SCIE Learning Together

social care institute for excellence

Report of the Significant Case Review carried out by Highland Child Protection Committee - Child S

Executive Summary

May 2018

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Reason for Case Review

Child S's mother and her oldest children became known to Care and Protection services in early 2015. Concerns had accumulated, particularly about the risks of neglect and substance misuse and the mother had recently begun a new relationship. The older children had their names placed on the Child Protection Register in February 2015 after mother and her new partner were deemed unable to care sufficiently for them due to their lifestyle and substance dependency.

Later that year the home situation deteriorated further to the point where the older children were placed in temporary foster care under section 25 Children (Scotland) Act 1995. A referral was made to The Children's Reporter but the decision was taken not to proceed to a Children's Hearing.

After the children were taken into foster care, their mother and her new partner appeared to begin to co-operate with services. The children were returned to their mother's care following the decision not to proceed to a Hearing. It became known to professionals at this point that mother was pregnant again.

Although mother was assessed as a high risk pregnancy, no pre-birth assessment was completed for unborn S until shortly before birth. Following best practice and procedures within Highland, the plan was for Child S to be born in Raigmore Hospital, Inverness. Mother then went into labour prematurely, an emergency delivery took place locally then mother and baby were transferred to Inverness.

Child S was discharged home at 9 days old. At 30 days old he was referred and admitted to Raigmore Hospital, Inverness following a routine visit from health visiting staff and examination at the GP practice. Injuries were recorded as being consistent with violent head injury and no explanation was offered by Child S's mother.

As a result of these injuries, the older children were subsequently accommodated by the Local Authority.

REVIEW SCOPE AND RESEARCH QUESTIONS

The period that Highland CPC agreed should be the primary focus of the SCR begins in January 2015 and ends in February 2016.

Learning Together Reviews focus on recent time periods in order to support the aim that systems findings and learning related to operational, strategic and leadership arrangements are relevant in the present day. This also maximises the chance that information can be gathered from the people who are involved in the case during the period being reviewed.

Events that occurred prior to the above dates were not subject to the same level of detailed scrutiny, and were considered only as pertinent to the wider context in which the period subject to review took place.

All Learning Together reviews are framed around case specific research questions which are directed towards the learning about practice within the wider system that the commissioner, in this case Highland CPC, hopes to achieve through the review process. In this review the CPC agreed to consider three broad research questions with the Lead Reviewers. These were:

1. *What can this case tell us about what helps or hinders the quality of practice around ante-natal planning in Highland?*

2. *What can this case tell us about the effectiveness (or not) of the maternity discharge processes in Highland?*

3. *How effective are professionals in recognising and responding to the needs and risks in non-mobile babies?*

METHODOLOGY

Learning Together reviews take a systems approach to understanding the current practice realities for agencies as they work together to protect children and to identifying learning about what is working well and where there are difficulties. The aim of such reviews is to use the review and analysis of practice in a single case (i.e. what happened and why) to gain insight into underlying patterns that either support good practice or make poor practice more likely. Learning Together reviews therefore aim to produce generic or generalised findings or lessons that will support learning and improvement across the multi-agency child protection system as a whole.

Findings of Review and CPC Response

This section identifies what this review has told us about the effectiveness and impact of multi-agency strategies and interventions for children and their families. As with all cases there are unique factors which relate to the children and their parents and carers. However, in carrying out the SCR it is necessary not only to understand what happened and why in this particular case but to go further to reflect on what it tells us about future cases and what we can do to be more effective in protecting children placed within their extended family. The case acts as a 'window on the system', (Vincent 2004: 13).

The findings of the review provide an insight into the underlying patterns that influence professional practice and outcomes for children. The systems model developed by SCIE includes six broad categories of these underlying patterns. The ordering of these in any analysis is not fixed and will change according to which issues are felt to be most fundamental for systemic change. The categorisation of the findings is as follows:

1. Innate human biases (cognitive and emotional)
2. Family-professional interaction
3. Responses to incidents
4. Longer term work
5. Tools
6. Management systems

Finding 1

Are there sufficient resources available within the Family Team to provide assurance that risk to children and families is effectively identified and managed?

The Family Team has a pivotal role to play in a multi-agency response to safeguarding vulnerable children and families. The consistent availability of experienced, qualified staff is essential along with the accountability for caseloads and supervision provided by appropriate practitioners, with the required skills and experience.

This Finding has no easy solution and highlights a vulnerability within the system which will almost certainly be long-standing. This does not make it any less worth revisiting, particularly since it was the issue that practitioners involved in the review felt most strongly about.

Questions for the CPC to consider

- **How assured is the CPC that the current resources available to the Family Team are flexible enough to meet the demands both of the complexity of the work and the geographical context?**
- **What kind of risk management tools are in place to monitor the fact and impact of staff absence due to sickness, to make sure that any negative impact on staff and on families is identified early?**
- **Are there specific contingency plans, in the event of the absence of a social work practice lead, for cover to be provided by an appropriately experienced social work practitioner?**
- **Has there ever been any canvassing of families for their experience of Care & Protection services?**
- **What options are available to the CPC to support member agencies to address any acknowledged shortfall in resources?**

Finding 2

Are supervisory arrangements in the Family Team functioning effectively enough to guide, support and challenge the quality of social work leadership of the multi-agency Child Protection process?

"Effective supervision is the cornerstone of safe social work practice. There is no substitute for it": (Lord Laming, Public Inquiry into the death of Victoria Climbie 2003). Good quality, regular supervision is essential in supporting effective and reflective practice. It is crucial in supporting individuals in the challenging work that they do. Research demonstrates that regular and effective supervision is associated with enhanced skills, improved resilience, reduced burn out, increased staff retention, improved case load management and better decision making as well as job satisfaction and organisational commitment *(SSSC 2016)*

The challenge for Highland is to figure the degree to which the breakdown in the line management and supervision in the Family Team at a particular point in time has had a negative impact that is long-lasting and through what kind of quality assurance mechanisms they can monitor the effectiveness of efforts to turn the curve.

Questions for the CPC to consider

- **Was the Child Protection Committee (CPC) aware of this issue and if so, has this finding provided a different perspective?**
- **Does Highland Practice guidance place enough emphasis on unborn and non-mobile babies when it considers risk assessment?**
- **What kind of processes are in place to measure the quality of supervision across Family Teams?**
- **To what degree are managers supported to enable staff to be reflective?**
- **How might practitioners and managers be involved in the solution-finding around this Finding?**

Finding 3

There is a tendency for professionals to "label" how a parent presents too prematurely, too frequently and without thorough assessment, which is impacting directly on the quality of analytic thinking in case work and is not being picked up in supervision.

Research coined the term 'disguised compliance' by parents to describe one of a number of common behaviours that workers should be alert to and indeed predict. Other terms coined by the same research include 'start again syndrome' and 'toxic

trio' – referring to ways that mental ill health, domestic abuse and substance misuse often occur simultaneously in a child's life, with toxic consequences. While such terms are helpful for social workers to hold in their minds while assessing child wellbeing and reflecting on their own practice, there is a danger that they become over and mis-used, with the result that instead of a holistic assessment of individual circumstance, families become too quickly labelled as being this or that, disguising their real needs.

The professionals in this case referred to the parents as 'disguised-compliant', without a proper exploration of what this term meant. While attendance at Planning Meetings and Core Groups was generally good, in reality, neither adult was complying with tasks, was not disguising this fact and was openly resistant to implementing change. This did appear to change once the children were taken into foster care in June but there was later little professional consideration of what impact the return of the children might have i.e. how far could apparent change for the better be sustained. The adults' response to supportive intervention was superficial with a tendency of workers to instruct change rather than think through how to most effectively address particular behaviours and risks with family members themselves. There should have been greater analysis and consideration of the behavioural patterns associated with drug and alcohol use and the actual ability of the mother and her partner to comply with instruction, even if they genuinely wanted to.

This Finding highlights a particular human bias that was not picked up or challenged in supervision and persisted even into this review as a description of mother's behaviour. One reason practitioners and supervisors may be unusually susceptible to confirmation bias, is that they have to make decisions quickly, often with inadequate information. If there are shortcomings in the ways in which they are supervised or supported to then reflect on the nature of the evidence, initial impressions can easily develop into beliefs and become shared. Confirmation bias ensures that these beliefs will be difficult to shift.

Questions for the CPC to consider

- **Does the CPC recognise this Finding?**
- **Is the CPC assured that appropriate training, guidance and tools are made available to support professionals, at an individual, team and service level and across all agencies, in critical thinking? How is critical thinking tested?**
- **In what ways are managers supported to enable reflective practice?**

Finding 4

Do arrangements for monitoring the quality of professional conduct and practice in the different areas of Highland place too much faith in geographically isolated Area Managers, at the expense of targeted checks and balances?

A safe system to protect vulnerable children works most effectively if it operates a 'learning' culture, where everyone feels supported to carry out a difficult and complex job. Creating such a culture relies on paying attention to the 'view from below' (Dekker 2017) (view of practitioners), so that any difficulties are discussed openly and concerns raised by practitioners are listened to and appropriate action taken. Disclosure of error becomes not only possible, but acceptable. The perspectives of frontline practitioners or families at the receiving end of their services can provide an insight into local conditions. This more qualitative, experiential data is arguably much more informative than whether an assessment is completed within a timescale, as it will indicate the health of teams, services and organisations. A healthy team or service culture is in turn more conducive to good, careful and caring practice.

One of the main components of the Highland Practice Model is the integrated service delivery structure at an area level. Family Teams are an integral part of that structure and are managed by a District Manager who in turn reports to the Children's Services Manager for health & social care. The Review found that the geographical area can have an impact on:

a) the frequency of meetings together and/or with senior managers;
b) meetings which can easily be disrupted by weather and road conditions
c) the way in which area based managers support delivery of local services

The size of Highland makes area management arrangements inevitable and the rationale for the current organisational structure has clarity and logic. This Finding is not a criticism of the Highland Practice Model. However, given the geographical spread of population to be served in Highland, senior managers need assurance that the culture of practice in the areas is healthy and effective and that they will be alerted to any concerns in a timely way. For this, they rely mainly on feedback from area based managers and on quantitative data collected against specific indicators or as part of a programme of audit.

Questions for the CPC to consider

- **Was the Child Protection Committee (CPC) aware of this issue and if so, has this finding provided a different perspective?**
- **How might an 'area culture' be tested?**
- **How might practitioners be involved in the solution-finding around this Finding?**

Finding 5

There is a difference in professional understanding of what constitutes a well-evidenced argument for statutory measures in neglect cases that is risking an impasse between SCRA and referrers, potentially placing children at greater risk of significant harm

The Children's Reporter, in conjunction with the Children's Hearing process, holds significant and independent responsibility for making decisions about children's lives. Professionals making a referral into SCRA need to understand how to present evidence that will support any Grounds that may be available for the Reporter to consider.

The Children's Hearing System in Scotland is governed by the Children's Hearings (Scotland) Act 2011 and acts as a care and justice system which aims to ensure the safety and wellbeing of vulnerable children. A child is referred to the Scottish Children's Reporter Administration (SCRA) because an aspect of their life is giving cause for concern sufficient to consider statutory measures to protect them. A Reporter will receive referrals for children who are believed to require compulsory measures of supervision. The Reporter then reviews whether the child or young person should be referred to a Children's Hearing by assessing if there are legal grounds to do so and if a compulsory supervision order is needed.

Although the Reporter at the time was no longer in post at the time of this review, the feedback received from SCRA was that the way the referral was presented made it difficult to see what the actual risks were to justify taking the case to a Hearing. In other words, the evidence for professional concerns was not presented clearly enough. The problem of evidence presentation was compounded because there had been no written assessment or Child's Plan prior to this point, so the evidence that formed the referral to the Reporter had to be constructed quickly and without reference to supporting documentation.

Questions for the CPC to consider

- **Is the CPC assured that there are no unnecessary delays for cases being referred to the Reporter as a result of practitioners assuming they will be 'rejected'?**
- **Are the CPC aware of the number of referrals (and in particular in relation to neglect) that do not progress to a Hearing because of insufficient evidence?**
- **What is the most effective way to ensure practitioners and the SCRA are in agreement on evidential requirements for Hearings (and in particular for cases of neglect)? Could SCRA do more to educate referring professionals?**
- **How does the CPC assure itself that practitioners are sufficiently trained and competent in completing referrals to the Reporter which are clearly weighing up evidence to justify progression to a Hearing**

Finding 6

The different communication lines between, and within, agencies at the point at which babies on the CPR are discharged home from Raigmore hospital constitutes a system's vulnerability for Highland unless there is shared clarity around who does what and a process for quickly checking whether they have done.

The absence of a pre-birth assessment and Child's Plan had a direct impact on the kind of information available to staff in Raigmore and the local hospital. Despite this, Child S was on the CPR and as such, notice of his discharge home should have been received by everyone with a need to know at the time, but it was not. There are some quick wins to safeguard against this happening again, but updating procedures will not necessarily address the human factor which can unintentionally undermine them and it is important to stress that. It is not realistic to expect any process involving communication to be 100% foolproof, but it should nevertheless be possible to reduce margins for error where communication lines vary and are multiple.

Questions for the CPC to consider

- **To what degree might communication between and within agencies at the point of discharge from hospital leave room for error, even with a shared Child's Plan?**
- **Has there been any analysis of the kind of variables that might affect the reliability of information transfer?**
- **What are the implications for the kind of procedures/guidelines that require clarification and update across a number of different disciplines?**
- **Do they require explicit contingency plans?**
- **How might the current electronic recording systems be improved in order to give people from different disciplines who need information about the same child, access to each other's email addresses? Are shared systems a possibility?**
- **Are the Named Person responsibilities to coordinate communication clear enough at the point of discharge**?

Additional Learning Points - Facial bruising in babies

There was a point in this case, soon after S's birth, when a Health Visitor noticed a mark on S's face when she made a home visit. She rightly recognised the potential for this to be indicative of rough handling or a lack of supervision and was worried enough to raise it with her colleagues. There was doubt at the time as to whether or not the mark was a bruise. Had it been, the Health Visitor's concerns are likely to have been escalated but because it was unclear, the benefit of doubt was given to the parents.

Given the fact that S was on the Child Protection Register this was the wrong call, but the issue has not been made a systems Finding because it is not clear enough that there is a lack of understanding of the significance of facial bruising that might affect multiple cases. However it does raise the following questions around which the CPC might want to seek assurance:

a) **Is there confidence that all hospital and community health staff are aware of risk indicators for non-mobile babies and the possible significance of facial bruising in particular as being indicative of physical abuse?**
b) **To what degree do non-health visiting staff understand risk indicators for non-mobile babies – i.e. any professional who might visit the home – are they alert to what they might see and curious enough to follow through?**
c) **Do current procedures give the right emphasis to balance of probability decision-making when babies are on the CPR?**

Conclusion

This review has determined issues around the quality of response and assessment to risk and the quality of practice around planning that were stark around the ante-natal and post-birth planning for Child S, but which have a reach well beyond pre-birth and non-mobile babies. The Findings point to a culture of practice at the time that affected the operation in particular of social work practitioners who were Lead Professionals, against the background of the challenge of geographical context that Highland has perpetually to address: the impact of size, distance and weather on what is possible. Much of the learning about practice at the time was already highlighted prior to this review and there is no reason why the remedial mechanisms Highland are putting in place already should not be effective, but once a way of thinking about things takes hold it can be difficult to shift. For this reason, the Reviewers feel that known vulnerabilities have been worth stressing in order that mechanisms to assure quality continue to take account of them.

Learning from Significant Case Review
Highland Child Protection Committee Chair Summary

Cases where children have suffered significant harm are emotive and upsetting for all affected including practitioners and the wider community. Highland Child Protection Committee members are pleased that Child S continues to recover and is meeting all his developmental milestones.

As with all Significant Case Reviews (SCRs), this report has identified a number of improvement areas where agencies involved can learn from what happened. The reviewers suggested six key findings and a number of these are already being addressed by affected agencies with assurances being sought by Highland Child Protection Committee that the necessary improvements to practice are achieved.

This review highlighted the difficulties associated with large rural areas which are often difficult to recruit to and where practitioners spend a lot of their working time travelling to visit families and attend associated meetings.

Highland Child protection Committee members have met with practitioners working in rural and isolated communities to discuss the unique issues directly affecting them and measures have been put in place by Highland Council to ensure effective support and supervision in child protection cases locally. This will be followed up by Highland Child Protection Committee roadshows to share learning and discuss local issues across Highland in early 2019.

Highland Child Protection Committee child protection training has been updated to enhance risk assessment and management sections, and work is ongoing with the Scottish Children's Reporters Administration to ensure that practitioners are supported to develop effective plans for children in need of compulsory measures. Highland Child Protection Committee has supported the introduction of the Graded Care Profile 2 risk assessment tool to support practitioners involved with families where concerns around Neglect are identified.

Working with parental substance misuse, domestic abuse and/or mental ill-health is complex and it is important practitioners are supported to understand and respond to family dynamics effectively.

Highland Child Protection Committee has developed information and training to support practitioners to recognise signs of 'non-' as well as disguised compliance. Good quality and reflective supervision will help practitioners make sense of their hypotheses and review these regularly. NHS Highland has also developed a policy on 'Managing of Bruising and Injuries in Non-mobile Children'. This has been disseminated to practitioners and is available on the CPC website www.hcpc.scot.

I am hopeful our Highland communities are reassured that through the work of the Highland Child Protection Committee and partners that learning points from this review are being addressed and implemented by child protection agencies in Highland.

The Highland Child Protection Committee is committed to continuous improvement. Every child and young person in Highland should be protected from abuse, neglect and harm by others at home, at school and in the community. The Committee will continue to work with child protection partners in the public and 3rd sector across Highland to support a collaborative approach to improvement, promotion of good practice and quality assurance of child protection practice.

DCI Vince McLaughlin, Chair, Highland Child Protection Committee