RENFREWSHIRE CHILD PROTECTION COMMITTEE (RCPC)

LEARNING REVIEW

EXECUTIVE SUMMARY REPORT

CHILD 3 – 2024

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Independent Reviewer

1. Introduction

This Executive Summary Report has been published by Renfrewshire Child Protection Committee (RCPC) following the completion of a Learning Review into the death of Child 3. The Learning Review conducted met the requirements of the National Guidance for Child Protection Committee's Undertaking Learning Reviews in Scotland [1].

The overall purpose of the Learning Review process for child protection is to bring together agencies, individuals and families (where applicable) in a collective endeavour to learn from what has happened to improve and develop systems and practice in the future and thus better protect children and young people.

Thanks are extended to the family of Child 3 and staff across services who contributed to the Learning Review undertaken by Renfrewshire CPC.

After careful consideration, based on evidence across the partnership of consistent and comprehensive multi-agency support, the Reviewer is satisfied that the death of Child 3 could not have been predicted.

The Executive Summary Report offers an overview of the Learning Review and focusses on the following key areas:

- Circumstances that led to the death of Child 3
- Learning review process and methodology
- Organisational learning and effective practice
- Strategies for improvement

2. Sharing Personal Data

Renfrewshire CPC has given due consideration to the extent to which personal data can be shared in an Executive Learning Summary being placed in the public domain. It has been anonymised, insofar as is possible and includes only information that can be lawfully shared.

Any disclosure of personal data must comply with the Data Protection Act 2018, and the UK General Data Protection Regulation and Article 8 of the European Convention of Human Rights (the right to respect for private and family life)

This Executive Summary Report is a limited version of the full report.

[1] National Guidance for CPCs Undertaking Learning Reviews (2021)

3. The Circumstances

On Monday 15th May 2023, family contact was made with the early learning and childcare centre of Child 3 after unsuccessful attempts to contact Child 3 or his biological father (Mr A) for several days. Police made entry later the same day and found Child 3 and Mr A deceased within the property. Child 3 was 4 years old at the time of his death.

There is no doubt that the extended family of Child 3 have suffered an unimaginable loss.

In Renfrewshire and beyond, the death of Child 3 and his father has deeply affected the partners who supported the family, and members of the Renfrewshire community who knew them well. Renfrewshire Child Protection Committee (RCPC) respects the wishes of the extended family, and the staff involved in caring for him, that Child 3 is remembered not in death but in life as "a happy wee boy, loved by many".

Child 3 lived his father and was subject to statutory intervention, with supports in place to assist Mr A to care for Child 3. Both were in receipt of services.

4. The Learning Review Process / Methodology

Led by an Independent Reviewer, the Review commenced in November 2023 and was supported by a multi-agency Review Team with representatives from Early Learning and Childcare, Health Services (NHS Greater Glasgow & Clyde) including Children's Services and Adult Mental Health Services, Police Scotland and Social Work in Renfrewshire. The Children's Reporter was also consulted.

The Terms of Reference for the Review identified the key areas to be considered to include:

- A focus on the effectiveness of partnership working.
- The Intensive Parenting Assessment
- The identification of areas of strength in single or multi-agency practice.
- An examination of levels of protection for children where there is a complex parenting history.
- Consideration of the impact of risk management in cases where a child is subject to intervention, including the support needs of parents.
- The use of available resources, protocols, and guidance to protect children and young people in Renfrewshire.
- Whether a different approach to single and multi-agency working could have reduced the presenting risk for Child 3.
- How agencies learn together across all partnership areas in relation to the improvement of single or multi-agency practice.

Multiple case records were read with time set aside for direct engagement with family, staff and managers across services who knew both Child 3 and his father Mr A well. The focus was to consider in detail the circumstances relating to Child 3 and what, if anything, could have been done differently in supporting the family.

The Review considered how Renfrewshire CPC can best understand and manage future risk in helping to continue to keep children safe. The unique circumstances of this case were explored and addressed as sensitively as possible in the report.

The tragic death of Child 3 highlights the complexity of the safeguarding work that multi-agency partners undertake every day, and the associated risks of work-related vicarious trauma that staff who care deeply for the children they protect, can face.

5. Brief Family History

Child 3 was born of the relationship between Ms A (mother) and Mr A (father). A Child Protection Order was granted for the removal of Child 3 from the care of his parents.

Child 3 was placed on a Compulsory Supervision Order (CSO) to initially reside with foster carers before moving to the care of his father as a single parent, after Mr A satisfied the needs of an intensive parenting assessment completed during the first year of Child 3's life.

Mr A and Child 3 remained settled over a sustained period and successfully engaged with a comprehensive multi-agency package of support. Mr A was seen as an intelligent man whose sole focus was being able to evidence that he could care for his son. Services were confident in Mr A's ability to parent Child 3.

Child 3 had regular contact with extended family throughout his short life. He is remembered as a busy and energetic wee boy who was close to his father (Mr A) and a child who knew his extended family well.

6. Practice and Organisational Learning

The Review found professionals genuinely cared deeply for the infants, children, and young people they supported in Renfrewshire.

It was evident throughout the Learning Review that all professionals working with the family and supporting Child 3 had the child's health and wellbeing at the core of their work. Children's Services worked together and routinely updated the Child's Plan to inform the basis to work from in supporting Mr A.

The practice considerations offered are based on the Reviewer's analysis of the information provided. The report acknowledges some of these learning points may already be in place or progressing across Renfrewshire but were not reflected in the case reviewed. The final recommendations, referred to as Suggested Strategies for Improvement, can be found in Part 8.

6.1 The Parenting Assessment

The intensive parenting assessment that took place ahead of the decision to return Child 3 to his father was overall an excellent piece of work. It is thorough and explores risks and effective planning for Child 3, with time given for Mr A to provide evidence that he was ready to care for his son and had reformed some past behaviours.

The assessment is strengthened further through very good multi-agency planning, clear information sharing and strong and consistent engagement with Mr A. The Reviewer was confident that at the time the decision to place Child 3 with his father was made, it was the right decision. In the months that followed, there was very good evidence of sustained change that could have led to the removal of compulsion.

As a learning point, the Reviewer felt future parenting assessments should include consideration as to how domestic abuse and any history of parental mental health may impact parenting over time and include a contingency plan for potential areas of risk. This will enable staff and the parent / carer concerned to have confidence in potential back-up plans from the outset. Where adult mental health services are known to support a parent, they should be included in the assessment process.

The Reviewer is satisfied these points can be built into an already robust process.

6.2 Voice and Rights

Children and young people are not always able to tell us that they are being harmed or are in danger. Children living with abuse (whether physical or emotional) often do not understand the risks within their own environment and therefore will not report concerns. They may however display it in their behaviours. This was noted at some points in agency records.

The strong attachment Child 3 had with his father, Mr A, meant the early learning and childcare centre staff were able to build on this and offer Child 3 opportunities to express his feelings and his emotions.

As noted in the National Child Protection Guidance, the child's experience, views, and needs are central within the child protection process. The Reviewer was in no doubt that staff knew Child 3 well. With UNCRC now embedded in law in Scotland (from July 2024), for Renfrewshire CPC this is the right time to ensure the voice of the child whether words or presenting behaviours, are highly visible in records after any contact with services.

6.3 Chronologies

The lead professional (or relevant practitioner within a single agency plan) works with children, young people, and their families, and all of those involved in the child's plan to ensure that the support provided is regularly reviewed and evaluated for its effectiveness in the improvement of outcomes for the child or young person. Chronologies are a significant part of this.

The multi-agency chronology provided for the Review was very good quality. It was excellent to see many important points mirrored across chronological records within the partnership with accuracy, giving a good indication that information sharing was routinely taking place. Practitioners and managers expressed the importance of ensuring chronologies are kept up to date. There was some evidence of delayed recording of information, with outcomes or intended actions not always clear in associated case records.

Multi-agency professionals require time to fully analyse the chronological data they gather on a regular basis and not just ahead of a Children's Hearing. It is important to ensure that the chronology is up-to-date, and that identification takes place early for any emerging patterns of concern / associated risks.

The Reviewer suggests greater accountability of managers to ensure chronologies are discussed in supervision and signed off with any plans in response to changes noted. This will ensure patterns of risk are identified and acted upon early.

There is a strong foundation that can be built upon in Renfrewshire.

6.4 Learning and Development

Staff were able to share very good experiences of accessing learning and development opportunities in Renfrewshire. Professionals demonstrated a wide skill set of child protection knowledge and enjoyed good supervision and support. They understood the role of Children's Services and the Child Protection Committee in supporting multi-agency opportunities for all.

As a learning point, the Reviewer noted that the following areas may require to be strengthened or built upon, ensuring a confident and competent workforce in:

- Understanding the role of adult mental health / children's services when a child is subject to care and protection and supported by statutory intervention.

- Ensuring the multi-agency child protection workforce develops greater understanding in relation to mental health diagnosis and how symptoms may present in a parent at risk of repeated illness / relapse in wellbeing.

- Using the Inter-Agency Referral Discussion (IRD) as intended in the National Guidance for Child Protection[2] as a formal process of information sharing, assessment, analysis and decision-making following concern about possible abuse or neglect, or where a child may be at increased risk of harm.

7. Effective Practice Examples

7.1 Vicarious Trauma

Vicarious Trauma can have a lifelong impact on those practitioners and managers who deal with lived experience trauma for the children and families they support in their daily work. The significant event that occurred in May 2023 leading to the tragic death of Child 3 was highly traumatic for staff and at times felt overwhelming. The immediate support offered to staff who were at the forefront of this event by psychological services was outstanding.

With national interest developing in how we care for staff involved in Learning Reviews, Renfrewshire CPC should consider sharing their experience of managing multi-agency staff dealing with this level of trauma with CPCScotland and show what impact this kind of support has had on their staff. This was truly commendable.

7.2 Early Learning and Childcare

The established relationship that early learning and childcare centre had with not only Child 3, but his father Mr A, demonstrates what high-level care can look like in a community early learning and childcare centre setting.

Time had been taken to build a strong relationship with a parent known to social work and reassure them that he would be supported rather than judged. There was evidence that Mr A had built a strong and trusting relationship with the centre, who responded by seeking them out for advice and guidance. The early learning and childcare centre were clear on the boundaries in relation to this and were open and honest with Mr A when information needed to be shared with another service.

Child 3 had built a wonderful relationship with the early learning and childcare centre staff and had found favourites for cuddles and play. The voice of the child was represented strongly in records and in the reflections of practitioners during the Review.

[2] The National Guidance for Child Protection in Scotland (2021) - Updated 2023

7.3 Understanding Change

At the practitioner event there was clear evidence of services understanding the vulnerability that Mr A could feel at times whilst acting as a new parent caring for his son, Child 3. Mr A was known to be anxious and worried about his role as a father, and how he was perceived by others.

Acknowledging that change was difficult for Mr A was demonstrated in careful planning by social work and meant the move to a new social worker, by way of early introduction and joint visits assisted Mr A to build trust, whilst still having a connection to his outgoing worker. This was very well managed.

7.4 The Children's Hearing

'Services shifted focus to Mr A being a low-risk parent and he was regarded as a success within the system that protects children, along with services collectively referring to support being shaped around contact with extended family. Despite this, panel members did not lose sight of the intensive parenting assessment that had made it clear that ongoing involvement was required to support Mr A. This was best practice.

7.5 Health and Wellbeing

Many of the interventions for this child were during COVID-19. Within health records, the Reviewer found a consistent approach in ensuring the health needs of Child 3 were met despite challenges. Staff continued to visit Mr A and Child 3 at home as planned. They offered reassurance and care during a critical time.

Health staff worked hard to keep in regular contact with Mr A, reminding him of appointments for his son, whilst offering advice and guidance during age-related assessments. Mr A always responded positively and demonstrated real trust in the care provision he experienced. This consistency was important and saw health services as central to meeting the needs of Child 3 during this time.

8. Suggested Strategies for Improvement

The actions of both the Renfrewshire Chief Officers and its Child Protection Committee in undertaking a Learning Review, reflect the commitment of key agencies working together to improve or strengthen the protection of children and young people.

Many parents with a history of mental health, like Mr A, can manage their condition well and minimise its impact on their children, particularly if they are able to access support.

Partners in Renfrewshire recognised that sometimes mental health concerns do affect a parent's ability to cope with family life. Services involved in the care of Child 3 provided extensive evidence of appropriate support to Mr A throughout the period being reviewed. In this case there had been few, if any, indicators of the level of crisis that was about to take place.

There are, however, some suggested strategies for improvement.

8.1 The Family

Services had not adequately considered what a contingency plan would look like for a parent with severe and enduring mental health concerns in relation to the safety net that could be provided by the family. This was important when the family formed part of the original intensive parenting assessment.

Although mentioned occasionally by Mr A, this established relationship as reported by the extended family, was not recorded, or understood by professionals. No single practitioner was aware of the extent of support received from the family for Mr A and Child 3 once the child moved to live with his father.

Professional curiosity about the role of extended family should perhaps have been given greater consideration. The child's plan is the main source of coordinated information and central to the support of Child 3. It should carry forward the aspirations of the intensive parenting assessment.

Renfrewshire CPC partners are encouraged to ensure with the re-focus of the national whole family wellbeing approach, that agencies consider family in its widest context, establishing where possible that they are included in supporting those from their family unit who need help. This will reflect the increasing recognition that family support is an effective response to many of the current key priorities for children and young people - including mental health and early intervention, to reduce the number of children coming into care and enable them to avoid crisis. The aspirations of The Promise[3] and family support must be upheld.

8.2 Liaison between Child and Adult Services

The Reviewer found that practitioners from child and adult services relied solely on Mr A to provide information about his own mental health and wellbeing and did not contact each other when there were concerns. Both services should have considered the impact of the enduring mental health diagnosis on Mr A for a very young child and the likelihood of periods of instability.

[3] The Promise

Local guidance for children affected by parental mental health expects that staff will be alert to parenting responsibilities and consider when they are unlikely to be able to fulfil their responsibility as a parent adequately. Mental health services were not involved in the intensive parenting assessment that took place prior to Child 3 moving to live with his father.

Mr A did extremely well for a sustained period and was therefore not flagged up as a person of concern which meant there was no system in place to report to child and family services. Instead, mental health services relied on other agencies to let them know about any deterioration or concerns in his mental health. The plan of how this could be done was less clear. Mental health services who took part in the Review stated details for children's services were not always held if a child was not on the Child Protection Register. This requires to be reviewed and reconsidered to ensure adult services are clear on when to contact Children's Services.

Practitioners must have the confidence to contact and be able to ask adult mental health professionals questions about diagnosis, the effects of medication, any concerns about a parent's behaviour, and chances of recovery. This is a matter for learning and development.

When a parent or carer has a mental health diagnosis that may impact their ability to safely care for their child. Professionals must approach any assessment or review as a shared task between children's services and adult mental health services.

This sharing of professional expertise will provide a full understanding of how the situation is impacting the child. All services working with a looked after child or a child on the child protection register should know about any presenting risks from the adult who cares for them.

8.3 Injuries in Younger Children

Child 3 sustained several injuries over a short period of time in 2021, consideration should have been given by services to greater multi-agency information sharing, and perhaps an inter-agency referral discussion to consider whether the multiple injuries occurring over a matter of weeks could have been of concern.

Whilst there was evidence of discussion taking place between services and good assistance from health in considering if there was anything to suggest deliberate harm or potential neglect, there was no consistency of approach in determining the possible cause, reasons for the change, or wider information sharing.

Earlier recognition of emerging patterns, ultimately through good chronological recording and information sharing, could have led to wider professional curiosity much earlier with a risk assessment taking place as the pattern was emerging.

It is important to note that repeating patterns with such frequency could be assessed / risk assessed in the context of a developmental stage, and the explanation given by the child, or parent. This information would have formed an important part of any multi-agency meetings if they had routinely taken place.

The Reviewer suggests consideration is given to how services respond to multiple injuries, whether considered non-accidental or not, in the context of being a looked after child and where there is known vulnerability.

8.4 Adult Protection

The Renfrewshire CPC should seek to share the findings from this Learning Review with the Adult Support and Protection Committee to ensure explicit ownership of a joint risk management agenda for all children who are vulnerable and / or at risk of harm where parental mental health history is complex.

IN CONCLUSION

The Promise Scotland refers to scaffolding for children, families and the workforce and states it must be supported by a system that is there when it is needed, noting "The scaffolding of help, support and accountability must be ready and responsive when it is required".

The Reviewer is confident, given the openness, honesty, support, care, and real concern for the wellbeing of children and young people in Renfrewshire that was evidenced during the Review, that the scaffolding already exists.

To develop this further, Renfrewshire CPC should ensure that a succinct improvement plan is drawn up to support the implementation of these suggested strategies, followed by evidence that change have been sustained over time.