Executive Summary

Significant Case Review

Undertaken on behalf of

Glasgow CPC

On Child B

February 2016

CONTENT

Introduction

This Significant Case Review (SCR) was commissioned by the Glasgow Child Protection Committee (CPC) in the context of the National Guidance for Child Protection Committees on Conducting a Significant Case Review March 2015, Scottish Government. A SCR is intended to discover whether lessons can be learned about the way local practitioners and agencies work together, following the death of a child in the community or where the child has not died but experienced significant harm or is at risk of significant harm.

A SCR Panel was convened on 16 June 2015 and agreed the initial Terms of Reference, which were subsequently amended and agreed by the Review Team and Panel.

Terms of Reference

- To provide an overview of the family context prior to Child B's birth.
- To consider the visibility of the child and family in the community, particularly health and education services.
- To review information about the contact the family had with agencies from 2012 until 2014.
- To review information, from the time of mother's pregnancy with Child B, with a particular focus from July 2014 until March 2015.
- To consider what assessments were made when Child B had lice and what actions were taken as a result of these assessments.
- To review communication between partner agencies.
- To consider how effective the assessment process was in identifying risks and in decision making.

Agencies Requested to Provide Reports and Chronologies

In order to undertake the SCR, each agency that had direct involvement with the child and family was requested to instigate a single agency review and submit a report with a chronology to the review panel. There had been no Scottish Children's Reporter Administration (SCRA) involvement until after the child's death and so it was agreed that there was no need for assistance from SCRA in the Significant Case Review.
The Review Team and Review Panel met during the period June – December 2015.

Single Agency Reports were received from the following:

- NHS Greater Glasgow &Clyde
- Education Services
- Social Work Services
- Police Scotland

Membership of Review Team

Independent Chair	
Lead Officer	Glasgow CPC
Interim Director	NHSGG&C
Professional Nurse Advisor	NHSGG&C
Quality Improvement Officer	Education Services
Senior Officer	Social Work Services
Service Manager	Social Work Services
Detective Inspector	Police Scotland

Process

Information for the SCR was collected from the respective agencies using individual interviews and access to case record files. The Review Team members then completed a Single Agency Report and chronology. These documents were submitted to the Review Team and Review Panel for consideration and discussion of the findings.

The chair drafted a composite chronology and report of findings which were discussed with the Review Team and Review Panel. A verbal update of progress with the SCR was given to Glasgow CPC on 2 November 2015 with a written summary of progress given to David Williams, Executive Director Social Care Services/Chief Officer Designate Glasgow City HSCP.

The final report was due to be submitted to the Chief Officers in December 2015 but in the light of further information being submitted in December 2015, a request for an extension until the end of February 2016 was made and granted. The report was completed in February 2016 but, on instruction from the Crown Office and Procurator Fiscal Service, publication was delayed to allow for criminal proceedings to conclude.

Notes on redaction of this Report

This document contains the conclusions and recommendations of the Significant Case Review relating to B. In the interests of transparency, every effort has been made to disclose as much of the SCR as is lawfully possible. The only editing prior to disclosure is the redaction of personal data, disclosure of which cannot be justified under the General Data Protection Regulation and Data Protection Act 2018. Although there has been a criminal trial and extensive media coverage of this case, and a certain amount of both personal data and special category personal data is, as a result of this, publicly available, disclosure of the personal data contained in this report must still comply with data protection law. This means that even though some of the redacted information may already be publicly available, or it may be considered to be in the public interest to disclose, it cannot automatically be disclosed, as data protection law contains certain conditions which must first be met. The process of redacting the SCR has involved careful consideration of:-

- The need for transparency and the overall purpose of the SCR in the identification of any lessons learned.
- The public interest in disclosure.
- Considering whether information is sensitive personal data, (for example, because it is information about a person's physical or mental health or condition, his/her sexual

life, or the commission or alleged commission of an offence) and whether its inclusion in the SCR complies with data protection legislation.

- Balancing interests in terms of the right to respect for private and family life in terms of Article 8 of the European Convention on Human Rights, meaning that any information contained in the report relating to B herself and other people whose history was closely linked to B can only be released if it is lawful, necessary and proportionate to do so.

The executive summary of the SCR follows but with certain text (generally containing biographical details) redacted for the reasons set out above. Any redactions are clearly marked with the word "[Redacted]". Some minor grammatical changes have been made (unflagged) to maintain consistency of language following some redactions.

The Facts

On the morning of 20 March 2015, Child B, aged 2 years 5 months, was found to be unresponsive on the couch within her home. An ambulance was called. While waiting for the ambulance, her Biological Mother was given advice on how to administer CPR which was then commenced in the home by her Biological Mother on the advice of the ambulance crew. Child B was taken to the Royal Hospital for Sick Children (RHSC), Yorkhill where she was pronounced dead at 8.07am.

An initial post mortem examination was undertaken on 23/24 March 2015 and findings were consistent with the preliminary examination i.e. Child B showed no signs of obvious trauma or injury but was filthy with severe head lice infestation and was extremely thin and underweight with evidence of severe neglect.

A further double doctor post mortem examination undertaken on 2 April 2015. There was no evidence of serious underlying natural disease or abnormality. Child B was very thin, 80% of the expected weight for her age, with her ribs, shoulders and backbone very visible through her skin. Her hair was heavy and matted appearing to have been unbrushed for a substantial period with areas of the scalp being thickened and leathery (usually seen as a result of chronic irritation) and some areas of baldness. Multiple ulcers and crusted scabs were also in evidence. Massive numbers of head lice were present in her scalp, face and chest. The infestation period was estimated by the Pathologist to be for at least 6 months but possibly up to 17 months or longer. The palms of her hands showed black dirt in the creases. Her finger nails were dirty with black dirt beneath them. The soles of her feet and toenails were filthy and blackened. There were multiple small brown scabs on her right shin, both wrists and forearms and on the upper, mid and lower back, with multiple small healed scars on the mid back. Toxicology was positive for alcohol, diazepam and paracetamol. Alcohol was present at low levels consistent with exposure or possible contamination as a result of the post mortem examination. There was evidence of ingestion of diazepam between September 2014 and March 2015. Paracetamol was present at low levels within prescribed limits. In addition there were changes in keeping with dehydration, evidence suggestive of dental decay in the two upper first teeth, evidence suggestive of anaemia and probable Vitamin B deficiency. These findings are consistent with severe nutritional deficiency/starvation and investigations were undertaken in order to establish definitively whether this led to Child B's death.

Prior to her death, Child B must have suffered deterioration in her general health, nutrition and overall wellbeing, indicative of severe neglect.

On the day of Child B's death, the house was described as uninhabitable by the Investigating Police Officer. Specifically, the house was filthy with head lice apparent on the outside door frame. The conditions within the house were poor with rubbish strewn throughout. It was impossible to gain entry to the kitchen area due to it being packed full of rubbish bags which were waist high. The rubbish bags consisted of food and rubbish dating back to 2013. The couch which the Child B had slept on was so badly infested with head lice that it had a large hole and had disintegrated, and could only be described as being in a terrible condition.

Child B's siblings and parents were taken to the police office on 20 March 2015 and it was very apparent that they had extensive head lice. Officers reported that the head lice were visible, walking over the children. The children were dirty and had a strong body odour. The rooms in the police office and the vehicle in which the family had been transported had to be treated by Rentokil. The ambulance crew who took Child B from the house to the hospital had to remove their uniforms due to lice infestation and the ambulance required to be cleaned.

In March 2015, the family lived in a privately rented multi-story block of flats in an area of multiple deprivation within the city. Female Partner, Biological Mother's partner worked as a cleaner. The family was largely dependent on state benefits.

Police Scotland referred the case to the Child Protection Committee (CPC) requesting that consideration be given to a Significant Case Review (SCR) being undertaken. In June 2015, the CPC Review Panel discussed the case and all agreed that this case warranted a full SCR.

There was an ongoing police investigation into the circumstances surrounding Child B's death, and of the living circumstances of the children in the family unit. Given this, the family/carers were not involved in the SCR.

Analysis

When the Review Team had undertaken their investigations and discussed their findings it became apparent that agencies did not have an accurate, shared understanding of the family's circumstances and that many aspects of the case remained unclear. The police investigation following Child B's death provided hitherto unknown information to the SCR and prompted further examination of agency records and supplementary interviews with staff in Health and Education Services. In addition, the provisional post mortem report was not made available to the SCR until 12 November 2015 and contained information relevant to the SCR findings.

The following provides a summary of information available to the SCR and addresses the terms of reference. Where the term "family" is used in the report, this refers to Biological Mother, Female Partner, Sister 1, Sister 2 and Child B.

Family Background

In March 2015, the family consisted of Biological Mother, aged 34 years, Female Partner aged 33 years, Sister 1 [redacted – of primary school age], Sister 2 aged [redacted – also of primary school age but younger than Sister 1] and Child B who was 2 years and 5 months.

The family attended universal health services. The two older children, Sister 1 and Sister 2, attended nursery prior to starting school. There were no concerns reported by the nursery or school until issues related to hygiene were raised by the school with the School Nurse in November 2012, just after Child B was born on 8 October 2012.

The family was not known to Police Scotland until Child B's death in March 2015.
At the beginning of the SCR process, Health, Education and Social Work Services understood that Biological Mother was a single mother, perceived as a caring parent who loved her children but was struggling to cope. The Police investigation following Child B's death on 20 March 2015 shed light on the reality of the home and family circumstances when it emerged that the biological mother, Biological Mother was not a single parent but that Biological Mother and Female Partner had cohabited as a couple in a same sex relationship for approximately fourteen years, therefore from before the birth of Sister 1, Sister 2 and Child B.

Without exception, all health staff were of the impression that Biological Mother was a single parent and had no awareness of Female Partner being in a same sex relationship with Biological Mother. While Biological Mother may have found it difficult to share the fact that

she was in a relationship with Female Partner, it remains the case that the motivation for withholding this information is unknown.

The family are known to have occupied three tenancies since 2000, either abandoning or being evicted from the first two, and with issues being noted regarding rent arrears and the condition of the second property. The second property required a major clear out after the family vacated, with repairs and replacement of items also necessary.

No referral was made to SWS to alert them to the housing situation in 2011 when there were two children in the household. The family moved to a different tenancy in [Redacted] and Child B was born on 8 October 2012. The family remained there until Child B's death on 20 March 2015.

As has been indicated in the Facts section of the report, the police reported that the house was uninhabitable in March 2015. It is the view of the investigating police officer that it is not possible that these conditions had suddenly happened. The description of the house and hygiene of all family members indicate that the family had been experiencing unacceptable living conditions over a considerable period which had not been addressed by either Biological Mother or Female Partner.

Information from the composite chronology

Child B was primarily known to Health Services. Education Services had no direct responsibility in relation to Child B.

All Health contact for child B was as part of the universal service for children and she was seen 13 times by the Health Children and Families Team from when she was 11 days old until she was 1 year 9 months. There were eight home visits, six in the first six weeks.

During routine health visits, Child B appeared well and gained weight, and it was reported that she was meeting her developmental milestones and that her immunisations were up to date. Biological Mother declined the offer of the Childsmile Programme to assist with oral health and general dental care. Child B was not registered with a dentist though she had dental caries at the time of her death.

In November 2012, the Head Teacher (HT) of the school attended by Sisters 1 and 2 expressed concerns about Sisters 1 and 2 in relation to hygiene, head lice and inappropriate clothing to the School Nurse and raised the concerns with Biological Mother. This information was also passed to the Health Visitor who conducted a series of home visits, following which improvement was noted by the Health Visitor in the children's presentation.

Child B was assessed by health in accordance with the national guidance contained in "A New Look at HALL 4- the Early Years- Good Health for Every Child". In February 2013, a Single Agency Assessment was completed by the Health Visitor and Child B was described as achieving developmental milestones. The house was noted as being reasonably clean though scantily furnished with some household items in a poor state of repair.

In March 2013, when Child B was 5 months old, the Health Plan Indicator (HPI) was formally recorded as "Core", meaning that Child B was not seen as at risk, that her needs could be met through the universal child health programme and that she did not need additional support. Unless there was a change in circumstances, the next planned review (in line with the universal pathway) was due in April 2015, when Child B was 30 months. Child B died when she was 29 months old.

Over a period of 25 months, Biological Mother sought support from the Community Pharmacy Minor Ailments Scheme (MAS) in relation to Child B on 17 occasions from two months old until two months before her death. Child B was not seen by the pharmacist on every occasion and although the attendance at MAS may seem very high as listed in the health chronology, there was sufficient time between visits for there to be no alert to the General Practitioner (GP).

In addition Child B attended the GP on two occasions for upper respiratory infections, when she was physically examined at an emergency appointment.

The SCR found no evidence of any assessment having been made of Child B having head lice. Biological Mother had been given sufficient treatment for all four known family members but reported to the School Nurse that she had treated Sister 1 and Sister 2 for head lice but had not treated either herself or Child B. The School Nurse had advised Biological Mother to treat all of the family and had offered to go to the house to do this. Biological Mother declined these offers.

In February 2014, the Depute Head Teacher (DHT) raised further concerns regarding head lice and hygiene with the School Nurse about Sisters 1 and 2, who subsequently contacted the Health Visitor. It was agreed that a joint visit to the family home would be undertaken but there is no record of a visit taking place at that time.

In May 2014, the DHT again contacted the School Nurse in relation to persistent head lice infestation and poor hygiene about Sisters 1 and 2. The School Nurse and Health Visitor attempted to arrange a home visit but this was cancelled by Biological Mother, so the School Nurse made an unannounced home visit in June 2014. Additional concerns noted during this visit prompted the School Nurse to make a referral to Social Work Services (SWS). There had been no SWS contact with the family prior to this.

SWS made an unannounced visit to the home but did not gain access. The Health Visitor visited separately and did gain access to the family home. She had serious concerns about the living conditions, describing the home as unsafe for a child, and arranged a joint visit with SWS. Significant improvement in the condition of the home was noted at the joint visit and it was deemed appropriate that health staff would manage the treatment of head lice whilst school staff would monitor Sister 1 and Sister 2.

The School Nurse had three further contacts with Biological Mother regarding head lice and reports that Sister1 and Sister 2 had sickness and diarrhoea, advising that the children should be taken to the GP. There is no record of an appointment with the GP for this.

Child B was not seen by a Health Visitor after 4 July 2014.

Child B attended the Emergency Department at Glasgow Royal Infirmary (GRI) on one occasion in July 2014. Biological Mother advised the hospital that Child B had been running in the living room, tripped and hit her forehead on the edge of the table. Child B was seen by an Emergency Nurse Practitioner (ENP). Her weight was documented and there was no mention of head lice in the notes. There was no suspicion of non-accidental injury and Child B was discharged home. As a matter of routine, a letter advising of this attendance was sent electronically to the GP. This was not shared with the Health Visitor and therefore could not be followed up by the Health Visiting Service.

Four requests were made by Biological Mother to MAS following this attendance at hospital, the last time being 6 January 2015. There is no evidence that Child B was seen by the Pharmacist at MAS on these occasions.

There is very limited information for the period July 2014 until March 2015.

From the information gathered by the SCR team, there is no evidence that anyone outside the family saw Child B after 9 July 2014 until 20 March 2015.

At the time of her death, Child B was noted to have suffered signs of extreme neglect. Her general condition in the months leading up to her death included severe head lice infestation, being physically emaciated and malnourished, listless and lacking energy typical of a normal two year old. Although Child B was not seen by any professionals during the 8 months prior to her death her poor general state would have been evident to all who came in contact with her. Whilst Child B was not visible to agencies, she was visible to her care givers and to her family who would have seen her every day.

Key Issues

Lack of basic information

Staff in health and education believed that Biological Mother was a single parent and that the children's father had no involvement.

There was no knowledge of Female Partner as Biological Mother's partner until after Child B's death and therefore no understanding of the shared parenting arrangement at home.

The ongoing unhygienic condition of the family home was unknown.

Thresholds

The view was taken that this was a mother doing her best in difficult circumstances. The SCR found that this family was compared to other families in an area of multiple deprivation, rather than the individual needs of the children being addressed. The SCR found that, as a consequence, thresholds for intervention were high in this case.

Biological Mother appeared to be cooperative, but declined offers of counselling to address her anxiety, Triple P, Childsmile and help with head lice treatment all of which would have afforded the opportunity to make an impact on parenting skills. Health accepted Biological Mother's word that Sister 1 and Sister 2 were clear of head lice. This should have been checked in the light of the reported recurrent infestations over time.

Assessment and Professional Challenge

Although there were a number of indicators of neglect, observed over a period of time, there was a lack of focus on the children's needs and no clear assessment of needs, particularly in relation to Child B and no effective intervention made. The child was not at the centre of the assessment process

Professional staff dealt with each incident in isolation and did not take a holistic approach to working with this family. The SCR found that there were general ongoing hygiene issues and recurrent head lice infestation, noted for Biological Mother, Sister 1 and Sister 2, and in the home. There was no evidence that the professionals involved considered the impact on Child B, though the school did mention to both School Nurse and Health Visitor that there was a baby in the family. There is evidence that hygiene issues were present from the time of Child B's birth, and indeed probably before. However, there was no recognition that the children were suffering neglect.

The school worked closely with the school nurse around their concerns about hygiene and head lice. They had regular discussions with the school nurse and collaborated with her and Biological Mother on attempting to tackle the issue of head lice in particular. Biological Mother always appeared to be responsive to the school's concerns but with no sustained improvement. Although hygiene and head lice were the focus of their concerns, the school should have considered the impact of neglect on the family and made this known to Social Work Services by submitting a Notification of Concern for the family.

There was a low level of the use of formal assessment tools. The education chronologies for the two older siblings provide an account of the school's discussions with the school nurse. It is not clear that these chronologies were used to assess that, over a protracted period, the girls were suffering neglect. The use of chronologies as an assessment tool is crucial.

At no time did health assess Child B for head lice, in spite of the school mentioning to the school nurse that there was a baby in the house. The school nurse and health visitor did discuss the concerns and agreed to make a home visit on 19 June 2014, but this was cancelled by Biological Mother. They did make unannounced home visits separately the following week but no re-assessment was done.

Following the individual home visits and the joint home visit in July 2014, there was no formal reassessment of the Health Plan Indicator although there was evidence that the home circumstances had changed. The Health Plan Indicator should have been changed to "additional" to reflect the need for additional support until such times as the professional staff were confident that the observed improvement in the physical home environment had been sustained.

Health and education staff recognised that there were parenting concerns but there was no recorded professional challenge of Biological Mother when she declined or made no response to offers of assistance. Similarly, there appears to have been no professional challenge when Childsmile was declined or when offers to assist with the treatment of head lice were turned down. There was a failure by professionals to identify non-engagement.

Consideration was not given to the impact of Biological Mother's [Redacted] problems on the care of her children, nor was there communication between the GP and Health Visiting Service.

There appears to have been a "wait and see" approach in spite of the GP recognising sufficient concern to note a possible referral to SWS in April 2014, but there was no such referral to SWS.

Following the joint social work and health home visit in July 2014, there was no further involvement by SWS. The key factor in determining the response from SWS lies in the acceptance of the professional assessment and autonomy of the health visitor which then shaped the approach with regard to roles and responsibilities, allowing the Health Visitor to be the lead professional. The briefing of the Social Worker by the Team Leader as to the purpose of the visit and the conversation between the Social Worker and Health Visitor

resulted in the focus being on the home conditions rather than the health and hygiene issues pertaining to all the children as per the initial referral by the School Nurse. SWS should have reviewed the referral information and made a broader assessment of the home circumstances than was made on 4 July 2014.

Although SWS had the expectation that health and education would monitor the situation and re-refer if necessary, SWS could have made a follow up visit to see whether the improved home conditions had been sustained. SW records from July 2014 indicate that there were no issues requiring follow up. There was no re-referral to SWS by health or education.

There was a lack of attention on agreeing outcomes for children.

Communication

The lack of good interagency information sharing and effective joint decision making is key to the failure to address Child B's needs. It is essential that professionals communicate both within their agency and across agencies to ensure appropriate sharing of information, joint assessment and planning in line with key components of the Getting it Right for Every Child framework (GIRFEC).

There was too great a focus on pre-arranged home visits and there was an over-reliance on telephone contacts to discuss important issues and share information. Unannounced home visits would have provided an opportunity to gain insight into home circumstances and would have supported a more robust assessment of need and care planning.

Whilst there is an alert to the GP should requests to MAS be deemed too high, there is no expectation of a link between MAS and the Health Visiting Service which would have given the Health Visitor the opportunity to review Child B's use of medication to manage minor childhood conditions including teething.

Clarity of follow up arrangements and respective roles and responsibilities should have been addressed. There was a reliance on colleagues and assumptions made in relation to following up issues with the family.

Liaison between Housing and SWS where a family with children has been living in adverse housing conditions would have led to sharing of information and subsequent assessment of need.

Administrative / Practice Issues

There were separate written records of the outcomes of the joint home visit in July 2014. The absence of a shared agreement/understanding of the outcome meant that there was no clarity about the action to be taken.

Administrative tasks should be undertaken timeously with case notes recording all relevant detail. For example, it is important to identify the adults living in the home, who is present on each visit and their relationship to the child.

There is a need to use, build and review chronologies within Education and Health.

Consideration should be given to supervision arrangements for staff and whether they are sufficient.

Conclusion

It is the view of the SCR team that, after the allocation of a Core HPI and, particularly, from July 2014 until her death in March 2015, this child was seen as planned in line with the core pathway in place at that time. Despite a change in circumstances, the HPI was unaltered from Core.

While services identified that this was a vulnerable family in need of support, the signs of neglect were underestimated for Sister 1 and Sister 2 and were unrecognised for Child B, leading to an insufficient assessment of the needs of all of the children in the family.

Attention was not paid to a young child living in a highly vulnerable situation. The focus of attention was either on Biological Mother or siblings Sister 1 and Sister 2.

The assessment process by Health Visiting Services in the first year of Child B's life allocated her to a Core level of support i.e. assessed Child B as being able to be supported by universal services, and therefore not requiring ongoing involvement. This assessment influenced subsequent involvement and decision making by agencies.

While education highlighted that there was a baby in the household, there is no evidence that the case was formally reviewed by Health Visiting Services. In addition, the home visits which highlighted adverse living conditions did not lead to a reassessment by the health visiting service of the allocation to Core support to Child B.

It is the view of the SCR that the lack of reassessment of Child B in June and July 2014 when she was 20/21 months old is key to the missed opportunity to provide the additional support required for this family. A reassessment would have put the focus on Child B for the first time since her assessment at 22 weeks old and would have, at the very least, provided the possibility of recognising and tackling Child B's severe neglect.

Education staff talked to Biological Mother about hygiene and head lice of Sister 1 and Sister 2, their pupils, and raised concerns repeatedly with Health, pointing out that there was also a baby in the household. The school did not seek advice from others (health, social work, education) apart from the school nurse. The school did not consider completing a Notification of Concern to Social Work Services in respect of the family, on the grounds of "a culmination of minor concerns over a period of time" (MC57) focussing on the hygiene issues of the older girls. This would have led to a closer look at the family circumstances.

Health sought to tackle the concerns about hygiene and head lice but this was confined to short term interventions. Input was triggered by individual incidents and there was no assessment of the overall family circumstances over time.

The SCR team concluded that while Biological Mother appeared to engage with services when prompted, in fact there was evidence of non- engagement and of keeping services at a distance.

Despite the large number of professionals involved and in contact with the family the communication and information sharing between professionals was inadequate to enable a comprehensive overview and assessment of the family.

There is a fundamental issue in relation to the thresholds used to determine what is acceptable in the care of children. In this case it is clear that the thresholds were high. There was insufficient professional challenge within and across agencies about the standard of care.

Unanswered Questions

Despite extensive investigation, a number of questions remain.

The SCR concluded that there were signs of neglect for all the children in the family. The evidence indicates that Child B was neglected to a differing degree from her sisters. The SCR could find no explanation for this and no reason to explain why the extent of the neglect worsened in the last eight months of Child B's life.

Whilst Child B was not visible out with the home, Child B was seen every day by her care givers and other family members. The information contained in the post mortem report indicated that prior to her death, Child B must have suffered deterioration in her general health, nutrition and overall wellbeing, indicative of severe neglect. The SCR could find no explanation for why there was no effective action taken by family members to improve Child B's health and wellbeing.

The role of the extended family and their level of involvement with the family is unknown, but it is hard to accept that the extended family did not recognise that the family's living circumstances were at an unacceptably poor standard for all the children, and, that all of the children, and Child B in particular, were suffering severe neglect.

The motivation for Biological Mother to present to professionals as a single parent is unknown, when in reality this was a two parent family. Biological Mother actively denied that there was another adult living in the home. None of the services involved were aware that Female Partner lived in the family home and was also the children's parent, until after Child B's death.

Female Partner's motivation for remaining in the background is not known, nor is it clear how much involvement Female Partner had in day to day parenting.

Biological Mother was perceived to be a concerned parent though evidence indicates that action about the children was often taken when prompted by professionals about particular concerns. Biological Mother was given much advice about head lice treatment and demonstrated that she was able to treat Sister 1 and Sister 2 successfully at least in the short term, though the improvement was not sustained. It appears that Biological Mother did not treat herself or Child B and so re-infestation was inevitable. We have no understanding of why Biological Mother did not treat herself or Child B for head lice.

While the shared parenting arrangement, paternity of the children, role of the extended family and housing history was not known, this in itself makes no substantive difference to the overall assessment by the SCR that this was a vulnerable family requiring additional support. Better, fuller assessment of the children and family circumstances would have given greater weight to the consideration of multiagency working which would have put a focus on addressing the needs of the children in this family.

Learning Points

Interagency Issues

- Within and between Health, Education and Social Work Services, there needs to be a shared understanding of the decision making processes in relation to thresholds, bringing clarity to providing interventions for children in areas of multiple deprivation who have the same right to protection as all other children. Assumptions about what is good enough in the care of children require to be challenged.

- There needs to be ongoing training within and across Health, Education and Social Work Services in the identification of signs of neglect, leading to informed use of the notification of concern process.

- Consideration should be given to the greater use, at an early stage, of formal assessment tools such as the Glasgow Neglect Toolkit, formerly the Graded Care Profile.

- There is a need for comprehensive assessment, addressing the impact on the welfare of all children in the family. Where a parenting need is identified for a particular child within a family the impact of that need should be considered for all children within the family.

- Where there are concerns regarding a child, there should be a specific focus on developing and using a chronology to assist those professionals involved in gaining a more comprehensive understanding of the family situation and potential impact on the health and well-being of the child. Chronologies should be reviewed and used as part of the assessment process to ensure that the accumulation of concerns is recognised and next steps taken.

- There should be appropriate professional challenge within and across each agency with regard to decision making and accountability.

- Workers need to access all relevant information prior to conducting a home visit.

- When undertaking joint visits, workers should remain mindful of their professional role, responsibility and accountability, ensuring that it is reflected in the joint assessment that results.

- Follow up arrangements should be clarified between agencies at the time of joint visits and a written record of outcomes agreed.

- Case recording must be completed timeously, with a clear account of the nature of the visit, what took place, who was present and their relationship to the family. It must also provide an analysis and a clear recommendation regarding whether further action is required or not. This is particularly important because there can be a series of staff involved throughout interventions.

- There should be greater use of constructive challenge. Professionals need to challenge parental decisions that do not reflect the best interests of the child. Professionals must be confident and skilled when they are required to deploy their skills in holding difficult conversations with a parent/carer. For example, parents should be challenged in relation to their own hygiene.

- Consideration should be given to follow up when self- reported assessment tools are inconsistent with observed circumstances. Agencies should not accept a parent's self-reporting of an issue being addressed without clear evidence to support the self-report.

Single Agency - Health

- There is a need to improve communication pathways within and across health services to ensure that professionals working in different parts of the system are fully informed. GPs and General Dental Practitioners should routinely share relevant

information with Health Visitors particularly where there is likely to be an impact on the child e.g. mental health issues.

- Consideration should be given to review the existing protocol between GPs & Community Pharmacy and consideration given to the development of a protocol between Community Pharmacy & Health Visiting when parents present frequently requesting medication for minor ailments, particularly teething.

- Agreed pathways should be followed and an explanation for any deviation from standard protocols should be recorded e.g. the Edinburgh Postnatal Depression Scale should have been repeated at 12 weeks.

- Health Visitors should formally reassess the Health Plan Indicator when there is a change in circumstances.

- Where there are ongoing concerns in relation to infestation of head lice, Health Visitors should ensure that all children are assessed and appropriate information is shared with parents and carers on prevention, treatment and follow up.

- School Nurses should fully assess wider health needs, using appropriate assessment tools, when receiving repeated referrals related to hygiene.

- The Triple P parenting programme needs to address their process for engaging parents who fail to attend. Consideration should be given to alternative parenting support if a parent fails to engage in the Triple P programme.

Single Agency – Education

- The school should have made their concerns known to Social Work Services by submitting a Notification of Concern (Management Circular 57) for the family.

Single Agency – Social Work

- Administrative tasks relating to screening forms should be completed timeously

Single Agency – Housing/Social Landlords

- The systems and processes between Housing/ Social Landlords and SWS need to be developed and strengthened leading to improved reporting

APPENDIX 1

GLOSSARY of TERMS

CPC	Child Protection Committee
CPR	Cardiopulmonary Resuscitation
DHT	Depute Head Teacher
ENP	Emergency Nurse Practitioner
GIRFEC	Getting it Right for Every Child
GP	General Practitioner
GRI	Glasgow Royal Infirmary
HT	Head Teacher
HPI	Health Plan Indicator
HSCP	Health and Social Care Partnership
MAS	Minor Ailments Scheme
MC57	Management Circular 57
NHS	National Health Service
RHSC	Royal Hospital for Sick Children
SCRA	Scottish Children's Reporter Administration
SCR	Significant Case Review
SWS	Social Work Services
Triple P	Positive Parenting Programme