East Lothian and Midlothian
Public Protection Committee

Learning Review
Family B

February 2025

Introduction

This Learning Review relates to a large family of several children, the oldest under the age of 12 and the youngest newborn. The children experienced significant neglect resulting in them being placed in a foster placement with parental consent. The family had moved into the Local Authority area a year before and were known to Universal Services but had no statutory involvement. All professionals (involved at the point the children were removed) advised this situation was the worst case of neglect that they had witnessed in their careers to date in terms of the presentation of the children, general home conditions and pets. A Learning Review notification was received in January 2023 and, after requesting further information from all agencies involved, the decision was made to undertake a Learning Review as it was agreed it met the criteria, specifically:

When a child has died or has sustained significant harm or risk of significant harm

and there is additional learning to be gained from a review being held that may inform improvements in the protection of children and young people

and

Abuse or neglect is known or suspected to be a factor in the child's death or the sustaining of or risk of significant harm.

National Guidance For Child Protection Committees Undertaking Learning Reviews

Process of the Review

This Learning Review adopted a systemic approach in accordance with the National Guidance for Child Protection Committees Undertaking Learning Reviews. This approach allows for a focus on learning for future practice. It involved analysis of summary reports from each agency in relation to their involvement, a meeting with the parents, a practitioners' and managers' event and further analysis and reflection by a multi-agency Review Team. The detail and context of agencies' work with this family was explored. The output of the Review is intended to generate professional and organisational learning and promote improvement in future multi-agency Child Protection practice.

The Review Team

A Review Team was convened to guide the process. It was chaired by a Senior Manager from a neighbouring Local Authority (to allow for independence) who worked in partnership with the Reviewer (Child Protection Lead Officer) in leading the Review. The Review Team included representatives from NHS Lothian, Police Scotland, Education and Children's Social Work.

The Review Team met four times. The National Guidance was followed in spirit and process, and the Review Team was clear from the start that this was not an inquiry into how the children were harmed and suffered neglect or to apportion blame on any individual or service. An emphasis was placed on supporting staff to engage and reflect within the process to ensure maximum 'buy-in' and establish learning themes and strategies for future practice. An on-line briefing was delivered for all staff invited to the two Learning Review Events (Practitioners and Strategic Managers). The purpose of this was to allow staff to gain an understanding of the Learning Review process, hear a brief overview of the case, give staff the opportunity to ask any questions and generally help them to prepare for the events and alleviate any anxieties that may exist.

Two Learning Review Events were held as part of the review process, one for Practitioners and one for Strategic Managers. The Review Team carefully considered and identified the practitioners and managers to be invited to these events and had representation from Education, NHS, Children's Social Work and Police.

The events were structured around the following questions:

- What were the challenges for you and your service?
- What went well?
- Voice of the parents – feedback from family engagement
- What could have been done differently?
- What are the learning themes and strategies moving forward – what needs to change?

The Report

This report is based on the underlying principles of proportionality and objectivity and was informed by the multi-agency information gathered following the initial Learning Review notification, the reflections and discussions with the parents, practitioners and strategic managers who attended the practitioner and strategic manager events as well as on-going discussion, reflection, and analysis by the Review Team.

The purpose of the learning events is to "…bring together key staff to reflect and learn from what has happened in order to improve practice in the future".

National Guidance For Child Protection Committees Undertaking Learning Reviews (www.gov.scot)

The Time Frame

The time frame of the Learning Review was agreed by the Review Team as the period when the family were living in the local authority area, during 2022. It was agreed this would allow the Review to gain an understanding of the family's interactions with services leading up to the children's removal. In light of this, there was agreement that information from the

previous Local Authority was not required to inform the Review, however, contact would be made with them once the Review was concluded to advise of any relevant learning.

The Circumstances that led to the Learning Review

Health professionals made a referral to Children and Families Social Work in December 2022 due to concerns about neglect, which were picked up during post-natal visiting to the home. This triggered a joint visit between Social Work and Health Visiting. This was the first time Social Work and Health Visiting had been in the family home. The home conditions were significantly unhygienic and were not suitable for children or pets to be living in. The children's' physical and emotional presentation was concerning, and they had unmet health needs which required them to need to be medically examined and treated. Police attended the family home to investigate the circumstances and an Inter-agency Referral Discussion was instigated in accordance with Child Protection Procedures. The children were placed in foster care with parental agreement. The animals were removed from the home.

Information known by services

Universal Services identified the family as being in need of support, both in the previous and current Local Authority areas.

There were delays in Universal Services transferring notes when the family moved Local Authority areas, and delays in notes being reviewed post-transfer.

There were some indications of neglect when the family was living in the previous Local Authority area – this included issues about attendance at school, the children's physical presentation, missed appointments with health professionals, tooth decay, toileting problems. These issues featured in the current Local Authority area.

The children were not seen by a Health Visitor in the year the family was living in the current Local Authority area. Arranged visits were cancelled by the family or professionals.
No professional had been in the family home in the past year until initial post-natal visits following discharge home after birth.

The mother had physical and mental health conditions; however, these were not explored further to ascertain the impact on parenting of a large family with differing and significant needs. The father worked long hours which impacted on his capacity and availability to parent.

There were no Team Around the Child Meetings instigated in relation to this family.

Engagement with Family Members

The Reviewer and the Chair met with both parents prior to the Practitioners' and Manager events. The children were not spoken to as part of the Review process but were being

supported by their Social Workers who gained insight into their views and experiences of family and home life.

The voice of the parents – reflections on their circumstances at the time

Both parents described the identified time period as being 'very difficult', 'challenging' and 'feeling isolated'. They had moved from the previous Local Authority for a 'fresh start' as well as wanting to be closer to Mr B's job as he had been doing considerable travelling. They felt they were 'past the stage of asking for help' and knew things were not good enough and felt a real sense of shame. They talked about their own experiences of Social Work as children and how this negative understanding and fear made them work hard at keeping professionals and services from getting through the door. Mrs B advised of the challenges within the pregnancy, remembering feeling exhausted trying to keep the family going at the same time as preventing too much professional attention. Mr B was working long hours meaning Mrs B was the main carer.

The voice of the parents – what they felt would have helped at the time

Being open and saying if things are not good at the time – they talked about the need for open and transparent communication. Whilst they acknowledged they might have responded defensively at the time, in the long run it would have been better as the extent of their situation would have been detected sooner.

Keep asking to visit and be persistent – they acknowledged that they cancelled appointments but at the same time so did the professionals which in some way made it easier to cancel and for more time to have gone past.

Relationships – making time, asking questions and getting to know them and the children. Often conversations were focused on one particular issue or child rather than probing for more information on the family background or general family functioning.

Creating an environment where there is no judgement – the parents talked about how they have often felt a sense of judgement from professionals over the years. They talked in detail about a more positive recent example where they have a good relationship with staff, communication is good and they do not feel judged, even when more challenging conversations need to happen.

Checking in with the children – the parents talked about how no one seemed to ask the children how things were. They acknowledged the children were aware of their parents' fear of services and might not have disclosed the extent of what their home life was like, but it might have helped instigate support sooner.

Context and complexities identified within the family situation and background

In order to fully understand this situation, it is important to gain a sense of the context and level of complexities within this family situation. The family had moved to a new area where they felt isolated and had no informal support networks. The parents advised this was particularly challenging as they did have support in the previous Local Authority where they lived from both maternal and paternal extended families. This was exasperated further through the lack of timely information sharing between Universal services. For example, Health Visiting, School Nursing and School records took considerable time to transfer. There was limited consideration (at the time) of the impact of Mrs B's health condition in the context of her pregnancy and parenting capacity of an already large family where there were issues around poverty and poor parental mental health.

The Practitioners' and Manager events highlighted issues around how the parents' previous experience of Social Work involvement acted as a barrier to asking for help and support. It also came to light that Mr B is neurodivergent, which was not known until the Social Work assessment within the Looked After and Accommodated Child Process took place. This raises questions around assumptions being made about his behaviour and engagement, particularly at the point when the children were accommodated. For example, he left the house and sat in the car while Social Work, Police and Health were in the house which could have been misinterpreted as disengagement rather than a coping response associated within his condition.

Effective Practice

There were some examples of effective practice identified prior, during and after the initial Child Protection concern was escalated.

The parents identified that the support from School during holiday periods in the form of vouchers for activities and food were helpful. They added that it was less about the financial aspect and more about being able to give the children nice experiences.

Children's Duty Social Work Team responded in a timely manner once Child Protection concerns were raised and instigated a joint visit with the Health Visitor.

There was evidence of experienced, confident and skilled professionals successfully negotiating their way through the door of the family home and explain their concerns in a trauma informed sensitive way. This enabled the anxieties of the children and parents to be contained as well as laying the foundations for good relationship-based practice. The parents advised of their appreciation of this despite it being a very challenging time and has allowed them to build trusting relationships with Social Work and engage in the assessment and intervention.

Once accessing the family home and acknowledging the severity and extent of the neglect an Inter-agency Discussion (IRD) was convened in a timely manner. Within this there was a clear sense of multi-agency unity to support the children and their parents. This has continued and been maintained throughout the Looked After Children review process.

Practice and Organisational Learning

The section below identifies the themes emerging from the Review and the learning that can be gained from them. They have been informed by the practitioner and manager events, along with further reflection and analysis by the Review Team.

Use of GIRFEC – information sharing and use of chronology

This Review highlights the importance of timely sharing of information, particularly when children move into a new area to ensure Universal Services in the receiving area are aware of any previous Child Protection or wellbeing concerns. The GIRFEC practice model is the starting point for any assessment in ensuring a comprehensive understanding of the needs of the child and their family situation. It allows practitioners to see life through the child's eyes, gather and share information and work collaboratively with other agencies in order to gain a picture of their everyday experiences and need.

The impact of neglect is often cumulative and progresses gradually without being fully recognised. Lack of recognition and earlier intervention by agencies can place children at risk of harm. Assessments by all services need to be holistic, viewing the wider family functioning rather than a focus on one child or adult.

> "Children should get the right help, at the right time, from the right people (GIRFEC). Early interventions through Universal Services and multi-agency supports can provide proportionate responses to reduce the risk and impact of harm before a Child Protection intervention is required."
>
> Edinburgh and the Lothians Multi-Agency Child Protection Procedures

Challenges recognised within this Review highlighted the complexity of multiple recording systems, particularly in Health, where information has to be sought from different systems. Different agencies had different pieces of information. For example, information around previous lack of engagement with Health services (Health Visiting and School Nursing), concerns of neglect, school attendance, concerns around poverty, and cancelled appointments were known but not brought together in order to recognise the signs or patterns early enough and allow for the bigger picture in terms of both a multi-agency and whole family lens. It was acknowledged that use of chronologies would have allowed for patterns of potential neglect to be recognised and responded to earlier.

There was assurance around the family being viewed as 'core' by Health Visiting at the point they moved into the area. Earlier multi-agency assessment and information sharing could

have highlighted that the allocation of the health plan indicator was not representative of the needs of the children/family (large young family, previous concerns, isolation, school attendance issues and current pregnancy). It was later ascertained that a multi-agency meeting had taken place in the previous Local Authority (instigated by the School), but the purpose and outcomes of this meeting were not recorded or flagged by any agency in the transfer of information when the family moved.

Learning Points

- Recognising the signs and patterns of neglect at an early stage and having confidence to share that information with other agencies. There should be consideration of when inter-agency escalation is required to identify emerging issues and possible unmet needs to address issues before they become more severe and lead to children having to be accommodated away from their parents and home.
- Responding and monitoring missed appointments - what actions need to be taken? Do other services need to be made aware?
- Ensuring the timely sharing of information within Universal Services when a family moves into the Local Authority, reviewing that information and ensuring different recording systems (on-line/paper) do not act as a barrier.
- Effective use of chronologies and for this to be integrated into practice as a tool to support assessment, analysis and planning (both on a single and multi-agency basis) particularly where there are wellbeing concerns.
- Knowledge of local early intervention support services – being aware of what is available and how to refer.
- Promotion of a whole family lens - ensuring all services are alert to the wider family needs.

Recognising and Responding to Neglect – the complexity of thresholds

The Review highlighted challenges around thresholds in identifying and responding to neglect which may have contributed to assumptions made by services that the circumstances of this family did not reach a multi-agency threshold for intervention. The catchment area of the School the children attended was recognised as a socially and economically deprived area with large numbers of pupils experiencing poverty. This may have acted as a barrier in specifically identifying the indicators for both support and protection as the children did not particularly stand out within the school community in terms of their presentation and behaviour.

Health services also recognised this challenge when working within socially and economically deprived areas. Within these situations professionals can become ‘complacent’, normalise what they see or struggle with ‘what is good enough’. Many services were involved in light of the ages and stages of the children and there may have been an over-reliance on another agency taking action giving a false sense of security that things were okay.

"A disproportionate intensity of child protection interventions occur in the most materially deprived neighbourhoods. This indicates a need, not only to 'think family' but to think beyond the family, addressing patterns of concern and supporting positive opportunities in communities."

National Guidance for Child Protection in Scotland 2021

Learning Points

- Whilst we know families in poverty do not always experience neglect, we do know that they are linked in terms of systemic stresses and can be an indicator that a family needs support.
- Being aware of children who are more vulnerable to neglect – in this situation, newborn and premature babies and children with additional support needs.
- Use of the EMPPC Risk of Neglect Toolkit can help to ensure a consistent multi-agency approach to thresholds for neglect both in recognition and response.
- Considering joint visits to support assessment and early identification of need within complex situations can be beneficial.
- If in any doubt about a potentially neglectful situation seek advice/consultation within or out with your service.

Recognising disguised compliance and use of professional curiosity

Within this situation Mrs B developed good relationships with some professionals out with the home (School staff and Midwifery) while at the same time keeping others (Health Visiting) out of the home. Engaging with some professionals and making sure one goes well, for example – ensuring Midwifery clinical appointments were kept, successfully diverted the focus away from seeing the 'bigger picture' of what was happening in terms of the home conditions deteriorating.

On reflection Midwives and Neonatal Nurses recognised the need to 'see past their initial service/team focus', ask questions to gain a picture, explore a wider family approach/lens, make less assumptions, have difficult conversations and not take information at face value. There was awareness of the need to consider 'disguised compliance' and the different ways this can present. There was also acknowledgement that the Covid pandemic has changed practice, for example Midwives/Neonatal Nurses no longer move out of one room to wash their hands, they now carry hand gel. In this situation, moving out of the living room and into other areas of the home, for example the bathroom or kitchen, would have given more insight to the significant poor home conditions.

Learning Points

- Disguised compliance can present in many ways to hide potential risk and give a true picture of the child's experiences. All practitioners need to be able to recognise when this happening and identify what action is required.

- Professional curiosity is the capacity to explore and understand what is happening within a family rather than making assumptions or accepting things at face value, applying critical evaluation to any information received and maintaining an open mind.
- The best predictor of the future is looking at the past – chronologies help to recognise patterns and gaps and consider the reasons for this. This in turn can help to instigate information gathering and sharing with other agencies involved with the family.
- Acknowledging and acting on 'gut' feelings in terms of considering what further information is required and consider what else might be going on in this situation.
- It is important to identify and explore what is not discussed as much as what is through use of critical thinking, sensitivity and persistence.

Child and family engagement

Children are often aware of the difficulties and challenges their parents face but generally do not understand or recognise that they are being neglected. In this situation very little is known about the children's views, their daily experiences and whether they fully recognised the impact their home circumstances were having on them. The Social Work assessment indicated that whilst the home conditions were poor, the children were very much loved and nurtured which fits with their emotional presentation at School. For example, their behaviour never initiated concerns at School, they were seen as children who were polite and engaging. One child attended a School trip, their parents ensured they were fully prepared in terms of clothing and equipment and were engaged throughout with no concerns being highlighted. While this was positive, it masked neglect being detected and a sense that things were okay at home.

In this Review, the parents were clear they knew they needed help to prevent problems from escalating, but for many reasons (shame, fear, not knowing what support was available) found it hard to ask for help. The parents actively kept professionals away from coming to the home through cancelling appointments or going to the School or meeting staff in the car park to collect the food parcels despite having the offer for them to be dropped off at home. No professional accessed the family home until Health professionals visited following the birth as part of their focused role. Within this, contact was restricted to the living room and was significantly task focused with a clear operational purpose on the physical health of a newborn.

Learning Points

- Children rarely disclose that they are being neglected. It is important for any professional involved with children and families to be alert to the early signs of neglect and be responsive.
- Seeking the views of the child and seeing the child in their home is crucial in understanding their lived experiences.

- Seeking to understand the impact of physical and emotional health conditions on parents to gain insight into coping strategies in both the short and long term is required to assess the level of support that may be required.
- Promotion of a whole family lens to ensure all services are alert to recognising unmet needs of all children as well as the wider family functioning and needs.

Learning and Development

All services, particularly Health, recognised the need to fully utilise the multi-agency training that is available on neglect in terms of recognition and response and have opportunities to learn and gain professional confidence around understanding disguised compliance and how it can present. Other areas that were identified as being associated with neglect were professional curiosity, developing skills around managing challenging conversations and working with families who find it hard to engage. There was also recognition of the need for services to better understand the roles and responsibilities of other agencies and there was a sense there can be limited opportunities for this in light of capacity and service pressures.

The change in the learning and development landscape post Covid was also highlighted as a challenge in terms of less opportunities for staff shadowing other professionals, peer reflection and face-to-face training (locally we were just moving back to face-to-face training in early 2023).

The benefits of bringing together professionals on a multi-agency basis to reflect and de-brief on their practice was highlighted within this learning review process. The Practitioners' and Manager events were viewed as a positive learning opportunity.

Learning Points

- Knowing where to go for advice and consultation within and across services. For example, NHS staff can use the Child Protection Hub for advice/consultation (Child Protection Advisors) and Children's Duty Social Work can be contacted for advice.
- Multi-agency case de-briefs after a 'significant event'. This could be identified at the IRD Oversight Group.
- Further use of the NHS Peer Support Team which offers single agency de-briefs (can be on a one-to-one basis or group sessions).
- Ensuring all services are aware of the multi-agency learning and development opportunities that are already in place.
- Encouraging shadowing opportunities for staff to help gain further understanding around roles and responsibilities.

Social Work Response to Crisis Situations

While there was an excellent multi-agency response as part of the Inter-agency Referral Discussion there was reflection on the co-ordination of a significant event in terms of

direction being given to the staff who are with the family and the children by staff within the office. This highlighted the need for a 'one point of contact' to be identified which in turn would help to manage anxiety levels of all involved and support a trauma informed approach.

Learning Points

- One point of contact for the Social Worker who is liaising with the children and parents identified at an early stage can help to maintain a sense of calm and clear direction.
- Planning should always consider the practical elements around a trauma-informed approach within a significant event, for example, identifying an appropriate environment for children to have space and food etc.

Use of Section 25 of the Children (Scotland) Act 1995

Section 25 of the Children (Scotland) Act 1995 enables parents, supported by Social Workers, to voluntarily place their child to secure their safety into the care of a Local Authority away from the parental home. A CELCIS report exploring use of Section 25 highlighted there can be substantial variation in how these orders are used. Within this situation the address of where two of the children were accommodated was withheld from the parents in light of the foster carers being involved within adoption processes. There is no lawful authority to withhold a placement address to the parents.

Learning Points

- Ensuring multi-agency staff are clear about the parameters when using section 25.

Improvements in practice since the Learning Review period

Multi-agency

- Neglect had been identified as a priority area by East Lothian and Midlothian Public Protection Committee (EMPPC) for multi-agency improvement to ensure staff are equipped to understand and respond to neglect. 265 staff attended multi-agency neglect awareness raising briefings in the year 2023 – 2024. An EMPPC Risk of Neglect Toolkit, associated guidance and resources was launched in June 2023. Regular multi-agency Risk of Neglect Toolkit Workshops have taken place since this date and have been well attended by all staff.

Single agency

Health

- Health Visiting revised the 'New to Area Standard Operating Protocol' which now includes specific time frames for following up with families who are new to the area to ensure a more robust hand over process from Health Visiting to Heath Visiting and

incorporates an assessment of level of need/or concern. It can be accessed on the NHS Health Visiting Intranet site. This has also prompted improvements around information sharing at pupil enrolment.
- Health Visiting and Midwifery devised and circulated a seven-minute briefing highlighting practice issues around disguised compliance, Child Protection procedures, GIRFEC and risk assessment.
- There is now a tracking system which is instigated by School Nursing for new families coming from another Local Authority School. This new process is in the pilot stage and progress is being evaluated.
- NHS Lothian 'was not brought' procedure has been launched.

Education

- Role of Education Child Protection Lead:
    - Offers consultancy for Schools to discuss any cases that are a cause for concern, in relation to wellbeing and safeguarding.
    - Encourages school nurseries and early years partner agencies to link in with Health Visiting teams when any issues or concerns arise.
    - Links and ensures regular communication between agencies at a strategic level.
- A transition policy is currently being drafted for sign off for children who transfer in and out of the Local Authority.
- Child Protection Awareness training has been updated to ensure specific reflection and discussion points on neglect and disguised compliance. School staff are accessing the Neglect Toolkit training sessions.

Children and Families Social Work

Awareness raising of use of Section 25 – an email communication from the Service Manager was sent to the whole of Children's Services (Guidance in relation to Section 25 agreements). This included a reminder of information sharing with parents and their rights to know where their child is living.

Suggested strategies for improving practice and systems identified by the practitioner and managers' events and Review Team

Learning has been identified throughout the Review process. It is important to note the points integrated throughout the report and strategies below are identified with the benefit of hindsight. Any learning should contribute to improving current and future practice and ensure services are robust in protecting children.

Local Neglect strategy

- Evaluation of the EMPPO Neglect Toolkit and its impact on the effectiveness of a multi-agency response to neglect. How can we be assured the individual needs of all children within a family are recognised and responded to?

Learning and Development

- How can we ensure all staff, in particular Midwives and Neonatal Nurses, access general multi-agency Child Protection training - with specific training needs highlighted in recognising and responding to neglect?
- Ensuring maximum opportunities for staff to fully utilise muti-agency training – recognising that this is in relation to increasing professional knowledge and confidence and becoming more aware of roles and responsibilities within Child Protection. This also involves promoting a culture of using a family lens and a move away from a task-oriented approach.
- 7 Minute Briefing – this will outline case circumstances and overall learning and will be communicated across all services as well as holding a specific EMPPC multi-agency briefing.
- Ensuring all multi-agency staff have access to learning and development opportunities in relation to disguised compliance and professional curiosity. This can be achieved using a range of methods (EMPPC Workshops/EMPPC Newsletter/ EMPPC Spotlight communications/ Education communications and input to Head Teacher conferences).
- Chronologies – we need to be clear on local expectation out with Child Protection as well as when to merge/escalate with other agencies to ensure the fuller picture is recognised. This can be achieved using a range of methods (EMPPC Workshops/EMPPC Newsletter/ EMPPC Spotlight communications/Education communications and input to Head Teacher conferences).

Strengthening links between Education and Health

- A forum for Health and Education with a focus on transitions is now in place as part of the local Integrated Children's Services Plan. This forum identifies clear timeframes to follow up on information when a new family move into the area. Evaluation of this forum will help to gain an understanding of its impact in terms of ensuring the early sharing and, where appropriate, escalation of information between agencies.