IN THE NEWS

RECENT SCOTTISH GOVERNMENT PUBLICATIONS

NHSScotland Staff Survey 2013 National Report
Consultation on Giving Children and Young People a Sporting Chance – A Draft Strategy for Scotland
Scottish Government: Suicide Prevention Strategy 2013 - 2016
Private Fostering in Scotland - Practice Guidance for Local Authority Children's Services
NHSScotland 2020 Local Delivery Plan Guidance
NHSScotland Chief Executive's Annual Report 2012/13
Guidance on Developing Policies to promote the Safe and Responsible Use of Mobile Technology in Schools
Inter-Agency Guidance for Child Trafficking
Fetal Alcohol Spectrum Disorder Awareness Toolkit
Young People's Knowledge and Understanding about Sexual Health and Blood Borne Viruses - Research Findings
Evaluation of the Family Nurse Partnership Programme in NHS Lothian, Scotland: 4th Report - Toddlerhood
Domestic Abuse Recorded by the Police in Scotland, 2012-13

STATISTICAL REPORTS

Educational outcomes for Scotland's Looked After Children 2011-12

NEWS WITH SCOTLAND 2013 (click on link to access website)

WithScotland on-line seminars
WithScotland is now offering the opportunity to participate in 'virtual seminars'. The next one, entitled, 'Child Trafficking and Sexual Exploitation', will take place on 28th January 2014. Information is available on the WithScotland website on how to register and take part. These on-line seminars have been devised with the purpose of ensuring as many people as possible can take part, without having to leave the office, or their desk!

GIRFEC Conference
Delegates who attended the GIRFEC conference 'Developing Practice Enhancing Assessment and Improving Outcomes for Children and Young People' in October can now download copies of the presentations. A conference report will be available shortly.

New WithScotland Website Pages
They have two new additions to their websites which you might be interested to visit. They now have a new page dedicated to WithScotland's own events. Here, you will be able to find information regarding their own seminars, on-line seminars, conferences and events. You will be able to download materials relating to each event and find booking information and research links. Please visit them at WithScotland Events.

They have also recently added the new Research and Practice Developments page. This page is dedicated to highlighting research and practice developments across Scotland for both child and adult protection.
JOURNALS/ARTICLES

Adverse childhood experiences, health perception, and the role of shared familial factors in adult
swig Child Abuse & Neglect, Available online 20 July 2013
Fatal child neglect: Characteristics, causation, and strategies for prevention Child Abuse & Neglect, Avail-
able online 19 July 2013
A brief intervention affects parents’ attitudes toward using less physical punishment
Child Abuse & Neglect, Available online 13 July 2013
Involvement with child protective services: Is this a useful question in population-based surveys? Child Abuse & Neglect, Available online 6 July 2013
Fatal child neglect: Characteristics, causation, and strategies for prevention Child Abuse & Neglect, Available online 13 July 2013
Why are suspected cases of child maltreatment referred by educators so often unsubstantiated? Child Abuse & Neglect, Available online 5 July 2013
Intimate partner violence in the family: Considerations for children's safety
Child Abuse & Neglect, Available online 4 July 2013
Listening to victims: Use of a Critical Incident Reporting System to enable adult victims of childhood sexual abuse to partici-
pate in a political reappraisal process in Germany
Child Abuse & Neglect, Available online 22 June 2013
The Challenge of Gender Variant Children: Research and Practice—This is the first of two papers on the subject of gender vari-
ant children. Download the latest paper now.

GIRFEC - Colcis, Centre for Excellence for looked after children in Scotland has published the updated the Scottish Govern-
ments response to Stage 1 Report on the Children and Young Peoples (Scotland) Bill—access full report here

INSPECTION

Argyll & Bute—18TH September 2013 Pilot Inspection
Particular Strengths—
♦ Strong commitment to prevention and early intervention.
♦ Very positive culture of partnership working at all levels.
♦ Flexible approach to working with families to improve outcomes for children and young people.
♦ Sound work to promote strong and resilient children, young people and families.

Improvement Areas—
♦ secure further and continuous improvement in the quality of assessment of risks and needs and planning for individual children
♦ complete and implement the integrated children’s services plan
♦ continue to develop rigorous and systematic joint self-evaluation to improve outcomes for children and young people
♦ ensure continued leadership and direction is provided to implement the planned improvement for services for children, young people and families.

North Ayrshire—28th October 2013 Pilot Inspection
Particular Strengths—
♦ The strong commitment to prevention and intervening early to provide children, young people and families with the help they need
♦ Highly motivated staff, committed to giving children and young people the best start in life an improving their life chances
♦ Involvement of individual children and young people in decision-making
♦ Strong and successful partnership working to tackle long standing inequalities
♦ Improvements in the wellbeing of the most vulnerable children and young people.

Improvement Areas—
♦ Implement robust and systematic approaches to joint self-evaluation across services for children and young people
♦ develop and implement an effective joint commissioning strategy to reflect the community planning partnership’s vision and ambitions
♦ Continue to improve the joint assessment of risks and needs for individual children and young people.

EARLY YEARS COLLABORATIVE

The Early Years Collaborative (EYC) is a multi-agency, local, quality improvement programme delivered at a national scale, taking forward the vision and priorities of the Early Years Taskforce. The EYC is centred on four work streams based on a fam-
ily centred, life-course approach with a focus on conception to one year, one year to 30 months, 30 months to primary school age and Leadership. At their meeting in August 2013 the Early Years Taskforce agreed to an additional work stream focused on start of primary school to the end of PS/age 8. This is the first time that this quality improvement approach has been used in a multi-agency context.

National Learning Sessions to support CPP’s and all work streams were held in 2013. The Sessions provided an opportunity for teaching improvement methodology and an opportunity for sharing of learning.

More information available on the Scottish Government Website
Significant Case Reviews

Child D (Glasgow City) date— Conclusions and Recommendation of the SCR is now available, the following actions were identified—

**Action 1**—All other agencies, with the exception of Police Scotland, should review existing staff supervision, support policies and systems to ensure that structured reflective supervision is embedded, especially in the management of complex cases. Police Scotland has their own arrangements in place.

**Action 2**—All agencies should ensure that the use of inter agency and single agency chronologies and case histories is embedded in policy and practice and that sufficient importance is given to reflective consideration of chronologies and case histories in case planning and risk assessment. This should have specific emphasis at the point of transfer to another worker or system.

**Action 3**—During the period under review there were significant changes within both organisations, the local authority was subject to change in organisational and staffing structures and the independent foster care organisation was subject to change associated with rapid growth. In both organisations, there was also a relatively high turnover of front line staff and first line managers in the particular offices involved. This can impact on the continuity of services, supervision and case management. Glasgow City Council Social Work Services and Core Assets (FCAS) need to ensure that robust systems are in place to ensure there is continuity of high quality services for vulnerable children and that there are sound processes for the transfer of information between “old and new” systems and workers.

**Action 4**—The Inter-agency Guidance on working with Hostile and Uncooperative Families should be reviewed and refreshed, with particular reference to what should be done when local options have failed to bring sufficient control to the management of a case. The review should also include agency policies on reporting violent incidents. Specific consideration also needs to be given to managing aggression and threats directed to foster carers.

**Action 5**—Glasgow City Council Social Work Services should put in place a system to monitor all permanence recommendations and decisions and where necessary, put practical measures in place to ensure child centred and timely outcomes.

**Action 6**—Glasgow City Council Social Work Services should always agree and sign placement agreements with independent fostering agencies, where possible prior to placement. They should also always provide copies of LAAC reviews and other relevant documents to the fostering agency. When approving foster carers and matching children with them, greater weight should be given to the foster carers’ previous experiences, particularly with regard to the age range of children to be placed.

**Action 7**—All agencies should review practice to ensure that, where children’s unusually good behaviour is not in keeping with their experiences, carers, foster agency, health and local authority staff are alert to potential risks and have opportunities to discuss them. The focus for these reflective discussions should be on underlying reasons and possible responses.

**Action 8**—All agencies directly involved in making and supporting foster placements should review how their systems, services and decisions can be more conducive to developing children’s attachments and resilience and to mitigating trauma.

**Action 9**—Glasgow City Council Social Work Services and Children’s Hearings Scotland should consider how supervised, restricted or terminated contact can be managed appropriately in the context of children having access to social networking sites.

*The full report can be accessed here*

National Significant Case Reviews

A Significant Case Review was conducted by Coventry Safeguarding Children Board into Child Fatality: Daniel Pelka (September 2013) : 15 Recommendations were made and related to—

♦ Domestic Abuse
♦ Referral and Assessment
♦ Training
♦ Schools
♦ Education
♦ Issues of culture and language

*The full document can be accessed here*
Executive summary

October 2013 - York - Baby A
Death of a 20-week-old baby from a brain injury thought to be non-accidental. Mother and her then partner were arrested on suspicion of murder and causing or allowing the death of a child. Baby A was known to children’s services and a pre-birth core assessment was commenced when Mother was 12 weeks pregnant. Issues identified include: insufficient significance given to request from Mother not to pass information regarding Baby A’s weight loss to children’s services; lack of attention paid to mother-baby attachment in hospital's medical model of care following Baby A’s premature birth; and reluctance among nursing staff to record observations about a parent, which may be considered judgemental rather than a record of professional judgment. Executive summary

October 2013 - Wilshire - Child H
Serious injury of a 5-month-old baby boy in December 2011. Injuries are likely to impact on Child H’s long term development. Medical report concluded that Child H was subjected to an escalating pattern of physical abuse thought to have occurred within 20 days of the incident. Mother and father were both arrested on suspicion of causing grievous bodily harm; neither were ultimately prosecuted due to insufficient evidence. History of: paternal and maternal excessive drinking; conflict in the parental relationship; father’s previous prison sentence for violent assault; and regular admittance of Child H to hospital. Issues identified include: irregularity in Child H’s care; insufficient attention paid to the impact of parents’ backgrounds on their parenting capacity; and lack of attention paid to issues of racial and cultural identity.

October 2013 - Southampton - Child G
Death of a 3-month-old baby boy (Child G) and injury of his twin brother (Child H), in September 2011. History of maternal depression and incidents of maternal and paternal self-harm. Father had been convicted of child cruelty against one of his children from a previous relationship and served a 12 month prison sentence when living in a different local authority and before meeting mother. Following the death of Child G, Child H was placed in the care of the local authority and mother and father were arrested. Issues identified include: lack of robust enquiry into the background of father or his role with the children; inaccurate record keeping/information sharing in regards to fathers convictions; need for exploring potential risk factors associated with maternal mental health during the ante natal and post natal period. Recommendations include: review of national systems for monitoring individuals who have offended against children; and review of local outcomes from the implementation of action plans from previous local serious case reviews in respect to engagement with fathers and the transfer of GP records. Physical abuse, offenders, abusive fathers Executive summary (PDF)

October 2013 - Kingston - Tom and Vic
Serious, life-threatening injuries to two young men in 2012. The incident involved a third person; all three individuals were considered suspects and arrested. Tom and Vic pleaded guilty in 2012. Both were well known to agencies, had histories of periods of going missing and substance misuse, convictions for criminal behaviour and experienced inappropriately using thresholds; and overreliance on less qualified staff playing the role of lead professional in Common Assessment Framework (CAF) cases. Recommendations are organised into four headings covering: practice, process, management oversight and organisational culture.

October 2013 - Isle of Wight - Baby T
Serious injury of a 3-month-old baby boy in July 2012, thought to be caused by shaking. At the time of the incident, baby T was living with his mother, his sister, S, and S’s father. Baby T had been looked after by 4 people shortly before he was injured. Mother and S’s father were arrested but criminal charges were not pursued to trial as it could not be identified when T’s injuries occurred. Maternal history of: mental illness; substance misuse; domestic abuse; child abuse; homelessness; and reported miscarriages and a stillbirth following being kicked in the stomach when 13 years-old. Issues identified include: lack of professional curiosity and insufficient examination of parents’ histories; inappropriate use of thresholds; and overreliance on less qualified staff playing the role of lead professional in Common Assessment Framework (CAF) cases. Recommendations are organised into four headings covering: practice, process, management oversight and organisational culture.

October 2013 - Hampshire - Child R and Child S
Death of two siblings in 2012 at their family home in Wiltshire. Cause of death is still to be determined but it is believed that father drugged then suffocated Child R and Child S before hanging himself. Family were well known to services and the children had spent time looked after by the local authority. History of: parental substance misuse: domestic abuse; paternal convictions for violent offences and possession of illegal substances; and concerns regarding emotional abuse. Issues identified include: destructive nature of the parents’ relationship; insufficient multi-agency assessment and planning; failure to revise professional judgments and evidence of ‘rigid’ thinking; and lack of clarity and confidence among professionals in the use of legal processes to protect the children. Recommendations include: review of management and supervision processes across agencies, to ensure that fixed thinking by professionals is identified and challenged; and evaluation of frontline professionals’ communication with children to ensure a balance between responding to children’s wishes and ensuring that their needs are met.
October 2013 - Birmingham - Keanu Williams
Death of a 2-year-old boy in January 2011 from multiple injuries, later determined to be the result of separate incidents with several major injuries being sustained over a period of days. Mother was convicted of Keanu’s murder and of ‘cruelty to a child’ in respect of one his older half siblings; she was sentenced to 18 years imprisonment. Mother’s partner was convicted of ‘cruelty to a child’ and received a 9 month suspended sentence. Mother spent periods of time in foster care subject to care orders throughout her own childhood. Keanu’s older siblings were subjects of residence orders to maternal grandfather. History of; frequent house moves and periods of homelessness and frequent changes in maternal relationships, including partners met over social networking sites. Issues identified include: focus on the child; commitment to interagency child protection processes; and professional curiosity in relation to injuries. Recommendations include: multi-agency audits to track records across agencies; critical review of the interagency protocol for child protection medical assessments; and procedures for managing internal and external professional disagreement and escalation, to ensure it does not delay service provision.

November 2013 - Surrey - Child J and Child K
Death of Child J, aged 3-years and sibling, Child K, aged 2-years. Mother was convicted of murder. Child J and K were known only to universal services until 4 months before their deaths. Mother left father and moved to Surrey from East Sussex at which point Father reported concerns for the welfare of the children to police. Issues identified include: allegations of domestic violence made by mother and accepted “at face value”; and concerns from Partner 1 and teacher of emotional abuse by Mother towards older children. Identifies lessons emerging from the review, including; the potential impact of gender and class bias; the need to verify allegations of domestic violence in order to inform action; and challenges of identifying where parental separation is adversely affecting children. Makes various interagency and single agency recommendations.

November 2013 - Bradford - Hamzah Khan
Death of a 4-year-old boy in December 2009, as a result of chronic neglect; Hamzah’s body was discovered by police during a search of the family home in September 2011. Mother was convicted of manslaughter and child cruelty in October 2013. Maternal history of; chronic alcohol dependency; depression; social isolation; domestic abuse; and reluctance to engage with services, including registering children for health and education services. Father was made the subject of a non-molestation order in 2008 following an arrest for assault against mother. Issues identified include: lack of interagency cooperation; failure of children’s services to identify Hamzah’s needs; and issues from Partner 1 and school of emotional abuse by Father towards Hamzah. Identifies lessons from the review, including; missed opportunities for assessment; impact of emotional and mental ill health on parenting capacity; impact of persistent housing concerns and debt on mother’s wellbeing; lack of professional curiosity and challenge; and allegations from mother deflecting agencies’ attention away from children. Makes various interagency and single agency recommendations covering health services, children’s services and police. Executive summary

December 2013 - Oxfordshire - Child Y
Death of a 22-month-old baby boy from a serious head injury in November 2010. Mother and father were arrested; father later pleaded guilty to child neglect and received a 15-month custodial sentence. Maternal history of; troubled upbringing; behavioural issues at school; alcohol and drug misuse; depression; housing and debt problems; and one known suicide attempt. Issues identified include: missed opportunities for assessment; impact of emotional and mental ill health on parenting capacity; persistent concerns of domestic abuse and debt on mother’s wellbeing; lack of professional curiosity and challenge; and allegations from mother deflecting agencies’ attention away from children. Makes various interagency and single agency recommendations covering health services, children’s services and police. Executive summary

December 2013 - East Sussex - Child G
Abduction of a 15-year-old girl in 2012, by her teacher, Mr K. Child G was involved in a sexual relationship with Mr K, which began around her 15th birthday. Mr K was found guilty of abduction and admitted a number of charges of sexual activity with a child under 16-years; he received a custodial sentence of 5-and-a-half-years. Identifies serious concerns relating to school’s actions, including; failure to identify the abuse and exploitation of Child G; fixed thinking; failure to hear concerns raised by students; failure to involve Child G’s mother; insufficient recognition of Mr K’s inappropriate use of Twitter to communicate with Child G; and serious concerns with the ways in which information was recorded, stored, retrieved and provided for the review. Identifies procedural failings in police handling of allegations relating to inappropriate images of Mr K on Child G’s phone. Makes various interagency and single agency recommendations covering: East Sussex Local Safeguarding Children Board, children’s services, school and police services. Executive summary

December 2013 - Derbyshire - BDS12
Death of a 2-year-old boy in March 2013 from cardiac arrest. BDS swallowed his mother’s methadone, which was in a child’s beaker. Posthumous toxicology reports found traces of Class A drugs and alcohol in BDS’ system, thought to have been directly ingested. Mother and father were convicted of manslaughter and received custodial sentences. Mother was also convicted of cruelty against BDS, which began around her 15th birthday. Mr K was found guilty of abduction and admitted a number of charges of sexual activity with a child under 16-years; he received a custodial sentence of 5-and-a-half-years. Identifies serious concerns relating to school’s actions, including; failure to identify the abuse and exploitation of Child G; fixed thinking; failure to hear concerns raised by students; failure to involve Child G’s mother; insufficient recognition of Mr K’s inappropriate use of Twitter to communicate with Child G; and serious concerns with the ways in which information was recorded, stored, retrieved and provided for the review. Identifies procedural failings in police handling of allegations relating to inappropriate images of Mr K on Child G’s phone. Makes various interagency and single agency recommendations covering: East Sussex Local Safeguarding Children Board, children’s services, school and police services. Executive summary
Please be advised that a desktop icon for child protection procedures has been installed on computers for the Acute Division and is up to date. It will gradually be introduced in primary care starting from January 2014 onwards. This is in addition to the procedures also being available on the CPU website and in folders that are updated locally.

**NHSGGC Child Protection Unit—Sexual Exploitation Conference** held on Thursday 28 November at the RAH.

The following speakers presented at the conference —
- Jackie Brock, Chair of the Ministerial Working Group for Child Sexual Exploitation in Scotland
- Daljeet Dagon, Children’s Services Manager, Barnardo’s Scotland
- Norrie Conway, Police Scotland
- Nazir Afzal, Chief Prosecutor for North West of England
- Anela Anwar, Head of Projects, ROSHNI

The Conference was a great success and evaluated very well.

**CHILD PROTECTION TRAINING**

CPU offers a range of methodologies for the delivery of training.

1. Face to face training can be booked by filling out the request form which is available on our website on staff net - we will then allocate your request and get back to you to confirm
2. Our generic calendar dates for CPU are now available, please contact the Training Coordinator for more details YKH-CPTRAINING@ggc.sct.scot
3. Interagency training for 2013—2014 is now available, please access via the following link — CPC Inter-agency Training
4. We also have an online suite of Tier 2 and 3 training which we are continuing to develop, courses currently available online are:
   - Induction
   - Foundation
   - Case Conference
   - Report Writing and Record Keeping
   - Attachment
   - Child Protection and Parental Substance Misuse
   - Child Protection and Parental Mental Health
   - Child Protection and BME (Black/Ethnic Minority) Families
   - Childhood Sexual Abuse
   - Risk Assessment
   - Parental Learning Disability
   - Working with un-cooperative families
   - Emergency Department Module
   - Domestic Abuse
   - Learning From Enquiries
   - Neglect

Please check the CPU website on staff net for regular updates!! - NHSGGC Child Protection Unit

From all at the Child Protection Unit
# CHILD PROTECTION UNIT

## Head of Child Protection Development
Marie Valente: 0141 201 6970
marie.valente@ggc.scot.nhs.uk

## Clinical Director for Child Protection
Dr Jean Herbison 0141 201 9355
jean.herbison@ggc.scot.nhs.uk

## Service Manager
Michelle Magennis: 0141 201 0469
michelle.magennis@ggc.scot.nhs.uk

## GP Specialist in Child Protection
Dr Kerry Milligan: 0141 201 0468
kerrymilligan@nhs.net

## Service Manager
Michelle Magennis: 0141 201 0469
michelle.magennis@ggc.scot.nhs.uk

## Administration Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catherine Martin—Business Manager</td>
<td>0141 201 0667  <a href="mailto:catherine.martin@ggc.scot.nhs.uk">catherine.martin@ggc.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Dorothy Ramsden—PA to Marie Valente &amp; Child Protection Advisors</td>
<td>0141 201 0642 <a href="mailto:dorothy.ramsden@ggc.scot.nhs.uk">dorothy.ramsden@ggc.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Karina Hamilton – Early sharing &amp; collation of information</td>
<td>0141 201 9225 <a href="mailto:karina.hamiton@ggc.scot.nhs.uk">karina.hamiton@ggc.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Sharon Menzies – Early sharing &amp; collation of information</td>
<td>0141 201 9225 <a href="mailto:sharon.menzies@ggc.scot.nhs.uk">sharon.menzies@ggc.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Marion Crammond—Early Sharing &amp; collation of information</td>
<td>0141 201 9225 <a href="mailto:marion.Crammond@ggc.scot.nhs.uk">marion.Crammond@ggc.scot.nhs.uk</a></td>
</tr>
<tr>
<td>Linda Lamont—Early Sharing &amp; collation of information</td>
<td>0141 201 9225 <a href="mailto:linda.lamont@ggc.scot.nhs.uk">linda.lamont@ggc.scot.nhs.uk</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiona Miller: 0141 201 9225 <a href="mailto:fiona.miller2@nhs.net">fiona.miller2@nhs.net</a></td>
<td></td>
</tr>
<tr>
<td>Phyllis Orenes: 0141 201 9225 <a href="mailto:phyllis.orenes@ggc.scot.nhs.uk">phyllis.orenes@ggc.scot.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>Carol Bews: 0141 201 9225 <a href="mailto:carol.bews@nhs.net">carol.bews@nhs.net</a></td>
<td></td>
</tr>
<tr>
<td>Donald Murray: 0141 201 9225 <a href="mailto:donald.murray@ggc.scot.nhs.uk">donald.murray@ggc.scot.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>Mary Ann Tanzilli: 0141 201 9225 <a href="mailto:mary-ann.tanzilli@ggc.scot.nhs.uk">mary-ann.tanzilli@ggc.scot.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>Liz Lamb: 0141 201 9225 <a href="mailto:liz.lamb@ggc.scot.nhs.uk">liz.lamb@ggc.scot.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>Claire Keenan: 0141 201 9225 <a href="mailto:claire.keenan@ggc.scot.nhs.uk">claire.keenan@ggc.scot.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>Janice Thorn</td>
<td><a href="mailto:janice.thorn@ggc.scot.nhs.uk">janice.thorn@ggc.scot.nhs.uk</a></td>
</tr>
</tbody>
</table>

Questions or comments? E-mail us at dorothy.ramsden@ggc.scot.nhs.uk or call 0141 201 0642