South Lanarkshire Child Protection Committee (SLCPC)

Learning Review Executive Summary

Young Person C & Young Person D

December 2023 (FINAL)

Contents

1. Context

This Learning Review Summary has been published by South Lanarkshire Child Protection Committee (CPC), following the completion of a Learning Review into the circumstances of siblings YPC and YPD.

This Learning Review was carried out in compliance with the National Guidance for Child Protection Committees: Undertaking Learning Reviews (Scottish Government, 2021)[1].

Learning Reviews are a vital part of improving child protection systems and are an opportunity for an in-depth analysis and critical reflection, in order to gain a greater understanding of inevitably complex situations and to develop strategies to support practice and improve systems across all services and agencies. Learning Reviews are not an investigation. The key features and underlying principles and values of a Learning Review can be found in the National Learning Review Guidance.

This Learning Review Summary provides a high-level summary of the –

- Circumstances leading up to the death of Young Person D (YPD)
- Review process and methodology
- Key findings and learning points

2. Why was the Case Chosen for Review?

YPD was looked after and accommodated by South Lanarkshire Council. On 27 November 2021 she was reported missing by the children's house in which she resided. On 28 November, her body was found in the local area and Police Scotland launched a murder investigation. YPD was 16yrs old at the time of her death.

On 2 December 2021 YPD's brother, YPC was charged with her murder. YPC was 19yrs old at the time of the incident and was being supported by Throughcare & Aftercare services. In July 2023 at Livingston High Court YPC was found guilty of murder and on 21 September 2023 sentenced to life imprisonment.

3. The Process of the Review

Methodology and comment

Agency files were reviewed by the Independent Reviewer prior to two learning events with practitioners and managers. Participants engaged fully in the workshops and

[1] National Learning Review Guidance (2021)

were insightful and eager to participate in a process that could bring about positive change.

The purpose of the learning events was to "…bring together key staff to reflect and learn from what has happened in order to improve practice in the future" (National Learning Review Guidance, p6). The SCIE (Social Care Institute of Excellence) approach to learning allows the exploration of the interaction of the individual and the wider system to understand why things developed the way they did.

In March 2020, the country went into lockdown due to Covid 19 and this impacted both young people and their care givers.

Review Group

The Learning Review was undertaken by one Independent Reviewer and supported by a Learning Review Group whose membership was drawn from agencies involved in the case but who had no decision-making responsibility in relation to both young people. The Learning Review Group contributed to the analysis of data and the formulation of the final report. Members of the Learning Review Group also assisted in the facilitation of two workshops.

Terms of Reference

South Lanarkshire Chief Officers Group (COG) agreed the following –

The Learning Review process must consider each young person's perspective and experience individually and ensure that learning arising from the young people's circumstances is brought together in one Learning Review report at the conclusion of the Learning Review. The following objectives will be addressed -

- Examine single and multi -agency case files in respect of the young people as appropriate and proportionate
- Establish a multi-agency chronology to include all relevant events /meetings /discussions/ assessments/decision making and contact with the young people
- Establish the circumstances culminating in multiple indicators of concern presenting for the young people
- Examine the extent of the contact between agencies known to the young people prior to the decision to undertake a Learning Review and establish whether there were any opportunities for agencies to have intervened earlier
- Examine communication and information sharing in and between agencies and establish strengths and identified areas for improvement
- Adopt an analytical and evidence-based approach that looks beyond what went wrong to include an analysis of effective practice
- Explores the interrelated and interdependent parts of different services and agencies and the impact this has had on the lived experience of the young people

- Analyse whether decisions and actions taken were in line with available single and /or multi-agency policies, procedures, and guidance.
- Establish single and multi-agency best practice examples across South Lanarkshire and what can be learned from the Learning Review
- Report findings to the Chair of the South Lanarkshire CPC for consideration by the Strategic Case Review Sub-Group

Engagement with Family Members

It was not appropriate to engage with YPC while awaiting trial and both birth parents had not actively taken part in the young person's lives since 2014.

The Review Officer met with relevant professionals involved in this case.

Other external scrutiny processes

In planning the Learning Review contact was established with the Procurator Fiscal as per the national guidance. The Procurator Fiscal was given information regarding the scope of the review and the workshop proposals.

4. Data Protection and Publication

South Lanarkshire CPC has given due consideration and diligence to the extent to which personal data and special category data contained within this Learning Review process can be placed into the public domain. Any disclosure of personal data and special category data must comply with all relevant legislation including the Data Protection Act 2018; the General Data Protection Regulation 2018; Article 8 of the European Convention of Human Rights (the right to respect for private and family life) and the law on confidentiality.

It is the practice of South Lanarkshire CPC to anonymise personal data contained within Learning Review reports. South Lanarkshire CPC has anonymised this Learning Review report as far as possible to ensure that living individuals featured within the report are no longer identifiable. Anonymisation is the process of turning personal data into anonymous information so that an individual is not (or is no longer) identifiable.

However, this Learning Review process captured a significant amount of personal data and special category data relating to living individuals who could be easily identified from that data and other information in the public domain. As a result, South Lanarkshire CPC has agreed that there is a need to protect that personal data and special category data and this Learning Review summary has been published to include only the information which can be lawfully placed into the public domain.

5. Brief Historical Context

Both young people have been known to social work services since birth and were removed from the care of their birth parents in 2008 aged 3yrs (YPD) and 5yrs (YPC).

Following a long history of child protection concerns South Lanarkshire Council secured a permanence order for both children in 2014 when their Compulsory Supervision Orders were terminated, and parental rights and responsibilities were withdrawn from their birth parents.

Both young people received intensive support from a range of children and family services since becoming looked after by South Lanarkshire Council and both continued to be supported by services at the time of YPD's death.

Both young people's mental health and psychological functioning were assessed to have been seriously impacted by their experience of extreme trauma from birth until they were removed from the care of their birth parents.

Both young people were of an age that their views and wishes about contact were paramount and practitioners supported contact when this was requested.

6. Effective Practice

6.1 Practitioner commitment to both young people

It was evident throughout this Learning Review that all professionals working with both young people had the young people's health and wellbeing at the core of their work. There was evidence throughout the young people's care journey of practitioner's stickability and commitment to support them through their transition into adulthood.

At different times, both young people opted out of services and practitioners worked hard to engage them as they continued to be worried about their safety and wellbeing.

6.2 Foster Placement

Both young people were supported in their placements for several years by their foster parents who were committed to their care providing a nurturing home environment.

There is evidence of sustained support by social work, CAMHS (Child and Adolescent Mental Health Services), education services, intensive family support and other services all working together to support the carers to care for children with challenging behaviours and needs.

6.3 Educational Placements

Education services for both young people worked very hard to maintain both young people in mainstream education and when the decision was taken to identify alternative education placements, there was evidence of robust transition planning and transitional support. Both educational establishments provided a high degree of support encouraging both young people to achieve their educational potential. Professionals worked closely together to ensure a team around the child approach to care planning and support.

6.4 Consistency of Workers

Children and Family social workers were well known to both young people and worked with them for many years before the case was transferred. Workers understood the needs of both young people and the challenges they and carers experienced.

From 2018 onwards there were three changes in social worker and other professionals in the young people's lives and there is clear evidence that both struggled to cope with worker changes and building new relationships.

6.5 Support for Staff Working with Children with Complex and Challenging Needs

As a result of this case, children's house workers now receive external psychological supervision/support helping them as a care team to focus on the impact of trauma, how this presents in children's behaviour and developing trauma informed responses. Residential workers spoke positively of this support and regarded this as a necessary component of staff wellbeing and creating safe spaces for children.

7. Practice and Organisational Learning

Introduction

While this Learning Review focuses on the three-year period proceeding these tragic events, the young persons' history of abuse and trauma has had a significant impact on their emotional wellbeing and psychological development and provide context and meaning to the young people's behaviours and life challenges.

The Learning Review has concluded that YPD's death could not have been predicted by professionals involved in the care of YPD and YPC, however, the Learning Review has identified practice and organisational learning.

7.1 Placement Decision Making and Sibling Assessment

There was a delay in securing permanence for the young people. A decision was quickly taken following their accommodation that they would not be returning to their birth parent's care. Permanence planning did not commence until 2010 and it took 4 years after this decision for the permanence order to be secured (6 years after being accommodated). For both young people, the delay in securing their future caused distress and uncertainty which impacted their emotional wellbeing and behaviours.

A decision was taken in 2011 that both young people should not be placed together and that an alternative singleton placement be found for YPC. There is no evidence that an alternative placement was sought and YPC continued to reside in the same care placement as YPD.

This Learning Review highlights the importance of understanding the individual needs of siblings and while The Promise[2] and research reinforces the importance of placing

[2] The Promise Scotland

siblings together, we cannot assume that this is always in the best interests of children and careful assessment and ongoing monitoring and review is necessary to ensure that their needs are being met within their care environment.

Comment

It is important to provide comment on current practice as the issues described above reflect the drift and delay across the service at that time. South Lanarkshire through Inspection reports have significantly improved their permanence planning processes, and while drift and delay can still be a feature, it is not the norm. Local Government Benchmarking Framework (LGBF) and local authority looked after children's data (CLAS) returns indicate that South Lanarkshire is now one of the better performing areas for permanency planning.

7.2 Sibling Contact

Both young people's relationship was complex but there was evidence that they cared for and worried about the other. As young adults contact happened at the request of either young person, supported by practitioners.

There is no evidence that sibling work was undertaken to help them to manage contact in a way that helped them to have a more positive and healthy relationship.

At the managers workshop discussion took place around the role of SCRA (Scottish Children's Reporters Administration) can play in overseeing sibling contact. If supervision orders had been in place sibling contact would have been considered by the Children's Panel and provided a degree of external scrutiny. While discussion took place about referring both young people to SCRA it was felt that a legal order would not have assisted or impacted positively on worker relationships/engagement with both young people.

7.3 Sexual Abuse

Two practice areas were considered under this practice heading.

Management of the sexual abuse allegations and subsequent legal proceedings

Between 2008 and 2018 YPC gave details of sexual abuse at the hands of his birth parents and other adults to carers. YPC underwent joint investigative interviews (JII) on a number of occasions but was not always able to repeat these allegations during interview resulting in the police not being able to take action at that time. With the implementation of the Scottish Child Interview Model (SCIM) now significant pre-interview planning would take place to ensure that the appropriate arrangements are in place to support children to tell their story.

Between 2018 and 2022 there were a series of incidents that resulted in delays in the court process. In November 2019 a court date was cancelled and in early 2021 new information came to light which resulted in the court process being delayed while further police investigations were undertaken.

From July 2020 to March 2023 the court process was delayed once again for a number of reasons including a court backlog due to Covid and no available court time. It was not until March 2023 that the case was heard and YPC's birth father found guilty of child abuse offences and given a custodial sentence.

The delay in the court process impacted significantly on YPC and his mental health deteriorated, and workers directly related his challenging behaviour to the stress and uncertainty he was feeling.

There is no evidence of active engagement with the procurator fiscal to seek clarity as to the delay and to discuss the impact the delay was having on both young people. The procurator fiscal was progressing the case, but there could have been improved communication between the procurator fiscal, the young people's key workers and YPC.

Child victims of sexual abuse

Child victims of sexual abuse have been exposed to inappropriate sexual contact which they do not emotionally understand but which has evoked a physical response. We know that young children can act out sexually at times of stress and anxiety. The young people were 3yrs and 5yrs when they were accommodated and there could have been the opportunity for age related personal safety work which could have looked at their understanding of their own bodies, their own and others personal space and boundaries and help them to manage their stress and anxiety in a nonsexual way.

There is no evidence that direct work was undertaken with carers to help them to understand and manage the children's behaviours or to give them tools and activities to do with the children to address the behaviours within an everyday context.

7.4 Harmful Sexual Behaviour

There was no evidence of multi-agency risk management meetings being convened or any agreed frameworks to guide staff in the assessment and management of concerning behaviours.

YPC has never been charged with a sexual offence prior to his arrest and therefore was not managed through youth justice or the Children's Hearing System. There were incidents over the years which could have led to charges being brought which would have given a legal mandate for worker's interventions. This was discussed at length in both the practitioner and manager workshops with no definitive agreement as to what impact this would have had on both young people whose behaviours were often an indicator of their distress and trauma.

The workshop highlighted workers did not feel confident in this area of practice reflecting the need for basic awareness at all levels across all partner agencies including early intervention, assessment, risk management and long-term interventions. While CARM (Care and Risk Management) processes were in place

these were not used for YPC. There was a lack of awareness amongst practitioners of these processes.

7.5 Working with Young People at Risk of Significant Harm

Practitioners highlighted that there were several workers and services involved with both young people. At times it was hard to know who the core team members were, who was doing what and, in some instances, key practitioners were not invited to key meetings. One practitioner described the young person's life as having lots of moving parts and it was hard for all the different pieces to fit together and make sense for them and for the practitioners.

Practitioners identified that building relationships with young people was core to this work and that "stickability" was central. For young people to feel supported and to be able to trust, workers need time and space to build positive relationships and to be able to demonstrate commitment. Throughcare staff talked about having more time to work with their young people than their colleagues in children and family areas teams.

There was no evidence of chronologies being used to identify changes/patterns in risk. Chronologies are one of the key tools that can be used to analyse and manage risk and a multi-agency chronology would have been helpful in identifying increased risk.

A focus on contextual safeguarding may have allowed a greater awareness of risk within the community and to identify strategies that would go beyond the young person's care plan to address wider issues such as places, spaces, and people that both young people were coming in to contact with. There were many young person's meetings, but the practitioner workshops identified a lack of process in supporting and working with older young people at risk of significant harm.

The needs of older young people are often complex and require to be manged through robust structures that bring together relevant practitioners to share and analyse information, agree need and risk and work together to implement the child's plan (protection plan) within a shared understanding of respective agencies roles and responsibilities.

Both young people were of an age that their views had to be considered and their capacity to make decisions respected, even though at times these could be in conflict with practitioners who were concerned about both young people's vulnerability in the community.

7.6 Transitions

Throughcare

South Lanarkshire Throughcare Team was in the early stages of service development when they began working with YPC and noted that YPC was one of the first young people they worked with.

Workers indicated that systems were not in place at that time and no pre-planning transition meeting involving all key partners took place. They were involved with YPC at the time YPC was charged with this offence. There is evidence that YPC had a good relationship with his Throughcare worker.

Throughcare workers indicated that transition planning for young people in South Lanarkshire now starts at around 15/16 years when transition meetings are held involving all services involved with the young person and those services that they will require as they transition from children to adult services. They have good working relationships with partner agencies and systems and processes are well established. Throughcare workers indicated that they were still having to work hard to get adult services around the table at a much earlier stage in the planning process and their involvement continues to be minimal.

Health / Mental Health Services

In South Lanarkshire CAMHS are not funded to work with 16 and 17yr olds who are not care experienced. This means that there are young people who require mental health support who will not receiving a service from CAMHS, but they can access other mental health services and supports. CAMHS spoke about working towards being able to extend services up to 18yrs but this will be impacted by service capacity and funding issues.

South Lanarkshire has no forensic CAMHS service but can access the IVY (Interventions for Vulnerable Youth) Project for consultation and risk formulation, but this is usually for cases within the justice system. YPC was not in the justice system, however, the involvement of Forensic Child & Adolescent Mental Health Service (FCAMHS) in a risk formulation may have informed worker knowledge and planning.

The Learning Review has highlighted different parts of Lanarkshire health services do not always connect well with each other and CAMHS do not have strong links with LAAC health services who are responsible for the young person's physical health. Throughcare has a dedicated nurse attached to the service but it is hard for them to navigate the various health systems.

7.7 Support Structures for Workers Working with YP with Challenging Behaviours and Needs

Practitioners across partner agencies worked hard to engage and hold both young people when there were no legal orders in place to give them a legal basis for their interventions. YPC could have chosen to exit the care system at any point after their 16th birthday.

This Learning Review report highlights the complex nature of the needs of both young people. Over the years practitioners were challenged on many occasions describing professional relationships at times as "mirroring the chaos of the young people's lives". They spoke about feeling "frustrated and insignificant" and the impact of working with

young people wo have experienced extreme childhood trauma and how overwhelming the work can be.

This work is time intensive to do properly and practitioners spoke about the need for managers to understand this and put structures in place to support them to be able to work with children/young people where there is a high degree of risk. They spoke about needing to feel safe and valued and to feel they are doing the job to the best of their ability. Residential care staff share a very intimate space with children and young people and they spoke about the need to feel the environment is safe for themselves and the children they care for.

Practitioners also spoke about the impact of vicarious trauma and the need for good supervision structures that provide space for workers to reflect on their feelings and emotions as well as reviewing practice and progress.

This case highlights the importance of staff supervision and across agencies processes vary. There is a need for supervision to be restorative for those workers who are managing high degrees of risk.

Within the workshops there was discussion around peer supervision and the coming together of the team around the child in complex cases where practitioners are holding a high degree of risk. Peer supervision creates the opportunity to explore worker feelings, processes and practice out with the care planning structures, encouraging open and honest reflection led by a skilled facilitator.

8. Strategies for Improving Practice & Systems

8.1 Placement Decision Making, Sibling Assessment and Contact

The Promise clearly sets out the principle that when children can no longer be cared for by their birth parents/carers alternative care arrangements should seek to place siblings together ensuring family identity. However, for a small group of children it will not be in their best interests to be placed with siblings and such decisions should be based on robust individual child assessments, a strong evidence base and regular review.

Recommendation 1 - For the small group of children where a decision has been taken not to place siblings together, the CPC should request reassurance that permanency decisions have a robust evidence base and that any variation in the care plan is accurately recorded, is presented to the Fostering & Adoption Panel, ratified by the agency decision maker and is under constant review.

8.2 Sexual Abuse Allegations & Investigation

This case has highlighted the length of time legal process can take and the impact delay can have on child victims and witnesses.

It has been recognised for many years that the Scottish Justice system needs to reform to meet the needs of child victims and witnesses. Children have often reported that

their right to be heard in judicial and administrative proceedings (Article 12, UNHRC) is not upheld.[3] This case only highlights the need for reform. Delays in legal proceedings can significantly impact a child/young person's mental health and their ability to engage in the process may be compromised.

The Bairns Hoose is key to Scotland's aspirations that children experience child centred, protection, trauma-free justice, care, and support to recover and this needs to extend to children up to 18 yrs.

This Learning Review has highlighted the importance of the interface between police, social work and procurator fiscal services to ensure the needs of child victim are at the centre. While there is not a specific recommendation relating to this, consideration should be given at a local level to the interface arrangements between procurator fiscal services, police, and social work services for child victims/witnesses to ensure that delays in legal processes are understood and communicated with child victims and their carers.

The Learning Review has highlighted a lack of use of child protection processes for older young people. The implementation of the national child protection guidance (2021) reinforces the use of child protection processes for young people up to the age of 18 years to ensure their safety and well-being.

Recommendation 2 - The CPC should seek reassurance that practitioners have a clear understanding of the national child protection guidance (2021) ensuring that child protection processes are being used to protect young people at risk of harm up until the age of 18 yrs.

Recommendation 3 - The CPC should seek reassurance that the threshold for convening an IRD as defined in the national guidance (2021) is understood by key practitioners and when that threshold is met IRD's are being convened irrespective of any other processes that may be in place.

Recommendation 4 - The review has identified a lack of sexual abuse recovery services in South Lanarkshire and the CPC should request that a service mapping exercise be undertaken to identify what supports are available and to highlight gaps in service provision.

8.3 Harmful Sexual Behaviour

There was no recognised multi-agency framework in place to bring agencies together to assess and manage young people who may be displaying harmful sexual behaviour. Such a framework would provide practitioners with processes and structures to assess and manage risk.

Recommendation 5 - The CPC should ensure that there is a comprehensive multi agency risk assessment and risk management framework in place for

[3] Bairns Hoose Scotland

working with young people displaying harmful sexual behaviours which supports early intervention and identification of risk but which also provides workers with long term interventions and strategies.

Recommendation 6 - The CPC should undertake a multi-agency training needs analysis to identify what training is available for staff and where necessary commission/develop appropriate multi agency training.

8.4 Working with young people at risk of significant harm

There were many meetings including LAAC (Looked After and Accommodated Children) Reviews and Pathway planning meetings, however, the practitioner workshops identified a lack of process in supporting and working with older young people at risk of significant harm.

This finding will not be unique to South Lanarkshire and this case highlights the complex nature of working with young adults who have capacity and the right to self-determination but who are at risk of significant harm and the high degree of risk professionals are managing daily.

The GIRFEC[4] continuum pathway should ensure that all aspects of a young person's needs are addressed, and that vulnerability and risk are robustly managed within a child protection framework which reflects a trauma informed, strengths based, young person centred and rights-based approach to working with older young people.

The Learning Review identified challenges of information sharing for young people 16+yrs across partner agencies. The rights of the young person to confidentiality and their consent to information sharing needs to be balanced with the risk of future significant harm and the legal framework surrounding this can be confusing both for the young person and those professionals involved. The different legal definitions of a "child" can be a barrier to information sharing especially for care experienced young people who are supported through Continuing and Aftercare and adult services up to 26 yrs.

Recommendation 7 - The CPC should consider the implementation of a contextual safeguarding approach to include young people up to the age of 18yrs but may also include care experienced young people who are supported by Continuing and Aftercare. The established multi agency meeting for missing children/young people has the potential to be extended to consider risk and vulnerability more widely within a contextual safeguarding framework.

The Learning Review has identified a gap in mental health services for children 16-17yrs who are not care experienced. Due to capacity and financial pressures CAMHS are unable to provide support to this group of young people.

[4] GIRFEC Scotland

Recommendation 8 - The CPC should request a positional statement from CAMHS as to the future development of services for young people up to age of 18yrs who are not care experienced. The CPC should request CAMHS and adult mental health services provide reassurance that there are robust transfer protocols in place that are understood by practitioners which ensure the safety and well-being of the young person and reflect the need for flexibility in responding to the individual needs of young people.

8.5 Transitions

This older group of care experienced young people present significant challenges for all partners in understanding needs and risk and how practice and policy need to adapt to meet the needs of young people.

South Lanarkshire Continuing and Aftercare Services have now been working with young people for over 3 years and have gained significant experience in working with young people transitioning into adulthood, however, the Learning Review has identified that adult services are regularly not involved at an early stage of planning for a young person.

Recommendation 9 - This Learning Review has highlighted challenges in relation to information sharing across partner agencies and the engagement of adult services for young people transitioning from children to adult services. The CPC should review existing transition pathways to ensure that all partner agencies including adult services have a clear understanding of their roles and responsibilities for care experienced young people up to the age of 26 yrs.

Recommendation 10 - The CPC should seek to share the findings from this Learning Review with the Adult Support and Protection Committee to ensure explicit ownership of a joint risk management agenda for all young people who are vulnerable and at risk of harm.

Recommendation 11 - The findings from this case should be shared with CPC Scotland who are currently undertaking work on transition pathways.

8.6 Support Structures for Workers Working with YP with Challenging Behaviours and Needs

This Learning Review has identified the challenges and emotional impact on workers working with young people who are at significant risk of harm. Practitioners need to be supported to reflect on the effectiveness of their interventions but also to feel that the emotional impact of the work is understood by managers.

Practitioners spoke about building relationships with young people to gain trust, but how difficult this was to achieve with demanding caseloads and busy children's houses. Practitioners spoke about being frustrated and how the young person's chaotic state could be reflected in the uncertainty of the team around the child.

Supervision within organisations varies and services need to reflect on the effectiveness of their supervision policies and processes. In addition to single agency supervision, the use of peer review for the team around the young person can provide a very effective forum for practitioners to come together to reflect on what is working well, what are the challenges and how might things be done differently, recognising in some instances change may be slow and not without risk.

Practitioners need to know how to escalate concerns when there are professional disagreements that are impacting on the young person's plan.

Recommendation 12 - The CPC should request that work is undertaken to identify the need for a practice forum for practitioners to bring high risk and complex cases for discussion. Such a forum would provide the opportunity to review the young person's plan, identify practice challenges and thresholds, ensure professional roles and responsibilities, and explore potential resources and professional disagreements .