EDINBURGH CHILD PROTECTION COMMITTEE (ECPC)

LEARNING REVIEW REPORT

CHILD E – Executive Summary

May 2025

CONTENTS

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1. INTRODUCTION

"The overall purpose of the revised 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."

Scot Gov 2021.

Undertaking a Learning Review[1] (referred to as the "Review" in the report) provided an opportunity for the multi-agency partners of the Edinburgh Child Protection Committee (ECPC) to gain a broader understanding of how the child protection system in Edinburgh operated in protecting children and young people in need of care and protection during the Review period.

The Review went beyond the significant events that occurred and worked to understand how people saw things at the time and why things happened as they did. The Review looked at what child protection systems were operating during the review period and how capabilities and capacity were affected by the roles and positions adopted by professionals and family members.

ECPC and its partners welcomed the opportunity to understand why things developed as they did for a child already known to services. A lifespan Review was agreed.

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 significant event for Child E
- The Learning Review process and methodology
- Organisational Learning and Effective Practice
- Strategies for Improvement

The Reviewer noted the impact that working in high-risk child protection activity can have on the workforce and ensured throughout the Review that vicarious trauma was recognised and responded to accordingly.

Edinburgh Child Protection Committee has acknowledged the impact of the significant event(s) for the child who came to harm in this case and continues to support the child and her family. It extends its thanks to all who contributed to the Learning Review, including the family of Child E.

[1] [1] National Guidance for CPCs Undertaking Learning Reviews (2021 - Updated 2024)

1.1. Sharing Personal Data

Edinburgh CPC has 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.

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

2. THE CIRCUMSTANCES THAT LED TO THE LEARNING REVIEW

In the autumn of 2023, the subject of the Review (referred to as Child E), then aged 12 years, suffered a serious sexual assault by an adult male in the community. The adult who perpetrated the abuse did know and had engaged with the family on more than one occasion before the significant event that took place. There was already evidence to suggest that the child had been subjected to both child sexual abuse and child sexual exploitation in the past.

Child E lived at home with their mother (Ms X). Older siblings of the subject of the Review were part of the household initially but moved to live independently of Ms X and Child E during the period under review. Child E and Ms X were assessed as having a learning disability, albeit formal diagnosis was delayed for both.

Child E received the support of many services throughout their whole life due to persistent concerns related to parenting capacity, risk of sexual or physical harm from multiple adult males, neglect, and the general standards of care offered by their mother and extended family.

Child E had two periods on the Child Protection Register and had experienced long-term interventions from many services. Referrals to the Children's Reporter for statutory measures were explored at times. A comprehensive account of the period under review was provided in the full Learning Review report.

3. PRACTICE & 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. The insight offered by practitioners and managers was invaluable.

The aim of this section is to offer potential markers to strengthen already effective processes or develop practice areas further. Strategies for improvement (previously referred to as recommendations) can be found in Part 5.

3.1 Applying GIRFEC

The Reviewer had access to multiple forms, records, and assessments across the partnership, most of which referred to or were directly influenced by the principles of GIRFEC. Wellbeing indicators shaped tools being used and encouraged comprehensive plans to be shared at meetings. This included the Child's Plan.

Staff told the Reviewer they knew about GIRFEC and saw it as a baseline to their practice, all appeared familiar with the terminology used, and what the "*My World Triangle,*" for example, aimed to do. Some staff, however, were less confident in the practicalities and said at times it was not always clear who would be the Lead Professional to drive forward the work, who could start an assessment, or who would be responsible for updating it. Not all reflected on the importance of the GIRFEC principles concerning early intervention, or in longer-term work, discussed at the practitioner and manager's event.

The Reviewer found the forms used by different services based on wellbeing indicators were utilised effectively most of the time, there were however examples where updates were less obvious, and boxes were left unpopulated. These are changes that will make a difference and are something Edinburgh can easily resolve.

The most important learning point relates to the Child's Plan. Here the Reviewer found that staff were confident in recording outputs, which were almost always actioned by the next review. This was good practice. Less often evidence was seen of using the wellbeing indicators to agree and drive forward outcomes. Staff showed less confidence in understanding or defining outcomes. Professionals showed a real interest in gaining more knowledge in this area.

3.2 Effective Chronologies

A chronology is a summary of events key to the understanding of need and risk, taken from comprehensive case records and organised in date order. It is regarded nationally as an important summary that reflects both strengths and concerns evidenced across children and families in need of care and protection. The multi-agency chronology provided for the purpose of the Review was comprehensive and detailed with very few gaps.

Agency case records were particularly good and often carefully detailed in their observations of risk and child protection concerns.

The quality of chronologies however varied greatly and were not always used effectively for their intended purpose. The Reviewer found that there were many significant events carefully detailed in case records (often by more than one agency) that were not added to the chronology itself. This practice was consistent over the period of the Review and did not improve over time. There was also almost no reference to how chronologies were being used in practice. Some staff did say chronologies were discussed in supervision.

Staff told the Reviewer that unless a child is subject to child protection registration, time was not always taken to look back at emerging patterns in chronologies when preparing reports or attending meetings. This may be because the central recording point is very much focused on case records.

Whilst chronologies were good in Edinburgh, case records were very good. These should mirror each other. The chronology must be used as a central point to highlight patterns and incidents critical to understanding needs, risks, and harm to children.

Going forward the Reviewer suggests time is taken to revisit how best to encourage practitioners and managers to regularly create very good chronological information from interactions and observations.

The Reviewer is satisfied that a fresh look at how they are used will make this an achievable learning point. The new *Leading Chronology Improvement – Reflection and Assessment Tool* is currently being developed by IRISS[2]. It is a strong starting point to revisit, evaluate, and strengthen both strategic leadership and operational practice.

3.3 Escalation

The Reviewer noted at times that the work with Child E and their family was challenging, difficult, and stressful. On occasion, records indicated a real sense of staff feeling overwhelmed, weary, and frustrated by a lack of progress. Staff did not always feel heard.

Despite this, there were only five occasions when a staff member recorded escalating a situation at the most critical point. In all but one case, this led to no change. Team leaders and practitioners in social work and other multi-agency professionals across the partnership often felt powerless in affecting change.

As a learning point, time should be taken to strengthen already available and valued supports, such as formal and informal supervision, to ensure staff and managers are aware of escalation protocols and know how to apply them in practice.

[2] Leading Chronology Improvement (IRISS) 2024

Where managers do not have the answers staff need, this escalation should continue with partners until a resolution can be reached to ensure the safety and wellbeing of children, either at the most senior level or via a forum that reviews high-risk cases.

There were clear examples during the Review of where opportunities could have taken place and would have made a significant difference in reducing risks for Child E.

3.4 The Role of Housing

The family lived in local authority tenancies throughout their lives. Tenancy rules in Edinburgh include paying rent on time, taking care of the property, gardens, and common areas, and ensuring the tenant or any visitors are not antisocial.

At varying times, the standard of the tenancy was reported as being anywhere from borderline acceptable to messy, dirty, and, latterly, uninhabitable. Police who attended regularly often described the home as unfit for a child to live in. Bags of rubbish could be piled high, flies were seen in the hallway of the property, the house smelled, and staff often recorded clothes strewn across floors, mice infestations, piles of dishes, smoke-filled rooms, and multiple male visitors.

There were arguments with neighbours, an unkempt garden, and other visible signs of a tenancy that was struggling to be maintained, and a family living in poverty and neglect. On one occasion, maintenance workers refused to return to the property.

Except for one reference to rent arrears, housing was not mentioned in any case record. Their advice was not sought, and they were not routinely invited to contribute to multi-agency meetings in an attempt to improve the environment and the safety of the vulnerable tenants who were often out of favour with neighbours, and latterly the focus of a community social media page.

Housing services were not routinely considered or consulted as part of multi-agency work in child protection. Staff told the Reviewer that it was difficult to contact the service for help at times, and other professionals were not always sure what housing would be able to do to help or whether they could involve them at all.

After a detailed discussion with a senior housing manager, the Reviewer is satisfied that a willingness to effectively engage with the Child Protection Committee to better understand roles and responsibilities will help. This, along with the time taken to increase staff knowledge about available supports from housing, and knowledge of who the key contacts are to increase staff confidence in sharing information, can be resolved as soon as possible. Shared training or briefings may be necessary.

3.5 Voice and Rights

The Reviewer was in no doubt that staff knew Child E very well, they worried about them, and worked to get it right. This was occasionally described through the child's eyes in case records. What is rarely seen, except in a couple of particularly good practice examples, is the direct involvement of Child E in decision-making or in having their views considered.

From an organisational perspective, the rights of Child E were not 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*.

- Article 34 (UNCRC) – *Requires public authorities to undertake to protect children from all forms of sexual exploitation and sexual abuse,*

With some good practice examples available noted as learning points from the Review, these can be built upon and emphasised as part of broader work being taken forward across Scotland with the introduction of the UNCRC (Incorporation) (Scotland) Act 2024. The Lundy Model[3] of Participation is also a helpful tool.

[3] The Lundy Model of Participation

4. EFFECTIVE PRACTICE EXAMPLES

4.1 Early and Primary Education

Early years were able to demonstrate a strong and consistent relationship with the mother and Child E. Outreach work assisted in building trust and enhanced skills for both mother and child. Early years recognised a potential disability for the mother, supported her literacy issues, taught cooking, and supported her mental health. Child E experienced many positive experiences at nursery, and the assistance with improved play and parenting skills made the child safer.

By the time Child E started primary education, they had begun to move away from their peers; the primary setting embraced this and worked tirelessly to maintain Child E in school and keep them safe. There was evidence of regular meetings within the school setting. Support during COVID was child-focussed and worked to monitor and support the family. Primary education demonstrated a never-ending drive to develop strategies of support and enhance the child's protection by working side by side with the social worker. The school recorded evidence of neglect and reported concerns as they arose.

The understanding of the challenges faced by a parent with a learning disability, poor health, and limited parenting skills was recorded and reflected in communication and practice. The stickability was excellent.

4.2 Learning Disability Services / CAMHS and Community Learning Disability

Although involvement with the abovementioned teams came later for Child E once engaged with the services, the action taken to get it right by staff was good. The ADHD assessment and the subsequent support from CAMHS trauma service, once allocated, were very good.

Health practitioners within these settings actively supported the child, reported regularly to partners, found support for a parent with a disability who also needed help, and worked with them both individually to ensure the focus stayed on meeting individual needs. Staff shared essential information to assist in understanding the abilities of both Child E and their mother and championed their needs.

There was an excellent example of real tenacity shown by a manager within one service when risks increased considerably for Child E concerning child sexual exploitation/ abuse and neglect. The professional challenge was always appropriate in ensuring every opportunity was taken to keep the child safe, which involved making it clear that, given the concerns, these had to be escalated.

4.3 Social Work

Social Work had a crucial and enduring role in Child E's childhood and there were periods where contact was almost daily. The quality of case records given the amount received, and the time taken to ensure information sharing routinely took place was very good.

Social workers appropriately sought advice and guidance from team leaders and quickly shared decisions and updates as they occurred. They spoke to social work staff supporting the extended family to ensure consistency and always reported concerns.

Despite multiple challenges, resistance, and at times aggression, the support offered to the family never changed. At critical times, concern (and no doubt stress) must have been very high, but social workers simply never gave up. This was particularly good practice.

4.4 Effective Intervention (Family Support / Social Work Assistant)

The mother of Child E told the Reviewer how much she enjoyed working with Family and Household Support (FHS) and identified one member of staff as someone she valued highly. They had a trusting relationship where they could work together to get things done and improve standards at home. This was an example of very good practice.

A referral to the locality team for a social work assistant to assist with a family in need, meant the Reviewer was able to witness what effective and time-focussed intervention could look like. From day one it was clear this was a well-planned and considered piece of work by the social work assistant that set boundaries and goals for both the mother, child, and extended family.

Led by a very competent practitioner, the child responded well, demonstrated extended periods of improved behaviour, and was overall more settled. The child's mother, for the first time, demonstrated insight into her roles and responsibilities as a parent and began to develop strategies in managing the challenges she faced. This was a very well-executed piece of work and although short-term it did make a difference.

4.5 Police Scotland

Police knew the family very well, and on attending, they took time to complete the Concern Forms effectively and settle down the presenting crisis. Staff recorded risk and appropriately identified when circumstances were not good enough. Inter-agency Referral Discussions (IRDs) were consistently good at sharing information about reported perpetrators and presenting risk.

The mother of Child E told the Reviewer about how much she valued community policing and the significant role they played in helping her manage local issues and settle things down when Child E became out of her control. The mother of Child E told the Reviewer that she valued one community officer with whom she had built a great rapport and trust. This level of trust must be commended.

5. SUGGESTED STRATEGIES FOR IMPROVEMENT

5.1 Sexual Exploitation and Harmful Sexual Behaviour.

Child sexual abuse (CSA) is an act that involves a child under 16 years of age in any activity for the sexual gratification of another person, whether it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether the child is aware of what is happening or not.

Child sexual exploitation is a form of child sexual abuse. It involves a person or group taking advantage of a power imbalance to entice, force, or persuade a child into engaging in sexual activity.

Despite long-term interventions and support provided by multiple organisations, there was clear evidence from before Child E was born that sexual abuse was a presenting risk factor for Child E. Her ambivalence to the significant evidence presented to Ms X about her partners in part left Child E exposed to the risk of sexual abuse throughout their whole life and increased their sexual exploitation risks as they grew.

Case records confirm that in their 13 years, Child E was exposed to sexual exploitation or sexual abuse by adult males many times, they displayed harmful sexual behaviours to other children, were highly sexualised in their behaviour, and were also subject to sexual harm by other children.

The Reviewer is satisfied with reports of multiple male visitors to the family home and reported visits by Child E to the homes of unknown men in the community, the number is likely to be higher. The number of times the child was subject to the risk of / or endured serious sexual harm was considerable.

Professionals had limited knowledge in both understanding and responding to child sexual abuse and harmful sexual behaviour. This, alongside reports not always being shared or delays in decision making across the child protection system, meant Child E was at significant risk of sexual harm almost all the time.

This was reflected not only in the amount of IRDs / child protection actions that did take place, but was also demonstrated in the child protection actions that did not take place. Most of the time, Child E was not safe at home.

Child E would have met the criteria for a child protection order on more than one occasion and should have been removed on at least two separate occasions. Statutory intervention should have occurred much sooner.

The role of Police Scotland

Police Scotland has a broader safeguarding responsibility for vulnerable members of the community who are at risk of harm. Whilst multiple IRDs and many comprehensive reports detailed the appalling conditions that Child E was living in and concerns from the family and community, including anonymous online referrals or social media posts, highlighted the risks, these were often seen in isolation.

Police were aware of the multiple adult males frequenting the family home.

Whilst not all concerns were reported to the police, wider consideration should have been given to multi-agency engagement in reducing risk. Police were not routinely involved in regular planning meetings where intelligence was shared. This limited the opportunity to manage the risks of sexual harm/abuse. Police did not always respond to events that did not go to IRD as expected.

Effective sharing of intelligence by all partners, particularly in the latter period of the Review, could have led to a full police investigation with a focus on men in the community known, or seen with Child E. Some of whom will no doubt have been known for their sexual interest in children.

Edinburgh CPC must ensure staff training in child sexual abuse, child sexual exploitation, and harmful sexual behaviour is prioritised for review / or updated to ensure all staff and managers are equipped with the skills they need to identify and respond effectively to concerns of sexual harm.

Police must be routinely involved in multi-agency meetings for high-risk cases.

5.2 Responding to Neglect

The neglect of Child E was in plain sight most of their life. They endured both physical and emotional neglect. The conditions at times were at times so poor that the smell from the home was described as overwhelming, or the conditions uninhabitable.

Staff told the Reviewer they did know what neglect could look like and that they had the tools to assess neglect available to them. Evidence of their use was however not seen in records reviewed.

The word "*neglect*" was rarely seen in case records. Staff lacked confidence in recording it, and were not always clear when enough was enough. When it was called by a single agency, it was rarely supported and led to little or limited change. There was a distinct sense of some practitioners feeling sorry for Ms X (Child's Mother) and at times showing sympathy instead of professional empathy in their work. This can lead to professional

dangerousness and should be avoided. There was definite evidence throughout of over-optimism that by being involved, staff felt they would/could effect change.

Edinburgh already has a neglect toolkit that is not routinely used in multi-agency decision-making. All resources for assessing neglect in Edinburgh should be revisited to ensure staff have the competence and confidence they need to work with families where neglect is present.

5.3 Assessing and Responding to Risk

Many of the events that occurred were seen in isolation, and the opportunity for multi-agency assessments linked to chronologies to see the wider picture was lost. Much of the practice for this family revolved around reactive responses to each crisis as it occurred.

Whilst the staff at the event emphasised the importance of restorative practice in improving relationships and maintaining children at home, there was a sense that at times the focus on drivers like The Promise[4] could perhaps make staff over-optimistic in what can be achieved without statutory intervention (for example) being necessary. There was also some sense of powerlessness at the event in terms of what else could be done to maintain a child at home when it was not working.

Staff were able to offer an extensive list of different assessment tools available to them in assessing children at risk, many were described as multi-functional tools. The most expressed were the GIRFEC framework, the Risk / Resilience Matrix, Core Assessments, the Education Pupil Risk Assessment, and the Master Assessment. The latter was described as a tool that encouraged comprehensive risk assessments, developed safety planning, and created contingencies. All agreed they relied on multi-agency working to get it right.

This did not reflect the evidence available to the Reviewer when it came to multi-agency assessments in practice. This was multifaceted, and while there were very good examples, there was evidence of assessments that were promised and never started, and others that were not finished. There was confusion over outputs and outcomes. Some assessments were based on historical "cut and paste" with limited updates, and at other times, staff did not complete sections despite guidance and prompts. Multi-agency staff stated that it was not always clear who was responsible for completing them.

With the lack of clarity on who the lead professional was, a clear gap in achieving a comprehensive assessment was caused in part because meetings were not fully

[4] The Promise Scotland

represented by all agencies known to a child at risk. This was important for Child E when they were neither on the child protection register or subject to statutory intervention.

The quality of reports was variable, and not all included the key information to give partners or other forums the information needed to make informed decisions. This included reports to the Children's Reporter.

Without a full assessment and a comprehensive safety plan, over-reliance on self-reporting left Child E at risk.

The repeated example of why assessments were not as informed as expected was evidenced in the many meetings that took place, often monthly or more frequently and where the only people present were the social worker and the headteacher. On occasion, the parent or another professional did attend. The Reviewer accepts that attendance did improve during the latter years covered in the Review.

When planning meetings do take place it is important to ensure all those dealing with the presenting risks are fully involved and can contribute to the assessment. In this case, the limited involvement of police and health meant vital information was missed.

Alternative models such as Contextual Safeguarding[5] which complements the My World Triangle (GIRFEC) assessment, using the concept of resilience, was not considered.

Whilst the Reviewer acknowledges contextual safeguarding is a new model in many areas across Scotland, its Scale-Up Toolkit includes advice and support around the risk of extra-familial harm; harm that happens to children outside of their families through child sexual exploitation, harmful sexual behaviour, and violence. All these risks applied to Child E and would have been particularly helpful in decision-making. A review of how multi-agency partners come together to agree and carry out comprehensive assessments and outcome-focussed plans with clear contingency plans should be prioritised.

5.4 The Role of Education in Complex Cases

Every child has a right to an education.

Child E was maintained in a primary setting for as long as possible and until it was clear their needs went beyond what could be provided in a mainstream setting. By the time of Child E's exclusion, they were assaulting staff and putting pupils at risk. Child E had poor attendance, was behind their peers, and needed more support than could be offered.

The school cared deeply about Child E and remained in touch with them and their family during the pandemic. The school actively sought advice on meeting the child's

[5] Contextual Safeguarding Toolkits

educational needs. Solutions were found but not all were successful. The school noted that the chaotic home environment made it impossible for Child E to learn in that setting.

Child E had multiple adverse childhood experiences, which presented risks both to themselves and others. Despite this, they were expected to have their educational needs met by a parent with her own complex needs in an unsuitable environment. Added to this was knowledge of the mother's poor literacy skills and a learning disability.

Despite schools playing a crucial role not only in teaching but in the protection of children, the absence of a school placement meant Child E was not seen every day, nor did they have an opportunity to be heard. Child E wandered around their local community, sat in the library for hours on their own, and suffered unimaginable abuse with no school to monitor their wellbeing.

Education has a safeguarding responsibility for children currently in education. Whilst this worked well in the primary setting, this was lost as Child E transitioned into a secondary setting. Education must be part of any multi-agency meetings taking place, pending allocation, to fully understand the child's circumstances and the level of need.

Child E should have been flagged and prioritised by education in a bid to find solutions for a child with special educational needs and a learning disability, living with a learning-disabled parent. Being out of school for over a year fell below the expected standard that Education sets for itself and placed Child E at considerable risk in the community as the child tried to fill their day.

A review of the processes for allocation, perhaps with a flagging system for complex cases, should be considered. A child's rights must be upheld.

5.5 Learning Disability and Parenting

An early record stated that the mother's "diagnosis of a learning disability and significant mental health concerns makes her highly vulnerable and unable to resist hazards". This was not referred to again or considered in any work undertaken.

In this case, the expectations for a parent with limited parenting capacity and a learning disability were too high. The mother did not have the skill to carry out the expected parental responses to a challenging child who had their own needs.

Children like Child E, who are at risk and require support where a parent has a learning disability and are known to children's services, will have a higher level of need. Particularly so when the child also has a learning disability. This was rarely acknowledged in interventions that took place.

There was evidence that staff did use the Child in Need Assessment to assist in identifying risk and need. What was less clear was how often these were revisited or

updated. The multi-agency approach was inconsistent and at times turbulent. The mother reported to the Reviewer of becoming overwhelmed with the demands of services.

A parenting capacity assessment, with the advice and support of the learning disability team, should have been completed in the early years when staff knew the limitations and could observe and support a parent less able to understand and process situations, including preventing abuse, neglect, and harm to their child.

The Reviewer found little evidence that staff working with the mother and Child E completely understood their role or how to approach and best support a family with additional needs. It is likely this lack of knowledge played a part in informal assessments and threshold decisions and delayed putting the protection needs of Child E first.

The Reviewer did not see effective joint working between adult and children's services.

There were occasions where a referral to adult services would have been appropriate to offer the mother support. The evidence presented on a couple of occasions would have made an adult protection referral appropriate. The mother of Child E told staff on multiple occasions that she could not cope; this was rarely considered.

Whilst learning disability workers, on diagnosis later, established a good working knowledge of how best to support the mother and Child E, there was room for improvement in the system overall. Time should be taken to consider or strengthen joint protocols or guidance for children in need of care and protection, where a parent/parent and child have a learning disability.

5.6 The Role of SCRA and Statutory Intervention

Many of the agreed referrals to the Children's Reporter, based on a multi-agency assessment of the need for statutory intervention, did not take place. It is unclear why these were never progressed or discussed with managers or leaders. This ultimately led to considerable drift and increased risk for Child E.

Grounds of referral to the Reporter in terms of a Schedule 1 offence were met and clearly noted in earlier records. This included pleas from the mother of Child E to have her child referred when they were 4 years old.

The first referral to the Children's Reporter was not made until Child E was 6 years old. The "Assessment of Need and Risk" Report for the Children's Reporter was very good. It recommends statutory intervention. A later discussion took place between the children's reporter and social work, and a decision was made not to arrange a hearing. This change of position was made without a full multi-agency discussion.

An agreement was reached two years later, when Child E was 8 years old, to re-refer them to the Children's Reporter concerning a lack of parental care. There was no reference to the continuing risk of Schedule One[6] offences. The report was finally submitted 5 months later.

There was no recommendation in the report, and the Children's Reporter requested more information. Education received a request for information. Social work re-submitted their updated report. Again, there was an unexplained shift noted in the need for statutory intervention, and the recommendation of voluntary measures was agreed, and a Children's Hearing was not convened. The quality of reports submitted was variable.

Within a few months, a decision was made to re-refer to the children's reporter with a condition of no contact with the ex-partner of the mother, given his violent history. This does not happen. A few months later, a child's planning meeting contradicts this by stating that Child E "may" be re-referred to the Reporter.

A multi-agency decision is then made to refer Child E for statutory intervention to the Children's Reporter (SCRA). Social work requested a progress update from SCRA. With no response five months after submission, a re-referral was made. With no response, the report was submitted again.
Eventually, 11 years after statutory intervention was first considered for Child E and 15 months after the most recent formal request was made. Child E was made subject to a Compulsory Supervision Order.

The children's reporter confirmed the delays were "in part" related to the pandemic but could not explain why it took so long. Both social work leaders and the children's reporter acknowledged that the lengthy delays fell below expected standards, and the needs of the child were not prioritised. Other partners accepted that they could have done more.

As a partnership, work should commence to review cases subject to lengthy delays and develop a monitoring system, overseen by managers, to ensure due process is followed when agreement is reached to refer a child for compulsory measures. Regularly sharing data with the Child Protection Committee will ensure accountability in practice.

[6] Children's Hearing (Scotland) Act 2011

6. IN CONCLUSION

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

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