



Glasgow Public Protection Committees



Learning Review Report

Family C

Introduction, context and approach

This learning review considers the serious abuse and harm experienced by Child A, Child B, Child C and Child D, the four children in Family C. Dating back to offences committed from 2012 onwards, the children's mother, Adult E and father and stepfather Adult F ¹were convicted in November 2023 of multiple counts of neglect, serious and repeated physical assaults including attempted murder, offences relating to the misuse of drugs, and multiple serious sexual offences, including rape. Six other adults were convicted of sexual and physical abuse.

The children lived at home with their parents until June 2019 when they were moved to live in a kinship care arrangement. The family were well known to services. There had been multi-agency involvement with the children since 2007, including their names being on the child protection register for periods of time.

The lack of parental care and neglect experienced by the children was established within the children's hearing system shortly after their removal from home. Over the following 12 months, the children gradually disclosed the full extent of their abuse, eventually leading to a high court trial and convictions in November 2023.

The abuse the children experienced was appalling. The children are to be commended for the courage to disclose what happened, trusting professionals with their story, and their resilience in sustaining engagement throughout the prolonged investigation.

Whilst the review identifies learning for leaders in Glasgow (and nationally) about strengthening the systems within which staff and managers operate, the review held the perspective of these children at the core of the work.

Child A and Child B provided valuable insight into their experiences when living at home:

“Staff should be talking to the kids more, taking them out to talk to them without the adults, watching how they're acting, watching the adults. They should be paying attention to the little things” “People didn't have an understanding about what was going on in the house. I was the one going through it and I didn't think anyone would understand”

When reflecting on their experiences of the protracted investigation and providing evidence for court, they told us.

“Workers helped me understand the process [...] they let me go at my own pace” “Court was scary [...] but necessary as it gave me an opportunity to speak in front of the judge”

In Parts one and two, the learning review (referred to as the review) identifies learning about the impact of agency involvement with the children when they lived at home. Part three considers the children's experiences during the investigatory and court processes. It also examines the impact on staff.

¹ Adult F was the birth father of child C and child D only. As he was parenting the children with adult E and considered by them as their father, he is referred to in the review as the parent.

It is important to acknowledge the context of this case. The extent of the parents' capacity to manipulate and deceive was extreme and unusual. Staff were not aware of the sexual abuse the children experienced until the disclosures emerged.

The review was careful to avoid hindsight bias and not view practice through the lens of what was subsequently revealed to have been happening. The review examined what was known to services at each stage of the timeline, and importantly, what was *knowable* to professionals during their engagement with the children and the adults.

The decision-making process

Glasgow Child Protection Committee (CPC) and Public Protection Chief Officer Group (PPCOG) agreed the circumstances met the following criteria:

When a child has sustained significant harm or risk of significant harm as defined in the National Guidance for Child Protection in Scotland² 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 one or more** of the following apply:

- abuse or neglect is known or suspected to be a factor in the child's sustaining of or risk of significant harm
- the child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR or was a care experienced child

Terms of reference and governance (See Appendix ii)

Following engagement with COPFS and agreement to proceed, the CPC commissioned an independent reviewer to lead a comprehensive learning review to identify inter-agency learning throughout the period from 2007 until 2023. The review was to be carried out within the framework of the National guidance for child protection committees undertaking learning reviews³.

The learning review model takes a systems approach. It does not stop at the points when shortcomings in professional practice have been recognised, it moves on to explore the interaction of the individual with the wider context, including cultural and organisational barriers, to understand why things developed in the way they did. This is essential in understanding what needs to improve to ensure the system within which staff and managers are working facilitates safe practice to protect children from harm.

The overarching aim of the learning review was to identify inter-agency learning in relation to:

² <https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021-updated-2023/>

³ <https://www.gov.scot/publications/national-guidance-child-protection-committees-undertaking-learning-reviews-2/documents/>

- Assessment of needs, strengths and risks
- How services listen to children and interpret non-verbal behaviours
- Communication and collaboration across agencies and authorities.

In recognition of the wide timeframe, the terms of reference directed the review to consider the timeline within three phases or parts.

Part one: 2007-14 covers the period of the births and early years of Child A and Child B, with a focus on:

- Early identification of need and opportunities to support families, in the context of legislation, policy and practice standards at that time
- Single- and multi-agency responses and interventions when concerns are identified

Part two 2015-2019 includes the birth of Child C and Child D and the period of significant multi-agency involvement, with a focus on:

- Communication between agencies and services
- Single- and multi-agency responses and interventions to identified needs and risks
- Multi-agency collaborative practice to keep children safe

Part three: 2019 – 2023 covers the period following the children’s disclosures and the subsequent criminal investigation and court processes, with a focus on:

- Supports available for children, parents/ carers and staff during and after child protection investigations
- How child-centred and trauma-informed child protection investigation processes and decision-making are
- How child-centred and trauma-informed court processes are

Chief Officers delegated responsibility to a group of senior leaders, including the chief social work officer and independent chair of the CPC, to establish an executive group to monitor the progress of the review and address any barriers encountered by the lead reviewer.

Constraints

Bringing practitioners together in a multi-agency group is a core element of the learning review model. It provides an opportunity to generate immediate learning through joint reflection and analysis. It explores the direct experience of staff and managers working with the family as a means of understanding what happened, what might have been done differently and what prevented this.

Not all relevant staff took part in the engagement phase for Part two. A small number of practitioners were no longer working within Glasgow when the review began, and two of the first line managers involved had since died. This circumstances of the case and the abuse disclosed by the children has been distressing for staff and managers involved. As a result, some

frontline social work practitioners declined to be involved in the review. Also, some social work managers asked to be interviewed individually rather than being part of multi-agency group discussions. This impacted on how the review team engaged with staff for Part two and necessitated a departure from the guidance and the principles of the learning review model. Engagement sessions for practitioners and managers had to be undertaken as single-agency activities, alongside individual interviews as requested.

The review process

Full details of the review team and working processes developed for each part of the review are set out in appendix iii.

In summary, the review team was led by an independent lead reviewer, with senior managers from Glasgow services, representing medicine, nursing, social work, education, SCRA³ and police. The lead reviewer and the team was supported by the service manager for learning reviews and staff from the public protection team. Professor Alexis Jay was the expert advisor to the review and to the lead reviewer.

The review team benefited from the professional expertise of the consultant child psychotherapist and lead for NHSGGC and the forensic psychologist and Multi Agency Public Protection Arrangements (MAPPA) coordinator. Other managers working within Glasgow services were called upon as required to provide information or analysis to support the review.

Although services collated written information prior to the commencement of the review, the team met for the first time at the end of May 2024.

Family engagement

The review team carefully considered who to engage with and how this would best be done. Our primary responsibility was to the children. In recognition of the young age of Child C and Child D and the length of time since they were removed from their parents' care, the review team agreed it would not be appropriate or necessary to involve them, although noted they would have the right to seek information about the review at some point in their futures.

Child A and Child B were aware that a review was happening following press coverage of the outcome of the criminal trial. Senior managers were concerned about the potential impact on them of being re-traumatised by any discussion of their experiences. The lead reviewer wrote to Child A and Child B separately with an invitation to meet and hear about purpose and remit of the review before deciding whether they wanted to take part. Supported by their social worker, Child A and Child B agreed to meet with the lead reviewer. Their engagement helped the review team to understand their perspective and hear their thoughts about how professionals can better protect and support children in the future.

The review team decided not to engage with Adult E or Adult F for the purposes for this review. The team had access to case notes and written records of interviews and assessments

³ Scottish Children's Reporter's Administration

of both adults, recording their complete denial of the sexual and physical abuse towards the children. Whilst there was some acknowledgement of the neglect the children suffered, this was minimised with no indication of empathy and very limited accountability offered. The message to the children was that the review would be focused on their experiences.

Staff wellbeing

The review team acknowledged the likely distress for staff of re-visiting the details of the children's experiences of abuse. The team sought to ensure there was appropriate psychological and management support in place for those who were asked to engage in the review and members of the review team itself. There was no wellbeing strategy for learning review activity, beyond the support of individual line managers and access to generic employee assistance programmes. A mapping exercise highlighted considerable variation, with some agencies offering a more robust service than others. Most services available were on an opt-in basis. Those working within education services have particularly limited access to this kind of support.

The review team had an important role in supporting the staff from their organisation, providing information about the review, helping people prepare for their contribution, identify any unmet support needs, and signpost staff to the services available within their agency. Some staff chose instead to be supported by their own line managers. Practitioner packs were collated for review team members to give to participants. The lead reviewer provided a multi-agency briefing for staff in advance of engagement sessions to provide information on the purpose and process of the review.

NHS Greater Glasgow and Clyde (NHSGGC) Occupational Health Psychological Wellbeing Team recognised the importance for staff of having the right kind of support as well as a route into clinical services if required. They provided a helpful briefing to the review team. The plan for a pre-engagement group briefing for staff invited to take part, as well as access to an individual triage service and post-participation check-in could not be delivered as these services were only available for NHS and HSCP⁴ employees. This highlights a gap in the approach to supporting staff to engage in review activity.

Effective practice

Where the review found practice that resulted in a positive impact on the outcomes and experiences of the children, this is integrated within the learning issues identified within practice and organisational learning sections for each of the parts of the review.

⁴ Glasgow City Health and Social Care Partnership

Part one: 2007-2014

Strategic and policy context

The child protection reform programme 2003-2006, and Health for all children 4 ⁵ in 2005 laid the groundwork for Getting It Right For Every Child (GIRFEC), launched in 2006 as Scotland's framework for improving outcomes for children and young people.

Scottish Government published the GIRFEC guidance on the child's plan and first version of the GIRFEC practice model in 2008.

The 2008 Early Years Framework was aimed at giving children the best start in life, recognising the rights of children to high quality relationships and a holistic approach to meeting their needs. The Road to Recovery also published in 2008, was a new approach to tackling Scotland's drug problem, focusing firmly on the concept of recovery.

In 2011, updates to the Hall 4 guidance strengthened the delivery of community health services to children in the early years. The Maternity and Infant Feeding Framework published in 2011 included a range of policies and frameworks aimed at improving the health and wellbeing of parents, children and families in Scotland. The publication of CEL 13 (2013) resulted in a change from the previous Public Health Nursing role which enabled staff to work within both a health visiting and/or school nursing setting on completion of the programme. From 2013 the term Health Visitor was reintroduced with a specific focus on 0-5 year olds.

In 2013, Scottish Children's Reporter's Administration (SCRA) updated the Decision-Making Framework first launched in 2005, as the formal approach to making effective, timely and child-centred decisions about the need for compulsory measures.

In 2014, the Scottish Parliament implemented The Children (Scotland) Act, introducing significant changes for partners, including SCRA. Also in 2014, Scottish Government published new National Guidance for Child Protection (Scotland).

In terms of the local policy framework for staff working in Glasgow, at the beginning of the time frame, staff were working to the child protection manual and procedures, implemented in 2000.

In 2005, NHSGGC established a child protection unit (now the Public Protection Service), enabling all health professionals to access advice and support, and child protection learning and training. This included GPs, health visitors, school health and all community-based staff as well as acute, maternity and disability/specialist children's services. In 2006, NHSGGC implemented guidance for staff when raising a child protection concern.

In 2006-7, social work and partners introduced the integrated assessment framework as the basis of Glasgow's GIRFEC assessment. It was a shared assessment recording tool where health, social work and education could contribute to the assessment within one document on a shared IT platform. In practice it was used for child protection cases and reports to SCRA.

⁵ Hall 4

In 2008 Glasgow introduced inter-agency guidance for women assessed as being vulnerable in pregnancy. In the same year, partners published and implemented the neglect toolkit as a multi-agency framework for assessing children at risk of neglect.

Other local policies introduced in 2009 included a social work staff supervision policy and workload management framework; a hospital and community health service policy for responding to children who do not attend appointments; and further guidance for health staff and managers working in child protection including guidance for health professionals attending child protection case conferences and case discussions. This latter procedure was updated in 2013, 2016 (and 2023).

Between 2009 and 2014, Education services moved towards embedding principles of GIRFEC in strategic planning documents including 'Every Child is Included' [2009] and in children and young people's wellbeing assessments and planning.

In 2010 social work services moved away from the IAF and reverted to using a single-agency "word" document to record children's assessments.

In 2011, education services launched the GIRFEC and nurture policy guidance. Glasgow's GIRFEC developments included a training framework for 2012/13 and update in 2014.

Summary of approach and activities

Given the historic nature of the timeframe for this part of the review, chief officers agreed it should be a desk-top review of written material and would not include engagement with practitioners or managers who were involved at the time. Members of the review team provided information about the working context of individual agencies and teams, and multi-agency practice arrangements.

As part of the preparatory work prior to the formal commencement of the review, partner agencies submitted case notes and/or a record of contact and prepared single agency timelines of key events for Child A and Child B, Adult E and Adult F.

Following a full review of the documentation, the lead reviewer developed a multi-agency timeline of key events for 2007-2014. The review team identified six key practice episodes for deeper review. This enabled the team to explore single- and multi-agency practice around key assessment and decision-making opportunities and identify factors that may have influenced or impacted on the work undertaken.

Learning from the activities in Part one is drawn from observations of practice and systems from the review of records. This includes single-agency chronologies completed prior to commencement of the review, and the review team's knowledge and experience. Key themes and patterns emerged as relevant and were taken forward into Part two and tested through the wider engagement activities.

Chronology of agency involvement and children's experiences

Universal services:

- Midwifery services were involved during Adult E's pregnancies in 2007 and 2009.
- Public Health Nurses⁶ were involved throughout this period, following the birth of Child A in April 2007 until 2012 and with Child B from January 2010 – 2014. Homeless families health visiting service provided additional support. The frequency of contact was good.
- Education services became involved in 2010 when Child A began nursery and continued throughout the rest of this timeframe with Child A in primary school and Child B at nursery.
- The GP practice saw Adult E and Child A for appointments on request.
- Third sector services were involved 2007-2009 intermittently supporting adult E's drug rehabilitation. This included groupwork.

Targeted services:

- Adult E was supported by addictions services (ADRS) throughout the timeframe, having at least fortnightly contact. ADRS worked with Adult F from 2009. His engagement was less consistent and frequent.
- Children and families social work were involved 2007-2013. There was weekly contact in 2007 when Child A was on the child protection register, and in the weeks post deregistration. When the case was transferred to the locality team it was managed on duty, until allocated to a qualified social worker in October 2009.
- Glasgow Public Dental Service became involved with Child A and Child B in 2010
- Homelessness services had 23 contacts with the family during this period, and provided additional health visiting support in 2008
- SCRA had no direct contact with the family, but the children were referred by social work in 2007 and 2011.

2007

Child A born in April

Adult E received early intervention supports prior to and during her pregnancy with Child A. Prebirth processes led to allocation to a qualified social worker within the hospital social work team and an initial child protection case conference⁷ was convened in April 2007. Her name was placed on the child protection register⁸ as a child at risk of physical neglect. At birth, Child A was treated for neonatal abstinence syndrome⁹. Social work referred Child A to SCRA who made the decision to refer to the local authority for voluntary support. Adult E cared for Child A within a

⁶ up until 2013 Public Health Nurses visited families from birth to grave. It was only from 2013 that Health Visiting title was re-introduced, and health visitors focused on the 0-5 years (including pre-birth).

⁷ ICPCC

⁸ CPR

⁹ NAS

residential drug rehabilitation placement. Child A was accommodated into foster care for a short period when Adult E relapsed before Adult E ended the placement and moved with Child A to live with her mother, Adult G. A review child protection case conference¹⁰ in June agreed registration be continued.

Children and families social work become aware of Adult E's relationship with Adult F and his history of substance misuse. Child A's name was removed from the CPR in August 2007. In December 2007, a further ICPCC was convened due to concerns about Adult E's continued use of heroin and inconsistent engagement with services. There was a majority decision not to register Child A. The health visitor disagreed, believing the ongoing risks were significant.

2008

Child A is one-year old

In February Child A's case was closed to the hospital social work team and transferred to the locality team. No allocated worker was identified, and the case was managed within the duty system. Child A and Adult E moved between homeless accommodation and Adult G's home. Adult E completed some parenting work linked with addictions services. She experienced periodic relapses into heroin use. In April 2008, Adult F was looking to access a methadone programme. He was smoking heroin daily. He did not attend appointments offered.

Adult E presented as destitute on eight occasions within a few weeks. The health visitor submitted a notification of child protection concern¹¹ due to non-engagement and requested social work allocation. A multi-agency meeting emphasised the need for Adult E to engage with social work to address her addiction and meet Child A's needs. The case was allocated to a social care worker, with contacts between June and November relating to Adult E's requests for financial assistance.

Adult E was seen regularly by staff from the intervention team and ADRS during 2008 and sustained attendance and engagement in group work programmes. Adult E sought medical attention for Child A in response to presenting ailments but failed to keep planned appointments.

Adult E and Child A presented as homeless on two occasions during the year and moved into temporary accommodation. Adult F and his sister were charged with multiple offences relating to the intent to supply drugs.

¹⁰ RCPCC

¹¹ NOC

2009

Child A is two years old

From January to March Adult E presented as destitute on frequent occasions. During this period Adult F was charged, along with two others, with serious assault (slashing a man's forehead) and possession of 68 diazepam tablets.

Adult E and Child A moved from temporary accommodation to live with Adult E's mother. Adult E's mental health deteriorated along with her increased dependence on benzodiazepines and heroin, and she was engaging in illicit activity to fund her addiction. She took an overdose of paracetamol and experienced suicidal ideation leading to a short emergency psychiatric detention. Child A was accommodated with her maternal uncle for six weeks May – July.

A multi-agency meeting in June led to Adult E, now pregnant with Child B, beginning a 21-day assessment for a rehabilitation placement that became full time in August.

Following a positive start in the placement, Adult E did not comply with agreed plans and was using heroin. During this period, Adult E reported to more than one agency that she was "losing interest" in Child A and did not have feelings for her. She admitted to leaving her unattended on occasions. Staff from the residential rehabilitation service made a child protection referral due to their concerns about Adult E's care of Child A.

Adult F disclosed his relationship with Adult E to ADRS staff in August. He was smoking heroin daily. After missing repeated appointments with the service, his case was closed in September.

Following multi-agency meetings and attempts to sustain the rehabilitation placement, Adult E was asked to leave in September due to repeated relapses into drug use. She and Child A moved back to live with the maternal grandmother. There was no assessment of Adult G's capacity to provide safe care for Child A.

The pregnancy liaison group recommended a prebirth assessment be completed and a social worker was allocated in November. The family were transferred to a new health visitor in November. Adult F was recorded as being the father of Child B.

2010

Child A is three years old Child B born in January

Child B was born in January and required treatment for NAS. An ICPC was held in February, post-birth, with a unanimous decision not to place Child B's name on the CPR or refer to SCRA as Adult E was assessed as engaging well with addictions services. The decision was to monitor and review.

Adult E and the children lived with their maternal grandmother throughout the year.

During the first half of the year, Adult E was in regular contact with ADRS and described as cooperating well. Despite this, she tested positive for opiates / cocaine/ benzodiazepines on five occasions, and self-reported that she was using heroin.

In February, Child A was diagnosed with a squint and referred to ophthalmology but was not brought to the appointment. Child B was diagnosed with a small heart defect. By April he had missed three outpatient cardiology appointments.

In August, Child A started nursery. Adult E missed some scheduled appointments with ADRS and presented as destitute on several occasions. In October Adult E reported to the police that she had been the victim of a robbery though later admitted she had spent her benefit money.

Adult E began Triple P groupwork programme in July but, despite saying she was having difficulties managing Child A's behaviour, she withdrew from the programme. Around the same time, Adult E admitted using prescription drugs.

2011

Child A is four years old Child B is one year old

In February Adult E and Adult F presented to homelessness services who placed them in emergency accommodation before moving them to a temporary furnished flat. Homelessness services received reports of adults being involved with drug-related disagreements within the stairwell of the building. This information wasn't shared with social work.

Child A's place at day nursery ended. Her attendance had been 86% since Aug 2010.

In June, concerns escalated about Adult E's poly drug use and self-harming behaviours. Social work services convened a child protection case discussion, where an interim safety plan was agreed and a decision taken to proceed to case conference. The unanimous decision of the conference in July 2011 was not to register the children's names, although social work did refer the children to SCRA. Their decision was to refer back to the local authority for voluntary measures.

Social work reported the children were "well cared for" with "strong parental attachments" and health staff reported that the health and development of the children was positive. However, around this time case records also contained observations of the children seeking physical comfort and eye contact with visiting professionals. Child B, aged one at the time, presented as distressed on occasions, with episodes of headbanging, to which the health visitor offered adult E advice about alternative parenting strategies.

Child A and Child B had dental caries. Child A had 6 teeth extracted and Child B experienced untreated toothache. There was a pattern of either late or missed appointments for fillings. The family did not take Child A to ophthalmology appointments.

In August Child A started at an Early Years Centre. From August to Jan 2012, her attendance was 38%.

2012

Child A is five years old

Adult F was convicted of sexual abuse of child A from 2012 – 2019

Child B is two years old

In January, Adult E and the children left their temporary accommodation and moved to live with the maternal grandmother. The flat was left in a poor condition. They remained with Adult G until October. The children's living conditions were overcrowded and described on occasions as poor and dirty, and the children described as grubby with dirty feet.

Child B was assessed as meeting his developmental milestones at his two year and 30-month assessments.

Child A was diagnosed with gross dental caries, experiencing pain. She had a further six teeth removed under a general anaesthetic.

The family were referred to Parent and Child Together for family support. There was a delay before the service first contacted Adult E as she was reluctant for visits to her mum's house. Despite various attempts to engage, no work was undertaken with the family due to their lack of cooperation.

In August Child B started nursery. He was described on occasions to look unkempt, with unwashed clothes.

Towards the end of the year, Child A was noted as having persistent headlice. She missed three ophthalmology appointments. In October, the family moved into a temporary furnished flat. Adult F was attending a shared care clinic for substitute prescribing.

2013

Child A is six years old

Adult F was convicted of sexual abuse of Child A from 2012 – 2019

Child B is three years old

Child A and Child B were reported as making progress at school and nursery with appropriate attendance and presentation. At home, the parents described challenges managing Child B, with him spitting at them and banging his head on the floor when chastised.

Adult E was reported by addition services as being stable on methadone, although tested positive for opiates and cocaine in February. Addiction services reported that Adult F's drug use was stable.

In September, children and families social work assessed there was no further role for social work and closed the case.

Child A was referred to the growth clinic by the community staff nurse - school nursing, for her small stature. She did not attend two appointments. Child A and Child B and missed further

dental and dental treatment appointments. By the end of this year, both children had obvious dental decay, Child A had a squint and small stature and there was an established pattern of parents missing hospital appointments to address their health needs. These included ophthalmology, cardiology, dentistry, and growth clinic.

2014

Child A is seven years old

Adult F was convicted of sexual abuse of Child A from 2012 – 2019. Three other adult males were convicted of sexual abuse of Child A along with Adult F from 2014-2019.

Child B is four years old

At the start of the year Child A was in primary 2 and moved into P3 in the August. Child B was at nursery and started P1 in August. Their attendance was over 96% for 2014-15.

In January, the consultant paediatrician alerted the school nurse and health visitor to two failed appointments in 2013 for Child A at the growth clinic and made direct phone contact with Adult E to urge her to attend a third appointment in 2014. The letter noted: "Several illnesses which cause short stature can be clinically silent i.e. there are no signs or symptoms of the underlying illness carrying a risk of detriment to future health (e.g. untreated coeliac disease and long-term risk of lymphoma – a type of cancer). Similarly for some growth disorders there is a window of opportunity for treatment which if it is missed will result in permanent growth failure." Whilst clinical records evidence multiple instances of "did not attend" for different appointments, there is no indication that Child A was sent a further appointment or that the hospital followed up the non-attendance with the school nurse as referrer. Also, no evidence that the school nurse followed up with the hospital.

In September and November, Child B missed two paediatric cardiology appointments. The appointment was rescheduled on two further occasions by the family before taking place in March 2015. Child A and Child B missed further dental appointments towards the end of 2014.

Key Practice Episodes

The safety and wellbeing of Child A and Child B were considered within various multi-agency child protection processes throughout the seven-year period. These included including one period of child protection registration, prebirth planning and three subsequent ICPCCs. The review team identified six key practice episodes from the multi-agency chronology for deeper review.

1. Events leading to the RSPCC in August 2008 and decision to remove child A's name from the CPR
2. Events leading to the ICPCC in December 2007 and decision not to register
3. Multi-agency responses to escalating concerns about child A throughout 2009
4. Review of multi-agency engagement January – July 2010 including ICPCC in February
5. Events leading to ICPCC in July 2011 and the decision not to register
6. September 2013 and rationale for the decision of social work to close the case.

The lead reviewer provided analysis and evaluation of the practice and identified potential contextual factors that might have influenced the practice. This was organised within a framework that considered the following for each key practice episode:

- Recognition and response to escalating concerns.
- Assessment of needs and risks
- Voice and visibility of the child
- Multi-agency communication and collaboration

Review team members provided challenge and support to the analysis collectively and from a single agency perspective.

Conclusions

There were periods of relative stability within discrete domains of the adults' lives in each of the years of the Part one timeline. However, the above events illustrate little care or quality of life for the children, with poor physical care leading on occasions to pain. The parents were not sufficiently concerned about these matters enough to work with the visiting professionals unless it benefited themselves. The overall trajectory of stability and security was not improving. Parental engagement with the supports that could have helped them improve and meet the physical health, emotional and social needs of their children was never sustained. By the end of this timeline, the children were experiencing medical neglect, in terms of the parents' persistent failure to meet the children's physical health and dental health needs.

Observations of practice and adherence to policy and standards

1. Multi-agency practice during the initial months, prior to and after the birth of Child A was mostly positive. Services provided early intervention support during pregnancy; they made appropriate use of prebirth procedures with prompt allocation to the hospital social work team. Staff recognised that Adult E's history of childhood trauma was affecting her capacity to address her problems with addiction. Multi-agency communication was frequent, with a plan for intervention that focused on reducing risk to the children. Residential and therapeutic resources were available and deployed. Social work line managers had oversight of records and decisions. Staff considered the need for compulsory measures and determined they were not necessary.
2. Overall services responded appropriately when concerns that they recognised as causing risk or harm to the children began to escalate. Social work services followed child protection procedures, convening multi-agency child protection case discussions and case conferences without undue delay. The residential rehabilitation provider called placement review meetings in response to escalating concerns. There were a few occasions when records did not indicate or were not clear about the social work response to concerns raised by other services.
3. The management of the case within the duty system following the transfer of the family from the hospital social work team to the locality team, coupled with the absence of a

qualified social worker until late 2009, impacted negatively on the visibility and focus on risk. This management decision was particularly relevant for a family where there had been a recent child protection case conference and the failure of a second drug rehabilitation placement.

4. Good multi-agency communication was evident during the first period of child protection registration. Throughout the remainder of this timeline, addictions services provided regular updates to social work and inputted to recording systems from their contact with Adult E, and to a lesser extent Adult F. School staff provided updates to social work on request. Communication between health visiting services and social work was variable and not consistent in frequency, in some instances with months between recorded contacts. The social work case closure summary in September 2013 acknowledged this decision had been made without communication with the Child B's health visitor. It therefore didn't consider the medical problems the children were, by then, experiencing.
5. Although the frequency of health visitor contact was good, important information about the children's health, as contained in dental and hospital records was not consistently sought or considered as part of single- or multi-agency assessments of need and risk. This included information contained within paper records prior to the move to the electronic recording system, EMIS. This resulted in assessments that were based on partial information.
6. There was a lack of clarity within the records about the status of Adult E and Adult F's relationship and when and whether they were living together. Information about Adult F's offending (October 2008 and March 2009) was not evident within the children's social work records, although shared by the police at subsequent case conferences.
7. Communication between homelessness services and social work was limited, especially in the early part of Part one. Adult E and the children moved between temporary homeless accommodation and the maternal grandmother on 12 occasions and opportunities to coordinate and collaborate were missed. The impact of this on the children's wellbeing was not recognised within decision-making meetings. This information was of significance but not evident from the children's records.
8. Services working most closely and intensively with Adult E, namely the residential addictions service provider, articulated the risks to Child A from Adult E's poor care and provided important observations of the parent/child relationship. This was lost when the rehabilitation placements ended. Subsequent assessment reports prepared for case conferences listed historical information and identified some strengths and risks. They fell short of evaluating or prioritising these. The focus was on current risks and concentrated on the adults not the children. Written plans to direct the work of frontline staff throughout this period were based around a list of tasks and expectations

for Adult E to engage with services. This did not provide clarity for Adult E about precisely what professionals expected of her and didn't help staff to measure success or her capacity to evidence or sustain change.

9. Adult E successfully completed some work, including groupwork as part of her engagement with addictions services. A specialist intervention team worked alongside the service provider during Adult E's second period in rehabilitation. In terms of support for parenting, Triple P was the only formal programmed approach available at the time. She was offered this repeatedly. She did not sustain attendance or complete the programme. A referral to a targeted family support project was not initially considered appropriate but eventually led to an offer of support. Despite attempts, Adult E did not engage with the service.
10. Within child protection key processes and addictions services involvement, there was knowledge of the childhood trauma experienced, and severe domestic abuse witnessed by Adult E as a child, as perpetrated by her father. Those working with her recognised this as unresolved trauma and understood it impacted on her own mental health and capacity to successfully address her addictions. She was referred and re-referred for counselling on various occasions but did not engage in the work. It is not apparent that the impact of Adult E's trauma on her capacity to parent and make healthy attachments was explored or considered. Adult E's mother was considered a protective factor for the children, in the absence of an assessment or supporting evidence.
11. Adult E engaged well with midwifery supports during pregnancy, and her initial care of her babies caused no concern. This was a factor that carried weight within the prebirth assessment process for Child B. Although the 2007 pregnancy liaison guidance directs staff to consider the needs of existing children, it is likely that the positive view of her was a barrier to the visibility of Child A's needs.

System constraints

The review considered the context within which staff and teams were working during this period. Data was not available for separate localities, but across the city, there were 19 children and families social work vacancies in 2008 and 2010. This fell to 7 vacant posts in 2015 and 2016 before rising to 17 in 2018 and back up to 19 in 2019. The position in 2008 may be relevant to the decision of the locality team not to allocate the family once the case was transferred from the hospital team, although overall vacancy levels were not significantly high given the size of the city.

There was a resource uplift for health visiting services over this period, but the school nursing service was very limited. Triple P was introduced in 2009/10 and the only agreed parenting programme during this period.

Oral action health teams were working to reduce dental caries in children in recognition of public health concerns. It is likely that this did not extend to considering poor dental health as an indicator of neglect. Dentists have received child protection training since 2009, and NHS GGC implemented a child protection policy for dental services in 2013.

Early years education is a non-statutory service. Periods of non-attendance would not have been followed up within the attendance management policy used in primary and secondary education settings.

Key themes and patterns

The review team identified patterns in practice and potential thematic learning.

- **Voice and visibility of children.** Weight was given to visible presentation of how the children looked, rather than an objective evaluation of whether their needs were being met. Indicators of distress, like headbanging and deliberately seeking eye contact with professionals were not considered as part of a holistic assessment of the children's wellbeing.
- **Working with multi-faceted risks.** Professionals considered adult E's problems with addiction as the driving risk factor for the children. This became a barrier to the visibility of the children's experiences. Adult E's engagement with ADRS became conflated with safety for the children. When adult E's drug use was stable, this took precedence over previous/other risks. The focus on Adult E's own problems was seen as separate from her care of child A.
- **Managing a mixed picture of progress.** Small and short-term successes were given more priority than the factual evidence that the children's needs were not being met. The focus was on the here and now, which influenced decisions at ICPCs. More weight was given to Adult E's verbal commitment to change despite the evidence that she was unable to sustain improvements in her care of the children. Consequently, the children's lives were severely affected.
- **Lack of attention to the history and the children's experiences.** Whilst historical information was included within case conference reports, there was limited analysis of the impact of previous supports and interventions. There was a lack of whole family consideration within pre and post birth child protection processes.
- **Role of fathers.** Adult F was involved from very early stages of the timeline, but he wasn't fully considered within the whole family picture until much later. There was a lack of curiosity about his role / presence within the family and his offending behaviour and his view of paternal responsibility.
- **Use of voluntary measures.** Social work made two referrals to SCRA in 2007 and 2011. Both resulted in a decision for voluntary support, drawing on Adult E's apparent engagement with services at that point in time, rather than an evaluation over time of meaningful change and improvement.

Part two: 2015-2019

Strategic and policy context

At the national level, the Education (Scotland) Act 2016 introduced new laws designed to close the attainment gap and strengthen children's rights. The GIRFEC principles and a focus on children's wellbeing were within the supporting delivery plans and guidance.

Scotland's child protection review programme began in 2016. It aimed to strengthen systems after past failings, focusing on leadership, learning, and shared practice, leading to a national review and 35 key actions, all driving a shift towards prevention, early intervention, and better integration with other services like GIRFEC.

Locally, the timeframe for Part two aligned with the whole-system programme, led by the HSCP to transform services to children and families within Glasgow. Put simply, this involved a radical shift towards early family support and primary prevention, targeting resources within the most deprived communities as a vehicle to ensure more children could be looked after within their own communities, and reduce the need for children to need high-cost care. The review considered a comprehensive chronology of the evolution and implementation of the strategy and supporting documentation, noting the challenge, support and scrutiny from external and internal stakeholders. It noted that funding for core social work and health visiting services was protected and enhanced throughout the transformation programme.

SCRA and social work developed an operational protocol in 2014 to define and clarify working practices. Partners reviewed and updated this in 2022.

In 2014/15 NHSGGC introduced the Electronic Management Information System (EMIS) as a single shared record for community-based children's services. It was accessible to the NHS Child Protection Unit, CAMHS, community paediatrics, Family Nurse Partnership, health visiting, school nursing, and speech and language therapists. Clinical colleagues in acute services could view a summary of EMIS records. Primary care and the community dental services could not access full EMIS records. Although the content of paper files was not scanned onto EMIS, they remained accessible to staff if accessed from storage.

In 2015, NHSGGC launched chronology guidance, giving all staff responsibility to contribute to a chronology of significant events. In the same year, education services integrated the child's Wellbeing Assessment and Plan into SEEMIS.

The refreshed universal pathway for health visiting was implemented incrementally from 2015 /16. health visiting students were recruited to the programme in line with Scottish Government investment. The aim was to ensure a preventive approach throughout early years by providing critical support and interventions to children under five and their families. The programme consists of 11 home visits to all families - 8 within the first year of life and 3 child health reviews between 13 months and 4-5 years. It would be complemented by a stepped-skill approach to universal and targeted services for all school-aged children.

In 2016, Glasgow HSCP implemented updated child protection procedures in response to the national guidance 2014. This included the responsibility to create and maintain a chronology of significant events.

In 2018, health services implemented policies and procedures to support the transformation of nursing, midwifery and health professions roles. Although initially developed in 2015, the refocused role for school nursing to be integrated within the community nursing teams was taken forward from 2018. This latter development was important to enhance the perception and ability of schools as an important portal for universal access to health services for school-age children.

In 2018 the Glasgow assessment and plan was implemented, replacing the GIRFEC assessment format.

In 2019, Glasgow reviewed the Neglect Toolkit and implemented a revised version, known as the Assessment of Care Toolkit, to be used by staff working all services, including the third sector. This was accompanied by multi-agency briefings and a training plan.

Summary of approach and activities

As in Part one, following a review of single- and multi-agency agency chronologies and case record documentation, the review team considered the multi-agency timeline of key events for 2015-2019 and identified six key practice episodes for deeper review. This enabled the team to explore single- and multi-agency practice around key assessment and decision-making opportunities and identify factors that may have influenced or impacted on the work undertaken by staff and managers:

- Prebirth planning (2015)
- How well staff collaborated to assess and inform the safety and wellbeing of the children (2016)
- The assessment of risk during periods when concerns escalated and there were pre and postbirth child protection case conferences (2017/18)
- The voice and visibility of the children as concerns increased (2018)
- The impact of child protection registration on the children's safety and wellbeing (2018/19)
- The use of legal measures to protect the children (2018/2019)

The lead reviewer provided analysis and evaluation of the practice and identified potential contextual factors that might have influenced the practice. This was organised within a framework that considered the following for each key practice episode:

- Recognition and response to escalating concerns.
- Assessment of needs and risks
- Voice and visibility of the child
- Multi-agency communication and collaboration

Review team members provided challenge and support to the analysis collectively, and from a single agency perspective. What emerged from this work, combined with the thematic learning from Part one, became the agenda for the practitioner and manager workshops in Part two.

Chronology of key events and experiences

In compiling the multi-agency chronology, the review noted the high number of services in contact with the children and the adults during this period.

Universal services:

- Midwifery services were involved during Adult E's pregnancies in 2015, 2016 (ectopic pregnancy), and 2017.
- Health visiting services were involved continuously from Child C's birth in December 2015 and following Child D's birth. Universal pathway visits were the minimum, but the family's vulnerability should have required additional contacts. Not all of these took place.
- Education services were involved throughout Part two, with Child A and Child B at primary school, and Child C at a provider nursery (Aug 2018) and school nursery from December 2018
- Primary Care: the family were registered with a GP who had a long-standing knowledge of the adults.

Targeted services

- ADRS had regular (at least fortnightly) contact with Adult E and Adult F from 2015 until March 2018 when they withdrew from substitute prescribing. ADRS continued to have some engagement with Adult E intermittently until 2019.
- Pregnancy and Early Years Addaction supported Adult E during her pregnancy with Child C
- Glasgow Public Dental Service were involved with the children from 2015 onwards.
- School nursing service (provided by a community staff nurse – schools) was involved with Child B in 2016 (oral health support) and in 2018 with Child A to address the headlice problem
- Homelessness services had seven contacts with the family during their moves into and out of temporary accommodation.
- Children and families' social work were involved in July 2015 for the vulnerable pregnancy referral for Child C; duty social work was involved with post domestic abuse referral enquiries in October 2016; following a child protection referral in May 2017; vulnerable pregnancy referral for Child D in Sept 2017 and allocation to a social worker from that point onward.
- SCRA was involved following the referral in September 2018 to the decision in February 2019, then again following the re-referral in May 2019.
- Cordia began visits to the family home in July 2018, beginning twice daily, then varied until June 2019 but at minimum of three times per week.

Community, voluntary and third sector services

- Church youth group: Child A attended each year from 2015 and Child B from 2016
- A weekly drama club (within a local hall): Child A attended 2016 – 2019 and Child B in 2017
- A family support project – provided after-school and school holiday supports.
- NSPCC: a nurse practitioner visited the family home 12 times from Jan 2018- Sept 2018 to deliver the Parents Under Pressure programme.
- An out of school care project provided weekly support to Child A and Child B Aug – Dec 2018.

2015

Child A is eight years old Child B is five years old. Child C was born in December 2015

Adult E and Adult F were convicted of physical neglect and emotional harm of the children between 2015 and 2019, (alone and with others) separate offences of assault to injury and danger of life on various occasions between 2015 and 2019, and multiple separate offences of sexual abuse on various occasions 2012-2019.

At the start of the Part two period, Child A aged 7 years and Child B aged 5 years were in primary school. Adult E and the children were living with the maternal grandmother. Adult E was in regular contact with ADRS. In July, Adult E was pregnant with Child C. Midwifery services referred the family to the pregnancy liaison group. Based on the information gathered, the decision was to take no further action. Case records noted that Adult E reported she was finding it difficult to manage Child A's behaviour. In August Adult F moved to live with Adult E and the children at the maternal grandmother's home. In October, the family presented as homeless due to overcrowding and family tensions. They moved into temporary furnished accommodation. In November ADRS recorded that Adult F was making progress on his methadone reduction programme.

Child C was born in mid-December and discharged home several days later.

2016

Child A is nine years old. Child B is six years old. Child C is one year old.

Adult E and Adult F were convicted of physical neglect and emotional harm of the children between 2015 and 2019; (alone and with others) offences of assault to injury and danger of life on various occasions between 2015 and 2019; multiple offences of sexual abuse on various occasions 2012-2019.

During this year, Adult E completed an addictions groupwork recovery programme and continued to have regular contact with addictions services who assessed her as being stable and successfully reducing her methadone use.

Health visiting services followed up on repeatedly missed vaccination appointments and home visits for Child C and reported a mixed picture in terms of the children's presentation, sometimes smelly and unclean, other times well presented. Aged six months, Child C was allocated a health plan indicator (HPI) of "additional low risk"¹².

Child B began soiling, once or twice per week, commonly in the evening. This is referenced in case recording and minutes on several occasions over subsequent years. Adult E discussed this with the GP who noted that Child B's description of the problem was different from Adult E's.

From March to May, a dental support worker liaised with the health visitor after failed attempts to engage with the family. In July, the Public Dental Service contacted the Child Protection Unit with concerns about the long-term failure of the family to meet the dental needs of the children, with Child B missing seven consecutive dental appointments since 2013. They referred the concerns to the health visitor who requested support from school nursing service. Child B required a general anaesthetic to have decayed teeth extracted. He did not attend the first appointment. The extractions went ahead in September. The family did not keep later dental appointments for Child A or Child B. Child C was assigned an "additional" low risk health plan indicator in August.

In October, the social work duty team made follow up enquiries with the primary school after a domestic incident between Adult E and Child A's birth father in June. The school reported that the children did not raise concerns within the school, but she was aware that Adult E was having feeding difficulties with Child C.

Midwifery services referred Adult E to the PLG when she reported she was pregnant although this was an ectopic pregnancy.

2017

Child A is 10 years old. Child B is seven years old. Child C is two years old.

Child D is born in August.

Adult E and Adult F were convicted of physical neglect and emotional harm of the children between 2015 and 2019; (alone and with others) offences of assault to injury and danger of life on various occasions between 2015 and 2019; multiple offences of sexual abuse on various occasions 2012-2019; misuse of drugs on various occasions between 2017 and 2019.

Addictions services recorded an overview of Adult E's progress, noting successes. They rereferred her for psychological support to address earlier trauma.

From January to April, the family missed six health visiting appointments for Child C. Child B attended the dental hospital, needing to have 10 teeth removed. His parents reported a five-month history of intermittent dental pain. They did not respond to subsequent letters, and he was subsequently discharged from the extraction waiting list.

¹² HPIs identify children's needs which require additional level of support over and above the minimum universal pathway visits. In Glasgow there are 3 HPIs, core, additional low risk and additional high risk.

In May, the community drama project referred concerns about Child A to social work, describing her as emotionally needy, undernourished, untidy and on occasions smelling of urine. Social work contacted all relevant services. The school acknowledged Child A and the family's vulnerabilities. Health visiting and education services did not consider there was evidence of neglect or risk. There was no reference to the children's dental health.

There was a change of health visitor in June, and again in August. The parents did not attend multiple appointments and Child C was not seen by the health visitor until November.

The family moved to a settled tenancy in August. Adult E was pregnant with Child D. Midwifery services referred the family to the pregnancy liaison group. The group agreed the need for a prebirth assessment. The family were allocated to social work.

In October, the school and a third sector organisation that children A and B attended, submitted separate notifications of concern that the children were experiencing physical neglect and were exhibiting distressed behaviour. School made a further referral in November with the same concerns. Social work advised they would be arranging a prebirth case conference, requesting the school discuss concerns directly with the family. In November, police charged Adult F with intent to supply drugs and dealing heroin.

A prebirth case conference was held in December, with a unanimous decision not to register unborn Child D but agreed to implement a safety plan and monitoring visits and to convene a postbirth case conference in January 2018.

2018

Child A is 11 years old. Child B is eight years old. Child C is three years old. Child D is one year old.

Adult E and Adult F were convicted of physical neglect and emotional harm of the children between 2015 and 2019; (alone and with others) offences of assault to injury and danger of life on various occasions between 2015 and 2019; multiple offences of sexual abuse on various occasions 2012-2019; misuse of drugs on various occasions between 2017 and 2019.

In January, the postbirth case conference considered the family history, including recent concerns about the children being hungry, poorly dressed and smelly. The decision of the conference was not to register the children or make a referral to SCRA as the parents were deemed to be engaging fully with addictions, social work and health services. Social work would remain involved providing guidance and support. NSPCC would provide a parenting programme within the family home.

Adult F appeared in court on the same day as the conference for earlier drug-related charges. He was later given a 50-hour unpaid work order. His attendance was poor, and he was breached by the court in April. He withdrew from his methadone programme in February and ceased all contact with addictions services. Between January and March, Adult E presented as destitute on several occasions. In March, Adult E withdrew from her methadone programme. She continued to have sporadic contact with her addiction worker.

Child B had a tooth extracted but did not attend two further scheduled appointments.

In May, a third sector service submitted a NOC with concerns that Child A had obvious tooth decay, had been regularly seen wearing clothing inappropriate to the weather, often seeking food and saying she was hungry. They also described concerns about behaviour being inappropriately “adult” such as discussing how she would behave if she were in an adult relationship. Child A and Child C were described as giving off a strong pungent smell. They referred Child C to the health visitor, describing her as having rotten teeth and hungry, dirty and unsupervised in the community. An anonymous referral from the community reported that Adult E was using Child A to beg for money and had a problem with headlice. Adult E cancelled five groupwork sessions with NSPCC.

In June, the police raided the house and found drug paraphernalia, although no drugs. The house was very dirty and untidy. An anonymous referrer raised concerns to social work that they had seen Adult E at the bus station, presenting as destitute along with Child D who was described as dirty and smelly. As a result of accumulating concerns, an ICPCC was arranged for July. At school Child B alleged he was being physically abused at home and following an IRD¹³ Child A and Child B were jointly interviewed. Child B maintained he didn’t feel safe at home and didn’t have enough to eat. Child A said she felt safe and reported no worries. At the subsequent case conference, all four children were registered with risk indicators of non-engaging family, parental drug misuse and emotional abuse. Decisions included a referral to SCRA, daily visits by Cordia, completion of the Assessment of Care Toolkit¹⁴ and urgent follow up for unmet health and dental health needs.

GP records indicate Child B was seen in July for bowel issues, including difficulty controlling bowel movements and faecal staining. Whilst the decision to place the children’s names on the CPR was noted, along with “concerns the children are mistreated”, the GP did not share information about Child B’s bowel issues.

Subsequent core groups recorded poor and inconsistent engagement with the plan and suspicions of drug dealing. In August, Adult E was not at home most mornings when Cordia staff made their first visit. There were two anonymous referrals about Adult E using drugs. In September, the parents refused permission for the social worker to see the children alone.

The children’s names were kept on the CPR in October. No outcome from the referral to SCRA was noted and the AoCT had not been completed by health and social work as previously agreed. The children needed urgent dental appointments. The GP shared concerns that both parents were presenting at the surgery requesting prescription drugs. Child A presented as an increasingly distressed child, and school referred her to CAMHS. The community staff nurse – schools withdrew on the basis she considered there was no further role for the service.

¹³ Inter-agency referral discussion

¹⁴ AoCT

2019

Child A is 12 years old. Child B is nine years old. Child C is four years old. Child D is two years old.

Adult E and Adult F were convicted of physical neglect and emotional harm of the children between 2015 and 2019; (alone and with others) offences of assault to injury and danger of life on various occasions between 2015 and 2019; multiple offences of sexual abuse on various occasions 2012-2019; misuse of drugs on various occasions between 2017 and 2019.

In January, the after-school care service reported a deterioration in the presentation of Child A and Child B with them both having dirty clothes and faces and Child A having headlice. The children continued to miss health and CAMHs appointments.

In February, the children's reporter called a meeting with Adult E and the children's social worker. The outcome of the referral to SCRA was no further action on the basis that concerns were not considered significant enough to establish grounds. Around the same time, the records indicated that the social worker and health visitor discussed the AoCT with both parents. The child protection core group meeting recorded increased evidence of neglect and lack of cooperation with the plan. Child A missed three weeks of school due to her severe infestation of headlice.

In March, a neighbour and local community group the older children attended reported increasing concerns to social work about parental drug use and described multiple examples of neglect observed over a period of months. Staff at the community group also recorded concerns about Child A and Child B communicating online with adults and described making a "wee cupboard" in the house where they go to let their frustrations out. Child A was unable to attend school camp due to headlice. The school submitted a NOC. The children's names were retained on the child protection register at a RCPCC in March with full completion of the AoCT still outstanding.

By May, both parents were increasingly presenting under the influence of substances, and the home conditions were very poor.

In June, education referred the children to SCRA for lack of school attendance and being outwith parental control. Social work re-referred the children for lack of parental care. The parents themselves arranged respite care for the children with Mr and Mrs H, who ran a local community church group and had known the family for some time. At a further review child protection case conference on 14.06.19, neglect was added as a risk indicator. By this time, Child A's peer relationships had completely broken down. Child B was ostracised by classmates because of his sister's headlice infestation. The children were asking neighbours for food.

Later that month, Adult F took Child C to the dental hospital for an extraction assessment. He presented as under the influence of substances, fell asleep and couldn't be roused. Child C was seen and assessed as needing 12 teeth removed. Social work decided the children could not remain in their parents' care and with Adult E's consent, they moved to stay with Mr and Mrs H.

In July there was an initial children's hearing and grounds were established in court. By the end of July, the children were the subject of interim compulsory supervision requirements. Social work referred the family to the Family Group Decision Making service to identify potential family-based supports and/or respite options for the carers. Social work supervised the children's contact with their parents as part of the assessment for rehabilitation. Records indicate that the parents were unable to consistently meet the children's needs, were frequently under the influence of substances and Adult F displayed angry and abusive behaviour in front of the children and towards Child A.

In August Child A and Child B disclosed to their carers that they had been physically abused by their parents. Neither child was able to discuss this further in a JII arranged in September, saying life at home brought up "bad memories".

The children's names were removed from the child protection register in October 2019.

System constraints

The review considered data around workforce pressures during the timeframe under review. Whilst it hasn't been possible to isolate data for each locality, overall quarterly absence levels for children and families social work staff rose steadily from 5.3 % in 2014-15 to 7.9% in 2018-19. As a point of comparison, figures haven't been below 10% since quarter 2 of 2022-23.

Social work managers acknowledged general workload pressures throughout 2015-19 but didn't identify any critical gaps in staffing capacity.

Numbers of health visitors were increasing from 2017-2019 which meant moving caseloads as new staff came into post. Team leaders carried large numbers of direct reports impacting on caseload management processes and capacity.

There were no qualified school nurses across the locality due to previous cuts made in school nursing budgets. The nurse holding the role was a Band 5 staff nurse which does not provide the qualification or experience to manage the complexity of this case. An appropriately qualified team leader supervised her. GIRFEC was not fully embedded in midwifery services. Recording systems in primary care did not readily support the identification of patterns of concerns and /or neglect.

At the beginning of this period, public dental service recording systems were not easily visible to other health professionals. Following a test of change in 2021, the public health dental team can access EMIS, but don't record on it. Dental health appointments are visible on TRAK¹⁵ but health visitors, family nurses and school nurses do not have universal access and can only view the records through the clinical portal.

¹⁵ TRAK is an electronic health record.

Practice and organisational learning

The key learning points emerged from the evidence established through review activities and have been organised under the aims set out in the terms of reference. They are not necessarily discrete, and some practice examples are used in more than one issue to illustrate the learning.

How we listen to children and interpret non-verbal behaviours

1. Children's experience of day-to-day life must underpin how professionals assess their safety and wellbeing and make sense of the family's functioning.

Professionals need a clear picture of children's reality and their vulnerability. Children experience risks differently from their siblings. Understanding what daily life is like is crucial to building an accurate assessment.

Staff, including those in adult services, recorded in the children's records when they had seen the children. They described the children's physical presentation, along with brief observations of parent/child interactions. Information from school shared within multi-agency meetings offered some insight into the older children's social and emotional functioning. However, there was limited evidence of any reflection or analysis within records. Instead, they tended to be descriptive accounts of what was seen or what was said.

The children's experiences did not guide professionals in making sense or making judgements about the children's safety and wellbeing. Assessments were written with an adult lens. The GIRFEC assessment format should have facilitated a holistic assessment of each child, but as these written assessments were only produced for specific multi-agency meetings and key processes, it was July 2018 before all four children were considered within that format, and the resilience and vulnerability matrix was not completed. Previous case conferences held in December 2017, and January 2018 were part of prebirth child protection processes and largely focused on the parenting of Child D as the new baby.

The assessment document submitted to SCRA as the referral in September 2018 contained information about the children's dental needs not being met, describing Child A's headlice and information about other clear indicators of neglect. However, there was no attempt to communicate the impact of these experiences from the child's perspective. There was no consideration of the physical impact of needing multiple teeth extracting under a general anaesthetic, or the social impact of losing so many teeth at one time. Emotional abuse was one of the risk indicators identified at the case conference in July 2018, but there was no exploration of what this risk meant to the children.

Overall, professionals accepted the parents' view of the children's behaviours as being "challenging". When staff raised concerns about the children's care with the parents, they would effectively shift the issue to what it meant for themselves. Child A's behaviour was generally described by staff from the parents' perspective i.e. that her behaviour was "challenging", and they couldn't cope with her. In meetings, professionals on occasions described her behaviour as "nasty" and that she "interferes in matters that don't concern her". Despite being part of national GIRFEC practice guidance, staff we met with said that in the early

stages of Part two, the focus on recording the child's experiences/from the child's perspective was not common practice.

Adult E flagged concerns to various services about her relationship with Child A over many years. She said she hadn't bonded well with her as a baby and regularly described her behaviours as challenging within the home. Professionals noted this was in contrast with Child A's behaviours within school, but it didn't trigger further consideration of it as a barrier to her meeting Child A's needs.

There were limited attempts to engage with the children around their experience of life at home. When school staff met with Child A and Child B as part of preparation for the forthcoming case conference in June 2018, this prompted and enabled Child B to speak about being hit and not having enough to eat. This led to an IRD and JII¹⁶. School staff recognised that with hindsight there were opportunities to have enabled the children to speak about life at home more, but they lacked confidence about having the authority to do that. After the CPCC in July 2018, social work staff understood that the children needed help to make sense of what was happening at home, and attempted some engagement with Child A. She became anxious when spoken to within the family home, saying she was scared of the worker, and told her she was not hit at home and that she was "fed and looked after". Staff were clear she would have heard this from her parents, but it did not prompt active consideration of why she might be fearful of being asked. Resistance from the parents was a barrier and by September 2018, they were refusing to let professionals meet with the children alone. This was a clear indicator that the family were actively resisting the care plan.

The children's views

Child A and Child B recognised in general that professionals were trying to help them, but that no one understood what was happening or what life was like for them. They were clear that it was not safe enough for them to disclose whilst living at home. However, adults did not create opportunities to talk to them. Child B said that being one of four children meant it was less likely he could develop a relationship with visiting workers. Child A's recollection was that the Cordia staff "patched me" and only asked about where her mum was.

When asked what could have been done differently, both young people said that professionals need to spend time talking to children out of the home and away from their parents.

"Staff should be talking to the kids more, taking them out to talk to them without the adults, watching how they are acting, watching the adults. Paying attention to the little things and coming out more to see what's going on"

"I feel like there should always be someone there [...] getting me into school more and someone there out of school to check in at the weekends"

¹⁶ Joint Investigative Interview

I didn't feel safe enough to talk to teachers" "It's not safe enough to tell anyone about what's going on when living with them [...]"

"People in the community knew" "People were trying to help [...] I trusted my head teacher"

Staff understood that children communicate through their behaviour. In this case, there were a few instances where staff knew something wasn't right about the way the older children reacted or responded. However, this was not explored further or considered as part of the risk assessment. Child A tried to prevent the school nurse from driving away after she had visited the house and didn't want to be left at home. On another occasion Child A banged on the windows shouting at the health visitor not to leave. This was rationalised as characteristic of Child A's challenging and "streetwise" behaviour rather than a serious indicator of distress.

There were other examples of indications of the children's unhappiness that featured within records but were not explored within multi-agency forums. Child A wrote a note at school saying, "I hate myself" and had previously said she wanted to kill herself. Child B asked staff to smell his trousers because other children said he was smelling of poo. His presentation became more withdrawn towards the end of Part two. These behaviours didn't appear suddenly, rather it was gradual over time but were signalling increasing stress and unhappiness.

Statutory services were aware that the older children regularly attended church and local community-based voluntary and third sector projects running out of the local hall. These services held important information and observations about the children's presentation and life in the community that was not sought out during child protection planning processes. In 2018 the out of school care project observed that Child A was reserved with other children, clearly embarrassed by the headlice issue and upset that other children said she smelled bad. Staff working in the drama club observed Child A and Child B being bullied by other children eating food in front of them, as they were always hungry. These children "stood" out in the group, physically, behaviourally and how they were treated by others.

The records provide a limited understanding of Child C or Child D's experiences. From January 2019, nursery staff recorded Child C's daily presentation and shared this with the headteacher. Child D was the focus of the NSPCC's parenting under pressure course. The observations of Adult E's relationship with Child D as described by NSPCC did not align with the observations of staff at the family support project. They observed a child who did not respond when separating from or reuniting with her mother.

A focused piece of work to understand the world as experienced by each child would have been a powerful evidential tool in supporting staff to see the risks.

2. Children need trusting relationships and a protective space as part of child-focused interventions to improve their wellbeing.

In this case services were aware that the older children regularly attended church and local community-based voluntary and third sector projects running out of the local hall. In the main however, interventions planned as part of improvement and monitoring arrangements were focused on support for the adults, rather than the children. During the timeframe of Part two, whilst there were limited options available for therapeutic supports for children, these weren't considered as being a necessary part of the child protection care plan.

Nevertheless, the children did benefit from time spent in local activities. Child A described the importance of the time she spent at the local church: "It was safe and fun; we could forget about things". The children valued their relationship with Mr G (who later became their carer) when he worked in the church hall. Child B said, "he was there for me".

Assessment of needs, strengths and risks

3. Staff must recognise and respond to neglect as harm.

The harm caused by neglect is usually cumulative, stemming from the persistent failure to meet a child's basic needs rather than a single event. This is what makes it particularly insidious and damaging. Its impact extends across all stages of children's development.

Partner agencies in Glasgow demonstrate a shared commitment towards reducing the impact of childhood neglect across the city. They have a long-term strategy towards transforming services alongside a significant investment in supporting families. There has been a focus on supporting staff to identify and respond to neglect since 2008, with the development of what was first named as the Graded Care Profile, becoming the Neglect Toolkit, then revised and updated in 2019 as the Assessment of Care Toolkit.

Almost all practitioners and managers spoke about the importance of children living their lives free from the impact of neglect, and the relevance for their own professional role. It remains a core part of single- and multi-agency child protection training. Despite this, the review found a disconnect between the theoretical understanding of neglect, and the recognition that it was causing actual harm to these children, requiring a response within the sphere of child protection at a much earlier stage.

Staff in universal services were not confident about naming neglect either within their own records or feeling equipped to talk about it with families. They were not clear about understanding neglect within the context of families with long-standing problematic substance use. The learning point discussed later, about using factual language when describing a child's presentation meant concerns were diluted and/or minimised.

Information about Child A and Child B's unmet medical and dental needs was available within primary care and public dental service recording systems. However, without a child-focused chronology and without recognition of the importance of this as evidence to inform the assessment of risk and need, it became "lost".

For these children, the term “neglect” only began to appear within records from 2017 and often linked with referrals from third sector services. When the children’s names were placed on the child protection register in 2018, neglect was not recorded as a risk indicator, despite the abundance of evidence by that stage. This continued at the review case conference in October 2018. There is little doubt that the parents, who were already disputing the concerns of professionals, would have been unhappy with this language. However, this became a barrier that masked the full reality of the children’s experiences. It would have strengthened the consideration of the need for compulsory measures of care.

The initial case conference in July 2018 identified the need for staff to complete the neglect toolkit. This would have enabled the core group of professionals to collate the facts and “see” the accumulation of concerns over time and the relevance for each child. The work wasn’t completed until 2019, when a subsequent review case conference did add neglect as a risk indicator, albeit just two weeks prior to the children being moved from their parents’ care. The lack of basic care the children were experiencing, as recorded within the case conference minutes, was extremely concerning. However, it was Adult F’s presentation that triggered the decision that the children weren’t safe enough to remain at home, not the neglect.

The toolkit is designed to be done in partnership with parents. Records indicate that Adult E and Adult F did not want to engage in this, probably contributing to the delay. However, it could have been completed as a desk-top exercise by the social worker and health visitor, enabling staff to draw upon the information sitting across current and historical records. As it was, information contained within the referral to SCRA in September 2018 wasn’t recognised by the first reporter as evidence of neglect, or harm that was significant enough to warrant consideration of compulsory measures. The completion of the toolkit at an earlier stage would have supported staff to recognise the urgency of the need for compulsory measures to protect the children.

Frontline staff in universal services were not confident about using the toolkit and still see it as a social work tool. Social work managers acknowledged when used it works well, but it is not used frequently and there is a degree of reluctance from staff to use it routinely. Services do not monitor the use of the toolkit as part of quality auditing around the effectiveness of practice to address neglect.

Work with families to address neglect can be rooted in belief that harm is unintentional and that once parents have the tools to parent effectively, things will improve. Strength-based practice is important but must be proportionate and underpinned by factual evidence of engagement, risk and capacity to change. Medical neglect must be seen for what it is and services can’t use a relational approach to make sense of it. Working with long-term and multifaceted concerns of neglect must take account of what might begin as parenting that is not intending harm, and what then becomes persistent and entrenched failure to meet children’s needs. In such cases, it is too complex to be seen as a binary issue.

Another barrier that emerged within the review was the context of working within Glasgow and the levels of deprivation and need experienced by families. The commitment of leaders to communicate the aspirations and intended outcomes of the transformational agenda was

acknowledged by staff. However, they spoke about the inevitability of neglect within the profile of the communities and services they worked in. For these children, this normalisation of neglect impacted on the tolerance and threshold for viewing the children's care as harmful. It was a barrier to the GP's recognition of child protection concerns with parents under the influence of substances. Some staff were confused about the extent to which poverty manifested itself as neglect or was a driver for neglect in this family. Others were very clear that what they observed with these children should never have been confused with poverty.

Dental neglect is an important source of evidence within legal frameworks to protect children from harm. Staff working within the public dental service recognise that it is entirely preventable but highlighted the challenges within current diet where people consume high levels of sugar, making tooth decay much more prevalent. It is important to separate this national public health challenge from the experience of these children. Children A, B and C experienced gross dental caries leading to multiple extractions requiring a general anaesthetic. This was first identified with Child A in 2012 and continued until they left their parents' care in 2019. In 2016, dental services responded to the family's failure to attend seven appointments for Child B and followed this up with the health visitor and school nurse. Whilst this resulted in Child B being treated, it did not change or improve the parents' care of their children's teeth. When considering the apparent "tolerance" of failed appointments, dental service staff thought there was a difference between failed appointments for a child, and for a family. For example, missing an appointment for one child one week, but bringing a different child the following week reduced concerns they might have about lack of engagement, even if the first child wasn't seen.

Dental services were not invited to attend case conferences or asked to contribute to the assessment of risk and need at any time for this family. Child protection guidance and training is in place for dental services, and practitioners have access to the NHS public protection team for advice and support. There is no way of reporting numbers of child protection referrals made by dental services as they are logged under a generic "health" heading. Anecdotally, numbers are thought to be low, and relevant managers reflected on referrals that did not result in social work taking further action. Taken together this would suggest a lack of recognition of dental neglect as harm both by dental services and those responsible for responding to concerns raised.

4. Assessments of risk and need must consider a whole-family view.

From 2012, implementation of My Wider World triangle directed health and education staff to consider each child within the context of their family within assessment recording templates. This should have supported professionals to consider the needs of the older children and not focus solely on the child within their caseload or classroom. Until 2018, although services recognised Adult E and Adult F as being vulnerable in pregnancy, leading to prompt referrals to the pregnancy liaison group, the birth of Child C and Child D did not lead to a holistic assessment of the parents' ability to meet the needs of their existing children.

Prebirth guidance (2007 version still in use) states that it is necessary to assess the parenting history of any older children when considering their ability to parent the latest child. It

recognises that this process of assessment may uncover significant concerns that agencies were not previously aware of. With this family, the first of two pregnancy liaison groups concluded there were no concerns, based on Adult E's current contact and apparent cooperation with addiction services along with the absence of any recent contact with social work. As discussed earlier, information about parental capacity to meet Child A and Child B's needs wasn't sought as part of the assessment. Although the review did not have sight of a minute / record from the second pregnancy liaison referral discussion in July 2017, it led to allocation for a prebirth social work assessment so there was some consideration of wider issues.

There was a lack of clarity at the pre and post birth case conferences about where the focus of the assessment should rest. This is particularly significant in this case as it was evident from Part one that Adult E coped reasonably well with babies, but her capacity to parent declined as the children grew older. The concerns contained within the NOC submitted by school and third sector organisation two months prior to the December 2017 case conference, were rationalised and explained sufficiently well by the parents (and professionals) to assure those present that the threshold for registration was not met. The decision not to register Child D at the pre and post birth conference was recorded within her own record, not those of the older children.

When the children's names were placed on the CPR, this strengthened both the capacity and motivation of services to consider how they were operating as a whole family.

Part one of the learning review identified that although Adult F was involved from very early stages of the timeline, he wasn't fully considered within the whole family picture until much later. Even then, references to Adult F in health visiting records was minimal. Overall, there was a lack of curiosity about his role / presence within the family and his offending behaviour and his view of paternal responsibility. Despite the observations by professionals of a range of behaviours exhibited by Adult F, including presenting as the more caring/able parent, minimising Adult E's role, aggressive behaviour and evading/avoiding engaging with professionals, domestic abuse and/or coercive control wasn't explored as a risk factor within assessments.

Until 2017 when they were allocated a secure tenancy, the family's living arrangements were fragile and fragmented and there were short periods when Adult F was using a different address.

However, Adults E and F were long-term partners and essentially parented the children together. He believed he was the father of Child B, and he was the birth father of Child C and Child D. Addictions services provided feedback and updates on Adult F's progress and attendance at clinic. This was largely positive until he withdrew from methadone prescribing in February 2018. However, information about his drug-related offending behaviour did not feature strongly within the assessment of how this family was functioning. Collaboration and communication between the adults' addictions workers was limited, with each having a different understanding of the status of Adult F within the family during the early part of the timeline.

Staff had differing views about which parent provided most of the care to the children. Adult F was seen as the more stable adult by some and a safer carer. Some staff described him as more

observant and in control, whereas others were very concerned at his angry outbursts within meetings and refusal to accept the concerns raised by professionals. Adult F frequently opted out of engaging with social work during the period of registration. This didn't challenge the narrative of a family who was engaging in the work.

The focus and expectations of professionals remained largely on Adult E as the mother to be responsible for the children's care. The referral to Cordia identified the need to support Adult E to improve conditions within the home and establish good daily routines for the children.

5. Staff should be equipped to evaluate and prioritise multiple risk factors and understand how these impact on each child.

Addiction issues were considered the source and leading risk to the children. This narrative emerged in Part one and was not challenged with any rigour throughout Part two. It became a barrier to the visibility of the children's experiences of harm. Adult E's engagement with ADRS became conflated with safety for the children. When Adult E's drug use was stable, this took precedence over previous /other risks. Staff looked for evidence of this within the parents' presentation – whether they were under the influence of drugs – rather than considering whether they were meeting the children's needs.

Staff in universal services considered that addictions issues were being dealt with by other services. Addictions staff recognised and demonstrated their responsibilities for protecting children. However, they believe too much weight is placed on their feedback and not enough is done to fully understand what behaviours can be attributed to drugs and what belongs elsewhere.

There were periods with progress and strengths in one area of the family's functioning, but weaknesses in another. This required professionals to be confident in analysing conflicting evidence. As with other learning points above, assessing risk from the perspective of each child's experiences would have supported staff with this task. The escalation of concerns leading to the ICPC in June 2018 was driven by the drug-related risks, however many of the children's unmet needs were present long before this time. The GIRFEC recording format should help staff to collate and organise information to inform a firm evidential basis for the assessment. In this case, 25 risk factors were identified in total, but not prioritised or evaluated. The protective factors identified were based on future actions agreed by the parents, rather than past evidence of sustained improvements.

6. Assessing parental capacity to change requires the meaningful acceptance of relevant concerns and sustained progress in addressing these.

Another crucial aspect of the narrative surrounding this family was that the parents were seen as engaging well with services. This had a leading influence on multi-agency decision-making throughout Part two (and Part one). The pregnancy liaison group ahead of Child C's birth concluded that Adult E was engaging well with addictions services. Those attending the prebirth

case conference in December 2017 and post birth case conference in January concluded the family were “fully engaging” with services, and that concerns did not meet the threshold for child protection registration.

The reality was much more of a mixed and conflicting picture. The long-term pattern of missed health visiting, dental and hospital appointments and avoidance of home visits didn’t feature in the assessment of parental engagement. It did not alert staff to the likelihood that this would recur. A few weeks after the post birth conference, Adult F withdrew from his methadone programme, followed by Adult E and concerns about the children escalated rapidly.

The review explored the barriers to assessing capacity to change for those working with this family. Both parents, though particularly Adult E, was compelling in her promises to address outstanding tasks, always providing a plausible rationale for concerns raised. Practitioners noted that the parents were visible, not shy to attend events at school, would call into the clinic and be seen. On reflection staff recognised this was often on their terms. Health staff did not challenge previous multiple missed appointments once the family had been seen.

NSPCC delivered just 13 out of 34 sessions between January 2018 and Autumn 2018, with 18 planned sessions cancelled by the parents. Case records indicate the visiting nurse practitioner did consider they were deliberately avoiding the work, but this wasn’t used as evidence towards the need for tighter care planning. The parents generally (though not always) allowed Cordia staff into the home. They refused them access to certain rooms on occasions. Although the overall impact of this resource on improving standards in the family home was very limited, being allowed access to the house was considered by the reporter and other professionals as evidence of cooperation and engagement.

The focus on addiction as the leading risk factor meant staff gave weight to whether Adult E and Adult F were attending addictions appointments as a source of assurance about cooperation and engagement. As seen from the chronology, there were periods of progress from both parents towards detoxing. However, this should have been recognised as the adults meeting their own needs, rather than successfully engaging with work to meet their children’s needs.

Another barrier to assessing commitment to change was the absence of SMART outcome focused care plans that could effectively hold parents to account. Intervention tended to focus on monitoring the parents’ contact and engagement with services rather than measuring the impact of the commitments being made on improving the lives of the children.

Non-engagement was recognised as a risk indicator by the July 2018 ICPCC, along with the unmet health needs of the children. Core groups held in July to October noted that home standards had improved but not sustained. The children’s dental needs were not met. Adult E was lying about seeking treatment for Child A’s headache problem. Despite this, the parents were still being described within records as “doing their best”.

7. Assessing the strength and safety of parent-child relationships must be based on evidence of parents' capacity to meet their children's needs and sustain this over time.

Assessing parent-child relationships when working with neglect must involve a multi-faceted approach that includes direct observation of interactions, listening to the child's perspective, and evaluating the parent's capacity to change and respond positively to their child's needs.

In this case, staff placed significant weight on what they saw as warm, responsive and often reciprocated physical interactions between the parents and children. These included Child D running into the open arms of parents at the school gates, and Child A and Child B wanting to be physically close to Adult E.

Feedback from NSPCC who were working within the family home during 2018, raised no concerns about This narrative emerged during Part one of the learning review. Adult E's engagement with services through her pregnancies and observations of positive post birth and early care of Children B, C and D contributed to the maintenance of the perception that the mother-child attachment relationships were strong. the interactions between the parents and Child D. However, a third sector organisation observed poor engagement and eye contact and no reaction on separation or reunification between Adult E and Child D which conflicted with this view.

The review team noted the strength of belief from staff during engagement sessions that these were essentially "warm and loving parents" and were "doing their best". Phrases like this were used within written records from individual agency contacts and multiagency meetings, almost until the point the children were moved from their parents' care. The verbal commitments, as recorded by the reporter, made by Adult E during the meeting with SCRA contributed to the decision that compulsory measures of care were neither necessary nor evidenced. This position provided professionals with assurance that harm was unintentional, and the underlying relationship was a protective factor. It became a compelling factor in influencing decisions about risk and intervention.

Whilst professionals working with the family were not aware of the extent of the parents' capacity to manipulate and deceive, the assessment did not take account of the children's experiences, evidence that their needs were not being met at home or the lack of change and improvement over time.

The review of records from Part one of this learning review identified examples where Adult E told professionals she was "losing interest" in her child and not developing a strong relationship with Child A from an early stage. There were many other later examples where both Adult E and Adult F described Child A's behaviours as challenging and problematic. Professionals responded by giving advice about boundaries and structure within the home. Whilst Child A would certainly have benefited from improvements in these areas, it did not prompt any reconsideration of the underlying quality of relationships or capacity of the parents to understand the meaning of Child A's behaviours.

In June 2018, during the joint investigative interview, Child B was unable to identify anything positive about his father and maintained his description of not having enough food to eat at home. Whilst the ICPCC and child protection registration followed shortly after this, the importance of Child B's comments was not identified as an area for further exploration with him within the care plan.

The long-standing pattern of parental failure to meet medical and dental needs did not feature within the assessment of the attachment relationships. Recognition of the dissonance between allowing three of your children's teeth to become black and rotten and requiring multiple extractions, with the belief that parents were doing their best was not highlighted within records, and not evident when we spoke to staff.

Adult F's behaviour towards Child A at the children's hearing in July 2019 was described by staff who witnessed it as absolutely appalling. There were other angry outbursts towards the children noted by education staff during family contact sessions, but no obvious reflections within records to challenge the previous assessment of the parent-child relationships.

Frontline health and education staff did not believe they were well-equipped to assess attachment relationships, despite this being a core part of health visitor role and included within learning and development for neglect and nurture.

8. Professional support and oversight must deliver assurance about standards of practice and provide reflection and challenge where intervention is not improving outcomes for the child.

The critical role of professional and clinical supervision within safe child protection practice has been established for many years. It should help staff retain a focus on the child, promote reflective practice, ensure professional accountability, help staff manage the emotional impact of the work, improve case planning and encourage collaboration.

Core services have a professional or clinical supervision policy, and /or arrangements for staff to access professional advice when working with children at risk of harm. Social workers should have regular supervision, and managers should provide enhanced oversight of child protection case records. Health staff have clear processes to access child protection advisors. In education services, all schools have a child protection lead and class teachers can independently access support from their allocated quality improvement officer for protection concerns. Professional oversight of practice can be delivered through line management attendance at multi-agency meetings, the role of independent chairs for case conferences and review or audit of written records.

An internal audit of health visiting records prior to the start of the learning review identified significant concerns about the absence of supervision, and lack of governance of the health visitor role from mid- 2017 onwards. It identified very limited assessment of the children, lack of care planning, lack of home visits and very poor record keeping, none of which was in keeping with policy and professional standards.

The staff nurse working in the role of school nurse played an important role in addressing the children's headlice problem. However, team leader oversight of this role had limited impact in identifying other potential opportunities for intervention or supporting her to make sense of the children's behaviour, for example when Child A tried to prevent her from leaving in her car. As this was the single qualified school nursing manager for the whole of Glasgow, lack of capacity for supervision may well have been an influencing factor.

Social work managers were involved in the decisions of the pregnancy liaison group in 2015 and 2017 when the case was allocated for a prebirth assessment. Case conference chairs provided independence from the line management of the case. First line managers attended case conferences and some core groups, and after the children's names were placed on the child protection register in July 2018, they routinely reviewed the children's case records. Supervision discussions and decisions are not recorded within children's records in Glasgow. Although the learning review did not meet with frontline social work practitioners or team leaders involved at the time, service managers were confident that regular supervision was in place as part of established practice.

Ultimately though, professional support and managerial oversight did not strengthen the focus on the children, re-visit the agreed narrative about the drivers of the risk to these children or reflect on the long-term failure of the parents to improve their children's lives. Decision-making meetings went ahead without key staff in attendance. Managers were not aware of the delay in the submission of the SCRA referral and did not robustly address the lack of completion of the neglect toolkit. There was no challenge to the length of time SCRA took to reach a decision, or use of the escalation procedure to challenge the decision of the reporter in February 2019 not to pursue statutory measures.

The learning issues identified above highlight opportunities and barriers that impacted on the effectiveness of the assurance arrangements. The system must work to challenge staff from reaching for what seems like the obvious "hook" to provide an explanation for what seems to be happening. However, the right conditions are needed for supervision to fulfil its professional functions. Those giving and those receiving supervision need sufficient time to prepare ahead of meetings and time within each session to reflect and be curious.

Communication between agencies and services

9. Partners need a shared understanding of the child and family history to inform an accurate assessment of each child's current safety and risk of future harm.

Services introduced chronology practice guidance in 2015, with associated training over subsequent years. The critical importance of seeing patterns of events over time, evaluating the effectiveness of previous interventions and understanding the impact of the adult's experience of trauma from the perspective of what it means for the child has been repeatedly identified within case reviews and inspection as an enabler of accurate assessments and child centred practice.

In this case, there was no multi-agency chronology of significant events developed throughout the period under review. Single-agency chronologies within health visiting records did not prompt staff to review their assessment of parenting capacity. Detailed recording of the children's presentation within education services was not used to review what was known or emerging as new or escalating concerns. Professionals generally focussed on what was happening at a particular moment.

Information contained within recording systems provided clear evidence that the parents were not meeting the children's physical and oral health needs. This pattern of parenting was established within Part one of the review, but the information was not brought together to inform single- or multi-agency assessments or used to direct plans for intervention. Some agencies were aware of the family's history of involvement with services and reports prepared for multi-agency meetings referenced decisions made within previous child protection processes. Staff in education services had limited knowledge and understanding of the parents' addiction issues. Homelessness services held information about the lack of stable home base, with Child A experiencing 12 moves by the time she was eight years old, and 15 in total before the family moved into a secure tenancy in 2017. Child B had moved house seven times by the time he was aged seven.

Overall, staff had a poor or partial understanding of the whole picture for the family. Some information about the children's health needs was available and known to some partners. It was used to address a particular problem at a point in time but not retained as something relevant for a later time when it recurred, or for subsequent children. Other information was not shared, as there was no trigger to do so, or decision made by the person holding the information to act.

The area of greatest significance for these children, was the failure to access and make use of information sitting across health recording systems, and the lack of recognition and response to what this information meant for the children's wellbeing and safety. The transfer from paper health visiting records to EMIS in 2014/15 was a potential barrier, but they had access to paper records until the children started school. Information about the children's oral health needs was contained within Public Dental Service records. Missed paediatric appointments at the growth clinic, cardiology and ophthalmology clinics were contained within primary care records. The history of Child B's bowel problems was held within GP records, but this wasn't considered a cause for concern and referred to the school nurse or considered an issue that might have been related to other parts of his life.

Education staff were aware of "talk" within the community about what local people knew/thought was happening within the house. The family home was visible to staff who lived locally and observed adults visiting the house. This information was not included within the risk assessment.

10. Decisions made within multi-agency key processes should be based on information from all relevant partners, with professional opinion supported by evidence.

Over the period of Part two, there were at least ten multi-agency meetings or key processes that provided opportunities for services to jointly consider the children's safety and wellbeing. In the majority of these, critical information was missing about the children's health or care, impacting on the accuracy of assessments and affecting decisions taken by professionals.

The vulnerable pregnancy liaison group for Child C in July 2015 did not seek information from health visiting services as part of their decision-making about how well the family were likely to meet the needs of another child. The timing of this meeting may have been a barrier, as it was convened during Adult E's pregnancy, by which time Child B was at school and there was no allocated health visitor. The focus was on the family's current circumstances and Adult E's cooperation with addiction services.

Follow up enquiries (NORM process) to a domestic abuse incident involving Child A's birth father sought information from the school about Child A's and Child B's progress, but there is no indication in social work records of contact with the health visitor or school nurse to consider information about the children's health needs. This was just a few months after a referral from the health visitor to the school nurse for untreated dental caries for three children and a referral from the public dental service (PDS) for multiple failed appointments for Child B. Whilst the NORM process is focused on risk of domestic abuse, services must be alert to wider evidence of harm.

Child protection procedures directing practice during the timeline of Part two set out the expectation that core services should provide a written report in advance of the meeting, or contribute to a composite report, stating their involvement with the child and family. Those who cannot attend should also prepare and submit a written report prior to the meeting.

In most instances with this family, social work provided the only written report for case conferences. Whilst reports included some information about the children's health and education needs, it was often summarised without evidential detail. Where other services attended meetings, they gave verbal updates. Staff we met with for the review considered this was standard practice at that time and generally remains the case today. Whilst hearing directly from practitioners within the meeting is important, not having time to review written information became a barrier to the visibility of relevant concerns and patterns, as decisions about risk were focused on the current situation. Education services didn't share Wellbeing Assessment Plans for multiagency meetings. Health visiting services did not record the children's needs within the My World Triangle assessment format.

Addictions services, education and police were well represented at key meetings convened by social work services. However, there were key staff missing from some meetings meaning that information was either missing or presented by other professionals on their behalf. There was no health visitor present for the pre-birth case conference or the ICPCC in July 2018 and RCPCC in October 2018. There was no primary care representation at any of the case conferences. Staff from addictions services were frustrated by poor information sharing from the GP when both

adults presented at the practice requesting pain relief medication. Information about Adult F's criminal activities was not considered within some meetings.

As discussed in learning point 1 above, third sector services held information about the family functioning and the older children's wellbeing. Whilst some of this was referenced within case conference reports, there was no indication that they were considered as a potential source of evidence to be explored further.

Staff in universal services recognised that the parents' often angry response to hearing about concerns was a barrier to full and open discussion within multiagency meetings. The absence of evidence in writing based on information was a contributory factor to concerns being diluted or minimised. This places significant responsibility on the conference chair to "see" the full range of relevant evidence.

11. When recording and sharing information about risk, staff should communicate using factual language to accurately represent events and experiences.

It was notable that education and health records often "professionalised" the children's presentation using language such as the child was "malodorous" or has "dental caries". Whilst this is accurate, it contrasted with the language more often used by third sector services, who described the children as having "blackened and decayed teeth" and "smelling of urine" or "unwashed clothes". This diluted the severity of the concerns and was a barrier to accurately assessing risk and need.

During engagement sessions, school and health staff expressed a lack of confidence about using language that the family would object to. They were wary about using what they saw as unprofessional language to describe what they observed. Midwifery staff were aware that parents can request access to their records on BadgerNet¹⁷ and saw this as a barrier to how issues would be recorded. Similarly, education staff were concerned about parental requests to access SEEMIS. Some staff spoke about having off-record discussions and "lightening" records for fear of being challenged. Professional standards and single agency guidance supports staff to communicate around risk using unambiguous language. This shouldn't be confused with being disrespectful or pejorative.

Single and multiagency responses and interventions to identified needs and risks

12. Implementation of Getting It Right For Every Child¹⁸ and child protection procedures should enable staff to identify where children's needs are not being met and direct them to respond effectively.

¹⁷ BadgerNet is a digital end-to-end maternity record system allowing access to information for professionals and parents.

¹⁸ GIRFEC

The integration of child protection within the GIRFEC continuum was strengthened as a feature of the revised national child protection guidance 2021. Nevertheless, national guidance, local procedures and training in effect during the timeline of Part two of the learning review provided staff with an overarching framework to support early intervention within the GIRFEC approach and processes to escalate child protection concerns when required.

The role of the health visitor as the named person should be straightforward in children aged pre-five but is less so for school-age children. National developments to enhance the role of the school nurse were aimed at addressing this gap but, as noted earlier, for this family there were no qualified school nurses working within North West locality during this period of the review. Instead, a staff nurse was holding this role. The school nursing service struggled to identify its role with this family in the early stages of the timeline. The review found that information sharing between midwifery, health visiting, school nursing and dental services did not contribute to an accurate and shared understanding of family history, the pattern of previous parenting, identification of unmet child health needs or lead to a focused plan for intervention.

Although joint working between midwifery and health visiting services has improved, GIRFEC is not fully embedded in midwifery services due to resourcing and workforce issues.

The extent to which schools are enabled to respond to concerns about children's oral health is impacted by data protection barriers. The National Dental Inspection Programme, established in 2002, gathers information to inform children and parents of their oral/dental health status and provides anonymised data to the government and NHS Boards. Children in P1 and P7 are examined and parents are sent one of three possible letters informing parents about the state of their child's dental health. The parents of the children in Family C were sent Letter A, meaning they "should seek immediate dental care on account of severe decay or abscess". Letters are given to the children who should then give them to their parents. Schools receive a generalised report about their students but not individualised due to data protection requirements. Whilst the dental decay was clearly visible for these children and therefore known about, having this written assessment would have supported the school to take a more assertive approach in their named person role.

From 2015 until the allocation of a social worker as the lead professional in mid-2017, there were sufficient concerns about poor parental engagement, multiple missed appointments, avoidance of home visits, knowledge of unmet physical and oral health needs and examples of the older children presenting with neglect to have triggered meetings within the GIRFEC framework. Staff in universal services believe team around the child meetings need the support and attendance of social work services. The review concluded that staff in universal services we met were not confident enough to effectively operationalise GIRFEC.

The family was "overseen" by social work during the period from September 2017 to July 2018, but the role focused on monitoring the engagement of the parents with other services. The absence of a SMART shared plan for intervention with clear child-focused goals relied on the other agencies to be holding the family to account for successfully addressing the right concerns.

Child protection procedures were appropriately invoked in response to Child B's allegations along with progression to the initial child protection case conference in July 2018. Once the formal multi-agency process commenced, joint working and communication was more effective. Interventions included weekly planned and unannounced home visits and core group meetings and initially twice-daily visits by the Cordia home support service. Along with NSPCC staff delivering the Parenting Under Pressure programme, this ensured there was an intensive presence of workers within the home. However, having so many "eyes on" the family home didn't result in the parents sustaining any improvements either to the state of the house, or more importantly with their care of the children.

From the beginning of 2019, the evidence of serious physical neglect within the children's daily lives continued to escalate. The parents were becoming increasingly chaotic, defensive and avoidant. In May, services escalated child protection processes, referred the children for comprehensive medical assessments and re-referred the children to SCRA. In June, the children's names were retained on the child protection register, with neglect added as a risk indicator.

As discussed in learning issue 9 above, addressing long-term entrenched problematic parenting requires a comprehensive and SMART care plan that holds the adults to account in achieving very specific outcomes for individual children within a stated time frame. In this case, although partners were working within the child protection framework, the absence of such a plan left the children experiencing these awful conditions for too long.

13. Children at risk and experiencing harm must be protected through the effective use of legal measures and frameworks.

The children's hearing system is an effective legal framework for the protection of children in need of compulsory measures of care. Staff and managers working within children's services need sufficient and relevant knowledge of legal frameworks to protect children. They must be equipped to recognise when to refer children and ensure the evidence they hold is used to support a referral. They should be confident to request a review of decisions they believe are not in the children's best interests. This case shines a light on two different approaches taken within the timeframe of the review and their impact on the children's wellbeing and safety.

The children's experiences from May 2019 when services re-referred the children to SCRA, demonstrated a prompt and effective use of the legal framework. It established the evidence of cumulative harm experienced by the children, ensured they were secured in a safe placement away from the parents' care and provided appropriate controls around family contact arrangements. In contrast, the approach taken to the referral to SCRA in 2018 ultimately resulted in a decision not to arrange a hearing based on the conclusion of SCRA that the concerns were not significant enough for grounds to be established. Most of the concerns presented in May 2019 were present in 2018 and had been evident over preceding years.

The review identified practice and organisational barriers that contributed to the outcome of the 2018 referral. Attendees at the initial child protection case conference on 2 July 2018 made a unanimous decision to refer the children to SCRA. The referral process relied on business

support staff sending the GIRFEC assessment reports with a brief covering letter requesting these be accepted as a formal referral. Although the final sentence of the report makes a recommendation for compulsory measures of care, there was no further detail about why the conference considered that compulsory measures of care were required. Whilst the reporter is responsible for framing grounds, it would have strengthened the referral to have set this out from the start. This referral wasn't submitted until 07 September 2018.

Managers who engaged with the review were unaware of the delay. SCRA decision-making timeframe from referral to decision should have been 50 working days. In this case, the allocated reporter made a final decision in February 2019, taking 111 days. The review has been unable to establish why the SCRA decision took so long. SCRA performance monitoring arrangements did not identify the delay or trigger the need for line management intervention.

By the time of the RCPCC in October 2018 the parents had withdrawn consent for social work to have contact with the children without them present and the initial period of registration had not led to sustained improvements in the children's care or the standards within the home. The conference noted the lack of a decision by SCRA but did not consider escalating the case. As discussed in earlier learning points, the belief that the parents were "doing their best" took precedence over evidence they were avoiding and lying about tasks they had agreed to complete.

The decision that concerns were not significant enough for grounds to be considered was seriously flawed within the context of the SCRA decision-making framework. Whilst the parents' deliberate intention not to cooperate with services was not recognised, the impact of the lack of care and lack of improvement for the children within the "voluntary" child protection framework was abundantly clear. The reporter's decision to meet with Adult E to emphasise the need to cooperate was unusual. Adult E had a long history of promising to address issues then not following through and this was another example of that pattern. Social work managers did not use the SCRA/social work protocol to challenge the decision in February 2019, despite it coinciding with an escalation of concerns about the children being dirty, having headlice and being late or absent from school.

Whilst referring to Local Authority for voluntary support is a disposal which is available to the reporter, it should only be considered in circumstances where there is acceptance of the index concern, an appropriate care plan to address the concerns and emerging impact or improved outcomes for the child. The level of engagement and detail of the care plan and impact of intervention should always be balanced against the gravity of the index concerns. The higher the level of concern (and in this instance duration), the greater the level of engagement and impact there should be. In this instance, chronic neglect over a significant period, engagement should have been measured against acceptance of concerns and significant and sustained progress if considering referring for voluntary support. Managers in universal services were not confident about the impact of voluntary measures on the progress of children's care plans, giving examples of plans that had drifted and where the focus tended to be on the parents rather than the children.

Social work and education referred the children to SCRA in June 2019. The recommendation from social work was for compulsory supervision requirements, at home. The case conference in June 2019 did not consider using emergency legal measures to protect the children.

The review considered whether the strategy to transform care and support services had impacted on the thresholds for statutory intervention in this case. A small number of staff we met shared their reflections on this possibility. The review did not find evidence to support any overt avoidance of considering legal measures, rather that they weren't considered.

Data on referrals to SCRA indicates that overall numbers increased slightly during this period, from 4103 in 2014/15 to 4247 in 2019/20. However, differences become apparent when considering the source of the referral, with social work referrals falling from 769 in 2014/15 to 266 in 2019/20. Senior officers within SCRA had not been included within partnership engagement during the early development of the transformational strategy. Once the decline in referrals became clear, SCRA escalated their concerns and these were discussed with senior leaders in the HSCP. Leaders were and remain confident that the transformation work has supported the continued focus on protecting the most vulnerable children. The review suggests that routine scrutiny of the thresholds applied for referring children to SCRA would provide additional assurance to leaders.

The sexual abuse

The harm which can be caused by the experience of sexual abuse as a child cannot be overestimated or ignored. Its impact can be lifelong and unpredictable. Education, familial relationships, sexual relationships, mental, emotional and physical wellbeing, education and job prospects can all be affected. Where coercion has involved drugs and alcohol, it can also lead to addiction and the acquisition of a criminal record.

Many victims feel a deep sense of shame, guilt and embarrassment about what has happened to them, which often acts as a barrier to disclosing the abuse. In some cases, it has driven victims to self-harm and even take their own life.

It is not the function of this review to seek to understand why Adult E and Adult F sexually abused the children or chose to involve others as multiple perpetrators in group sexual abuse. Evidence led in the trial demonstrated the highly unusual and corrupting nature of the emotional abuse and the terror and fear that was part of the sexual offending. This abuse was not caused by parental drug addiction. The children were coerced into taking drugs to facilitate the abuse and made to take drugs during the abuse. The adults took drugs during group sexual abuse. The parents took drugs, to varied levels, throughout the lifetimes of the children. However, the children are clear that Adult E and Adult F each knew exactly what they were doing, and what they were organising for others to be involved in.

Those who experience childhood neglect are nearly five times as likely to experience child sexual abuse as those who have not. That is not to suggest a causal link between the two, but that children whose basic needs are routinely not met, where they have no confidence that their parents will put their needs first, leaves them more vulnerable to coercion and control.

Child A, Child B and Child C were subjected to dehumanising experiences where adults repeatedly took pleasure in perpetrating brutal acts of harm and encouraging others to do the same. Their capacity to trust anyone out with the family would have been severely impacted by the control and fear the parents used to achieve their aims.

The deficits in the assessment of the parent/child relationships and failure to engage meaningfully with professionals contributed to the children not benefitting from compulsory measures of care at an earlier stage and remaining at home for as long as they did. This was particularly pertinent for the period 2018- June 2019 when much of the group sexual abuse was happening.

The review has highlighted the poor recognition, assessment and response by professionals to signals of distress as exhibited by Child A and Child B, that were entirely coherent within the context of what they were experiencing. It is difficult to comprehend that the physical impact and damage caused by the abuse was not observed through professionals routine contact with the children. Staff who engaged with the review, who had reflected on this after the children's disclosures emerged, also struggled to understand this. Professionals did know about Child B's long-standing bowel problem that may well have been either linked physically or emotionally to the abuse.

The review acknowledged the well-documented barriers to children disclosing sexual abuse during childhood²¹. Therefore, services working with vulnerable children and young people have a responsibility to be alert to potential signals of sexual abuse, and to create the conditions that reduce the barriers to disclosure.

The review acknowledges the extreme nature of this case. However, if the scale of child sexual abuse nationally is as suggested in the best efforts of researchers to quantify it, then professionals need to be equipped and supported to consider what is still considered as the unthinkable. Services were very aware that these children were vulnerable, but the challenge for professionals working within child protection is to consider what they are vulnerable to, and at risk of.

Learning from scrutiny, quality assurance and case reviews

The Care Inspectorate published a report from the joint inspection of services to children and young people in May 2017²² which reviewed services over the preceding two-year period. It provided a positive evaluation of the partnership, with recognition of strong leadership and capacity for improvement. It identified some aspects for improvement in multi-agency practice that chime with the learning from this review. Whilst the impact on families was evaluated as good, the inspection noted staff did not always assist, engage and challenge families assertively enough to effect real and lasting change and help them to cope better in the long-term. There was no shared understanding of what constituted a significant event, how events should be recorded, or how a chronology should be used and analysed to identify and manage risk and concerns.

Poor recognition of neglect has been an issue in a quarter of the significant case and learning reviews that the CPC has commissioned. Case reviews completed since 2016, which considered

practice before and after the Family C timeline, identified themes for improvement that are relevant for this review. In particular:

- Consideration of all available information on the family unit and the needs of all children within a family
- Use of chronologies to support assessment
- Use of assessment tools
- Use of pre-birth procedures
- Professional curiosity
- Use and management of dissent
- Shared understanding of need and risk, and thresholds
- The measurement of sustained progress
- The number of health recording systems, and professionals' access to the various systems
- Consideration of the impact of parental behaviours on children

The partnership has a multi-agency improvement plan in response to these findings, and the CPC oversees the implementation of actions.

Scrutiny of child protection activity data provides a downward trend of numbers of child protection registrations and numbers of children whose names are on the child protection register, beginning in 2017. This aligns with the development and launch of the transformational strategy, although the start of the trend pre-dates full implementation of enhanced support services.

In terms of learning through auditing practice, partners have results from one sample of 26 cases, a large-scale audit carried out by the HSCP in 2021/22 and the multiagency audit for the joint inspection of children at risk of harm, August 2025²³ The inspection recognised the social and economic challenges of delivering services children's services in Glasgow. It identified key strengths with the child poverty programme and long-term investment in family support services and evaluated the impact of services on children and young people as good.

Within this positive context, the areas for improvement identified by the inspection align, in the main, with the learning issues of this review.

²¹ <https://www.iicsa.org.uk/reports-recommendations/publications/investigation/nottinghamshirecouncils/part-f-cross-cutting-themes/f1-barriers-disclosure.html>

²² <https://www.careinspectorate.com/images/documents/3845/Glasgow%20services%20for%20children%20and%20young%20people%20joint%20inspection%20report%20May%202017.pdf>

²³ https://www.careinspectorate.com/images/documents/8217/Joint_inspection_of_services_for_CYP_at_risk_of_harm_Glasgow_City_August_2025.pdf

In terms of relevant learning identified, the inspection found

- the quality and consistency of a range of key protective processes needed to improve. This included the quality of assessments, plans and chronologies. There was no routine multi-agency quality assurance of key child protection processes.
- Given the levels of poverty and deprivation it was challenging for staff to make decisions about when to make referrals and whether children were subject to physical neglect.
- Staff across services were trained in the Assessment of Care Toolkit though partners had identified that further work was required to ensure this was being used consistently and at an early stage.
- There were examples of assessments and plans that were for family groups which meant that the needs of individual children were not always being identified or support tailored to them as individuals. More could be done to ensure that assessments and plans were child focused.

Significant practice and service developments since 2019

Review team members and staff who participated in engagement sessions detailed some of the key changes and developments introduced since 2019. These include the family support strategy, updated child protection procedures (including pre-birth) for HSCP staff, continued work on chronologies, and NHSGGC school nursing specification. Education staff are now involved in IRDs along with an overall strengthening of quality assurance for child protection practice. New policies and service developments are underpinned by an understanding trauma and use of the national trauma training model. The review acknowledges these changes but cannot provide assurance about the impact of these developments as they relate to the practice and organisational learning identified.

Strategies for improvement

The review has used the experiences of these children to provide a window into professional practice and the systems within which staff and managers were and are operating. Some aspects of practice will have developed, and the family support service landscape has changed significantly.

Internal reviews and external scrutiny have provided the partnership with a good understanding of the areas for focused improvement work, especially around key child protection processes. On this basis, the review was keen to avoid repeating many of the recommendations that have been made before. Assurance that leaders take from the work to address these, should be underpinned by a robust and systematic approach to multi-agency quality assurance that tests and demonstrates the success of implementation, and how well this is sustained over time.

Within this context, the strategies for improvement for Part one and Part two of this learning review focus on where to make the system as safe as possible. The system needs to promote and nurture what works well, and protect against the risks inherent in high workloads, newly

qualified staff, vacancies, absence and poor performance. Leaders need to create the conditions for practice to be safe and effective.

The review identifies four high-level strategies where improvements can have the biggest impact on making the system safer. These strategies will require partners to carefully consider a range of actions needed to deliver the intended outcomes as they relate to the learning points illustrated above.

The first of these is the keystone.

1. The individual child's voice and experiences take prominence within recording, assessments, decision-making and planning – single- and multi-agency.
2. Professional opinion given as part of assessment and decision-making is always supported by factual evidence of a child's health, wellbeing and safety.
3. Professional supervisors and managers demonstrate oversight and accountability for the work and provide critical reflection for the work of staff.
4. Staff are confident in recognising and responding to neglect as harm. This includes children's dental services.

Part three: 2019-2023

This part of the learning review is concerned with the child protection investigation and court processes and considers the impact of multi-agency collaboration and decision-making on the children, parents/carers and the staff. The review has already acknowledged the scale and complexity of the investigation, and the learning identified should be seen within the context of this and the successful outcome of the trial and prosecution of those who caused so much harm to these children.

The lead reviewer met Child A and Child B separately to speak to them about the review. They shared some of their experiences and memories of the investigation and court arrangements.

Child A:

“It was rubbish that we didn’t get a summer, [but] we were able to do fun things between interviews” “I was prepared for the interviews by the social worker, or [carer’s names]”

“Workers helped me understand the process. The police were nice and understanding. They let me go at my own pace.”

“Court was scary, [but] the commission process gave me the opportunity to speak in front of the judge. It was nerve wracking, but I would do it again”.

“I got letters from the PF about developments in the case. Police and workers have kept me up to date”.

Child B:

“It was draining as it was long”

“I got 5 minutes before and after all meetings to talk about whatever I wanted – I did like this”.

“There was a lot of support, everyone explained why and what they were doing”.

It is positive that Child A and Child B recognise the efforts made to mitigate the impact of processes that spanned the four-year period. This part of the report explores the challenges for professionals in ensuring the needs of children remain paramount when part of adult focused investigatory and judicial processes.

Strategic and policy context

Although there had been two joint interviews in 2018 and 2109, most of the children’s disclosures emerged following (and likely because of) the restrictions on face to face contact

due to the COVID pandemic. National restrictions also impacted on the delay between some of the early IRDs and the joint interviews. The backlog caused by the closure of the courts during lockdown affected the timing of the trial.

Partners were working to the West of Scotland Child Protection Procedures, updated in 2016 and multi-agency IRD guidance implemented in 2018.

Scotland's formal commitment to trauma-informed practice began around 2016. In 2017 NHS Education for Scotland (NES) published the "Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce", which outlined the necessary knowledge and skills for different workforce levels. The National Trauma Training Programme was established in 2018, and partner agencies in Glasgow have been working towards the ambition of having a trauma informed and responsive workforce and services.

Until October 2021, police and social work staff involved in Joint Investigative Interviews of children followed the Stepwise model as set out in national guidance of 2011¹⁹. Glasgow JII partnership was the fourth pilot site in the national JII project and went live in practice with the Scottish Child Interview Model in October 2021.

Summary of review activities

The review team considered written case record material and notes and minutes from meetings. The lead reviewer had access to the transcripts from the joint interviews. Fourteen staff and managers, identified by the review team as people who were either directly involved in the investigation, or in supporting the children, responded to an anonymised online survey. Face to face engagement sessions were held with staff involved in the JIIs, operational managers, strategic leaders, Crown Office senior officers, CAMHS lead and representatives from justice social work, HALT and the Family Support Service.

Constraints

The children's carers did not take up the invitation to participate in the review. The review was therefore unable to hear their perspective of the supports offered to themselves, and those provided to the children. It also meant the review was unable to hear from those caring for them, what it was like for the children at the time of the interviews, and how they coped, especially during the weeks of intensive sessions.

As noted at the beginning of the report, the frontline social work practitioners declined to take part in engagement sessions. They did work with the review team to plan and prepare Child A and Child B for meetings with the lead reviewer and attended the meeting with Child B which worked well.

As discussed later in the section, multi-agency planning meetings held outwith the Gold command meeting structure were recorded in the individual children's social work case notes.

¹⁹ <https://www.gov.scot/binaries/content/documents/govscot/publications/advice-andguidance/2011/12/guidance-joint-investigative-interviewing-child-witnessesscotland/documents/0124263-pdf/0124263-pdf/govscot%3Adocument/0124263.pdf>

Whilst these contained a good level of detail, they were tailored to meet the needs of children's case records and there was no agreed shared formal record of the meetings and decisions taken.

Following the conclusion of the trial, the Crown Office and Police Scotland jointly sponsored an externally facilitated de-brief that considered themes of communication between COPFS and Police, use of JII/SCIM and use of evidence at court. Whilst the COPFS managers indicated a willingness to seek permission to share the final report from this work with the lead reviewer, it was not made available prior to the completion of the report.

Chronology of investigation and arrangements for court

2019

Child A was 12 years old. Child B was 9 years old. Child C was 4 years old. Child D was 2 years old.

In September, Police and social work staff carried out joint investigative interviews (JIIs) with Child A and Child B following disclosures they made to their carers about abuse experienced at home. During the interviews, however, both children said they didn't want to talk about life at home as it brought up "bad memories" for them.

2020

Child A was 13 years old. Child B was 10 years old. Child C was 5 years old.

During this year, Child A and Child B were each joint interviewed on three occasions, and Child C had two joint interviews.

The first COVID lockdown began on 24 March. Social work services suspended all face-to-face contact between the children and adults E and F as per the national public health restrictions. Children A, B and C made disclosures to their carers of serious and repeated physical abuse by both parents and witnessing drug misuse. The IRD agreed to invoke child protection procedures and planned joint interviews with the children once COVID restrictions were eased. The JIIs took place in May, and all three children made disclosures that included physical abuse, emotional abuse and neglect. Child B made further disclosures about seeing his parents using drugs at home, daily. This followed a phone call with Adult F where he threatened to kidnap Child B, making him very fearful. Telephone contact was stopped at the children's request.

Later in May, all four children disclosed experiencing repeated and terrorising abuse, involving witchcraft and animals and naming other adults as being involved. The carers requested emergency mental health support for Child B due to his significant distress. This led to an urgent tier three referral to CAMHS which Child B agreed to. He attended an emergency appointment in June. A joint interview followed for Child A where she was able to repeat her disclosures. Child B was not interviewed due to concerns about his mental health, nor Child C because of her age.

In June, the children requested no further contact with Adult E and Adult F, and social work requested a children's hearing to vary the supervision requirement. This variation was established at a review hearing in September and all contact was suspended.

In August, the children made further disclosures to their carers, who reported these directly to police. Following an IRD in September, Child A was interviewed and disclosed sexual abuse of herself, and Child C. Child C was interviewed, against advice from social work due to her age. Child B was interviewed and disclosed he was forced to take drugs. He disclosed his own sexual abuse and that his siblings had also been sexually abused. Other adults were named by the children as participants in the abuse.

In October, Children A, B and C were medically examined for historic child sexual abuse. Child B was jointly interviewed following disclosures he made about being made to sell drugs by his parents.

In October, Adult E and Adult F appeared in court charged with offences of neglect, physical and sexual abuse. They were initially remanded then bailed. Housing and addiction services provided support to both adults and Adult E received support from mental health and justice social work services. Social work coordinated services to support the carers and the CAMHS complex trauma team commenced assessments and support for Child A and Child B.

Also, in October senior social work leaders convened the first strategic multi-agency case discussion to consider information on all the adults and children. Police arranged three Gold command meetings in November and December where representatives of other agencies were invited to attend part of the meetings to discuss high-level plans for the investigation.

In December, Child A disclosed further sexual abuse perpetrated by Adult F and sexual abuse between the siblings. Child B's mental health deteriorated in December. He was assessed by a psychiatrist who advised his presentation was trauma related.

2021

Child A was 14 years old. Child B was 11 years old. Child C was 5 years old.

Child A was jointly interviewed on 13 separate days in July and September. On these dates, the interviews were broken down into a total of 32 sessions, the majority of which took place as morning and afternoon sessions.

Child B was jointly interviewed on 12 separate dates in November and December. The interviews were broken down into a total of 17 sessions. In November, most of these were morning and afternoon sessions.

Child C was jointly interviewed on one occasion.

In January Child A and Child B alleged they saw Adult E in the vicinity of their school and made disclosures about their parents harming animals. In January and February, there were multi-agency meetings and communication in anticipation of the need for further joint interviews, involving the national vulnerable witness advisor from the national crime agency. Partners expressed their commitment to a trauma-informed approach.

From January to June, CAMHS offered regular appointments to the carers. Child B benefitted from individual sessions and established a relationship with his worker. CAMHS supported Child A through advice and guidance given to the carers. Child A had no direct involvement with CAMHS beyond January (and in June decided she did not want to engage with them any further).

In April Child A expressed anxiety about interviews she had been told would be needed. She was afraid that the future safety of her siblings rested with her.

In May and June, multi-agency care planning meetings provided oversight of supports to the children and the carers, including formulation feedback from the HALT service ²⁰.

In July Child A was joint interviewed for eight days over a two-week period, totalling 23 sessions. Mid-way, police called an urgent multi-agency meeting to request a review of the approach by the fiscal. Social work managers escalated concerns to senior management. In August a Gold command meeting was convened where senior officers from social work, health and SCRA voiced their concern at the number of interviews of Child A, and the lack of therapeutic input throughout the process. COPFS advised they had arranged a virtual psychological assessment of Child A as she had not wanted to meet with CAMHS. This was followed the next day by a further multi-agency meeting with strategic leaders from all relevant agencies. Attendees considered stopping the interviews but were concerned about the impact this may have on Child A given that professionals had told her that more interviews were planned. Interviews were to be kept to a minimum, with essential questions only. In September, Child A was interviewed over five consecutive days.

In September Child B attended his CAMHS appointment, but not the next two that were scheduled in October. COPFS sought the view of CAMHS about whether Child B could cope with the planned schedule of interviews. CAMHS clarified that their clinical expertise was in helping the children make sense of their experiences and it was not their role to provide this advice.

In October, during Child C's third (and final) joint interview, she repeatedly made it clear she did not want to discuss the abuse.

In November Child B was assessed by an independent psychiatrist as being able to take part in further joint interviews. Child B was interviewed on seven days within a two-week period; the interviews were broken down into 12 sessions taking up most of each day. They followed the newly implemented Scottish Child Interview Model (SCIM). Child B said it was too much to manage the interviews and attend CAMHS appointments at the same time. He wanted to attend after-school activities instead.

Following the conclusion of these interviews, operational managers across all partners attended four multi-agency meetings to discuss the impact of the interviews. Child B had been triggered by some of the topics, exhibited distress and was tired. Social work and SCRA were clear that Child B was communicating that he needed a break. Crown Counsel instructed police to discuss

²⁰ The HALT service works with children and young people where their sexual behaviour causes concern to themselves or others

this again with the carers, following which Child B agreed to further interviews before Christmas.

In December Child B was interviewed over a further five days. SCIM interviewers were concerned about Child B's mental health. Social work managers did not feel included within the interview planning. Child B expressed worry about being responsible for meeting the time-bar deadline for indicting the adults. This information had been shared with him during an expert witness assessment session. He displayed distress, biting hairs on his arms. On 21 December, he was advised the interviews were now over.

2022

Child A was 15 years old . Child B was 12 years old.

In January COPFS advised they needed to interview Child B again to strengthen the evidence on certain disclosures. Following a careful assessment of Child B's wellbeing over the Christmas period, and his agreement, this interview went ahead. He was described as "uneasy" during the session, and keen for it to end.

Child A and B were anxious about the forthcoming trial in particular being identified by the press. Appropriate supports were applied by social work to ensure the children were protected.

In February, COPFS served indictments on the accused. Police convened a Gold command meeting where court processes were discussed. Partners acknowledged they were unable to tell the children exactly how they would be involved in the trial, however, CAMHS was very clear the children must be protected from being cross-examined by 11 defence agents. Interviews by commission with a commissioner was seen as the best option. COPFS indicated they wanted to engage expert witnesses for further psychiatric and psychological assessments of Child A and Child B.

Over the following months, operational managers were in close contact with each other, and kept the children informed of developments. Police convened a Gold command meeting in July.

In October COPFS advised social work managers that the newly appointed Advocate Depute would undertake the commission interviews with Child A and Child B. It was also likely that they would not use evidence gathered during the 35 joint interviews and the children would need to give evidence as new. Social work had not been informed of COPFS meetings with the carers or plans for them to meet with the children.

At the same time, COPFS shared excerpts with a social work manager from a recent expert witness report. This assessment included face to face interviews with Child A, Child B and Child C. Child B repeated his disclosures in detail. COPFS acknowledged the writer had stepped outwith the remit of the Crown's instruction and furthermore, had shared his findings with the children's carers.

2023

Child A was 16 years old. Child B was 13 years old.

In January, Child A and Child B completed their commission interviews. Social work services progressed permanence plans for the children.

In July and August, the care placement for Child A and Child B became increasingly fragile, with both children finding it difficult to live with each other. The carers struggled to manage their feelings and navigate the complexity of the children's experiences alongside their own role in meeting the emotional and safety needs of all four children.

The criminal trial began in early September. Child A moved to live with family kinship carers, before moving to her present placement. Child B became increasingly dysregulated emotionally and moved to respite before settling in his present placement. Child C and Child D remained with the carers.

On 14 November, the trial concluded, with eight of the accused including Adult E and Adult F, found guilty. Charges against three other adults were not proven.

Practice and organisational learning

1. Children's rights must have primacy within investigation and court processes

Whilst living at home, these children's human rights, notably the right to protection from violence, abuse and neglect, and the right to the best possible health, had already been breached to a significant degree and on multiple occasions. Within the investigation and court processes, it was statutory services (in the main) who were charged with upholding and promoting the rights of the children. Whilst the investigatory models aim to be child-centred, and courts must enable the effective and safe engagement of children and young people; the judicial processes and legal framework are essentially designed to achieve outcomes for adults.

Article 3 of the UN Convention on the Rights of the Child²¹ states that "In all actions concerning children, whether taken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration". Article 12 states "Parties shall assure to the child, who is capable of forming his or her own views, the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child".

These articles complement each other and are intrinsically linked. Whilst neither right takes automatic precedence over the other, the best interests principle should ensure that the child's views are not simply accepted without question but are evaluated within the broader context of their safety, wellbeing and development. Adults retain the responsibility to make the final decision, ensuring it is in the child's best interests, even if it differs from the child's expressed view. They must balance all relevant interests, giving larger weight to what serves the child best,

²¹ <https://www.unicef.org.uk/what-we-do/un-convention-child-rights/>

whilst ensuring the child's voice is central to the process. Those making decisions must demonstrate they have:

- Listened to and considered the child's views, giving due weight based on their evolving capacities
- Evaluated the personal condition of the individual child
- Made a transparent and proportionate decision that prioritises their best interests.

In this case, there was good evidence that staff and managers representing key agencies listened to and considered the children's views about their willingness to take part in joint interviews. In multi-agency meetings, social work, SCRA and police ensured the views of the children were shared and heard. Staff directly involved in interviewing the children consistently informed the children of their rights about taking part and worked hard to help them feel empowered. Social work consulted the children's carers and school staff to gather feedback about the impact of the interviews. Once COPFS representatives became part of multi-agency meetings, they too considered what the children were saying about their continued involvement in the joint interviews.

There was some recognition of the developmental capacity of the children. After Child C's third joint interview, managers rightly decided she neither wanted nor had the capacity to continue with further interviews. Managers had to balance the weight given to Child A's clear verbal commitment to using the interviews to "tell her story", including arriving at the interview with a list of 12 points she wanted to discuss, alongside her developmental age and stage and the impact of her own trauma. CAMHS staff provided valuable insight in helping agencies understand how Child B was making sense of his experiences. COPFS sought expert psychiatric opinion as a means of evaluating the personal condition of Child A and Child B – described as a risk assessment – that they used to support how they directed the investigation to proceed. These expert opinions all confirmed the children were able to take part in further interviews.

There were instances where the fiscal's decision to continue to interview the children was at odds with what the children either said, or indicated they were able to cope with. In November Child B said he couldn't cope with the joint interviews as well as attending his CAMHS sessions, resulting in the CAMHS sessions being postponed. In December 2021 Child B made it clear that he could not continue with the interviews and needed time to recover and engage in normal-life activities that a 12-year-old boy approaching Christmas should be able to enjoy. His carers supported this position. COPFS instructed police to discuss this again with the carers, and they subsequently agreed, as did Child B, to further interviews around the Christmas week..

The review found significant concern about the lack of recognition of Child B's rights to be treated as a child victim of coercive sexual abuse with his siblings that became apparent during the interviews in 2021. Staff and managers from police, social work and SCRA were highly concerned that the direction of this part of the investigation was underpinned by attitudes and beliefs from the Crown Office that Child B had "perpetrated" offences, rather than being a victim of adult control, fear and coercion.

There were examples where COPFS requested that CAMHS would intervene or meet with Child A and Child B to inform their decisions about the investigation. CAMHS staff continued to advise of the boundaries of their role, and latterly that the children had a right not to engage. The commissioning of independent experts often followed shortly after. Whilst the children could have refused to meet with them, it was hard for them to exercise their rights about an unknown engagement. Child B later expressed his confusion about meeting a psychiatrist who was a stranger to him, rather than his own CAMHS worker.

It is important to consider the extent to which children, especially those who have experienced severe and repeated trauma, are able to give informed consent to take part in investigative and legal processes. These children **agreed** to be interviewed for the investigation and within the court processes. However, there was much at stake for the children themselves, and the professionals. During the multiple interviews in July and September 2021, Child A believed the outcome of the investigation and the protection of her siblings rested on her evidence. She expressed her fears about this. Child B was made aware during an interview by an expert witness, of the legal time bar for gathering evidence and expressed his anxiety and feelings of responsibility for this. For the professionals, the prospect of stopping the interviews or refusing to let the children continue, may have impacted the offences for which the adults were to be indicted on, and ultimately the outcome of the criminal trial.

Protecting children's rights within this complex context is not straightforward. The third bullet point above – making a transparent and proportionate decision that prioritises the children's best interests – is where practice can be strengthened. Records of meetings indicate that managers were committed to mitigating the impact on the children wherever possible. However, the pace of the interview schedule was a barrier to having the time and space needed to examine and evaluate what was truly in the children's best interests. There were no opportunities created to stop and take stock collectively. Without the recognition of partners as equals, the autonomous role of the fiscal in directing investigations did not protect the children's rights or give them primacy within this investigation. It is not the role of learning reviews to highlight the role of individuals. However, in this case, there was compelling evidence and unanimous feedback about the approach taken and direction given by the lead from COPFS. The internal case oversight arrangements within the COPFS did not bring significant positive impact on decisions taken, although the involvement of more senior officials towards the end of the investigative process brought a greater degree of focus on the children's rights and needs.

This raises the question of who advocates for the child? The children's status as looked after children is considered in a later learning point. Operational and senior managers in SCRA, social work, health and police did their best to advocate for the children's rights but were left believing they were unable to meet standards they aspired to. In discussion as part of the review, Crown Office managers recognised the critical importance of children's rights but were less clear about what advocacy would mean for them and who had authority to advocate on their behalf. The parents were the accused. The carers were managing the extremely challenging task of caring for four traumatised children.

Children's rights are disadvantaged within the legal and judicial processes and at risk of not being given paramountcy. Adults cannot pick and choose which of children's rights to focus on. Having their own legal representation might be the only means of truly controlling their involvement, particularly for those without safe parents to advocate for them.

2. In complex child protection investigations, children must be protected from experiencing any unnecessary and additional trauma and harm.

Learning point 1. explores this issue in relation to the extent to which the rights of the children were recognised and prioritised. There is additional learning when considering the application of the frameworks for jointly interviewing children, and the impact of the expert witnesses interventions on the children.

Outwith the joint interviews themselves, the children's mental health and wellbeing was monitored carefully and closely by social work and children's mental health services throughout the timeframe of Part three. It had prominence within care planning arrangements, and in engagement with education services. Social work coordinated the involvement of additional, and specialist supports for the carers, and the children. CAMHS were committed to provide "support in any form" to the children and carers.

The joint interviews held with Child A followed the Stepwise practice model that was implemented across Scotland from 2011. Child B experienced a combination of this model in 2019-2020, and the newly implemented Scottish Child Interview Model with interviews carried out from November 2021. Although the implementation of SCIM is aimed at strengthening the quality and consistency of the evidence gathered, the principles underpinning both frameworks are aligned and rooted in the rights of children to be protected from harm and their welfare being of paramount importance. Children must not suffer undue distress during investigations, and minimising re-traumatisation must be a key consideration. The number of interviews should be kept to a minimum in recognition that asking children to repeatedly recall events can have serious repercussions for their wellbeing. This is particularly important in sexual abuse investigations.

Police and social work staff involved in the joint interviews took great care to gather background information, understand the context for the children and importantly, plan the approach to each interview. Child A and Child B recognised and appreciated the commitment of the interviewers to build a trusting rapport with them and valued the efforts they made to let them move at their own pace. As already noted, the children agreed to the interviews. It is understandable that as the approach taken by the interviewers was skilled and sensitive, the experience will have proved validating for them. However, the JII is not a therapeutic environment. As decisionmakers, adults must ensure they don't use the relationships created through such frequent and intensive engagement to justify multiple interviews.

There were two periods of time where both Child A and Child B endured intensive joint interview activity with multiple interviews on an almost daily basis. The joint interview model does allow for a "continued interview" if something new arises. However, in this case, during these intensive periods, the children were "re-interviewed" about the same issues. Interviewing

staff received daily direction from the fiscal and felt they were not trusted sufficiently to achieve the required outcomes in the way they had been trained to do. The interviewers told the children that certain topics had been concluded, only to be told they had to re-visit them in a further session. Staff who engaged with the review understood the intention of securing the best evidence that would support a conviction. However, they were clear that these intensive interviews periods were breaching the parameters of the joint interview models and not all necessary.

Information recorded in the children's case records illustrates the challenges faced by the children at school as a result of the public awareness of the case. Child A had prelims in the run up to her giving evidence and didn't do as well as anticipated. Child B experienced peer pressure to call his sister names which caused her distress.

When children are asked to repeat their experiences of sexual abuse, research tells us this should be accompanied by therapeutic support. In this case, Child A did not want to take up the offer of support from CAMHS. Her response during and after the interviews was monitored by social work and police who sought advice and guidance from CAMHS. At the time, she appeared to cope well. Child B was able to engage in some direct appointments with CAMHS, until the end of 2022 which meant the support was in place during most of the time he was being interviewed. This therapeutic engagement enabled him to achieve a much more coherent understanding of his own internal thoughts. Nonetheless, specialist child support was not available as part of or at the same time as the joint interviews.

In 2022 the COPFS commissioned a forensic psychologist as an expert witness. This person was tasked with examining the evidence gathered to date through interviews and providing opinion on aspects of the psychological abuse and the impact of the abuse and neglect on the children. They had access to a significant number of documents and material about the children and the investigation. There was no collaboration between COPFS and other partners about whether the expert could complete their assessment through reviewing the extensive suite of records or whether direct interviews with the children were necessary. There was no collaboration between the expert and social work services and CAMHS about the potential impact of further interviews with people with whom the children had no relationship.

The expert attended the carers' home on three occasions. They interviewed Child A and Child B twice, and Child C was interviewed once. As noted in the chronology, the fiscal later advised social work managers that the expert had stepped outwith the remit of COPFS's instructions and in providing opinion about Child B's experiences of coercive sexual abuse and alleged "intimidatory behaviour" and implications for his safe care and those of his siblings. This review is not questioning the expert's professional competence in this area, however, to reach these conclusions, Child B once again recounted details of his behaviour and the abuse he experienced and was part of. There was no governance of this work or accountability for the expert witness going beyond what they were asked to do. Furthermore, they shared details of their findings with the children's carers, again, with no prior discussion with social work. The review finds this intervention to have caused Child B unnecessary and additional trauma. It was also challenging for the carers, who made "safety" arrangements within the placement based

on the opinion of the expert, that left Child B vulnerable to being emotionally isolated and viewed as a risk to others within his own home.

As set out in the chronology, COPFS decided that the transcripts of the Child A's joint interviews would not be used in court. The argument made by COPFS at the time that the information she gave played a valuable part in preparing the case is no doubt accurate but cannot justify the decisions made about the number and content of the interviews she experienced. Some of Child B's interviews were to be used, but he also needed to give evidence by commission.

The children received support to cope with the court processes, in terms of a visit in advance to the venue for the commission interviews, some choice about which of two rooms they preferred, and contact with the vulnerable witness officer. The Advocate Depute (who carried out the commission interviews) met with the children in the lead up to the interviews themselves. The preliminary court hearing in January 2023 decided the children would be questioned by three defence agents, in addition to the Advocate Depute, with judicial oversight of the questions to be asked. The interviews proceeded as planned and the children were said to have managed them well.

At the same time however, the children did feel the pressure and the stress manifested itself within their behaviours at home and school. This included tantrums, nervousness and being quieter than usual. Whilst they could speak to their carers, they could not speak to peers and were unlikely, given the nature of the abuse, to get support from each other.

In anticipation of press interest in the early court hearings, services supported the children well in protecting their anonymity. They implemented helpful safety planning for the children and the carers to mitigate worries about the court processes and provided good support in anticipation of the verdict.

3. Partner agencies in child protection investigations and court processes must demonstrate accountability for being trauma informed in all decisions – single- and multi-agency.

Scotland has a national vision that aims for a universal understanding and response to trauma as “everybody’s business”, supported by a national trauma transformation programme. key principles of a trauma informed approach are:

- Realise the impact: understand trauma affects individuals neurologically, biologically and psychologically
- Recognise the signs and symptoms: identify it in children and adults as clients and patients, and in staff
- Respond by integrating knowledge: embed understanding into policies, practice and culture
- Resist re-traumatisation: actively work to avoid triggering past trauma responses
- Empower and collaborate: involve individuals, build resilience ensuring they feel safe, heard and respected.

Whilst the term “trauma informed” has become common parlance, holding firm to the principles within complex scenarios and potentially competing factors is not straightforward. In terms of these children, there were examples of effective practice relating to these principles, in addition to those already illustrated in learning points 1 and 2 above.

SCRA staff carefully managed the scheduling of the concurrent legal processes the children were involved in to minimise the impact. They advocated strongly for the children to be recognised as victims within the investigation. Social work and police staff and managers involved in joint interviews effectively helped the children to feel heard and respected and validated their experiences. The SCIM training provided them with a sound understanding of trauma research and how theory should be translated into practice. CAMHS staff supported the carers and Child B to understand his own trauma and strengthened the understanding of police and social work staff to make sense of the signs and symptoms of trauma responses in the children.

Case records illustrate the intention of agencies to ensure decisions about the children’s involvement in the investigation should be trauma informed. The engagement of independent psychiatrists by the Crown Office was to provide assurance that the children were “able” to proceed with further interviews. Whilst there are many examples of the children being offered the chance to say “no”, there is little indication that those directing the investigation understood or asked what it was like for the children to be interviewed almost every day for two weeks and have to tell their story repeatedly.

For organisations to be fully trauma informed, they need sufficient knowledge and understanding of what this means, within the context of their own working environment and legal responsibilities. At a local level, staff and managers working within services provided by the council, HSCP, NHS and SCRA had access to national trauma training materials during the timeframe of part three of the learning review. The COPFS has access to learning and training and there is a trauma-informed “lead” within the organisation. As an organisation, it is a signatory, along with local partners, to the Leadership Pledge of Support²² for trauma informed and responsive practice across workforce and services.

Staff and managers across partner agencies who engaged with the review believe that a stronger understanding of the impact of severe abuse and trauma on the children’s development and functioning from those directing the investigation would have helped to safely shape the content of the interviews and minimise the number of interviews required thereby protecting the children.

The Trauma Informed Justice Framework was developed during 2021/22 and launched in 2023.

²³ This provides an opportunity to ensure all partners working with children and young people as part of child protection investigations and in preparation for court ensure their “systems” enable and facilitate trauma informed working practices. The trauma-enhanced roles include

²² <https://www.traumatransformation.scot/about/pledged-support/>

²³ <https://www.transformingpsychologicaltrauma.scot/media/2tzbc0lf/trauma-informed-justiceknowledge-and-skills-framework.pdf>

those in key decision-making roles relevant for the children in Family C, and therefore also for child victims in future complex investigations:

- Advocacy and support: those who provide advocacy, support or interventions to witnesses
- Evidence gathering: those who gather information or evidence directly from witnesses. Includes those who direct or oversee evidence gathering.
- Evidence presentation and interpretation: those who present, examine, or interpret evidence from witnesses who may be affected by trauma, or that otherwise relates to traumatic events. Includes those who direct or oversee evidence presentation.
- Leaders and managers of systems: those who lead or manage organisations & systems that affect witnesses and the workforce.
- The extent to which agencies demonstrated accountability for being trauma informed with their own workforce will be explored in learning point 7.

4. Where children are care experienced, corporate parenting duties must be recognised by all partners and those with corporate parenting responsibilities must be enabled to deliver them.

When the children of Family C were moved from their parents' care in June 2019, they became looked after children. By the time the children began to disclose their experiences of abuse, they were looked after within the children's hearing system and subject to compulsory measures of care. The local authority holds the primary duties towards children who are looked after.

The Children and Young People (Scotland) Act 2014 formally introduced corporate parenting with specific duties for public bodies coming into effect from 2015. These include the council, HSCP, the health board, Police Scotland and SCRA. COPFS is not identified within the legislation as a public body with corporate parenting responsibilities.

The relevance for this review is whether the children's looked after status gave them what a "good parent" would provide within the context of the investigation and court processes. Corporate parenting responsibilities are set out in statutory guidance²⁴. In summary they require corporate parents to be alerted to matters affecting the wellbeing of children; assess and provide support for children's needs and promote the interests of children and young people. Whilst all named public bodies have these responsibilities, as the lead professional for the children in Family C, children and families social work services were in effect the lead corporate parent.

Effective practice identified in earlier learning points represents positive corporate parenting practice demonstrated by social work, health, education, police and SCRA. However, the review found that within the context of the investigation into the abuse allegations, corporate

²⁴ <https://www.gov.scot/publications/statutory-guidance-part-9-corporate-parenting-children-youngpeople-scotland/pages/7/>

parenting bodies were unable to give full effect to their responsibilities. Barriers included the lack of understanding by COPFS of social work responsibilities towards looked after children; lack of communication ahead of expert witness engagement with the children and carers; and poor recognition of the social work voice within the joint interviews.

With hindsight, social work managers recognise they might have asserted themselves more robustly as corporate parents. However, the SCIM team was very new, the autonomy of the Crown in deciding on the sufficiency of evidence, and the potential risk of not securing the best evidence for the trial were all factors that got in the way.

5. Complex child protection investigations must be characterised by strong multi-agency communication and an effective governance and accountability structure

Throughout the investigation and court processes, operational managers across SCRA, social work, police and CAMHS established a highly effective and supportive approach to communication that ensured information available to partners was shared promptly. From mid-2021 onwards, the COPFS attended multi-agency meetings, meaning key partners were all present during these discussion forums.

Overall, frontline staff said they were kept informed of the progress and decisions, mainly through line management structures. Following the indictments social work and SCRA staff felt they were either excluded from information or there was a delay in them being advised of next steps in the investigation process.

Communication with school staff in the local authority the children moved to was positive. Education managers in Glasgow were not kept well informed about the progress of the investigation in terms of what it would mean for their staff who were later called as witnesses at the trial. This affected their ability to provide timely support to their staff.

In addition to multi-agency meetings as a discussion forum for the investigation, care planning meetings convened within the kinship care framework ensured the needs and experiences of the children and the carers were monitored and supported. In the lead up to the children's commission interviews, communication between social work and COPFS ensured there was a clear plan in place to support the children.

In Scotland, the Gold – Silver – Bronze structure, also known as the Strategic – Operational – Tactical framework, is the mandated command hierarchy used by Police Scotland and partner agencies for managing major incidents or investigations. A Gold command structure was stood up by police in October 2020, initially police-only but subsequently engaging partner agencies in the high-level plans for the whole investigation as it related to the children and all the adults involved. However, there were no further Gold meetings until August 2021, after operational managers had escalated concerns within their own management structures in July about Child A's wellbeing and the number of interviews she was experiencing and the lack of therapeutic support available to her. Senior officers in social work, police, health and SCRA met the same week to articulate concerns about the investigation. Whilst there was agreement of the need to

protect Child A from any unnecessary interviews, these meetings did not halt or pause the second intensive phase a few weeks later.

The pattern was repeated for Child B, with an intensive interview schedule in November and December. Operational managers, including the fiscal, met frequently to discuss the investigation and raise concerns about the approach to Child B's disclosures of his experiences of the sexual abuse. This had limited impact on the direction of the investigation.

Senior police officers escalated concerns within national structures and engaged in a rare degree of challenge to the COPFS about the impact of the interviews on the children and their own staff.

Whilst there were multiple multi-agency meetings with the right people attending, the governance and accountability arrangements didn't enable staff or managers to influence key decisions. They were mainly reacting and catching up with the demands of the Crown. The complex and unusual nature of this investigation was reflected to some extent in the volume and frequency of the meetings between operational managers. Whilst these meetings were recorded within individual children's case records, they lacked the formality of an established meetings structure. There were no minutes taken to hold agencies to account or reflect the highly dynamic and challenging debates that managers recall having with Crown Office representatives, which they described as "a battle". Managers recognised afterwards that:

"everything was getting lost in the rate of the interviews"

The Gold command structure (convened only once in 2021) could have established formal Silver and Bronze structures, with meetings scheduled in advance and clear reporting arrangements. As the most "formal" of the meetings that took place, there were too few Gold meetings called during critical times in the investigation.

Earlier anticipation of the need to escalate matters could have enabled partners to insist on the need to stop and take stock of the progress of the investigation. Had the COPFS been willing to sit down with partners to review the sufficiency of evidence, there would have been greater clarity about what was required from the children. Given that Child A's interviews were not subsequently used in the trial, this is a sobering point.

The prosecutorial independence of the Crown Office, and the unusual nature of this case underpin the barriers identified. Strategic partnership working requires a willingness to hear and respect the concerns of others.

Senior COPFS representatives who engaged with the review recognised the critical importance of good communication and strong working relationships. They expressed concern that partners felt unable to have a voice. The review is not confident that the issues that surfaced during the investigation had been fed back into COPFS for consideration and learning.

6. Staff and managers involved in complex and/or extended child protection work must be protected from the impact of vicarious trauma. A wellbeing strategy, with resources in place across all agencies that can be stood up at short notice and for as long as required.

The professional task of staff working within child protection services means they are routinely engaged in observing, hearing and reading about harm and distress experienced by children and adults in their own lives. Relationship-based practice requires practitioners to lean into the experiences of others. The importance of clinical and professional support to help staff manage the demands of the work and the impact on themselves is grounded in research²⁵ and widely understood.

Leaders across partnership agencies understand this case has had a significant impact within their respective staff and management groups. Many staff were and remain highly distressed by their involvement in the case. The sources of distress, in addition to an overarching response to the extreme nature of the case, varied depending on the roles people held. The key areas that emerged though the review included:

- Knowledge that the children had experienced such horrific abuse whilst living at home and subject to multi-agency involvement
- Hearing the children's experiences of sexual and physical abuse and fear through the disclosure and interview processes, and later at court
- Having to cross professional boundaries in asking the children to repeat their disclosures during multiple interviews
- Being subject to periods of intensive workload pressure, without due protection
- Lack of strategic communication strategy meaning they heard about information through press reporting or in a piecemeal fashion from their manager or a colleague.

Through responses to the anonymised survey and discussions within engagement sessions, staff (including managers) shared their experiences of what it meant for them, and the effectiveness of supports provided.

Overall, with a few exceptions, frontline staff felt they were supported best by their supervisors and valued the support available in scheduled sessions and on an ad hoc basis. Some received support and acknowledgement from more senior managers, whereas others felt that senior leaders didn't understand the extreme impact or didn't communicate this to those involved. Those working in joint teams benefitted from support and supervision from colleagues in other disciplines. Some working within small teams/ services were unable to access peer support due to the sensitivities of the case and the need to avoid traumatising colleagues.

The standard and availability of support services out with line management and supervisory arrangements was variable. Information about the Employee Assistance Programmes and Occupational Health counselling supports was provided, but people who commented felt this

²⁵ "C:\Users\judit\OneDrive\Documents\Consulting\Glasgow\Working documents\Analysis documents\Powell workplace stressors.pdf"

was poorly matched to the level of need, and some worried that accessing it would suggest they weren't coping. The dedicated psychological support for staff working in Glasgow Child Interview Team is seen as an essential protective factor for their staff who are continually exposed to risk of vicarious trauma.

Whilst senior social work managers recognised that staff needed more targeted supports relevant to these investigations, despite their attempts they were unable to source this from within their own services. Dedicated police support is available through the police treatment centre. Whilst individual officers valued a chance to spend a day there, they were aware that other close colleagues were not offered this experience.

Following the start of the trial, social work leaders arranged for staff at CELCIS to provide reflective sessions for social work staff who were cited as witnesses. The purpose was to support practitioners and managers to make sense of a highly complex and demanding area of practice. It was not a substitute for supervision or line management or counselling, or a learning review. These were held four months after the conclusion of the court case. Feedback was mixed, with some appreciating the opportunity, and others who were exposed to information about the case they hadn't previously known.

This investigation was rooted in multi-agency practice. However, the approach to staff welfare and wellbeing was single agency and missed important opportunities for collaboration and coordination. Recognition of the need for a formal multiagency de-brief as part of an exit strategy at the conclusion of the case was identified at one of the Gold command meetings but not implemented. Whilst there are barriers to establishing joint arrangements to support staff who work for different employers, it was within the gift of senior leaders and chief officers to mobilize and resource psychological supports and services that exist within Glasgow services. An investigation of this scale would have warranted such a response.

Strategies for improvement

Whilst this investigation was unusually complex, and partners have reflected on the learning from their own experiences, the review identified the following areas of focus for improvement:

1. Children's rights must be protected and promoted throughout all stages of child protection investigations and court processes. This includes the additional responsibilities towards looked after and care experienced children.
2. Staff investigating child protection concerns must be enabled to apply trauma informed principles within their work. Chief Officers should engage with COPFS to share learning from this case making use of the trauma and justice knowledge and skills framework.
3. Complex child protection investigations should be carried out within a formal multi-agency meetings structure that enables effective governance and accountability of decision-making and facilitates swift escalation of concerns. Managers need dedicated and protected time to lead and oversee the work.

4. Partner agencies ensure their staff and managers have ready access to early and appropriate psychological supports when working in complex investigations, that are available as long as required. Chief officers should resource and implement a partnership wellbeing strategy that enables staff to safely engage in learning review activity.

National and systems issues

5. The national guidance for undertaking child protection learning reviews makes no reference to the expectations of staff to engage in the review process. If learning reviews are to succeed in identifying the full range of learning to protect future children, the right staff need to be involved. Scottish Government should consider including expectations about participation within the guidance.
6. COSLA and the Scottish Government should take a closer look at the Scottish Child Interview Model to ensure the principles and practice framework protects children's rights and ensures their wellbeing through complex investigations.
7. The Scottish Government should consider including COPFS as public body with corporate parenting responsibilities.
8. The Scottish Government should engage with His Majesty's Inspectorate of Prosecution in Scotland to ensure full implementation of the justice knowledge and skills framework.
9. The Scottish Government should review and strengthen the role of independent advocacy for children within judicial processes.

Concluding remarks

The review has considered the life and experiences of the four children across sixteen years. The review has explored professional practice and the factors that influenced the practice as both enablers and barriers. It has shone a light on the areas for organisational improvement, that if implemented will strengthen practice and help to protect children now and in the future and better support and look after those working within child protection systems. It has revealed systemic barriers for national agencies to consider that, if addressed, will impact positively on child protection systems and wellbeing and learning for improvement

The review acknowledges and thanks Child A and Child B, and the staff, managers and leaders for engaging in this challenging piece of work. As lead reviewer, I want to thank members of the review team for their commitment to and ownership of the work, and their support for my role.

Judith Tait, lead reviewer

02 February 2026

Appendix i

Local strategies for improvement

L1.	Individual child's voice and experiences take prominence within recording, assessments, decision-making and planning – single- and multi-agency.
L2.	Professional opinion given as part of assessment and decision-making is always supported by factual evidence of a child's health, wellbeing and safety.
L3.	Professional supervisors and managers demonstrate oversight and accountability for the work and provide critical reflection for the work of staff.
L4.	Staff are confident in recognising and responding to neglect as harm. This includes children's dental services.
L5.	Children's rights must be protected and promoted throughout all stages of child protection investigations and court processes. This includes the additional responsibilities towards looked after and care experienced children.
L6.	Staff investigating child protection concerns must be enabled to apply trauma informed principles within their work. Chief Officers should engage with COPFS to share learning from this case making use of the trauma and justice knowledge and skills framework.
L7.	Partners promptly establish a multi-agency meetings structure for complex child protection investigations that enables effective governance and accountability of decision-making and facilitates swift escalation of concerns. Managers need dedicated and protected time to lead and oversee the work.
L8.	Partner agencies ensure their staff and managers have ready access to early and appropriate psychological supports when working in complex investigations, that are available as long as required. Chief officers resource and implement a partnership wellbeing strategy that enables staff to safely engage in learning review activity.

Proposed improvement strategies to address national systems issues.

N1.	The national guidance for undertaking child protection learning reviews makes no reference to the expectations of staff to engage in the review process. If learning reviews are to succeed in identifying the full range of learning to protect future children, the right staff need to be involved. Scottish Government should consider including participation within the guidance.
N2.	COSLA and the Scottish Government should take a closer look at the Scottish Child Interview Model to ensure the principles and practice framework

	protects children's rights and ensures their wellbeing through complex investigations.
N3.	The Scottish Government should consider including COPFS as public body with corporate parenting responsibilities.
N4.	The Scottish Government should engage with His Majesty's Inspectorate of Prosecution in Scotland to ensure full implementation of the justice knowledge and skills framework.
N5.	The Scottish Government should review and strengthen the role of independent advocacy for children within judicial processes.

Appendix ii

Terms of reference

The overarching aim of the learning review was to identify inter-agency learning in relation to:

- Assessment of needs, strengths and risks
- How services listen to children and interpret non-verbal behaviours
- Communication and collaboration across agencies and authorities, and for each part:

Part one: 2007-14 covers the period of the births and early years of Child A and Child B, with a focus on:

- Early identification of need and opportunities to support families, in the context of legislation, policy and practice standards at that time
- Single- and multi-agency responses and interventions when concerns are identified

Part two 2015-2019 includes the birth of Child C and Child D and the period of significant multiagency involvement, with a focus on:

- Communication between agencies and services
- Single- and multi-agency responses and interventions to identified needs and risks
- Multi-agency collaborative practice to keep children safe

Part three: 2019 – 2023 covers the period following the children’s disclosures and the subsequent criminal investigation and court processes, with a focus on:

- Supports available for children, parents/ carers and staff during and after child protection investigations
- How child-centred and trauma-informed child protection investigation processes and decision-making are
- How child-centred and trauma-informed court processes are

Appendix iii

Review Team information

The review team had agency representation as follows:

- Detective Chief Inspector, Police Scotland
- Professional Nurse Lead (Children and Families), Glasgow City HSCP
- Lead Officer Public Protection, Glasgow Public Protection Committees
- Principal Officer Child Protection, Glasgow City HSCP
- Public Protection and Committee Service Manager, Glasgow City HSCP
- Locality Reporter Manager, Scottish Children's Reporters Administration
- Quality Improvement Officer (Child Protection), Glasgow City Council Education Services
- Service Manager Children's Services, Glasgow City HSCP
- Public Protection Medical Lead, NHS Greater Glasgow & Clyde
- Professional Nurse Lead (Children and Families), Glasgow City HSCP

Following agreement by COPFS for the review to commence, the review team met on three occasions between January and April 2024 to collate single agency information.

In May 2024, Judith Tait was commissioned by chief officers as the external lead reviewer. Judith has thirty-seven years' experience as a qualified social worker in local government and national settings, most recently as head of service and chief social work officer. Judith has experience working in national scrutiny bodies, as an inspector with the Social Work Inspection Agency and led the children's strategic inspection team in the Care Inspectorate. Alongside her role as lead reviewer, Judith is the independent chair for the child and adult support and protection committees in another local authority area.

Professor Alexis Jay was asked by chief officers to provide support to the review in her capacity as expert advisor.

The review team met 14 times between 14.05.24 and 29.01.26. The team considered the three parts of the terms of reference and timeframe for the review consecutively, using the learning from each part to inform the next. The review team was fully involved in planning the approach to the review, providing support and challenge to the analysis of written records and practitioner engagement and agreeing emerging thematic learning. The lead reviewer produced written summaries of work undertaken, evidence considered and analysis agreed throughout the process.

Appendix iv

Practitioner engagement sessions

Review team members identified appropriate staff from their agencies. Practitioner packs were produced, containing a letter of introduction from the lead reviewer, information on wellbeing and supports available, and the statement of confidentiality for the review. Review team members made contact with the identified staff and prepared them to participate.

The lead reviewer offered an online briefing in advance of the planned engagement to provide information to staff on the purpose and principles of the learning review and the process.

In relation to Part 2 of the review, 45 staff contributed in engagement sessions. There were 14 sessions, comprised of single-agency group workshops and meetings with individuals:

- Alcohol and Drug Recovery Services frontline practitioners
- Education frontline practitioners
- Education managers
- General Practitioner
- Health frontline practitioners
- Health managers
- Glasgow Home Care (formerly Cordia) frontline practitioner and manager
- Public Dental Service frontline practitioner and manager
- Social Work managers
- Scottish Children's Reporters Administration frontline practitioners
- Scottish Children's Reporters Administration manager
- Third sector frontline practitioners and managers

For Part 3, 18 staff contributed during 4 sessions. There were 3 multi-agency and 1 single-agency groups:

- Crown Office and Procurator Fiscal Service managers
- Multi-agency operational managers
- Multi-agency senior managers/GOLD group
- Police and Social Work Joint Investigative Interview frontline practitioners and managers

Appendix v

Documents and written material

The review team had access to and considered a variety of records and documents for the purposes of the review, including:

- Legislation
- Single- and multi-agency policies
- Single- and multi-agency procedures
- Agency records in respect of the children and adults
- Minutes of meetings
- Assessment reports and care plans
- Reports of self-evaluation activity
- Other local significant case review/learning review reports
- Child protection data
- Vacancy data
- Scottish Children's Reporters Administration referral data