address Child H's needs as well as the wider family. It is my assessment that the family would benefit from, intensive support in order to address attachment issues and to support the family with parenting Child H, as they appear to be struggling to understand his* [redacted] *needs'*.

In light of the foregoing a TAC meeting was scheduled to take place on 6 September 2018 but this did not occur and it is unclear why.

On 4 September 2018, the Lead Professional was required to move location to support operational issues elsewhere. As a consequence, a new Lead Professional was required and noted that Child H would be allocated such on 11 September 2018.

In the interim, on 6 September 2018, the Head Teacher at Child H's school advised the Service Manager at East Ayrshire that Child H had not been at school all week and that there were concerns that his [redacted] needs were not being addressed, along with his education and social needs. The original Lead Professional spoke to the Head Teacher and confirmed that if Child H's family were unable to commit to care for him in the long term, then the possibility of Child H moving out of the family home would be considered but that contact could be maintained.

The Family were informed by the Lead Professional they would be getting a new social worker on 10 September 2018.

On 11 September 2018, Child H was allocated to a new Social Worker. The following day the Head Teacher contacted the Social Work Service Manager, advising Child H's [redacted] to her and he told her not to contact them again. Head Teacher advised a TAC should be arranged as soon as possible to discuss supports for the family, however, the newly allocated Social Worker was on leave from 25 September until 1 October 2018 (the office was closed 21 and 24 September due to holiday weekend). It is unclear from records why no TAC was arranged between dates 12 to 20 September 2018.

On 27 September 2018, the stepfather called the school to advise they were in England and would be back at the weekend. Having been advised of this by the school, the Social Work Team Manager then spoke to the stepfather on the phone advising him of the requirements of the CSO should Child H move elsewhere, who their new social worker was to be and that she would introduce herself on return from leave.

During the month of September 2018, there were eight calls from Education (the school) to Social Work, sharing information regarding Child H's absence from school, as per Education Standard Circular 05 *Attendance and Absence in Educational Establishments*. There is however no evidence of referral to the Reporter or direct request for a review hearing.

On 2 October 2018, Education received a call from the stepfather to the effect that Child H would not be back at school as the family were moving to England the following week. At that point it was noted that the Child H had not been at school since 26 September 2018. The Social Worker was to arrange a visit to the family and discuss concerns with the Team Manager on her return from leave on 4 October 2018.

Reflections

- Case transfer approaches and processes were not clear.
- Communication across the agencies did not work as effectively as they should.
- There where periods when Child H was not seen.
- There were issues of continuity in social work input.
- It is unclear why TAC meetings were not followed though.

- There was no direct referral or notification by any agency or member of the multi-professional team around the child to the Reporter or direct request for a review hearing.

Further reflections from the flow of the case review

- Little evidence of Child H's mother being given the opportunity of building meaningful relationships to affect change and share experiences at an early stage. From April 2014 to September 2014 there were 18 Social Work Visits and 86 Outreach visits.
- Further analysis of Child H's case file whilst South Ayrshire were the implementing authority highlight that there were 32 workers involved. Which is made up of 6 Team Leaders, 16 Social Workers, 8 Outreach workers and two Family Support Workers. There were 26 Children's Hearings. Given this level of contact, a stronger sense of the child's wishes could have been more apparent.
- Use of a genogram or family tree may have assisted with identifying kinship care options.
- Over-emphasis placed on mother's partner to attend Children's Hearings/meetings, and to be involved in the decision-making process for a child for whom he had no parental rights and relevant person status was not addressed.
- Ayrshare appears to have been underutilised and not always updated by practitioners.
- Outreach Services in South Ayrshire were involved with the family for a significant period. However, there is little evidence of assessment or information sharing with the Lead professional. By not sharing this information it was difficult to assess the impact on the family.

6. Specific learning issues identified from the case review requiring further scrutiny

Following the desk top analysis of the integrated multi-agency chronology and agency reports as set out in section 5 the Review Team scrutinised the issues highlighted. In so doing the team was able to summarise a number of themed areas for further consideration. The Review Team decided, through staff learning workshops, to consider in more detail the circumstances surrounding the themes outlined below

- **Drift and delay in permanence planning.**
- **The voice of the child, mother and carers in the decision-making process.**
- **Transition of case ownership between and within authorities.**

- **Organisational and Professional frameworks for decision making.**

The learning workshops with staff.

The learning workshops and the approach taken was impacted by the pandemic. This limited the level and depth of engagement and it is recognised that further work will be required, in line with approaches to improvement, to work with staff to secure the changes required.

The learning workshops were conducted with an approach that encouraged openness. It was stressed that this was a learning approach and understanding why things happened was part of that process. The workshops focussed on elements of Child H's experience of services and how effective they were. The discursive nature of this approach sought to ensure that participants shared their experiences and could receive support as required.

Participants were advised of confidential counselling that was available outside the learning workshop process should this be required.

Learning workshop feedback

Summary of feedback- South Ayrshire

Some social work staff felt under prepared for the complexity of the work they were asked to undertake.

Caseload management did not take cognisance of the collective complexity of the workload held by social workers.

Social work staff supervision and support models were not robustly applied. There was acknowledgment that staff's approach to Child H's mother were at times influenced by previous anecdotal accounts of behaviour. It was acknowledged that this behaviour was not always understood or considered in relation to [redacted]

Being trauma informed and applying this thinking or approach was not the norm.

Approaches to risk assessment were not clearly understood or applied.

The permanency polices required updating.

There was no clear quality assurance or robust oversight of the permanency arrangements and so staff did not receive the required level of feedback and challenge.

Record keeping was not as good as it should have been particularly for some key decisions, there was no clear reason for this.

Due to some of the challenges cited above staff felt unable to join together the bigger picture.

It was acknowledged that there was limited assessment or cognisance of the impact of Child H's mother's own life experiences on how she might engage with services or approach parenting responsibilities or make best use of the strengths she may have had. This reflected the limited experience of the key worker responsible for the case at the time.

There was limited experience or skills in securing the voice of the child in the complex arrangements that applied.

Information sharing was not what it should have been and staff acknowledged that further efforts could have been made to ensure the fuller picture of Child H's need was clearly expressed.

It was accepted that if the parenting assessment had been completed then this would have created space for reflection on the family's wider circumstance and given support to their voice.

There was insufficient engagement with the foster carers and not enough cognisance of their concerns. Staff were unsure how to cope with the challenges that came about in this relationship.

Social work policies and procedures to support practice were not easily accessible nor contemporaneous. There were gaps in areas such as the unseen child, case transfer and transition.

The focus on child protection training in South Ayrshire beyond the standard updates was limited.

There was a lack of continuity in social work input that may have challenged the establishment of a meaningful relationship with the family.

East Ayrshire

Acknowledged there were missed opportunities and not enough focus on the voice of Child H in decisions that affected him.

The importance of critical assessments prior to deciding to move a child.

More could be done to share information and communicate clearly across the disciplines and services.

Turnover of staff in a short period made it difficult to begin to establish initial relationships with the family and assess risks.

Renewed guidance provided to Health staff which includes advice on being more tenacious in following up on missed appointments and gaining access to a child.

There were periods when Child H was not seen and the use of IRD should have been further considered.

Sharing of risk to staff concerns could have been clearer and documented more effectively. This requires improved policy and staff awareness.

Staff across agencies gave examples of self-challenge and reflection recognising what they would do and are doing differently.

7. The Review Team's reflections summarised

Following the desk top analysis of the chronology and the learning workshops with staff the Review Team were able to summaries the issues and learning opportunities under the key headings.

These are noted below:

DRIFT AND DELAY IN PERMANENCE PLANNING;

Summary

- Staff in South Ayrshire did not have the opportunity for appropriate training in permanence planning for children and young people to ensure that they were confident and equipped with the necessary skills to undertake these tasks.
- Social work supervision, in South Ayrshire, did not adequately identify knowledge gaps for practitioners and therefore appropriate action could not be taken to ensure staff had the necessary skills, knowledge and training to take the child's plan and permanence planning forward.
- Managers should consider the level of complexity of cases when allocating to newly qualified staff.
- The Substantive Review set up in South Ayrshire, to consider substantive permanence decisions, was not properly utilised.
- There was a lack of organisational oversight as to why Child H's permanence plan continued to drift.

THE VOICE OF THE CHILD, MOTHER AND CARERS IN THE DECISION-MAKING PROCESS.

Summary

- Despite there being a number of non-verbal cues as to how Child H was communicating his feelings, there was limited evidence that Child H's views were being sought directly from him, documented or acted upon.
- There was a lack of evidence of a joined-up approach across agencies to consider the Child's and family's holistic needs.
- There was a lack of evidence of a trauma informed approach to supporting the family and a lack of training and awareness.
- Information sharing between services was clunky, which limited effective decision making.
- There was insufficient evidence that joint visits from the Family Placement Team and Locality worker in South Ayrshire to the Foster Carers and Child H, were taking place as directed on a 6 to 8 week basis. More regular meetings/visits may have allowed the Foster Carers to feel more supported, heard and included.

TRANSITION OF CASE OWNERSHIP BETWEEN AND WITHIN AUTHORITIES;

Summary

- There was no Case Management Transfer Protocol available (anywhere in Scotland) at the time.
- The child's transition to the care of his mother and her partner should have been managed in a more child centred way, at the child's pace, and with greater joint decision making with partners and Foster Carers.
- The Foster Carers' views were not reasonably considered or incorporated. They were not kept appropriately updated with regard to the changing landscape of Child H's plan. Particularly in relation to Permanence arrangements.
- Poor communication was noted between South Ayrshire and other agencies in respect of the plan to return Child H back to the care of his mother and following his return home from South Ayrshire to his parents who were living in East Ayrshire.
- Prior to 26 July 2018, which was the first transfer Hearing, there was little evidence of joint working or communication from South Ayrshire to East Ayrshire Social Work. It is incumbent on the authority transferring to initiate contact as early as possible as transitions are notoriously difficult for children.
- Following the transfer to East Ayrshire, the case was satisfactorily picked up initially but due to a further transfer to a newly allocated Social Worker, who then went on annual leave, the case did not receive the attention it required, relevant to the identified vulnerabilities.

ORGANISATIONAL AND PROFESSIONAL FRAMEWORKS FOR DECISION MAKING;

Summary

- There was an over-emphasis, in this case, on achieving successful rehabilitation home at the expense of the actual impact of this return home on the child.
- There were four cancelled TAC meetings (3 in South Ayrshire and 1 in East Ayrshire) which led to reduced multi-agency sharing of information and the opportunity for joint decision making. Had these meetings taken place they could have recognised the regular missed appointments and disguised/false/non-compliance issues, which appear not to have be effectively addressed.
- Child H did not attend school regularly which was a condition of his CSO. This was not followed through by the implementing authority and Reporter was not advised accordingly that conditions of order were not being followed.
- There were periods of time when the child was not seen by professionals, even when on Statutory Hearing Order.

- The importance of the chronology as a tool to provide clarity and oversight of the support available to the family and the effectiveness of this was not recognised.

8. Examples of good practice and actioned improvements identified as part of the review.

Good practice

Permanence decisions for Child H were made timeously, and early in his life, when clear grounds for permanence existed.

There were regular LAC Reviews that did seek parenting capacity assessments and tried to ensure that Child H's plan was appropriately directly and progressed. (However, there is no evidence within the review of the Independent Chair of the Panel escalating actions which were not being progressed)

Staff from the private nursery visited the local Primary and Early Childhood Centre to pass on Child H's folder, as he had a place at the ECC and also to express their concerns about the child' [redacted] after contact visits with mother and step-father. This unusual step is to be commended and shows the level of concern the staff at the private nursery had for the child.

The Head Teacher at the local Primary and ECC took the additional step of passing on the abovementioned concerns to the Named Person (Health Visitor).

It is evident throughout the multi-agency chronology that Health staff maintained accurate and contemporaneous notes on the child and his family, including robust child wellbeing assessments. Supervision is apparent and collectively Health staff helped to provide an accurate overview of the child's health and wellbeing needs during his involvement with services.

Health staff maintained communication with social work colleagues and used AYRshare for information sharing in most cases.

Use was made by health staff, of National Risk Framework tools to support analysis of risk and decision making and there were persistent attempts to engage and meet with the family, despite parental resistance [redacted].
There is evidence of the Health Visiting team placing the child at the centre of decision making, including early identification for the need for child protection and the referral to social work. There is also frequent liaison with GPs.

Prior to the Children's Hearing on 30 August 2018, when the implementing authority was transferred from South to East Ayrshire, a named Social Worker was identified by East Ayrshire to be Lead Professional, which allowed for an early introduction with the family.

Improvements already actioned in South Ayrshire

Three Service Managers from SA are working with the Centre for Excellence for Children's Care and Protection (CELSIS) and the use of the PACE project, being the Permanence and Care Excellence Programme to improve the approach to establishing permanence at an earlier age.

Quarterly permanence meetings have been established to track progress for all children for whom permanence is considered and to ensure time scales are met for permanence planning.

Legal advice is now sought via pro-forma from legal services to establish if there are grounds to pursue permanence prior to the child's Substantive Looked After Review taking place.

Since January 2019 no child's permanence plan has or will be discussed at permanence panel without medical information being available to panel members at the time.

Following a decision regarding adoption being made by a permanence panel, the child's profile is uploaded on to linkmaker within 12 weeks of the Agency Decision Maker's agreement to the plan.

A five day permanence training programme has been established. This takes place on a rolling basis and is compulsory for all social workers and team leaders.

Foster carers views on permanence plans for the children in their care are sought during meetings, and are recorded within the minute, for example at linking meetings and permanence panels if they are able to attend.

Looked After Children Review agendas have been revised to include the requirement to consider the child's views.

The Looked After Children's review minute records the child's views and reflects them.

Assessment reports now include mandatory fields to record the child's views.

The Carefirst (social work information and casefile) system will have the ability to extract data on children's views by age, legal status, gender, post code etc. Training has been delivered on communication with Children and is mandatory for all child care staff to attend. Additional training was introduced for the Children with Disabilities team enhancing skill in communication with children with additional needs.

Training has been commissioned and delivered on attachment and improving understanding of parental relationships and the impact of attachment on child development

Policies and procedures have been updated and rolled out to staff to embed the necessity to establish future dates for Looked After Children Reviews within meetings and incorporate this within decisions and actions of the minute.

License for Viewpoint has been extended.

There has been a programme of training on permanence attended by a mixture of qualified social workers and team leaders.

An Unseen Child protocol has been agreed by CPC and is being rolled out.

Commissioning and implementation of Signs of Safety- which is a relationship grounded, safety- organised approach to child protection practice.

East and South Ayrshire

IRD Protocol has been developed on a pan-Ayrshire basis. It has been presented at all three Ayrshire COGs and approved on an Ayrshire wide basis. An implementation plan has been agreed and training will be delivered to social workers and team leaders.

The East Ayrshire Transfer protocol has been adopted and rolled out to teams.

9. REVIEW SUMMARY

[redacted]multi-faceted.

Child H has experienced services and responses to his needs that, at times, have lacked focus, purpose and urgency.

Although there are examples of good practice and positive intent, the needs of Child H have been lost in the application of systems and approaches that have not necessarily focused on his specific needs or wants. It was not child centred.

The learning issues noted in the body of the report and the recommendations and actions noted below in section 10 clearly set out the rationale for the Review Team coming to this conclusion.

In setting out the improvement recommendations the Review Team recognise the efforts of organisations to act timeously to address emerging findings as part of the review process. Examples of this are the Transfer Protocol, developed by East and adopted by South, and implementation of the programme for Signs of Safety in South Ayrshire.

It is also clear that good communication, supervision, staff support and training are key organisational and professional requirements. Staff in South Ayrshire did not feel that this was always the case. Staff require to feel supported in all that they do whilst recognising the scope and importance of professional autonomy and responsibility.

This review has identified a number of procedural and practice issues, from which multi-agency learning can be drawn and many of the issues identified have featured in previous SCLRs across Scotland.

The renewed focus on the ambitions of UNCRC, GIRFEC and anticipated publication of the refreshed National Child Protection Guidance for Scotland alongside the commitment to the outcomes of the Independent Care Review and the Promise

create opportunities both locally and nationally for review of current cultures, approaches, policies and practice.

10. PRACTICE AND ORGANISATIONAL LEARNING - focus for improvement

It has been recognised by the Review Team that individual agencies have already reflected on practices highlighted within the report and have instigated significant changes in relation to process and practice in order to address some of the concerns raised.

The key recommendations and suggested improvement actions are informed by the "why" approach.

DRIFT AND DELAY IN PERMANENCE PLANNING;

Recommendation

Permanence Planning guidance, systems and practice in South Ayrshire, have been reviewed since 2017. However, there is further need of systemic refinement and improvement to ensure children's permanence plans are subject to the correct oversight to prevent unnecessary drift and delay.

Suggested improvement Actions

South Ayrshire

- Planned audits are established in respect of: 1) are permanence decisions made, within the preceding 24 months, in the correct forum and within agreed organisational timescales, and 2) that practitioners have the appropriate supervision, support and training to undertake permanence work.
- No approval for permanence should be made without a PCA that clearly evidences the parent's abilities to meet the needs of the child through childhood.
- Staff including newly qualified Social Workers, who are not already trained, should complete the 5-day permanency training course in the next twelve months and that local guidance in respect of newly qualified Social Workers completing this training in their first year, post qualification, should be updated.

THE VOICE OF THE CHILD, MOTHER AND CARERS IN THE DECISION-MAKING PROCESS.

Recommendations

- **Children's views should be actively sought in an age appropriate manner. These views, in conjunction with those of the parents and Carers, must be considered in all decision-making forums about the child. (This aligns with the values as outlined in the Independent Care Review's, 'The Promise'.)**
- **Practitioners should adopt a Trauma Informed approach when forming**

meaningful relationships with both children and adults.

Suggested Improvement Actions:

South Ayrshire

- That annual file/assessment audits are utilised in South Ayrshire to evidence that staff are aware of when, how and why to seek the views of children, confirming those views are thereafter incorporated in the child's care planning arrangements.
- South Ayrshire CPC should ensure that front line staff are provided with the necessary training and awareness of Trauma Informed practice, specific to their role.
- When a vulnerable parent and child(ren) seek refuge, an adequate risk assessment or investigation of reasons for homelessness is undertaken by Housing services, with a view to having more permanent and suitable housing options identified, at initial presentation.

East and South Ayrshire

- As a reflection of best practice services should ensure that the views and wishes of the child are clearly recorded reflecting a right based approach linked to the national and local implementation of UNCRC Due consideration should also be given in relation to advocacy provision for parents especially where they have experienced

TRANSITION OF CASE OWNERSHIP BETWEEN AND WITHIN AUTHORITIES;

Recommendations

South Ayrshire

- **Up to date local guidance for social workers should be implemented which supports transition planning for children returning home or moving care placements**.

East and South Ayrshire

- **The Case Management Transfer Protocol in Children & Families Social Work, developed and implemented in East and South Ayrshire, is considered for national implementation.**

Suggested Improvement Actions:

South Ayrshire

- Up to date local guidance for social workers should be implemented which supports transition planning for children returning home or moving care placements.

East and South Ayrshire

- The Case Management Transfer Protocol in Children & Families Social Work, developed and implemented in East and South Ayrshire, is considered for national implementation.

ORGANISATIONAL AND PROFESSIONAL FRAMEWORKS FOR DECISION MAKING;

Recommendations

- **South Ayrshire should complete its review of Child Protection policies and procedures as soon as practicable. This should link to the national review of the Child Protection Guidance.**
- **All organisations should use the implementation of the new national guidance as an opportunity to refresh staff awareness.**

Suggested Improvement Actions:

South Ayrshire

- Decisions not following current guidance and procedures require to be documented accurately, shared with partners timeously and where there are associated actions, clearly outline who is expected to implement them, what is hoped to be achieved within what timescale and when the arrangements will be for review.
- Effective review, updating, governance and dissemination to staff in South Ayrshire of Child Protection and Looked After Review policy and procedures to be completed timeously.
- Social work supervision policies should clearly outline the need for managers to ensure that workers have the necessary knowledge and skills to undertake complex case work. A refresh of supervision policies should be undertaken.
- Standards of record keeping and the tools to support this should be reviewed. Regular audit and refresh training should be available to staff across the agencies

East and South Ayrshire

- All services should be reminded of the importance of interdisciplinary and cross organisation communication with the timeous sharing of appropriated information to assist the management of risk.
- Multi-agency training on engagement with the Children's Hearing /panel system should be refreshed.

Signed and dated by: Professor Paul Martin CBE
Review Team Chair:
Date: 06/05/2021

Appendix 1

SCLR Multi-Agency Review Team

Name	Job Title	Service / Agency
Paul Martin	Independent Chair	South Ayrshire Child Protection Committee
Craig Stewart	Interim Chair	East Ayrshire Child Protection Committee
Mark Inglis	Head Of Service, Child & Families	South Ayrshire Health & Social Care Partnership
Jackie Hamilton	Senior Manager	South Ayrshire Health & Social Care Partnership
Meg Williams	Lead Officer	South Ayrshire Child Protection Committee
William Fisher	Social Work Officer	South Ayrshire Health & Social Care Partnership
Charles Rocks	Senior Manager	East Ayrshire Health & Social Care Partnership
Douglas Robertson	Lead Officer	East Ayrshire Child Protection Committee
Amanda McHarg	Detective Chief Inspector	Police Scotland
Marina McLaughlin	Nurse Consultant for Child Protection	NHS Ayrshire & Arran
Janie Allen	Strategic Education Manager	East Ayrshire Council
Gordon Bell	Practice Reporter	Scottish Children's Reporter Administration

Appendix 2

Information Accessed by the Review Team

Files

NHS Ayrshire and Arran

- GP Electronic Records (Child H, Mother and Step-Father)
- CarePartner Electronic Records for Child H
- Hospital Medical Notes (Child H)
- Symphony Electronic Emergency Department Records
- Medical Notes (Mother)

Housing Services

South Ayrshire Council

- Social Work records on the Child H
- Social Work records on the Mother
- Social Work records on the Mother's partner

East Ayrshire Council

- Social Work records on Child H
- Social Work Records on Mother
- Social Work records on the Mother's partner

Policies, Procedures and Guidance

NHS Ayrshire & Arran

Scottish Children's Reporter Administration

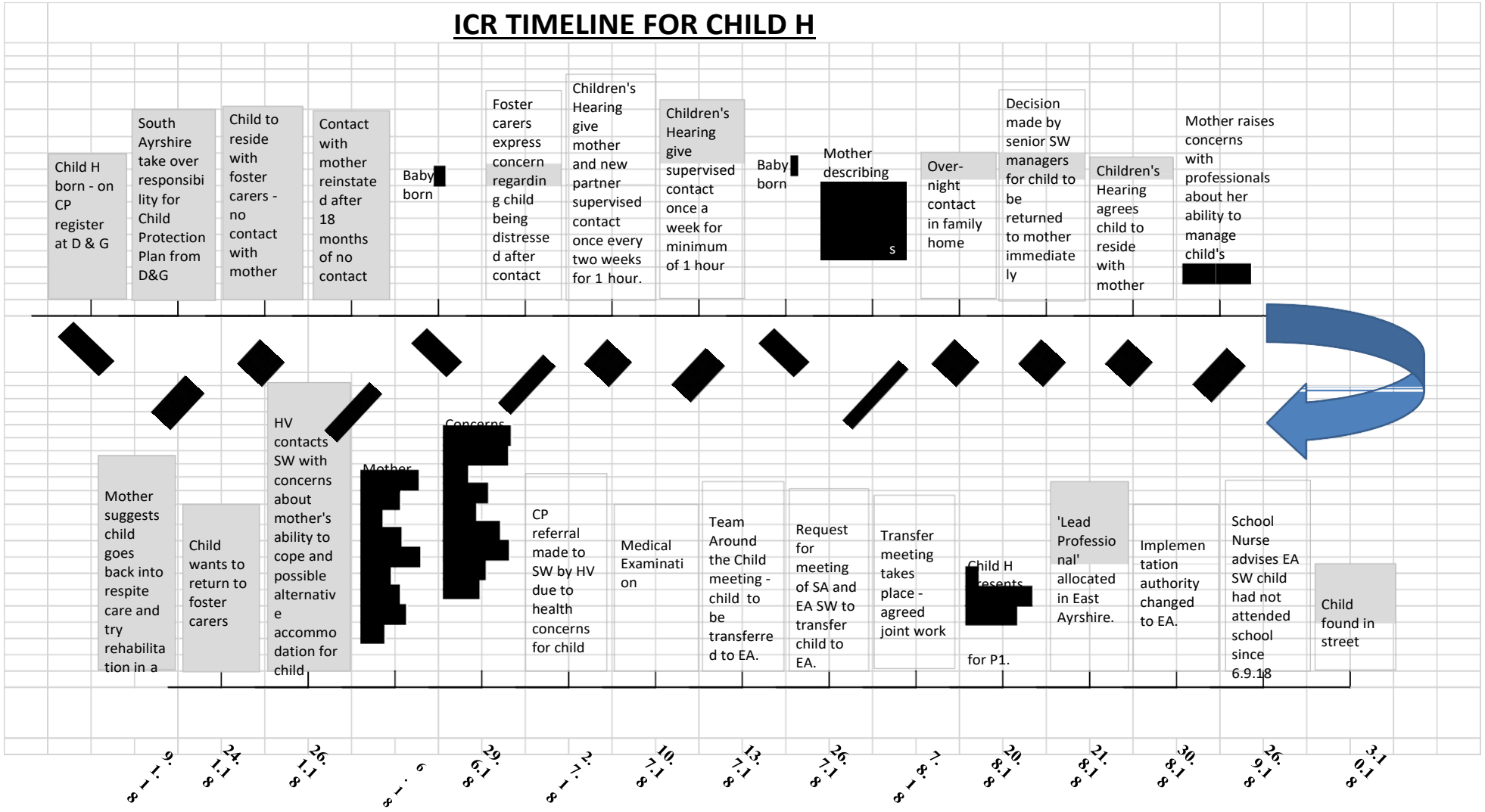
- Guidance on Referral to the Reporter (CHIP) – Information for Partners (2015)
- Hearings documentation and case notes

South Ayrshire Council Throughcare and Aftercare Services

- Throughcare and Aftercare Financial Procedures
- Throughcare and Aftercare Housing and Support Panel
- Throughcare and Aftercare Pathways Assessments and Plans
- Throughcare and Aftercare Policy

Education

Child H's records supplied by East & North Ayrshire


ICR TIMELINE FOR CHILD H
Child H born - on CP register at D & G
South Ayrshire take over responsibility for Child Protection Plan from D&G
Child to reside with foster carers - no contact with mother
Contact with mother reinstated after 18 months of no contact
Baby born
Foster carers express concern regarding child being distressed after contact
Children's Hearing give mother and new partner supervised contact once every two weeks for 1 hour.
Children's Hearing give supervised contact once a week for minimum of 1 hour
Baby born
Mother describing
Over-night contact in family home
Decision made by senior SW managers for child to be returned to mother immediately
Children's Hearing agrees child to reside with mother
Mother raises concerns with professionals about her ability to manage child's
Mother suggests child goes back into respite care and try rehabilitation in a
Child wants to return to foster carers
HV contacts SW with concerns about mother's ability to cope and possible alternative accommodation for child
Mother
Concerns
CP referral made to SW by HV due to health concerns for child
Medical Examination
Team Around the Child meeting - child to be transferred to EA.
Request for meeting of SA and EA SW to transfer child to EA.
Transfer meeting takes place - agreed joint work
Child H
for P1.
'Lead Professional' allocated in East Ayrshire.
Implementation authority changed to EA.
School Nurse advises EA SW child had not attended school since 6.9.18
Child found in street
9.1-8
24.1.18
26.1.18
6-8
29.6.18
2.7-8
10.7.18
13.7.18
26.7.18
7.8-8
20.8.18
21.8.18
30.8.18
26.9.18
31.10.18