Introduction to the report of a Significant Case Review carried out on behalf of North Lanarkshire Child Protection Committee

The untimely death of any child is a tragic and distressing event for everyone affected. There is a need to review such cases to ensure we learn any lessons and make any required changes to improve procedures or practice.

During autumn 2018 North Lanarkshire Child Protection Committee (CPC) considered a case referred to the CPC by the police. A child had died at home and there were concerns that neglect of the child's medical needs had been a factor in the child's death. In response to the referral the CPC commissioned a Significant Case Review (SCR.) There were parallel criminal proceedings in the case which affected both the process and timescale of the review.

All members of the CPC wish to extend their sincere sympathy to the family members and friends of the child who died and everyone affected by the tragedy. We recognise the impact that such events have on everyone involved.

Two accredited independent reviewers were commissioned, a lead reviewer and second reviewer undertaking the role of 'critical friend.' Both conducted the review under a recognised methodology.[1]

The lead reviewer produced an interim report in January 2020 in which the child was referred to throughout for ease of understanding as 'Anne.' The interim report allowed the CPC to address some of the emerging findings and take forward some practice improvements prior to the conclusion of the criminal proceedings. The impact of the Covid pandemic on public services throughout 2021 further delayed the production of a full report. At the conclusion of the criminal proceedings in summer 2021 the CPC contacted the lead reviewer to finalise the report and findings from the review with a view to publishing a summary report.

In common with all SCRs, this report identifies some areas for improvement where all services across North Lanarkshire can learn from what has happened. These areas for improvement have been considered and accepted by the CPC. Publishing the findings will allow services across Scotland and perhaps more widely to gain any learning from these circumstances.

These findings are:

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[1] Learning Together to safeguard children: developing a multi-agency systems approach for case reviews London: Social Care Institute for Excellence[1] Fish, S; Munro E and Bairstow (2008)

- Some key mechanisms for bringing the right people together to share information and make joint decisions are not working effectively. This results in some children not receiving the right service at the right time.
- Across children's services limitations to and inconsistent use of assessment tools and frameworks runs the risk of failing to identify the point at which older children are in need of protection.
- Insufficient opportunities for formal critical reflection within and across agencies and at all levels makes it more difficult to both develop and revise shared understanding of the needs of children in complex circumstances and this exacerbates the risk that assessments will rest on untested assumptions, leading to inappropriate responses.

The report also notes improvements identified by the independent reviewer which have already taken place in North Lanarkshire since the death of 'Anne' - prior to the review being completed. Since the completion of the review, CPC partners have made additional changes directly addressing the areas for improvement within the report.

As is usual with reports using the SCIE methodology the report concludes with a number of questions rather than with recommendations. The CPC has considered these questions carefully and tried to address them as fully as possible in making recommendations for service improvement. These recommendations are being implemented as part of an action plan in response to the review.

Consideration of privacy and the need for redaction

This report contains the findings of the SCR relating to the circumstances surrounding the death of 'Anne'. In the interests of transparency every effort has been made to disclose as much of the SCR as is lawfully possible.

Detailed consideration has been given to the extent to which information contained within the report can be placed into the public domain. This has involved careful consideration of:

• The need for transparency and the overall purpose of the SCR in identifying learning.

• The provisions of the General Data Protection Regulation (GDPR) and the Data Protection Act 1988 (DPA) and the statutory bases for sharing information.

• Whether information is sensitive personal data (for example, because it is information about a person's physical or mental health, their sexual life or alleged commission of offences) and whether inclusion in the SCR complies with data protection legislation.

• The public interest in disclosure, and in particular the public interest in ensuring child protection processes across North Lanarkshire are effective and that the relevant agencies work together effectively in assessing risks and acting where necessary to manage those risks.

As there have been criminal proceedings and some media coverage of this case, a certain amount of personal data (including sensitive personal data) is publicly available. Any disclosure of personal data and sensitive personal data must comply with relevant legislation such as the GDPR, the DPA 1998; Article 8 of the European Convention on Human Rights (the right to respect for private and family life) and the law regarding confidentiality. While no personal names are included within the body of the report, it contains a significant amount of personal data relating to living individuals who could be identified from that data and other

information in the public domain. This summary report is being published to include all information which can lawfully be placed in the public domain.

One of the principles of the SCIE review methodology used in this review is to avoid hindsight bias.

‘It is important to be aware how much hindsight distorts our judgement about the predictability of an adverse outcome. Once we know the outcome was tragic, we look backwards from it and it seems clear which assessments or actions were critical in leading to that outcome. It is then easy to say in amazement “how could they not have seen x” or “how could they not have realised that x would lead to y”.[2]

While the death of ‘Anne’ from an acute medical condition may not have been predictable, the report identifies some missed opportunities across services to provide more effective support to ‘Anne’. The CPC will continue to reflect carefully on the findings and questions posed by the review report and work to further improve approaches to working with older children.

Marian Martin

Independent Chair

North Lanarkshire Child Protection Committee

[2] Munro, E. 2011. The Munro review of child protection: Final Report. A child-centred system. London, Department for Education

Executive Summary of a Significant Case Review Carried Out by the Child Protection Committee

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Introduction

This Executive Summary includes the main Findings from the Significant Case Review in respect of “Anne”. All names have been changed to protect the identity of the child and her family.

The findings have relevance locally and are resonant of findings in other reviews and reports of practice nationally. While the practice subject to review took place between August 2017 and July 2018 and finalisation of the report has been subject to delay due to both judicial process and the disruptions caused by the Covid-19 pandemic, recent consultation with practitioners demonstrates that the issues continue to be current and relevant. The issues are fundamental to good practice and are judged to come about as a result of the way that the system is resourced, how professionals in different agencies relate to each other and how sense is collectively made of the lives of young people in their families.

Why this case was chosen to be reviewed

North Lanarkshire Child Protection Committee received a notification of a request for an Initial Case Review (ICR) in September 2018 from police colleagues. This was to determine the need for a Significant Case Review (SCR) in relation to an older child found deceased at home.

Based on a review of information provided by partner agencies it was agreed that the child’s death met the criteria for a SCR with neglect of her medical needs clearly suspected to be a factor in her death. The child had also been subject to child protection registration in the past and at the time of her death a child protection investigation was underway. The ICR identified potential significant concerns about professional and/or service involvement in relation to identification, assessment and response to potential child abuse and child neglect in the context of an older child who was exhibiting challenging behaviour.

Methodology

National guidance (2015) gives CPCs discretion to consider and agree a review methodology in this case, the SCR Executive Group agreed that SCIE’s Learning Together[3] (LT) methodology should be used and that this should be informed through structured conversations held with staff (“the case group”) who had been involved with the family. It is a central tenet of the methodology that the case group are given opportunities to scrutinise and, where appropriate, seek amendment to the representation of their practice at a number of points in the process. Both judicial and pandemic-related restrictions have led to a limitations in the involvement of the case group as a collective. Attempts have been made to engage meaningfully with the case group when this has become possible (February 2021).

Research Questions

Learning Together (LT) reviews take their focus from what a Child Protection Committee (CPC) wants to learn more about, using a review of a particular case ss the vehicle. LT reviews therefore have research questions rather than fixed terms of reference.

[3] Fish, S; Munro E and Bairstow (2008) *Learning Together to safeguard children: developing a multi-agency systems approach for case reviews* London: Social Care Institute for Excellence

The research questions were agreed as:

1. What can we learn about the conceptualisation and assessment of risk/need for protection for children of this age?

2. What can we learn about the processes of classification of work under “GIRFEC” and “Child Protection” titles and its impact on ongoing work?

3. What can we learn about how legislation is used to protect/secure children’s circumstances?

4. What can we learn about the assessment of parenting and of capacity to change in relation to parenting?

Reviewing Expertise and Independence

The SCR has been led by a reviewer, who is independent of the case under review and is accredited by SCIE. She has been supported by an accredited SCIE reviewer, who has acted as a critical friend to the process; and by past and current members of North Lanarkshire Child Protection Committee, who have provided valuable perspectives from their positions in relation to the multi-agency system. The lead reviewer has received supervision from SCIE as is standard. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

The Review Team

The Review Team are senior managers representing the agencies involved in the case. The limitations on the process placed by the Procurator Fiscal meant that this group have taken a more significant role than usual, in assessing the reconstruction of practice and supporting the process of examining key episodes in more depth.

The Case Group

The case group comprised 14 frontline professionals and managers who were identified as having had a significant role during or nearby at least one of the “key practice episodes”. They provided a detailed picture through individual conversations of what happened in the case and why. The limitations of their involvement up to the submission of the Interim Report in January 2020 is indicated above.

The SUMMARY APPRAISAL OF PRACTICE below gives context to the Findings.

The period of practice under review is from August 2017 to July 2018, when the child was known to professionals from Education, Social Work Services (SWS), Police and Health agencies in the area to which she had just moved, (Redacted)

Initial assessment and decision making August/September 2017 (HART meeting and NOCPC Referral); care planning October 2017 (including GIRFEC meeting).

There were appropriate early responses made by Education to rapidly emerging concerns in relation to Anne. These were somewhat undermined by failures in the transfer of information when Anne transitioned from primary to secondary school and the Review revealed systemic challenges with school based recording, including the extent to which communication relies on verbal communication. Such information becomes inaccessible over time and this is likely to compromise review and revision of assessments; this is an aspect of **Finding 3.**

SWS also carried out effective initial assessments, creating a potentially effective foundation for ongoing work. There was an appropriately timeous response to the needs emerging.

After the initial stages, however, parallel assessment processes emerged in SWS and Education and the step change from single to integrated assessment was missed, with consequent confusion about leadership and shared responsibility. The operation of mechanisms within Education ("HART" meetings) and SWS ("GIRFEC" meetings), designed to gather the right people together to make decisions about whether and how to respond appropriately, were both compromised by a lack of representation from all agencies and a lack of clarity about the purpose of such meetings. Neither of the meetings was furnished appropriately with written assessment, compromising the ability of incoming professionals to adequately absorb foundational information and sense-making. Neither meeting adequately recorded the means by which decisions were reached. **Finding 1** addresses the competent operation of these key 'mechanisms' while **Findings 2 and 3** address the related issues of assessment practice and critical reflection.

The key output resulting from the HART meeting was the submission of a Notification of Child Protection Concern (NOCPC), which was limited in scope and did not include sufficient professional rationale. The reclassification of the NOCPC to a Request for Assistance (RfA) by SWS after consultation with the Police was, nevertheless, inappropriate, given the insistence by Education that their concerns remained at this level. The procedurally enabled ability of SWS and Police to reclassify referrals in this way, thus diverting from Initial Referral Discussion (IRD) and the consequent impact on timeous responses, interagency relationships and shared responsibility is discussed in **Finding 1.**

SWS continued to construct a competent assessment of needs and circumstances, responded appropriately to concerns and tried, unsuccessfully, to identify relevant health staff via the school (Anne was not registered with a GP). The impact of reconfiguration of the School Nursing role on some children's access to health care through prioritisation protocols is a further aspect of **Finding 1.**

SWS made clear efforts to be inclusive, responsive and 'solution focused' at the initial GIRFEC meeting (27/10/17) but the process was compromised by being largely conducted from within some untested assumptions. A powerful narrative of relationship adjustment and expectation that the family's difficulties could be speedily resolved was established and a sufficiently holistic assessment of need was not made explicit. The conceptualization of need and risk for older children and the need to both personalise and frequently review understanding as well as progress with plans is discussed in **Findings 2 and 3.**

There were no written submissions to the meeting and the minute was an insufficient and unreliable record. Since minutes are often used for summary access to the history of interventions, this makes the task of discovery by (as here) an incoming practitioner unnecessarily difficult. It creates a vulnerability in the system of a failure to account for what is already known, how it has been understood and how decisions have been made. This increases the likelihood of misunderstanding and repeated process. Recording as a tool for effective (re)assessment is an aspect of practice considered within **Finding 3.**

November 2017 to February 2018

SWS and the Police responded frequently to the family during November and December 2017, often in the context of reports of conflict; both agencies noted physical assaults on Anne (Redacted). While there is evidence that professionals took each incident seriously and some were recorded in Police Concern reports, they were largely absorbed into the existing narrative of 'mutual adjustment' rather than reframed as an emerging pattern of problematic interaction.

SWS twice explicitly considered formal NOCPC but on both occasions ‘resolved’ the situations by removing Anne and by ‘substituting’ IRD or Initial Child Protection processes with a future GIRFEC meeting. The accumulation of incidents by this stage merited an escalated response and would have benefited from the more efficient and disciplined process that Child Protection processes offer (**Finding 1**). At this point it might also have been possible to reflect on the relationship between Anne’s adverse redacted experiences and conflict with/neglect by her carer(s). Professionals in all agencies currently involved observed that parent and child were living ‘like siblings’. Work began to be reoriented to enhance capacity to keep herself safe and calm. **Finding 2** discusses the accurate recognition of and appropriate response to older children’s needs for both care and protection.

Some effective recording was carried out within SWS, including some evaluation of current intervention. It is not possible to conclude that these notes were used effectively – in supervision or other forums – to form judgments or reach decisions. This is further reflected upon in **Finding 3.**

Education interpreted inconsistent and deteriorating rates of attendance as the result of home and peer-based problems but did not effectively raise the question of whether school and accessing education itself contributed to the pattern of absence. SWS’ request for an Educational Psychology assessment was not actioned for six months and while HART meetings considered the situation regularly, the repeated ‘decision’ was to continue to monitor. This raises further questions about the capacity of these meetings to critically reflect on both children’s situations and on the role each organisation might have in making sense of them. These are aspects of both **Finding 1 and 3.**

Referrals from professionals and community members escalated in number; self-referrals reduced. Agencies intervened on an almost daily basis. There was no substantial change to the goal or means of intervention, or reassessment of current frames for understanding. Professionals believed that the benefits of current circumstances outweighed the potential negative impacts of the apparently only available alternative, which was reception into a Children’s House; they also believed that all that could be done was being done. While risks were acknowledged, they were ‘familiar’ in the context of intensive community support for teenagers and practice began to refocus on helping Anne to take care of herself more successfully. This raises critical questions about how the needs of older children are understood and the use of legislation to effect care and protection via the Children’s Hearing System.

Decision making: changes to living arrangements 26 February 2018 to 2nd April 2018

Police Officers removed Anne to (Redacted) care. The Police Concern report gave a good summary of their assessment and indicated that there were concerns about her safety.

The (coincidentally) scheduled GIRFEC meeting which took place the next day (26/02/18) was the delayed ‘substitute’ for the IRD not held in mid-December. This was an opportunity to review the evidence in relation to Anne’s vulnerability to sexual exploitation and to discuss the detail of her experiences of parental lack of care and physical abuse. However, the meeting was dominated by the previous night’s removal. (Redacted) As a result it neither successfully considered the incidents which prompted the earlier NOCPC, nor the underlying and accumulating patterns. Its multiple purposes meant that the ‘step change’ from ‘voluntarily engaging with support’ to ‘becoming accommodated’ was not made explicit and a further opportunity to enlist and reorient support from Education and Health services and to structure a current assessment of need and risk was lost. What was known was neither collated nor understood. (**Finding 1)**

The (Redacted) placement may have been difficult to conceptualise as 'new', since it was a 'return' to previous arrangements. The complexity of the case at this point merited critical reflection separated from planning (an aspect of **Finding 3**). The mindset of 'continuation' and emphasis on voluntarism contributed to a failure to consider referral to and/or consultation with the Reporter about the need to consider compulsory measures.

The new arrangements broke down quickly and this should have prompted a significant response from professionals. An alert was submitted to Social Work Emergency Services but there is no evidence of a plan to convene a professionals' meeting to further reflect, resource and plan. SWS practitioners are notable for their high level of input at this stage. They would have benefitted from formalised reflective supervision separately and possibly together to capitalize on their experiences and the insights that they both had. (**Finding 3**)

When SWS made a referral to the Reporter, concerns were phrased with grounds for referral in mind (out-with parental control and non-attendance at school), practice that is consistent with the Reporter's usual experience and expectation that the practitioner would 'tend to point you in a [particular] direction'. The Reporter made use of the limited detail to note which of the statutory grounds might apply. Grounds for referral and the statement of facts to support them does not occur until/if a decision is made to progress to a hearing and the Reporter, having more complete information at this point, may choose to re-frame the grounds. All of this is consistent with guidance. However, there is a subtle but important issue here in the context of concerns about how older children's needs are framed. The practice of making limited initial referrals to the Reporter does seem to run the risk that such 'frames' are reinforced rather than subjected to criticality, since the request for a report in the context of particular grounds (here 'beyond control') creates a mindset of substantiation of the 'initial' grounds, rather than a more inclusive and exploratory account of the case. The latter would better reinforce the opportunity the Reporter has to reappraise the grounds and fulfil their potential to provide a relatively objective view of referred cases. Both prior to and at this stage a framing of Anne's needs as originating in a 'lack of parental care' had the potential to emphasise her stage-related needs as an 'older child'.

Professional responses to significant disclosure 19th May to 8th June 2018

SWS' initial response to Anne's disclosure was appropriate. The decision made (Redacted) not to raise an immediate concern with Police was not, however, 'proportionate' and suggests inappropriate default to particular roles within the agency. It also reinforced patterns of a lack of urgency and an inappropriate allocation of responsibility for achieving her own safety to the child.

When SWS raised the NOCPC with Police on 22nd May, neither agency appears to have considered scheduling an IRD. As a consequence: an exclusive focus on achieving comprehensive disclosure rather than understanding wider needs was established; assessment by and access to relevant services was further delayed; and the potential for insight into relationship dynamics was lost. The separation of Police process from multi-agency response resulted in silo thinking and unco-ordinated services. This is a further example of the issues discussed in **Finding 1.**

Separate sections within Police were not furnished with sufficient contextual information about relationship dynamics. This meant that a revised version of events was accepted too easily. Their experience of child and mother was not triangulated with other professionals.

In the absence of a Child Protection process it should nevertheless have been possible to effect Anne's access to health care. This is an aspect of practice which raises questions about how this age group and their needs and rights are understood across agencies and is an aspect of the discussion in **Finding 2.**

The thirteen-day delay between reporting to the Police and the request for an IRD did not adequately reflect the urgency or significance of the risks to the child's health and welfare.

Management of Child Protection Investigation June/July 2018

Health professionals provided an efficient and effective service from the point of their inclusion, although opportunities for their earlier inclusion had been repeatedly missed.

The specialist nurse provided a timely and effective service to Anne, fulfilling both a specialist role and contributing to the multi-agency response with appropriate urgency and with recognition of the need for a co-ordinated service. Improved knowledge about specialist service in the wider professional network may have appropriately prompted an earlier referral.

Within SWS the conduct of the Child Protection Investigation was not sufficiently distinct from ongoing support, resulting in a retrospective process within a protracted time frame. This diminished the capacity of the multi-agency system to come together and intervene in more co-ordinated ways.

THE FINDINGS

The Review Team and Lead Reviewer were able to establish three Findings with some confidence and these have been supported by the case group through the consultation held with them in February 2021. These Findings collectively explain why the Review Team think professional practice was not more effective in protecting the child in this case. These are issues that have been identified as not specific to this case, but recurring in the system and are therefore judged to offer a 'window on the system'.

In addition to the Findings, the Review Team noted that in a number of ways this case indicated two aspects of 'gaps' in practice that require particular attention. First, the lives of children who are transitioning from childhood to adolescence (both of which are imprecise constructs) appeared less well understood and attended to than either 'early years' or 'teenagers'; this may result in 'older children' being hurried towards their teenage years and inappropriate expectations of self care and self protection being applied. Secondly, the mechanisms for supporting situations between 'early problem identification' and 'high tariff/crisis led' responses also seemed 'missing' – that is, the provision of effective 'intermediate' services which fall under the umbrella terms of 'Looked After at Home' and 'voluntary support' and the active use of legislation to effectively support and 'secure' children's rights to such support also seemed largely missing. These issues 'bubble under' the Findings and are offered as observations for the Committee to consider alongside them.

The Findings themselves all relate to the way systems are managed within and between agencies in North Lanarkshire. They are about mechanisms, tools and processes for effective assessment and for making decisions about when and how to intervene to both protect the welfare and ensure the protection of children in their families and also in their communities.

HOW THIS CASE MIGHT OFFER A WINDOW ON THE SYSTEM?

This case highlights the extent to which reliable operation of mechanisms designed to enable shared assessment and intervention contributes to guiding and containing complex practice. Practitioners need to be able to rely on the system for an informative signalling of the level and nature of concern in respect of any child or young person and reasonable and equitable

access to services for them. This requires a competent and current understanding of the legislative, policy and procedural contexts.

'Late presentation' both in terms of age and degree of difficulty is an emerging experience in the multi-agency system and this raises some questions about the extent to which agencies, separately and together, are sufficiently equipped to recognise, conceptualise and so respond to the circumstances of older children. This includes clear and fair expectations of their carers. Being 'equipped' as a professional includes having both a relevant knowledge base and the capacity to apply it and this case raises some questions in relation to both these aspects.

Access to critically reflective conversations are necessary for all professionals, from practitioners to senior managers, to counter human and system biases and adequately understand the nature of the task. It is not entirely possible to prevent mis-conceptualisation of situations and so systems must devise – and make use of – forums which test and retest current understanding and to enhance the potential for identifying errors of reasoning. Failure to process the complex cognitive and emotional experiences leaves both practitioners and their supervisors vulnerable to misunderstanding risk and to misallocation of responsibilities in both the family and the professional systems.

FINDING 1: Some key mechanisms for bringing the right people together to share information and make joint decisions are not working effectively. This results in some children not receiving the right service at the right time. (Management Systems)
SUMMARY In the context of multiple overlapping changes over the evolution of GIRFEC policy and associated legislation, the fundamental purpose of the multi-agency system continues to be to make services available to children that are appropriate, proportionate and timely. In order to do so, mechanisms for bringing the right people together to construct shared understandings of their needs and risks have been designed. It is perhaps not surprising, given workplace pressures and changes, that the operation of some of these mechanisms has become inconsistent or outdated, no longer reflecting current configuration of key roles or lacking clarity about purpose. In North Lanarkshire there is evidence that some of these mechanisms cannot currently be relied upon to consistently enable holistic, focused and jointly owned assessment and decision making. Clarity of role, skills in participation and chairing and the establishment of collaborative relationships are crucial to the delivery of coherent and effective multi-agency services and these are jeopardised by the overlapping functions and inequalities in the current system. There has been significant organizational learning activity since the death of this child to address some of these issues, with the introduction of approaches to practice that have the potential to orient interagency working in helpful ways.
QUESTIONS FOR THE COMMITTEE 1. Does the Committee recognise these issues? 2. What is the Committee's role in supporting quality assurance and effective functioning of single agency, multi-disciplinary and multi-agency mechanisms? 3. What is the Committee's role in enabling and reinforcing the refocusing of practice in the light of the adoption of new models and approaches? 4. What is the Committee's role in connecting with other strategic groups in children's services to share and discuss the implications of this Finding? 5. What is the Committee's role in refreshing procedure and supporting the implementation of changes to current processes?

6. What is the Committee's role in ensuring the appropriate resourcing of key decision making mechanisms?
7. What is the Committee's role in enabling professionals to understand changes to and make effective use of each other's services?
8. What is the Committee's role in seeking further understanding about the use of the Children's Hearing System across children's services?

FINDING 2: Across children's services limitations to and inconsistent use of assessment tools and frameworks runs the risk of failing to identify the point at which older children are in need of protection. (Management Systems)

SUMMARY

Nationally approved assessment tools and frameworks are one means by which the principles of GIRFEC are enabled, being evidence based and providing a shared process for achieving a competent baseline understanding of children's needs and situations. The ubiquity and familiarity of such tools can lead to superficial engagement with them, one of the consequences of which is that they may be considered to be 'complete' at too early a stage and their cyclical, iterative process may therefore be under appreciated. The apparent simplicity of the tools is also deceptive, since even a 'baseline' assessment is comprehensive and requires considerable cognitive effort and time to achieve. Furthermore, some stages – such as the transitional stage of later childhood – do not lend themselves to easily establishing benchmarks, being in a constant state of flux. Some assessment tools exist but are not being used. The reasons for this are varied (cultures of practice; perceived utility and relevance; lack of knowledge and exposure; time). There has been recent activity refreshing and updating the frameworks, models and approaches to assessment practice, prompted in part by this review.

Not making use of assessment tools and frameworks increases the risk of misunderstanding, being unable to articulate (and so share) current understanding or being able to revise understanding of children's situations and therefore of failing to identify the point at which interventions need to change or measures of increased protection need to be offered.

QUESTIONS FOR THE COMMITTEE

1. Do the Committee recognise these issues?
2. Is the Committee confident that professionals across children's services are making sufficiently consistent thoughtful use of national tools and frameworks to establish baseline assessments in single agencies and when working together?
3. Is the Committee confident that professionals are given enough time and the right tools to conduct sufficiently informed assessments of parenting capacity and capacity to change?
4. What role does the Committee have in supporting new ways of assessing the lives of older children?
5. What is the Committee's role in communicating with other strategic groups across children's services to improve assessment practice?

FINDING 3: Insufficient opportunities for formal critical reflection within and across agencies and at all levels makes it more difficult to both develop and revise shared understanding of the needs of children in complex circumstances and this exacerbates the risk that assessments will rest on untested assumptions, leading to inappropriate responses.

SUMMARY

The uniqueness of young people's situations, the result of particular characteristics, developmental and environmental experiences, presents a challenge to all professionals in a system which is understandably designed to meet the needs of the majority; while national policy speaks to 'every' child it also demands that 'each' child's needs are understood. Where a young person's presentation challenges normative expectations it is reasonable for professionals to apply tried and tested responses and to make use of explanatory frameworks that 'usually' resolve the issue sufficiently for progress to be made. The challenge, then, arises when such explanations and responses do not resolve the problems being experienced and this is when the multi-agency system is called upon to add further perspectives and expertise. The capacity of the system to notice that a situation requires to be reframed or to be understood as 'complex' relies on practitioners having access to spaces in which to engage in critical thinking. Critical thinking itself can only be enabled in a context that is able to tolerate a mindset of 'safe uncertainty'[4] – incorporating acceptance that only a partial or temporary understanding may be reached of situations and that they therefore need to be subject to regular review, not just of *plans* but also of *premises*. Critical reflection – the capacity to surface the assumptions on which assessments are based, to notice how information has been selected to construct an understanding – is an activity that requires particular conditions that are difficult to achieve without systemic support. Opportunities to come together to conceptualise and critically appraise assessment and practice need to be created and supported both within and between agencies.

QUESTIONS FOR THE COMMITTEE

1. Does the Committee recognise these issues?
2. What is the Committee's role in supporting the prioritization of access to critical reflection individually and collectively for practitioners and their managers?
3. What is the Committee's role in supporting the use of recording as a tool to inform both supervision and assessment practice?
4. How does the Committee plan to share this Finding and its implications with other relevant strategic groups across children's services?

[4] Mason, B (2019) Revisiting safe uncertainty: six perspectives for clinical practice and the assessment of risk *Journal of Family Therapy 41 343-356*