West Dunbartonshire Child Protection Committee

Protecting People in Dundee

Joint Learning Review Executive Summary Report Child M1 and Child M2

Published December 2025

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Contents

1. Introduction

This Executive Summary Report has been published by West Dunbartonshire Child Protection Committee (WDCPC) and Dundee Children a Risk Committee (DCARC) following the completion of a Joint Learning Review into the circumstances for Child M1 and Child M2.

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

The Learning Review covered the period October 2020 – September 2023 whilst Child M1 and Child M2, with their family, lived in both West Dunbartonshire and Dundee. It involved reading multi-agency records, working with the assigned Learning Review Team. The children no longer reside with their parents.

Undertaking a Child Protection Learning Review in Scotland, referred to as the "Review" in the report, provides an opportunity for the associated Child Protection Committee (CPC) to gain a broader understanding of how the circumstances occurred the way that they did for the subject(s) of the Review.

In this case, as a cross-border review, it set out to offer guidance and support that will assist to enhance and further develop the protection of children in West Dunbartonshire and Dundee in the future.

The Executive Summary Report offers an overview of the full Learning Review undertaken and offers a summary of the following areas:

- The circumstances leading to the removal of Child M1 and Child M2
- The Learning Review process and methodology
- Organisational Learning and Effective Practice
- Strategies for Improvement

Thanks are extended to the mother of Child M1 and Child M2, who met with the Reviewer, the associated multi-agency Review Team, and the staff and managers across multiple services who contributed to the Learning Review undertaken by an Independent Reviewer.

The professionalism shown throughout was commendable.

2. Sharing Personal Data

West Dunbartonshire CPC and Dundee CARC have given due consideration to the extent to which personal data can be shared in any Executive Learning Summary being placed in the public domain. The report has been anonymised, insofar as is possible, and includes only information that can be lawfully shared.

Any disclosure of personal data must comply with the Data Protection Act 2018 and the General Data Protection Regulations (2018): Article 8 of the European Convention on Human Rights (the right to respect for private and family life) and must have acted in accordance with these requirements.

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

3. The Circumstances

The children focused on in this review will be referred to as Child M1 and Child M2 to protect their identities. Both were under five years during the period reviewed and lived at home with their mother (Ms A) and father (Mr C).

Mr C had a significant criminal history, including perpetration, although there had been no recent offending noted. Both parents (Mr C and Ms A) had periods of poor mental health and displayed some coercive control behaviours in their relationship. Gender bias was evident from services supporting the family.

Ms A and Mr C had a limited understanding of the work expected in parenting effectively and of the skills required in meeting a child's needs.

Child M1 and Child M2 had been known to multiple services throughout their lives due to continued concerns relating to standards of care and evidence of significant non-engagement with agencies, therefore denying the children access to vital services. Records indicated that at times, services felt powerless in affecting change.

Child M1 was seen as the focus of intervention and support by most agencies due to their specific disability and complex needs. Child M2 was, for the most part, an unseen child.

There was evidence of over-optimism and an over-reliance on self-reporting by the parents from multi-agency services. Services were not always clear on who should lead during periods of intervention.

The family moved often, travelling within and across Dundee and West Dunbartonshire. For both areas, effective engagement was challenging, and the levels of care provided for the children raised multiple concerns. Both children were subject to significant neglect and were not having their care or protection needs met. Child M1 had significant health needs and needed multiple support/intervention activities daily.

The children moved from Dundee to West Dunbartonshire, and within a short period of time were removed from their parents' care. At the time the children were removed the conditions within the family home were witnessed to be 'appalling'. The family home was described as having an 'unbearable stench and being uninhabitable'. The condition of the children was poor, with both children dirty and hungry. Child M1 was malnourished.

The hospital also noted concerning levels of self-neglect for both parents.

Child M1 required a period in the hospital due to their complex needs and the levels of concern about their presentation.

The concerns of the multi-agency partners involved had been high. Neither child had been placed on the Child Protection Register[1] despite opportunities to do so throughout three year period reviewed, nor had the children been referred to the Children's Reporter[2].

In understanding decision-making in context, the complexity of safeguarding work for all services and the associated risks of work-related vicarious trauma were considered and embedded in the Learning Review process.

4. The Learning Review Process / Methodology

Led by an Independent Reviewer, the Review commenced in September 2023 and was supported by a multi-agency Review Team with representatives from Police Scotland, Education / Nursery, Social Work Services, NHS Tayside, and NHS Greater Glasgow and Clyde. Other agencies supporting the Reviewer were Housing and the Children's Reporter.

The Review was completed following the expectations of the National Learning Review Guidance[3] and took cognisance of the Care Inspectorate's Code of Practice for Learning Reviews[4] and the associated SCIE Learning into Practice Quality Markers[5].

The National Guidance for Child Protection in Scotland (2021)[6] (referred to as "National CP Guidance") assisted the Review in its child protection considerations alongside local and other specialist national guidance.

The Review was an opportunity to consider systems and processes related to multi-agency working in West Dunbartonshire and Dundee, and what could be learned from them. This included the impact of multi-agency support systems for Child M1 and Child M2 before the significant event leading to their removal occurred.

[1] The Child Protection Register - National CP Guidance (Page 20, Part 1.87)
[2] Children's Reporter - Compulsory Supervision Order (Page 33, Part 1.159)
[3] National Guidance for Child Protection Committees Undertaking Learning Reviews (Updated 2024)
[4] CI - Code of Practice for the Review of Learning Reviews in Scotland (2021)
[5] SCIE Learning into Practice Quality Markers
[6] National Guidance for Child Protection in Scotland (2021) - Updated 2023

The Review aimed to establish whether there were any opportunities for agencies to have intervened earlier or worked differently to affect change or reduce the risks that were presented. Activity included whether decisions and actions taken reflected the expectations set within available single and/or multi-agency policies, procedures, and guidance in West Dunbartonshire and Dundee.

Of particular importance to the joint Review Team, as outlined in the Terms of Reference, was to be able to:

- Learn together across both partnership areas to improve or change single or multi-agency practices in protecting children.
- Focus on the effectiveness of partnership working.
- Identify areas of strength in single or multi-agency practice.
- Examine levels of protection for children where there are complex needs and challenges, including the care of a child with a disability.
- Consider parenting capacity and childhood trauma.
- Review the impact of risk management in cases where children are subject to multiple interventions but are not on the Child Protection Register or known to the Children's Reporter.
- Consider the use of available resources, protocols, and guidance to protect children in West Dunbartonshire and Dundee in keeping children safe.
- Establish whether a different approach to single and multi-agency working could have reduced the risks that were presented for Child M1 and Child M2 whilst living in both Dundee and West Dunbartonshire.
- Consider the management of cross-border cases.

Using a systems approach to understand why things developed the way they did, the Reviewer examined single and multi-agency case files with respect to Child M1 and Child M2 in detail. Learning from research is reflected throughout the full report.

5. Brief History

The parents of Child M1 and Child M2 both experienced multiple adverse childhood experiences (ACEs)[7] when growing up and suffered considerable trauma as children. This impacted their parenting capacity considerably.

Mr C and Ms A at the time of the Review had children from other relationships living elsewhere and two children of their own (Child M1 and Child M2) living in their care. They had moved frequently during their relationship, and always in an unplanned way, giving no consideration to the needs of the children.

In 2020, Child M1 suffered a significant physical injury. An inter-agency referral discussion (IRD) in Dundee agreed to proceed to an Initial Child Protection Case Conference. Despite significant concerns for the care, protection, and wellbeing of Child M1 by several professionals, a decision was made not to place the children on the child protection register. Instead, the family was offered intensive multi-agency support.

There was a short period of success in Dundee thereafter. However, for the most part, intensive supports were required in meeting the needs of the children. The children should have been subject to statutory intervention.

The case transferred from Dundee to West Dunbartonshire after the family moved to the area in 2023. Neither child was receiving the expected standards of care, nor were their needs being fully met due to chronic neglect and non-engagement with services. They continued to work hard to evade and avoid vital interventions for Child M1. Neither child had any real social interactions or positive play experiences outside the home during the time they stayed in West Dunbartonshire. This was despite multiple efforts by agencies to gain access to the children over many weeks. After arriving in West Dunbartonshire, increasing concerns led to significant child protection action when police officers and social workers visited the family home.

The children (Child M1 and Child M2) stayed in multiple different locations in the 14 weeks they lived in West Dunbartonshire with both parents.

On the day the children were removed, the home conditions and the physical condition of both children fell well below an acceptable standard for two very young children, one with complex needs.

[7] Adverse Childhood Experiences (Scot.Gov)

6. Practice and Organisational Learning

The areas highlighted in this section are not recommendations and are offered as practice and organisational learning points based on the Reviewer's analysis of the information provided.

This section offers potential markers to strengthen already effective processes or where practice was developing in both West Dunbartonshire and Dundee. Strategies for Improvement (previously referred to as recommendations) can be found in Part 8.

6.1 Effective Chronologies

Record keeping was good in both areas, and these were often detailed in their observations of risk and child protection concerns.

The multi-agency chronology provided by each area for the Review was detailed. Some single-agency chronological information was excellent, but other parts were less organised or repetitive. Key information found in case records did not always appear in the chronological information reviewed. Nearly all chronological records are related to Child M1.

Whilst chronologies were of a good standard in Dundee and of a reasonable standard in West Dunbartonshire, in both areas, case records were better. The Reviewer's observations of chronologies in West Dunbartonshire may have been different if the family had been there longer than 14 weeks.

The length of time the children were in Dundee meant that multi-agency meetings were established and provided a platform for information sharing from chronologies, records, and observations with concerns recorded via the Team Around the Child (TATC) meeting process. The chronological history offered to the Child Protection Case Conference (now referred to as CP Planning Meetings) in October 2020 was very good.

In West Dunbartonshire, staff showed less confidence in their use of chronologies. It did not seem like a valued part of the system in cases not subject to child protection.

In both areas, the Reviewer did not always find that the chronology was used to share key information and highlight risks to partners. The inconsistency in the importance of chronologies may have been based on how the information gathered and shared was valued, respected, and acted upon by partners.

Staff in both areas told the Reviewer time was not always routinely taken to look back at emerging patterns in chronologies when preparing reports or attending meetings. There was limited evidence that managers were discussing, acting on, or routinely signing off on chronologies with frontline staff.

The Reviewer is satisfied that staff know how to use chronologies and suggests a fresh look is required in how they are used and valued in taking effective action. This is an achievable learning point.

For Consideration by Both Areas:

The new Leading Chronology Improvement – Reflection and Assessment Tool being developed by IRISS[8] is a strong starting point to revisit, evaluate, and strengthen both strategic leadership and operational practice.

6.2 Relationships with Housing

The family was well known to housing services in both areas and moved frequently. In all tenancies, standards were poor, and at times when housing made visits, they were regarded as in an unacceptable and, latterly, an uninhabitable state. Whilst housing was responsive in both areas, the focus was on the standard of the tenancy. One visit raised child protection concerns in West Dunbartonshire.

Housing services routinely feature in a significant number of Learning Reviews. It is recognised nationally that relationships require to be strengthened.

Whilst the Reviewer felt the relationship between housing services in both areas and the rest of the operational child protection system was variable, overall, it was not good enough. There were, however, signs of improvement in the system.

Meetings with senior managers in both areas placed this action as a learning point:

Dundee Housing Services

Housing as a member of the Adults at Risk Committee recognised that relationships with partners in protection in Dundee were an improving picture. Housing stated they were not always involved at earlier stages and often only responded to crises. Training in child protection and trauma-informed practice had taken place along with learning in other key areas like gender-based violence. Whilst housing staff were invited to CP meetings, contributions varied, and the relationship with the CPC system did not always continue into other multi-agency meetings.

Housing in Dundee did provide a chronology for the Review and was actively seeking to be involved in other meetings like TATC. This is being profiled via their CPC member. The Reviewer was satisfied this was a positive shift in establishing and strengthening relationships.

West Dunbartonshire Housing Services

Like Dundee, housing was invited to CP meetings but no other multi-agency meetings. Staff in West Dunbartonshire described the relationship as variable. Practitioners and managers at the events said the relationship needed to improve. Some staff did not know who to contact within housing if they needed advice or support about situations involving vulnerable families.

[8] Leading Chronology Improvement (IRISS) 2024

Housing acknowledged that historically, representation at the CPC / APC was below the expected standard. More recently, action has been taken to improve this and move from the periphery of care and protection work into a more active role.

The housing manager expected that staff would have eyes and ears on the matter of concern but recognised more work may be needed to increase confidence in child protection practice.

For Consideration by Both Areas:

It is important to note that the National CP Guidance[9] (part 2.167) is clear that housing and homelessness services are important contributors to intervening early in the lives of children, young people, and families who need support and assistance.

It states, "Staff in these services can identify and coordinate a response to vulnerable families and young people and may prevent their circumstances from deteriorating further". The guidance also notes: "When housing or homelessness staff sign up a family to a tenancy or visit a property for any reason they may identify early indications of family support needs, or evidence that actions are needed to protect children".

To promote early support for vulnerable families, housing staff in both areas should actively seek inclusion in work at an earlier stage and have confidence in reporting child protection concerns. This should include staff from property service responsible to maintenance. The Reviewer is satisfied this is achievable.

6.3 Responding to Notifications of Concern (NOC)

Staff did not submit many NOCs in the period reviewed. In Dundee, this was perhaps due to regular TATCs taking place with joint decision-making being agreed.

When staff did submit, they appropriately raised significant concerns about the circumstances for the children in both Dundee and West Dunbartonshire.

In Dundee, staff expressed confusion about the complexity of the system and that some NOCs went to the Police and others to social work. The standard was always good. Both health and education professionals said that NOCs were more likely to be accepted and acted upon if they were received by police. There was more confidence from health staff in submitting if they first discussed the concern with the Child Protection advice line. The response to the concern was reportedly better.

Some cases in Dundee are discussed by police and social work who meet daily at 10 am to discuss the previous day's referrals. The Reviewer noted that health staff were not involved in these meetings. This may explain the reduced confidence in this part of the system by Health.

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

In West Dunbartonshire, the NOCs were detailed and appropriate. Responses were often slow from social work. Multiple NOCs were submitted before the emergency action that occurred in September 2023. The quality of two of the NOCs submitted was very good, and another was excellent. The NOCs should have been accepted as accurate from Health and given more consideration without the need for the escalation that took place to invoke the necessary response.

For Consideration by Both Areas:

The Reviewer felt a short-term piece of work could be undertaken to build confidence in the system and was satisfied this would take place.

6.4 Voice

The Reviewer found some evidence that the voices of both children were at the centre of decision-making. There were very good examples, particularly in Dundee via TATC, but there were inconsistencies in both areas.

The Reviewer accepts that non-engagement was key to this and caused staff considerable worry and distress in trying to communicate with the children by meeting their needs. An opportunity existed for partners to come together to express the child/children's circumstances through their eyes and use this to enhance decision-making.

From an organisational perspective, the rights of Child M1 and Child M2 were not always upheld. In particular:

Article 19 (UNCRC) The state must do all it can to protect children from violence, abuse, neglect, bad treatment, or exploitation by their parents or anyone else who looks after them.

Child M1 had no verbal skills but told everyone throughout most of their life they were dirty, malnourished, had limited play experiences (outside of nursery), neglected, got little stimulation, and wasn't able to use equipment important to them or get the treatment they needed to keep the child well. Child M1 couldn't tell anyone if they were hungry or in pain. Child M1 was telling everyone they urgently needed help.

Child M2 was telling everyone they were unseen, unheard, and an invisible child.

Practitioners must advocate for vulnerable children, including those with complex needs and limited opportunities to communicate with others. The Lundy Model[10] of Participation is one of many helpful tools. Participation strategies in both areas should include children with complex needs.

With a couple of effective practice examples highlighted throughout, this can be built upon and emphasised as part of broader work being undertaken across Scotland with the introduction of the UNCRC (Incorporation) (Scotland) Act 2024.

Children's voices must be represented in case records and inform decision-making.

[10] The Lundy Model of Participation

For Consideration by Both Areas:

Based on the views of Ms A at the time of meeting the Reviewer, partners should also consider advocacy for parents who are particularly vulnerable due to adverse childhood experiences and who do not always feel they have a voice. This may already be in place but not fully utilised.

6.5 Adult Services

There were occasions when it was clear that the parents of Child M1 and Child M2 could barely take care of themselves. Both could be dirty and unkempt. Their self-neglect made them appear as vulnerable at times as their children. They displayed fear and anxiety when professionals increased pressure on meeting the children's needs.

A consultant at NHSGGC, when reviewing the children's needs, commented that Ms A and Mr C were the 'poorest parents they had ever seen.'

The mental health of either parent was not explored to better understand how this was affecting the capacity to care for and protect their children. Ms A had a history of depression during pregnancy, which may have been a factor in the very rapid decline in the last few weeks.

For Consideration by Both Areas:

The Reviewer did not see evidence of effective joint working between adult and children's services. There were occasions where a referral to adult services would have been appropriate to offer them support. Police Scotland makes the one and only adult protection referral. There were other opportunities. The Reviewer is however satisfied based on feedback that this can continue to be encouraged through training, briefings, or by other means to staff to ensure they are reminded of the crucial role of adult services.

7. Effective Practice Examples

There are always more good practice examples in any learning review than those highlighted. This is a representative sample:

(a) The Physiotherapist:

In West Dunbartonshire, in the weeks leading up to the children being removed, the physio began to record copious notes outlining and sharing her concerns. She made frequent visits to try and see the children and challenged both the parents and professionals. She applied the escalation procedures within the NHSGGC "Was Not Brought" policy and showed real determination in bringing the circumstance to a child protection response. This was an example of very good practice. Their tenacity is to be commended.

(b) The Paediatricians:

The reports by both NHS Tayside paediatricians at the time of the ICPCC in Dundee in 2020 were of a very good standard; the report by one was outstanding. Both worked hard to express the importance of the children being placed on the Child Protection Register on the basis that the injury to Child M1 could not be confirmed as non-accidental. This was presented along with significant evidence of parents medically neglecting their child.

A letter to social work from another paediatrician from NHSGGC in Sept 2023 expresses, "In my opinion this case is one of chronic neglect. This has reached the threshold and needs urgent assessment and statutory intervention".

The Reviewer agrees the recommendations were accurate. This was good practice.

(c) The social worker and family support worker (Dundee):

The evidence collected in the CORE Assessment completed by the social worker in Dundee ahead of the ICPCC in 2021 is very good. It is thorough and factual and offers a holistic view of the parents and the child's circumstances. Whilst the focus is on Child M1, the assessment accepts that Child M2 is living in the same household in the information gathered.

The relationship with the retired family support worker in Dundee had with the family was the only period of real stability for the children during the Review period. Although there were still times of turbulence, a good and trusting relationship was built between the parents and the worker. They felt supported and permitted weekly access for a limited period. Ms A expressed that she missed this worker. This is to be commended.

(d) Education in Dundee:

The specialist nursery centre in Dundee for Child M1 and the other nursery for Child M2 worked well together to encourage attendance to meet the needs of the children. The TATCs organised by the head of the nursery centre went ahead even when attendance was poor by services / or parents in a bid to continue to monitor and share information. The service provision would have been excellent if the parents had engaged. The adaptability of the nursery centre to try and work with the parents was commendable.

(e) The social worker and senior social worker in West Dunbartonshire:

The senior social worker in West Dunbartonshire, during a time of staff shortages and challenges, responded to key concerns raised by services and was able to establish a relationship with Mr C and then Ms A. They were able to see the conditions and the children. This allowed them access to the family home more than any other professional during their short period in the part of West Dunbartonshire that they covered and just before the significant event that occurred.

A social work record offers insight into how Mr C sees himself. He tells a social worker in West Dunbartonshire that he is ashamed of his past behaviours. The report noted is very good, and subsequent supported disclosure of severe trauma from his childhood experiences was a good practice example.

(f) Inter-agency referral discussion debriefs:

At the time of the significant injury to Child M1 in 2020 in Dundee, the IRD process was well executed, after the ICPCC, the IRD de-brief to assist plan in protecting the children followed by a second debrief with good records of multi-agency decision making were an example of very good practice in child protection.

(g) The Health Visitors (Dundee & West Dunbartonshire):

The completed assessments by both health visitors were very good. The tool used encourages time to explore the ACEs for the parents, used GIRFEC effectively, and described the impact for the children. They took time to discuss concerns during the transfer phase and agree on what level of support may be required. Both used child protection supervision effectively and received good support. The case supervision case recording tool is an example of very good practice.

The assessment of the environment and the impact on both children by the health visitor in West Dunbartonshire is very good.

8. Suggested Strategies for Improvement

The actions of both the Dundee and West Dunbartonshire Chief Officers and its CPCs in undertaking a Learning Review reflect the commitment of key agencies working together to improve or strengthen the protection of children and young people. The suggested strategies for improvement for both areas are as follows:

8.1 Services that Find it Hard to Engage

Ms A had a fear of losing her children, the non-engagement may have been a way for Ms A to control her home environment. Ms A expressed how she hated feeling judged by the system when she became a young parent with her first pregnancy years earlier, while still a looked-after child herself. Ms A told the Reviewer that her looked-after history and associated ACEs always came first, and she did not always feel she was seen as a mother first. This was never fully explored.

Dundee services experienced an extended history of non-engagement with Ms A and Mr C. Success varied and consistency was poor. There was clear evidence of continued limited access to two vulnerable children (Child M1 and Child M2). This non-engagement had the greatest impact on Child M1, who was having almost none of their medical needs met most of the time.

Whilst a significant presenting factor at the time of the ICPCC in 2021, it was not considered in the context of all presenting risks and did not feature in the need for the children to be placed on the Child Protection Register. There was an over-reliance on self-reporting by the parents in the absence of attending appointments with no evidence to back it up. Services were unable to progress the work needed, and non-engagement became a serious concern. It should have been seen in the context of child protection.

During the 14 weeks in West Dunbartonshire, Ms A cancelled or did not answer the door for a total of 31 planned home visits. This figure does not include all missed clinical or other community appointments. There were multiple claims of COVID-19 infections and ill health for Ms A and her children. None of these appear to have been verified. The children were rarely seen.

On one occasion when access was gained, Ms A refused to let staff see Child M2 as the visit was about Child M1. With no regular multi-agency meetings taking place in West Dunbartonshire that included all partners, the scale of the non-compliant behaviour was not picked up as a significant child protection concern as quickly as it should have.

The family was ambivalent, avoidant, and non-compliant, sabotaging all efforts to get it right for the children. When under pressure, they raised complaints and worked hard to divert attention away from themselves. The case drifted considerably over almost three years. There were unsuccessful attempts to progress without any escalation taking place. Adult services should have been involved in a bid to support the parents.

The National CP Guidance states that “Persistent failure in engagement can contribute to significant harm. Urgent steps must be taken, if necessary, especially if babies and other very young or vulnerable children are involved”.

For Action in Both Areas:

Services must consider developing or strengthening current systems to ensure that established patterns of non-engagement are addressed much earlier than in this case. A multi-agency meeting should be convened by the lead professional and chaired by a senior officer/practice manager. The family should be invited to discuss barriers to family engagement and be advised of the possible consequences of continuing not to engage.

A contingency plan must be agreed upon, with an outcome-focused plan offering the family the opportunity to demonstrate a willingness to change. It should apply the GIRFEC principles with regular meetings to encourage improvements.

The recent "Was Not Brought" policy from Health Improvement Scotland, active in all NHS areas, could be developed further into multi-agency guidance with some additionality as suggested above.

8.2 Agency Awareness of the Role of the Reporter

Any service can make a referral to the Children's Reporter. In NHS Tayside, for example, there was clear guidance on the role of health in making a referral. No service ever did.

s60 (and s61) of the Children's Hearing (Scotland) Act 2011 places a duty of the local authority (and the police) to refer a child to the Reporter if they receive information that suggests that "the child needs protection, guidance, treatment, or control, and a compulsory supervision order may be necessary".

The Children's Reporter's primary function is to receive referrals for children and young people who are believed to require compulsory measures of supervision. In both Dundee and West Dunbartonshire both Child M1 and M2 would have met two grounds of referral:

(1) "the child, or another child in the same household, has been the victim of an offence such as sexual abuse, assault or neglect" and (2) "the child suffers from a lack of parental care"[11].

Despite very clear evidence of both grounds, the duty to refer was not upheld, and both children were never referred to the Children's Reporter until the time they were removed.

The children should have been referred to the Reporter and would likely have been made subject to statutory intervention in Dundee, firstly at the time Child M1 had a new significant physical injury and then later from 2022 when the circumstances deteriorated considerably.

West Dunbartonshire should have progressed a referral to the Reporter much earlier.

Staff at the Dundee practitioners event told the Reviewer they felt disempowered by changes in the Children's Hearing system, which slowed everything down or excluded them. Some said the agency concerned may have considerable evidence but were not always invited to submit a report or attend a hearing. Staff understood the minimum intervention approach but found the whole process slow and frustrating.

[11] (s67(2)(a) the child is likely to suffer unnecessarily, or their health or development is likely to be seriously impaired, due to a lack of parental care, and/or 67(2)(b) a schedule 1 offence has been committed in respect of the child - namely wilful neglect).

The Reporter(s) advised that it was the basis of the grounds that led to the decision as to what information was required and from whom. Barrier assumptions (pre-conceived ideas about what will happen if they refer) were acknowledged as a post-COVID legacy that needed to improve.

For Action in Both Areas:

Time should be taken in both areas to re-establish relationships that build confidence in the multi-agency workforce in making referrals to the reporter at the earliest opportunity when such risk is presented.

8.3 Recognising and Responding to Neglect

Neglect is one of the major reasons why a child is placed on the child protection register or subject to statutory intervention in Scotland. Agencies must know and be able to recognise physical, emotional, educational, and medical neglect as it occurs and respond appropriately.

The decision made to delay an IRD by almost two weeks on the premiss of a case transfer back to Dundee fell below the expected national standard. An IRD must take place as soon as possible and "without undue delay". It was difficult to understand, given the multiple CP concerns, why the decision was made or agreed upon by both areas to not respond immediately.

Professionals in Dundee told the Reviewer they had increased confidence in assessing neglect and applying tools in its assessment. There was some evidence to back that up. Staff in West Dunbartonshire were less confident. In both areas, the neglect continued, albeit there was a short period of success in Dundee.

In understanding neglect, any assessments, whether about parenting capacity or risk, must consider the adverse childhood experiences of parents and their capacity to change or adapt to meet their children's needs. In this case, neglect was severe:

- **Physical neglect** was seen in the children's presentation, their clothing, unhygienic conditions, filthy floors, and living in an often "foul-smelling" environment. They had repeated headlice, once reported as moving over Child M1's entire body. The children were often dirty and smelled. Practitioners must be familiar with the conditions throughout the home as part of an assessment and not only in the rooms routinely seen.

- **Emotional neglect** occurred through the children's inability to socialise with others or experience time with children. Nor did they receive consistent care and attention from vulnerable parents in meeting their emotional needs.

- **Educational neglect** was present, with both children being denied the opportunity to attend nursery and school. Limited access was given to vital communication opportunities for learning, including support from speech and language therapy.

- **Medical neglect** resulted from both parents refusing to engage with specialist services or follow through on medical care plans needed for Child M1 to grow and develop. Despite this level of evidence, there were considerable differences in thresholds across both areas at different times.

Despite the severity of the neglect, it was rarely directly referenced in records.

There were considerable threshold differences in this case This served to confuse and leave other professionals who had not seen the home overly optimistic. On other occasions, the neglect was minimised or normalised in case notes. The children missed out on the protective factors afforded by the child protection register or statutory intervention. This eventually resulted in the removal of the children as a means of meeting their needs.

Dundee

Time is required for Dundee to develop and strengthen a shared understanding of neglect and, where there are differences, how these are managed. Time is required to assist services to collectively transfer their shared understanding of neglect into practice and decision-making to reduce the risks at an earlier stage.

For Action in Dundee:

Services should prioritise multi-agency meetings like TATC before crises occur. Managers must always sign off on assessments undertaken, using any of the many tools available and know when escalation is required.

West Dunbartonshire

In West Dunbartonshire, there is a requirement to ensure multi-agency meetings like TATCs happen efficiently and effectively with assessments taking place to understand and respond to neglect at the earliest opportunity. There needs to be more evidence of multi-agency meetings taking place.

For Action in West Dunbartonshire:

In all cases with multiple staff involved, there should always be agreed representation by services with strong action plans and defined outcomes/contingency plans in place and understood by all. Professionals working with children with disabilities must have access to someone with specific knowledge and expertise in the child's disability or medical condition and be able to take part in take part in assessments and investigations to provide specialist knowledge and advice.

For Action in Both Areas:

Professionals must be respected equally in child protection and their knowledge of risks understood. Parents must know what is expected of them. A much greater emphasis is required on the importance of escalating concerns about neglect in both areas. A review of current multi-agency escalation guidance should take place.

8.4 Gender-Bias

Men can play a vital role in their children's development and wellbeing and have a major influence on the children they care for. In this case, there was a lack of professional engagement and curiosity, with an over-focus on the quality of the care children received from Ms A. This occurred in both Dundee and West Dunbartonshire.

Mr C demonstrated that he could take advice on board and was open to suggestions; he showed more interest when occasional engagement with him took place. Fathers like Mr C must know about and be involved in any concerns relating to their children. They should be consulted, invited to child protection meetings, and allocated tasks with the child's plan.

In plain sight, Mr C was void of any parental responsibilities for his children's upbringing and did not show any interest in being an active parent. Research (Berlyn et al., 2010)[12] tells us that partnering with fathers and valuing them as equal parents with the mother helps reduce the gender bias in child protection.

For Action in Both Areas:

Fathers have an important role to play as carers, and this must be encouraged and included in all assessments and plans to ensure services, and parents are clear on their roles when working with a vulnerable family.

8.5 The Case Transfer

At the time of the transfer from Dundee to West Dunbartonshire, a call was initially made to advise that the family, including a child with complex needs, had moved to the area in an unplanned way and would be staying with relatives. It was advised that the family did need support on a voluntary basis to manage multiple appointments and to keep on top of the demands of managing a child with such complex needs. A joint social work visit was planned for both areas to meet the family within the first week.

The system moved quickly with the health visitor receiving key information, social work immediately make a referral to educational psychology pending further information to allow Child M1 to attend school. Across health, multiple services began transferring information and setting up vital appointments. The efficiency across NHSGGC with so many services involved is notable.

Two weeks after moving, Dundee requested the case was allocated by social work in West Dunbartonshire as the family are vulnerable. Dundee advised that an assessment would be concluded ahead of the formal transfer. Although West Dunbartonshire was aware of historical child protection activity for the eldest child of Ms A years prior, there was no reference to current child protection concerns for the family.

[12] Understanding Gender-Bias in Child Protection

It became clear the family would need considerable support in meeting the needs of their children. Anonymous referrals were being received about neglect and a lack of care. Patterns of non-engagement were already established. By the time the assessment was received from Dundee social work (five weeks after the family arrived in West Dunbartonshire), it was clear that the children and their parents had extensive vulnerabilities.

The assessment as part of the formal transfer was good. It recommended continued support. There was however no reference to any immediate child protection concerns.

The family moved three times within West Dunbartonshire, requiring transfer information more than once for some parts of the system.

Only seven weeks later when the family first intimated their intention to return to Dundee, the social worker in receipt of the calls told West Dunbartonshire social work that before the family left Dundee there had been significant concern and that the children were almost at the point of a child protection investigation with a referral planned to the Children's Reporter.

This was in stark contrast to the information shared when the family first moved to West Dunbartonshire, which based the focus of the transfer on the needs of a disabled child.

For Action in Both Areas:

The Reviewer recommends that both areas consider with immediate effect, the development of a case transfer protocol for children who are not subject to statutory intervention or on the child protection register and where concerns exist (including frequent moves within and across areas).

Further discussion would be helpful with CPCScotland in relation to the transfer of such cases at a national level.

9. In Conclusion

Leadership and the importance of accountability in ensuring improvement and change were demonstrated throughout the Review by both areas.

The Reviewer is confident, given the openness, honesty, support, and concern for the wellbeing of children and young people in both Dundee and West Dunbartonshire evidenced during the Review, that progress will be made and sustained over time.