

# **REPORT** of the **CALEB NESS INQUIRY**

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Commissioned by Edinburgh and the Lothians Child Protection Committee



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## **0 EXECUTIVE SUMMARY**

On 18 October 2001, Caleb Alexander Ness was admitted to the Royal Hospital for Sick Children, Edinburgh, and pronounced dead. It was immediately suspected that the baby had been the victim of non-accidental injury, and an autopsy was carried out. There was evidence of very widespread focal fresh haemorrhage in all the compartments of the brain. The findings suggested rapid death following traumatic injury, probably caused by rough shaking of the baby. There was also evidence of 14 definite rib fractures, with three categories of age relating to those fractures. Some were new, probably sustained during the course of the morning of 18 October; some fractures were approximately one week to ten days old; and one fracture was several weeks old. It was concluded that there had been at least three separate episodes of trauma to the chest, probably caused by gripping during shaking. Caleb had been born on 30 July 2001, and was 11 weeks old at the time of his death. He spent the first three weeks of his life in a special care baby unit in hospital.

The baby's mother had been a drug addict for over 20 years, and was taking methadone by prescription throughout her pregnancy. She had a long history of prostitution, and many criminal convictions. Her two children had ended up by being taken into care, after many unsuccessful efforts had been made to end her addiction. News of her pregnancy in 2001 only reached the social work department by chance.

The baby's father, Alexander Ness, went to trial, charged with assault and murder. Eventually, in February 2003, he pled guilty to culpable homicide. It was accepted that he could establish diminished responsibility caused by brain injuries he had sustained some months before the baby was born. He had met the mother, Shirley Malcolm, in the autumn of 2000, soon after being released from prison on licence after serving most of a five year sentence for drug related offences. His earlier criminal history included a conviction for very serious assault of an adult.

A Child Protection Case Conference was held while the baby was still in hospital on 9 August 2001. Caleb was put on the Child Protection Register. Later, he went home with his mother. It was well known that his father would be visiting often, although he was not actually living with the mother. No further decision or formal review of risk took place before the baby died.

The Inquiry has reached the conclusion that this was an avoidable child death. Having reviewed all the evidence, we believe that neither parent should have had unsupervised care of Caleb.

No single individual should be held responsible. We identified fault at almost every level in every agency involved. Many concerned professionals did their best for this family, but too many operated from within a narrow perspective without full appreciation of the wider picture. We are concerned that, two years after Caleb's death, there is still complacency about this blinkered approach to child protection, particularly at a management level.

We are aware that many of our recommendations are not new, and that many have been made before, in earlier reports and reviews. However, we believe that this report highlights some specific problems in the interface between adult and child services, particularly in the fields of brain injury and substance misuse.

Some of the fundamental factors contributing to this baby's death were:

- Failure to take account of the background information readily available about each of the parents.
  - Shirley's lengthy record of failure to care for her existing two children was dismissed as "historical". Yet there was nothing in the evidence available at the time of Caleb's birth to suggest that there had been a major change to her lifestyle. In particular, she was still seriously dependant on drugs.
  - Alec Ness had suffered a brain injury in January 2001, and a thorough assessment of his disabilities had been made before the baby was born. The social workers concerned (including the criminal justice worker supervising him) did not ask for any medical advice about this, although the information would have been made available to them. Social workers assessing risk to Caleb did not seek information about his criminal background, although they knew that he was on parole.
- Social workers allowed themselves to be easily reassured, largely because the couple was apparently co-operating with them. They failed to undertake a rigorous assessment of risk, and instead took at face value what they were told by Shirley and Alec.
- There was an unspoken assumption that the parents had the right to care for their baby. This dominated events to the extent that Caleb's right to a safe and secure upbringing was never the focus of decision making
- The whole Child Protection Case Conference process was flawed. The report prepared for it was inaccurate in vital respects. In particular, it suggested that the couple was stable, whereas in fact Shirley had made Alec move out a few weeks previously. The gaps in information relating to the two older children in care, Alec's brain injury, the nature and extent of the criminal records of both parents, etc were not identified. The CPCC was not told that Caleb was suffering from neo-natal abstinence syndrome. They did not know that this might make him harder to care for than a normal new born baby. No one attending the CPCC really knew the couple. The Chairperson had never chaired a CPCC before, and had not been trained in how to carry out her role. The Minute taker had never taken Minutes before, and had not been trained in how to carry out that role. The people attending the CPCC appear to have had too little knowledge of the roles expected of them. No one was clear about the exact decisions which could and should have been taken at the meeting, including the need to refer such a case to the Reporter. Although the CPCC correctly decided to place Caleb on the Child Protection Register, no detailed Child Protection plan was agreed, and he was therefore left at risk.
- The Minutes of the CPCC were not distributed to the relevant professionals, contributing to a lack of effective monitoring after Caleb left hospital. This was only one of several significant problems we found in the recording and sharing of accurate documentation relating to a baby known to be at risk.
- The social worker and health visitor who were supposed to visit Caleb did so, but not often enough in the circumstances, even allowing for a gap between what was known about his home environment and what was the reality. What monitoring they did do was not jointly planned, or effectively co-ordinated. The Health Visitor did identify increasing levels of risk to Caleb, and notified the case co-ordinator appropriately, but he had formed the impression that Shirley would cope. He did not recognise the need for further

assessment of risk after the CPCC. The present system relies too much on the judgment of one individual case co-ordinator.

- The diagnosis of post-natal depression in Shirley, an increase in her methadone prescription, greater confusion and depression in Alec, - all should have been seen as giving rise to escalating concern for Caleb in early October 2001. In fact, because the individual agencies were not working together effectively, the information was collated in a piecemeal fashion, and no single person knew all the relevant facts. No formal decision making process took place at that time, and it should have done.
- We identified the lack of proactive senior social work involvement in the assessment of risk, in the re-assessment of risk, in decision making, and in ongoing supervision, as being a fundamental reason for that agency's failure to protect Caleb.
- There were alarming variations in agency managers' expectations of the appropriate level of monitoring for a baby like Caleb. At every level, in several agencies, the phrase "high level of monitoring" had different meanings.
- There was a tendency among professionals in all agencies to make assumptions about the knowledge, training and actions of others. The doctors assumed that the social workers knew things which in fact they did not. Some professionals failed to acknowledge their own responsibilities for identifying and responding to child protection concerns. This was particularly evident in the gulf we discovered between Children and Families team social workers and the separately administered Criminal Justice social workers. We found that there was a complete failure by Criminal Justice workers and management to recognise that they did have some responsibility for child protection. Similarly, we saw an incomplete understanding of their role in child protection in the actions of addiction professionals and brain injury specialists, who are accustomed to working with adult patients. The police were handicapped by the paucity of information sent to them by the social work department, and did the best they could do in Caleb's case, but we discovered that they were not routinely passing on as much information as the social workers expected.
- Issues of confidentiality were a concern to some of the professionals we interviewed, but did not have any direct bearing on what happened to Caleb. There were examples of people failing to seek information partly because they expected that it might not be forthcoming, such as the criminal justice social worker who failed to ask a doctor about Ness: conversely, the addiction specialist who knew that Shirley was under stress did not see it as his duty to pass that information back to the case co-ordinator. No one monitoring the pregnancy informed the social work department that a baby was on the way. Generally, the lack of knowledge about the relevant guidance on sharing confidential information in a child protection context was a matter of concern
- Almost all of the professional witnesses identified child protection training as a major requirement before services could be improved. Many expressed the view that it will have to be mandatory at all levels.
- The Inquiry identified an absence of clear accountability for child protection within Health agencies, to the extent that the agencies could not even easily identify an appropriate senior management witness to give evidence. At first sight, responsibility had



apparently been delegated to senior practitioners in lead clinician or advisory roles, but for their part, those advisors considered that they could only provide advice and training. They knew that much more needed to be done. True management and budget responsibility tended to rest at a higher level with people who have no training at all in child protection. This is also an issue at high levels within other agencies. We were particularly concerned about this.

- Some evidence suggested that this was not an isolated case.

We were encouraged, however, by the willingness of witnesses to attend this Inquiry, and by their commitment to child protection. We discovered that some practical changes have already taken place, but we could not tell whether they had been implemented throughout the area on a consistent basis. We were grateful for the many positive suggestions for improvements we might consider, and a summary of the Inquiry's Recommendations appears at the end of the Report.

# **1 INTRODUCTION**

## **1.1 Background to the Inquiry**

1.1.1 On 18 October 2001, Caleb Alexander Ness was admitted to the Royal Hospital for Sick Children, Edinburgh, and pronounced dead. It was immediately suspected that the baby had been the victim of non-accidental injury, and an autopsy was carried out. There was evidence of very widespread focal fresh haemorrhage in all the compartments of the brain. The findings suggested rapid death following traumatic injury, probably caused by rough shaking of the baby. There were 14 definite rib fractures, with three categories of age relating to those fractures. Some were new, probably sustained during the course of the morning of 18 October; some fractures were approximately one week to ten days old; and one fracture was several weeks old. It was concluded that there had been at least three separate episodes of trauma to the chest, probably caused by gripping during shaking. Caleb had been born on 30 July 2001, and was 11 weeks old at the time of his death. He spent the first three weeks of his life in a special care baby unit in hospital.

1.1.2 The baby's father was arrested on the same day, and ultimately charged with assault and murder. The trial was postponed several times, but eventually took place in February 2003. Alexander Ness incriminated the baby's mother, Shirley Malcolm, but after two weeks he changed his plea to guilty to culpable homicide. The Crown accepted that he could establish diminished responsibility caused by a brain injury, which he had sustained in January 2001.

1.1.3 The evidence led at the trial received a lot of publicity. Shirley Malcolm had taken Methadone during her pregnancy, and the baby had required treatment as he withdrew from drugs after birth. She had two children who had been taken into permanent care, and Alexander Ness had a history of serious criminal convictions. A senior nurse gave evidence at the trial that she had been unhappy about the baby being discharged from hospital into the care of his parents.

1.1.4 We take one example, to give a flavour of the publicity:-

*“A two month old boy was shaken to death by his violent, drug-dealing dad after Social Workers agreed the baby could go home. Little Caleb Ness’ mum was a recovering drug addict and her two other children were in foster care. But Social Workers ignored alarm bells and merely agreed to put the little boy on the “At Risk” Register. They even dismissed the advice of an experienced nurse, who expressed deep concern at Alexander Ness, 53, being left alone with his son, ...”* (Daily Record - 6 February 2003.)

The Director of a charity was interviewed by the press, and told them that she had tried to alert the Social Work Department to risk to the baby:-

*“We knew that Caleb’s life was in danger and repeatedly contacted Edinburgh City Council’s Social Work Department to warn them. Often our calls would not be returned or we were assured that he was in a high risk category and was being monitored. Responsibility for his death lies in the hands of the Social Workers. How many more children have to die before something is done to ensure vulnerable children are protected.”* (Daily Mail – 7 February 2003.)

On 18 February 2003, Cathy Jamieson, Minister for Education and Young People, told the Daily Mail: *“Too many children are getting lost in the system. Too much time is spent satisfying the needs of bureaucracy rather than the needs of the child. There is an endless round of referrals and too much duplication of effort.”* She also criticised Social Work bosses who are *“cocooned in their own corner of the system and don’t see the bigger picture”*. (18 February 2003.)

Some councillors in the City of Edinburgh Council called for a full independent inquiry into the events leading to Caleb’s death. The Director of Social Work defended the handling of the case, and promised that the death would be fully investigated by the region’s Child Protection Committee, a multi-agency body involving several local authorities, health service providers, and the police.

There was a dispute within the City of Edinburgh Council about the kind of Inquiry which should take place, but on 20 February 2003 an amended motion was passed in the following terms:

*“The Council*

- i. expresses its sincere regret at the death of baby Caleb Ness, who was the subject of Child Protection procedures;*
- ii endorses the decision of the Director of Social Work to request the Edinburgh and Lothians Child Protection Committee, to undertake a comprehensive review of the interagency discussions, decision making and involvement with Caleb Ness and his family; this review to be undertaken under the independent chairmanship of a Queen’s Counsel or other eminent legal person to be appointed by the Chief Executive, in consultation with the political group leaders;*
- iii asks the Child Protection Committee to make its report available to the Council and to the Boards and Trusts of the bodies represented on it and, thereafter, to the Scottish Executive; and*
- iv agrees that the review be completed as quickly as possible with the report being submitted to the Council at the earliest possible date.”*

Thereafter, the Conservative Social Justice spokeswoman, Ms McIntosh, *“expressed fears that the review could be seen as a whitewash because the Council and other health agencies involved in the case will sit on the investigating committee. We have to get to the bottom of this. People were trying to help. Learning lessons is the key issue to ensure this doesn’t happen again.”*

1.1.5 On the other hand, Councillor Kingsley Thomas, the City’s Social Work Leader, said that he hoped that the Charity Director would contribute to the Child Protection Committee’s review of the case. He was reported as saying that he believed the review would be sufficient and no other form of independent public inquiry would be necessary. (Evening News – 26 February 2003).

1.1.6 Susan O’Brien QC was appointed on 27 February to act as Chair, and this was announced on 12 March, the day when Alexander Ness was sentenced to eleven years’ imprisonment.

- 1.1.7 Edinburgh and The Lothians Child Protection Committee held an extraordinary meeting on 20 March 2003 to discuss the motion which had been approved by the City of Edinburgh Council already. By this time, Dr Helen Hammond, who is currently Vice Chair of the Edinburgh and The Lothians Child Protection Committee, had agreed to join the proposed Inquiry Team. She had no personal involvement in Caleb's case in any way. As a Consultant Paediatrician she has extensive experience of identifying physical and sexual abuse in children. She had also led the Inquiry into the death of Kennedy McFarlane in Dumfries and Galloway in 2000. An appropriate choice of a third person to join the team was discussed, and more information sought. It was decided that the appointee should have local authority Social Work Department experience of child protection at a senior level in another part of Scotland. The Committee confirmed that the report would be made available to the City of Edinburgh Council, and to the other constituent agencies, Boards and Trusts participating in the Edinburgh and Lothians Child Protection Committee. The Child Protection Co-ordinator was asked to facilitate the review, and it was decided that the Head of Operations for City of Edinburgh Council Social Work Department would relinquish the chair of the Edinburgh and The Lothians Child Protection Committee while the review was being carried out, in case of a possible conflict of interest.
- 1.1.8 A further extraordinary meeting of the Edinburgh and The Lothians Child Protection Committee took place on 27 March, attended by Susan O'Brien QC. This meeting endorsed the appointment of Mrs Moira McKinnon as the third Inquiry Team member. She is a Principal Officer (Child Protection) for Social Work Services with Glasgow City Council.
- 1.1.9 That meeting also agreed that the Inquiry Report would be made public, but that the Report would anonymise the staff concerned. A person's post could be named in the report, but not the person. Witnesses would be invited to bring along a friend/supporter/adviser, if they chose, and would be given the ground rules for the interview process. It was agreed that interviews with witnesses would be recorded on tape, and transcribed by professional court shorthand writers. However, the full transcripts will not be made available to the public. Extensive quotations from the transcripts are reproduced, in order to give the reader an indication of the basis for the Report's conclusions.

- 1.1.10 A list of the abbreviations we have used to identify the witnesses is at Appendix A, (a).
- 1.1.11 Any description of the background to the Caleb Ness Inquiry should also include reference to the major report of the Child Protection Audit and Review by the Scottish Executive, published in December 2002, and entitled “It’s everyone’s job to make sure I’m alright”. The Review was the widest Inquiry yet carried out into Child Protection in Scotland, ordered by Mr Jack McConnell (now First Minister) after the Kennedy McFarlane Inquiry reported. It was “carried out by a multi-professional team, was based on up-to-date information on the subject, was informed about systems in other countries, was supported by information and views provided by a wide range of agencies and organisations and – not least of all – had the benefit of views expressed by children and young people themselves affected by abuse and neglect” (page 4). Many witnesses referred to the Review, and many of the recommendations in the Review have a direct bearing on what we say in this Report. Caleb died in October 2001, and we have therefore not attempted any analysis of the procedures relating to his care by reference to the Review, although we are aware that the Scottish Executive was consulting in 2001. Two of the witnesses who we interviewed happened to be members of the Review Team (of 8). In many ways, our findings support some of the key recommendations in the review.
- 1.1.13 Sadly, there have been dozens of Inquiries throughout the United Kingdom relating to the deaths of children, but we should particularly mention the recent Inquiry by Lord Laming into the death of Victoria Climbié. A number of witnesses spontaneously referred to it. Victoria was born in the Ivory Coast in 1991, and reached the UK in 1999, in the company of a relative. She died following countless deliberate physical assaults, by the relative and her partner, despite two admissions to hospital and Social Work involvement. She spent extensive periods of time tied up in a bath, in a plastic bag full of her own excrement. She died in hospital in London at the age of 8. Her circumstances were very different from Caleb’s not least because we have no doubt that both his parents loved Caleb. None of the evidence we heard suggests that either ever deliberately wished to harm Caleb in any way. Nevertheless, it is worth remembering that Lord Laming found that it is not possible to separate the protection

of children from the provision of wider support to families. He stressed that effective support is a multi-disciplinary task, depending upon each different agency to fulfil its separate and distinctive responsibilities.

## **1.2 Methodology**

- 1.2.1 The Child Protection Co-ordinator provided the Inquiry Team with a list of the names and work addresses of 13 witnesses, and suggested that managers should be identified from two agencies. We followed these up, and duly interviewed all of them, except Shirley Malcolm. However, as we delved into the story, we identified more witnesses as we went along, and contacted them. In total, we interviewed 37 witnesses. The first interviews took place on 20 May and the last interviews took place on 4 July 2003.
  
- 1.2.2 The Inquiry Team met several times before the interviews started in order to agree its general approach to the Inquiry, and also the text of the letters sent to witnesses. We append a sample letter, and the “Notes for Witnesses” which we used. We also agreed “Stem Questions” which were followed in each interview, as appropriate. Copies are in Appendix A, (b), (c) and (d). We had the difficulty common to all internal inquiries that we could not compel people to attend and give evidence to us. We anticipated that some witnesses, particularly Social Workers who were directly involved with Caleb, might be reluctant to come and give evidence. We therefore reassured them that their names would not appear in the published report. However, it was important in the public interest that individuals could be identified by their line managers, if they had made serious mistakes. We spelled that out in the “Notes for Witnesses”, and their full names and work addresses will be available to the Child Protection Committee in a “Confidential Appendix” which this Inquiry Team has prepared. That appendix also includes a small number of documents which we regret that we cannot put in the public domain, largely because they contain sensitive information relating to Shirley’s two older children. The “Confidential Appendix” will not be made available to the public.
  
- 1.2.3 A further practical difficulty arose from the fact that this was an internal rather than public inquiry, namely the need to coax witnesses to find time to come and see us.

Many were very busy, and some went on holiday. We had to arrange dates and times to suit them, which is one reason why the Inquiry took longer than had been hoped. On the basis of the initial list of 13 witnesses, we originally hoped to complete the Inquiry by the end of June 2003. In fact, we were still interviewing witnesses through that month, so we tried to reach a deadline in early August. This proved impossible because the three Inquiry Team members were on holiday at different times. Thereafter, there were difficulties finding dates when all three of us could meet, as normal work commitments continued and intervened.

1.2.4 We wrote to the Lord Advocate, and obtained a copy of the charges on the indictment, and lists of productions and witnesses. (The list of witnesses included people who were not ultimately listed as witnesses on the indictment.) All the documents which were produced at Alexander Ness' trial were provided to the Inquiry Team, but not the documents which had been discarded as irrelevant by the Procurator Fiscal earlier. The documents included medical records relating to Caleb, both in the hospital and from his G.P. practice. They included extensive medical records relating to Alexander Ness, but not Shirley Malcolm's medical records. They included Social Work records relating to Shirley and Caleb from the Children and Families Team at Leith Social Work Department, and also the Criminal Justice Team's records relating to Alexander Ness, who was on parole following his release from prison when Caleb was born. There were police interviews, forensic reports, DNA analyses etc., some of which we have treated as accurate without requiring the attendance of witnesses to speak to the documents.

1.2.5 We did not conform to the usual procedures in court, treating the proceedings as inquisitorial rather than adversarial. There was no Counsel to the Inquiry. The Chair prepared questions for each witness, and the other two members added questions as and when it seemed appropriate. Often it proved useful to backtrack over what a witness had said initially from different perspectives. We considered recalling two witnesses, but decided against doing so. Many professional witnesses brought files along to the hearings, and we always permitted them to refer to those files to refresh their memories. For important entries, we actually scrutinised the files there and then. Some witnesses offered to send us supplementary information, and we accepted those letters and any enclosed documents, and read them. The documents are not all



referred to in our report, partly because some were of peripheral relevance. We asked for some records, such as the records relating to supervision between SW4 and SW3, and these were produced. In short, there has been all round co-operation, both from individual witnesses, and from agencies. We believe that the occasional gaps, which are apparent in our Report, are not critical. We should perhaps add that we have based our findings on matters explored in evidence with the witnesses, not on any knowledge we brought to the inquiry from our own areas of expertise.

1.2.6 Shirley Malcolm is the only key witness whom we have been unable to interview. We wrote to her at the address given in the records produced for the trial, but quickly discovered that she had been re-housed. We wrote to her at the new address, but the letter (having apparently been opened) was returned marked as “*Refused*” by the postman. It may be that she no longer lives at that address. Two witnesses told us that she had been re-housed yet again. The publicity attending the setting up of this Inquiry suggests that she could have contacted us, if she had wished. Some witnesses did contact us direct, and we saw them.

1.2.7 We thought of obtaining the transcript of the whole trial of Alexander Ness, but we were told that it could not be prepared until the summer, and the cost would have been prohibitive. We did obtain and consider the transcript of the evidence relating to the first three days, when the witnesses were Nurse1, HV and Shirley Malcolm.

1.2.8 We did manage to interview Alexander Ness, who was then in HM Prison, Edinburgh. With the help of a Prison Social Worker we first asked if he wished us to interview any witnesses in particular, and we obtained a list of five. We eliminated one after speaking to Mr Ness about what he might say, and wrote to the others. Some came to see us, some did not. We thought that his sisters, who had been very supportive when he was in hospital, might assist, but he advised that he had been “disowned” by all his family members, following the trial. We therefore did not seek them out. A Prison Social Worker attended our interview with him in prison, which lasted over two hours.

1.2.9 As the Inquiry Team wished to interview witnesses on neutral ground, arrangements were made with the Faculty of Advocates for the use of a room at their Consultation Centre off the High Street, Edinburgh. We would like to express our thanks to all the

witnesses who attended, some rather unhappily. We should place on record the fact that some of the witnesses are no longer employed by the agencies who participated in the Child Protection Committee, and they took time off work. We had no budget to reimburse witness expenses.

1.2.10 None of the witnesses brought a legal representative along to the hearings, but a few brought Union representatives (or the equivalent). The identity of any accompanying person was recorded at the outset of the interview. We used a small room, where everyone sat round the same table. We hoped that neither the location nor our approach was particularly intimidating. However, it is right to record that several witnesses were distressed about Caleb's death, even after the lapse of two years. It went beyond our remit to inquire what happened after Caleb's death, but we did receive indications that more help might have been appreciated by some of those closest to this tragedy.

1.2.11 Our analysis of the evidence tempted us to look at several issues, which we had to decide not to pursue, as they were outside our remit. We mention some as we go along, but we kept our remit firmly in mind. For example, although a perceived lack of resources was often mentioned by witnesses, we could not follow this angle up, however important it may be.

1.2.12 When it came to writing the Report, the Chair wrote a first draft, which was then discussed line by line with the other two members of the team. Many alterations and additions were made. The Team had no significant disagreements about how to evaluate the evidence, and we have no hesitation in recording that the findings in this Report are unanimous.

### **1.3 Acknowledgements**

1.3.1 The Child Protection Co-ordinator and his staff gave us prompt and invaluable help in tracking down witnesses, many of whom have moved jobs, and we were grateful for their help. We would like to express particular thanks to Mrs Pat Younger for offering part-time secretarial assistance, from booking witnesses to typing. We also wish to record our thanks to Mrs Sandra Mackellaig, of William Hodge (Shorthand Writers)

Limited, who arranged the attendance of shorthand writers and the speedy production of transcripts of witness interviews; Miss Irene Cumming, Faculty Superintendent, and her staff for acting as receptionists when interviewees attended; Mr C. Renton, Deputy Governor of HM Prison, Edinburgh, and Ms Emma Watson, Social Worker there for facilitating the interview with Mr Ness; and Miss Gill Lindsay, Depute Solicitor, for liaison arrangements with the City of Edinburgh Council.

1.3.2 The date of the delivery of this Report to Miss Gill Lindsay, for transmission to Edinburgh and the Lothians Child Protection Committee and the City of Edinburgh Council is 1 October 2003.

**Signed:** .....

**Ms Susan O'Brien QC (Chair)**

.....

**Dr Helen Hammond**  
**(Consultant Paediatrician, St John's Hospital, Livingston)**

.....

**Mrs Moira McKinnon**  
**(Principal Officer, Social Work Service, Glasgow City Council).**

## **2 CHRONOLOGY**

### **1999**

November Arrangements are made by (distant) Social Work Department to send money to Leith Social Work Department, for Shirley Malcolm to uplift for the purpose of occasional visits to see her children. A few further visits are arranged in the same way thereafter. The Children and Families team open a file.

### **2000**

25 May SW7, a criminal justice social worker, goes to a prison to meet Alexander Ness, to discuss how to plan and manage his release into the community on non-parole licence. The Parole Board had assessed Ness as being at risk from people to whom he owed money, and also of relapsing into use of controlled drugs. He had been sentenced to 5 years for dealing in cannabis.

7 June Ness is released from prison, and after staying briefly on his elderly mother's sofa, he borrows a flat from a friend for a short let. He soon starts visiting P1, the director of a charity who lives on the same premises as the charity in Leith. She gives him odd jobs to do, without payment. Shirley Malcolm, whom Ness has not previously met, lives close by.

September Shirley Malcolm is referred again to the CDPS (see 4.1), having been involved with the service for some time. She was then on a prescription for 50 mg Methadone and 30 mg Valium. She told Dr2, a General Practitioner specialising in drug addiction, that she was topping up significantly with extra Methadone. Shirley had been using drugs since the age of 14 or 15, and started injecting early. She was referred for specialist treatment (then offered by the Royal Edinburgh Hospital, prior to the setting up of the CDPS) at the age of 19, as a heroin user. At this point in time, she was "chaotically using a mixture of drugs, opiates and Benzodiazapine and injecting", and involved with the Criminal Justice system, crime, and prostitution.

November Shirley falls down stairs after taking a lot of alcohol, and Dr2 warns her of the dangers of combining alcohol with Methadone. Shirley admits to topping up with Temazepam, but says that her drinking was under control. She says she might be pregnant, and is advised to contact Dr.2 in 2 weeks, if the pregnancy is confirmed. Dr2 refers Shirley to the Methadone Titration Clinic, and Shirley's prescription is increased to 90 mg of Methadone, with 30 mg of Diazepam.

November Shirley's urine tests positive for Benzodiazapine, cannabis and Methadone.

## 2001

- 11 January Alec Ness, aged 51, who had been drinking heavily, is found in a state of collapse at the bottom of some stairs having sustained a serious head injury. He is taken by ambulance to the Royal Infirmary. He is transferred to the Western General. The diagnosis is occipital skull fracture, right frontal and temporal contusions, and right subdural haematoma. He is treated in Intensive Care, and nearly dies. He later says that he had fallen down steps, but any fall is in fact associated with an assault by a person known to him, who stole £7,000 from him at the time. No complaint is ever made to the police.
- 12 January Shirley completes a Community Service Order, imposed in 1999 for theft, shoplifting, and breach of the peace. The Social Inquiry Report prepared at that time refers to a substantial number of previous convictions mostly for offences of dishonesty such as theft, fraud, and uttering (i.e. signing stolen cheques and using them to purchase goods). She has several convictions for soliciting dating back to at least 1985, and a long history of unpaid fines, failure to appear in court etc. She has been on probation on many occasions. She seems to have served at least two prison sentences, certainly one in Holloway in London. She is now 36 years old.
- 15 January P1 telephones SW7 to tell him that Alec has had an accident and is on a life support machine.
- 25 January SW7 telephones the Western General: Alec is on a life support machine. His daughters visit daily. The prognosis is poor.
- 31 January Alec Ness is transferred to the care of the High Dependency Unit on the Neurosurgical Ward at the Western. He gradually improves. He has fits and thereafter requires anticonvulsant medication on a long term basis.
- 6 February P1 telephones SW7. (He returns the call, but they miss one another.)
- 26 February Alec Ness is transferred to the Astley Ainslie Hospital for a two-week assessment and neuro-rehabilitation. He is mobilising independently.
- 28 February Alec Ness is noted to be *“Compliant, but showing some frontal symptoms – poor rapport and social modulation – e.g. repeatedly states his anxieties about his girlfriend, and his case for a weekend pass; doesn’t make use of social/non-verbal cues. Also, distractible, loquacious. Obviously anxious re girlfriend (37), who seems to be putting him under some pressure to come home.”*

- March  
(exact date  
not noted) Shirley telephones Dr.2 to say that she is pregnant, having missed various appointments .
- 6 March Tests starting on 27 February and ending on 6 March suggest that Alec Ness had been in the upper half of the average range of intelligence prior to his head injury, but that his current quotients on the Wechsler Intelligence and Memory Scales are in the borderline range, between the fifth and tenth percentile.
- 8 March A Neuropsychology Report on Alec Ness notes:  
  
*“He presented as excessively talkative, distractible and was not able to attend properly to the tasks in hand. He was fully co-operative and orientated in place, person and time. He was anxious to get home to look after his partner, and lacked insight into his own condition. Specific deficits were noted in visually mediated functioning and in his mental processing speed. In general, his behaviour during the assessment suggested a frontal disinhibition syndrome. This refers to his distractibility, loquacity, and general, mild agitation. He was always fully co-operative and polite, and his behaviour was never offensive or difficult. He seemed also to lack due insight or concern about his condition or test performance. Although he was always quick to agree that he had had a severe head injury, his agreement seemed superficial and did not seem to have any bearing on his plans and preoccupations. A smooth recovery does not seem assured. His social circumstances are poor. My particular concerns are that he may resume heavy drinking, and that there is a potential for difficulties in the relationship with his partner.”* (written by Psyc, the Head of Neuropsychology).
- 9 March Alec Ness is discharged from the Astley Ainslie Hospital, and goes to stay with Shirley Malcolm. While in hospital, his address had been given as c/o his mother, in another area of Edinburgh. His general practitioner was in that area, far from Leith. On discharge the GP remains unchanged.
- 28 March Alec advises SW7 that he is living at Shirley’s address in Leith, and that she is pregnant.
- 3 April SW7 visits Alec at Shirley’s home, and SW7 notes: *“Alec has suffered from loss of short term memory and subsequent confusion since his discharge from hospital. He is also having problems with his ex-partner who is again obstructing access to his sons. Alec’s new partner is a recovering drug addict and is prescribed Methadone. Alec also told me she has a history of self-harm and had tried to kill herself while Alec was in hospital by jumping into the Water of Leith. Alec has been told he cannot drink alcohol as it will negate the effect of the many different types of medication he is taking. He*

*was frightened by his experience and tells me he now knows his life has changed. He has also been told that he cannot drive for the time being."*

- 3 April Shirley had been scanned 5 days earlier, revealing a pregnancy at approximately 23 weeks gestation. She is accordingly into the second trimester of pregnancy, before reduction of her Methadone prescription can commence. Gradual reductions start being made to her "script" (see Glossary and also entry in July). Shirley admits to topping up with 10 or 20 mg of Methadone, occasionally. Thereafter, Shirley generally attends the CDPS every two weeks.
- 10 April CN, an outreach nurse attached to the Astley Ainslie, visits Alec Ness at Shirley Malcolm's flat in Leith. CN reports to his G.P. *"Mr Ness appears to be managing well at home. He was well orientated and had remembered that I was visiting on that day. He has been doing most things about the house and has also been going out. Mr Ness reports no problems with this and feels that he is coping well. He did report some difficulty learning new information and tasks, although overall this did not particularly bother him. In conversation Mr Ness could be repetitive but generally appeared unaware of this. He and his partner spoke at length about their families and the birth of their baby. They asked if I would be able to contact the Housing Department about rehousing: however I explained that as it would not be in relation to Mr Ness' brain injury then I would have no influence on this. I asked Mr Ness if he had been taking either alcohol or non-prescribed drugs. He said that he had not and we discussed the risks associated with taking either following a brain injury. He assured me that he would not be taking either in the future, although I acknowledged the difficulty he may have abstaining given his past history."* Appointments for further support were made.
- 24 April CN notes the name and address of SW7, and notes *"Bickering – mutual. Crowded in small flat. Awaiting new flat Port of Leith Housing Association. Impression: somewhat precarious equilibrium at present."*
- 25 April Dr3, a Consultant in Rehabilitation Medicine, and Psyc separately see Alec Ness at Outpatient appointments. Dr.3 notes, in a report to Alec Ness' GP *"I reviewed this gentleman following severe head injury following a fall, which looks like it was probably preceded by an assault earlier this year. He feels he knows the people who performed this assault, but is unwilling to tell the police as he is concerned about reprisals. His partner who is apparently pregnant and on Methadone was able to report today that his memory is still poor. He occasionally bumps into doors and on examination today he had visual neglect on the left side. Neuropsychological testing revealed mainly defective visual memory, his verbal memory in the low average range. I wondered whether perhaps he ought to be reviewed by Neuropsychology as his partner feels that she is unable to leave him alone in the house and he usually has to go out into the community with her. He*

*feels more directed to the concerns of his partner rather than himself and has difficulty verbalising his own difficulties. I suspect, at least in terms of his mental processing, that he has improved since he was assessed in January ...”*

1 May SW7 visits Alec at home. The main issue is to obtain a single person’s tenancy if offered. *“Alec’s health not great at the moment. He is seeing specialists at the Astley Ainslie but remains affected by his injuries.”*

2 May Psyc, reporting on the appointment on 25<sup>th</sup> April, notes:

*“... Occupational Therapist and I saw him together with his female partner “Sam” on the same day. We were both struck by the fraught and tense atmosphere between the couple. “Sam” appears to have some drug dependency problem, admitting to 30 mg Diazepam a day, down from 80 mg a day. Her speech and demeanour were very obviously under some pharmaceutical influence at our meeting. Mr Ness undoubtedly has had problems in organising himself and remembering everyday things at home, to the extent that Sam feels she is “looking after him”. Sam is now 5/12 pregnant, and I understand that the couple’s accommodation is unsuitable and cramped. I suspect that there will be difficult times ahead with this combination of medical and social circumstances.”*

8 May Shirley fails to attend CDPS.

14 May Alec phones SW7 about housing problems.

May (exact date unknown) Shirley’s urine sample tests positive for Benzodiazapine, cannabis, and Methadone.

May A duty request from the Housing Department arrives on the desk of SW.4 a main grade social worker, whereby he requires to visit someone who is about to be evicted, to see if there is a need for support for the family. The name and the address is almost the same as Shirley Malcolm’s, and SW4 interviews Shirley Malcolm, under the mistaken impression that she is the person who is about to be evicted. This interview probably takes place on 8 June. The confusion of identity is immediately recognised, but she volunteers the fact that she has issues with the Housing Department, and is pregnant. SW4 ties this in with the existing Social Work records, relating to contact arrangements. (See November 1999 entry). He therefore realises that there might be Child Protection concerns. SW1, the Practice Team Manager in Leith social work department, decides to make this an allocated piece of work, rather than leave it in the duty system. As Shirley Malcolm was not under threat of eviction, the Housing issue ceases to be pursued, although she considers her flat cramped, damp, and unsuitable for a baby.



- 16 May SW2, a Senior Social worker, holds her first supervision session with SW4, following the departure of a Senior Social Worker to go elsewhere. Shirley Malcolm is briefly mentioned as a “new case”. SW2 records: “(SW4) will have space to take on new cases.”
- 25 May Shirley Malcolm leaves a telephone message for CN, noted as: “Partner, slurred, telephone message – she and his family are very worried about him.”
- 25 May SW7 records: “Telephone call from Shirley Malcolm. She says Alec is not well medically and mentally. He seems very depressed and sits staring into space for hours at a time. He has also hidden his condition from his doctors. Shirley is concerned about the burden of care placed upon her and the pressing need for housing. I told her I would be down on Friday and we would discuss the matter in detail then. Alec and Shirley have both told me about a local man who has been threatening them recently. She said he had smashed their windows last night and had been charged. He was subsequently released on bail.”
- 1 June SW7 requires to cancel a planned home visit to Alec.
- 10 June SW7 records: “Telephone call from Shirley. Alec is falling fifteen to twenty times a day and waking her up through the night. She is exhausted and thinks Alec needs to be reassessed. She also told me that the baby is lying in breach. I agreed to phone the Community Nurse – CN (telephone number recorded) to let her know about Shirley’s concerns.”
- 12 June SW7 records: “Telephone call from SW4, Leith C&F team, who has been allocated Shirley following contact from (distant) Social Work Department. He will be involved through the birth of the child given Shirley’s history of difficulties with her other children.”
- 12 June SW4 notes: “HV present. Shirley Malcolm and Mr Alec Ness (partner). Ms Malcolm stated that Mr Ness is the father of her unborn child. Ms Malcolm states the child is due in mid/late July. She says that she thought that SWD would be contacting her and my visit was not a surprise. The house was in good condition, comfortable and well maintained, is a private let and she and Mr Ness are pursuing a tenancy through the Housing Department. Ms Malcolm openly acknowledged her previous difficulties with drugs and stated that she has been in contact with the CDPS for over a year (Dr.2 named). She is currently on a script of Valium and Methadone, and is attempting to reduce amounts. She states she has been attending Simpsons regularly as well and has had a number of scans and is aware that baby may be born Methadone dependent. Generally spoke very positively about the new baby and showed me the baby equipment, clothes etc she has prepared for the birth. He is also just out of hospital, one week after a serious head injury after a fall in the concrete stair.... They

*described both their families as supportive. Mr Ness has a son of 14 from a previous relationship. Ms Malcolm spoke about her hopes to make the relationship with her older children better and intends to work with (distant) Social Services to achieve this. Told her that I had no involvement in that and said that I would simply be contacting (distant Social Work Department) to feedback on this visit. Inform them that I would also be in touch with their Health Visitor (HV) and again they were happy with this. (SW7) is of the view that the recent head injury has made Mr Ness think seriously about his future in a positive way. However given the head injury he remains quite dependent on Ms Malcolm. (SW7) agreed that generally he found both Mr Ness and Ms Malcolm well motivated and reasonably prepared for the birth of the baby. T/C to (Dr2) CDPS – again confirmed involvement with Ms Malcolm over past 18 months. Has been reliable in meeting appointments, no signs of unexpected substances in recent urine samples. (Dr.2) also agreed that at present Ms Malcolm’s circumstances were settled. Though she wondered how the impact of a new baby will change this. Asked CDPS to contact me should they have any concerns.”*

- 12 June Fax received by SW4 from (distant) Social Work Department, enclosing a report written in connection with an application by a local authority for a Parental Responsibilities Order relating to child 2, Shirley Malcolm’s son. The report extends to fourteen pages, and was written by SW8, the Team Leader of the Children and Families team, in January 1998. It recorded the fact that Shirley’s first child, a girl born in 1986, was made the subject of a Supervision Order when she was a toddler. She was eventually received into the permanent care of the (distant) Social Work Service. Shirley had been injecting heroin since circa 1985, when she was 16. Child 2 was born in 1989, and immediately placed on the Child Protection Register by an English local authority. His father was unknown. When Shirley returned to Scotland, the child’s name was placed on (distant) Council’s Child Protection Register in 1990. In the same year, after a Proof before the Sheriff, grounds of referral were established, and a home based supervision requirement was imposed. Frequent intervention, sometimes on an emergency basis, was required over the years until finally the Department agreed to pursue a Parental Responsibilities Order in 1998. During these years, numerous attempts were made to rehabilitate Shirley, by reducing her drug dependency. There were times when she was virtually drug-free, followed by relapses. We cannot repeat the details, but several episodes of very serious neglect are described.
- 14 June Alec Ness fails to attend an appointment, and this is actively followed up by the Astley Ainslie team.
- 14 June Supervision session takes place between SW2 and SW4: the notes for this session are lost.
- 15 June SW4 goes on holiday until 9 July.

- 21 June SW7 records: *“Home visit to Alec and Shirley. We went to the Housing Department to declare the couple homeless. The Housing have agreed to prioritise the couple and will make two offers. Shirley is still being sought by their neighbour and is in fear of attack and housebreaking. She also said that it may have been this guy who hospitalised Alec! Review tomorrow at Alec’s home. See report.”*
- 22 June SW5 and SW7 visit Ness at Shirley’s flat. She was asked not to be present, and was not there. They understand from her that she is anxious to end the relationship with Ness. They discover that multiple applications have been submitted to the housing department, both in joint names and in Ness’s sole name. The purpose of the meeting is to review his parole.
- 26 June Shirley fails to attend CDPS, but contacts them by telephone.
- 27 June SW7 notes: *“Review with SW5, a Senior Criminal Justice social worker, and Alec. See Minute in file.”* We did not see the Minute.
- Early July Reports reach CN from both Shirley Malcolm and Alec Ness’ sister, who say that Alec Ness is getting worse. *“He’s falling around.”* He is reported to be taking illicit drugs. Alec Ness’ own GP refuses to do a home visit, because his surgery is in west Edinburgh.
- 10 July Shirley fails to attend CDPS.
- 11 July SW7 records: *“Telephone call to CN. She has arranged for a GP to see Alec and will keep in touch. She also told me that Alec has been taking Temazepam and Valium as he has a source. This may be the cause of the falls but CN did not rule out a medical reason.”*
- 12 July SW7 records: *“Telephone call from P1. Alec has been walking the streets and is saying that he is being thrown out of the flat on Saturday. P1 is very worried and believes Alec may well be using drugs. He has gone to the chiropodist for a foot examination, and P1 expects him to come back to her place after. P1 will phone me when he returns.”*
- 13 July Psyc reports to Dr3: *“Recent reports from his partner, Shirley, are that he has been forgetful, vague, confused, weepy and highly dependent on her. She is due to deliver a baby at any time within the next month, and is a long-term Methadone user. She is concerned at how she will manage to cope both with a baby and Mr Ness. Their relationship had been established only a very short time before she fell pregnant, and Mr Ness had been released from a lengthy prison term for only a year when his accident occurred. Mr Ness was occupied as a volunteer in a charity shop at that time, but has not resumed since leaving hospital. This seems to be due, in part, to*

*animosity between his partner and the manager of the charity shop. The couple has complained before about their accommodation, which they say is damp and cramped. I understand that both Mr Ness and his partner have social workers. It seems likely that they will make a risk assessment of the baby's welfare. I shall try to see Mr Ness on 17 July 2001, as I understand he is scheduled for (an) outpatient clinic that day."*

- 13 July SW7 records: *"I saw Alec yesterday - he was disorientated and weepy saying one minute that he had been thrown out of Shirley's flat and the next that he loved her and wanted to go home. Given the concerns voiced by P1 and Shirley about Alec's health, I decided to get him to the hospital as voiced as an option by CN. The doctor at the hospital said Alec was in no imminent danger but was in the process of contacting the Astley Ainslie and Western General hospitals when I left. (A friend of Alec) stayed with him and took him home. Telephone call from (Alec's friend) to say that Alec had been discharged from hospital and given antibiotics for his foot infections. He returned first to P1 and then to Shirley's."*
- 16 July SW7 records: *"Telephone call from Shirley. She and Alec are over as a couple. She wants him to leave as soon as possible but remains concerned that he is not capable of taking his medication or looking after himself. Alec has a full medical assessment arranged for tomorrow and I have arranged to phone Shirley to find out what they are saying. Shirley also said she was scared of Alec and I advised her to throw him out."*
- 17 July SW7 records: *"Telephone call to Alec and Shirley. The medics have assessed Alec as unchanged and found him to have Diazepam in his system. Shirley is blaming (a member of the Ness family) who has been coming to the flat, saying he is putting drugs into Alec's tea! Shirley told me that Alec is moving out and staying for a few weeks with (a family member. Alec knows to phone me as soon as he knows (the address). We will have to get back in touch with the Housing Department to change his application."*
- July Shirley's drug use has reduced to 70 mg of Methadone, and 15 mg of Diazepam, on prescription. Dr.2 would normally hope to have reduced the Methadone to 40 mg by the time the baby was born, but there had been too little time to effect that degree of reduction.
- 17 July Alec Ness' urine later tests positive for benzodiazepines, cannabinoids and opiates. Methadone was detectable at a low level.
- 18 July CN notes: *"Own G.P. - won't do home visits because surgery is in (west Edinburgh). Reports from Shirley (and sister) - he's falling around - ? getting worse. Is taking illicit drugs (ex-family member). Going to sister for two weeks. At O.P. appointment: pinpoint pupils. Full of talk, but no obvious goals - just telling their worries. Criminal Justice Social Worker (SW7) Ch and Fam Team - aware of child health risk."*

- 18 July Dr3 reports to Alec Ness' notional GP. *"The episode of him falling and vomiting last week, which necessitated a referral, - followed taking a concoction of Valium, Temazepam, and a few pints of shandy. I understand since this has happened that his partner has decided on a trial separation and Alec is going to live with his sister for a couple of weeks. Mr Ness is quite down about this. It wasn't clear from today's discussion whether this was indeed because of the difficult circumstances of the housing in Leith or whether his partner just felt she had enough on her hands with her new baby over the next few weeks. Alec describes some continuing mild problems with memory and this can lead to arguments. He has to be given his tablets which are Epilim 200 mg TID, otherwise he misses them or indeed takes them twice. He was a little sleepier than I had remembered when last seen in April, in the clinic today and he had pinpoint pupils and I wondered whether he may be taking Methadone which is prescribed for his partner or indeed Diazepam (although this would have given dilated pupils). If indeed there is Methadone or Diazepam in his urine, I might suggest that he be referred to the Drug Problems Clinic. Certainly the present situation is not related to his head injury earlier this year, as his seizures have now abated and he only had mild memory problems at that stage. There is a complex psycho-social history including contact with a Criminal Justice Social Worker, who I understand is due to contact me shortly."*
- 19 July SW7 records: *"Telephone calls to Alec, his (family member) and Homelessness Assessment. Alec has been taken by his (family member) to the Housing Department. I spoke to (an official) to make sure that the application is not duplicated. Alec remains priority homeless and will be given accommodation if he presents at Waterloo Place. Alec' (family member) knows this but Alec remains confused and may phone often. Telephone call to CN. Not there but message left on the answerphone. If she calls in my absence could someone give her Alec's telephone number and this update."*
- 24 July Psyc and CN visit Alec Ness at his sister's home, and find him to be in an agitated and restless state. He is preoccupied with trying to contact Shirley by way of mobile phone, and by the prospect of the imminent birth of the baby. They warn Ness that it is possible that the baby will be taken into care.
- 25 July SW4 records: *"T/C from HV (the Health Visitor in the GP practice where Shirley is registered) – informed me that Ms Malcolm has moved house since midwives had been trying to visit her and neighbours had told them she has moved."*
- 30 July CN writes to Alec Ness' GP.

*“On 11 July I had a message left on my answering machine from Shirley, Alec’s partner, asking me to call back. She stated then that she could not cope and that Alec was falling about, nauseous, vomiting, urinating in inappropriate places, unable to speak clearly and generally unmanageable. I asked if he had bumped his head again or had a seizure which Shirley denied. I also asked if Alec had been taking non-prescribed medication and she admitted that Alec had taken Diazepam, Temazepam and alcohol. Shirley said that (a family member) had given it to him. Shirley expressed her fears as she is expecting a baby in the next few weeks and doesn’t know how she will manage to care for them both if Alec remains in this state. As it was difficult to give advice over the phone I advised Shirley to ask her G.P. to see Alec. Indeed I tried to arrange an appointment but given that Alec was out of your area it was not possible to have home visit and I suggested that Shirley ask her own G.P. to do a temporary resident visit as I had been advised. I also called Shirley’s surgery to let them know that I had given her this advice. On the same day I had a call from (SW7). He had been unaware of the state Alec was in and having seen him ten days before was quite surprised by this deterioration. He was aware however that Shirley was starting to suggest that she would require a break and that Alec may have to look for other accommodation. (Psyc) and myself had arranged to do a home visit on Tuesday 24 July at (Shirley’s address) and Alec was also offered an Occupational Therapy appointment the following week. On 18 July Alec and Shirley split up and Alec ended up at his sister’s house on a temporary basis until he could find accommodation. I have since had several conversations with his sister, the Housing Department and SW6. The outcome at the moment is that Alec will be offered temporary accommodation until he receives permanent housing. We continue to receive mixed messages from Alec and Shirley as to whether or not they wish to live together. (SW7) is working towards Alec having a single tenancy however I do not know what the outcome will eventually be. I am awaiting a call from the Housing Department to let me know what stage the process is at. I have listed the contact numbers of the variety of people involved in this case should you require to contact them at any point. I also appreciate that if Alec returns to Leith then you will not be his G.P. However I did think it was important that you knew what was happening should you have contact with Alec or be asked for information about him. I have had at least two hostile phone messages left by Alec’s partner and she certainly does not recall some of the conversations we have had. She denies that Alec has been offered appointments and states that we are only doing things because he is at his sister’s now.”*

Appointments were made to assess Alec Ness’ ability to carry out the activities of daily living. CN arranges a meeting with Alec and other professionals involved in his care on 8 August.

30 July

Caleb is born, at 39 weeks gestation, by way of an elective Caesarean section delivery. Weight 2630 grams.

- 31 July Caleb is admitted to the Neonatal Unit, with hypoglycaemia. He has been intermittently vomiting overnight, and is a slow feeder. He is diagnosed as suffering from neonatal abstinence syndrome. He is commenced on hourly feeds, and responds well.
- 31 July SW4 notes: *“T/C to CDPS – who informed me that Simpsons Maternity Unit had contacted them this morning to say that Ms Malcolm is in the hospital, had a boy yesterday.”*
- 31 July SW4 records: *“T/C to Simpsons - (Nurse2: - Ms Malcolm had a boy yesterday called Kalib (sic). Kalib is quite poorly, not feeding well, blood sugar very low. He was on the ward with his mum for a time but ward staff have concerns about Ms Malcolm’s ability to feed him, she needs constant supervision. Baby had to be force fed this a.m. due to continuing problems. Midwife anticipates Ms Malcolm will remain in hospital for a further week, however Kalib’s condition may mean he will be in hospital for some weeks. Ms Malcolm is currently on 70 ml Methadone plus 15 mg Valium per day. However ward staff suspect that she has been using other substances for some time. Mr Ness, Ms Malcolm’s partner, has also been seen on the ward.”* SW4 also phones SW9 (the main grade social worker in distant Social Work Department who currently has responsibility for Shirley’s two children) to tell her of the birth of the baby.
- 31 July SW4 and SW2 discuss the circumstances, and agree upon the need for a Child Protection Case Conference (CPCC), during the course of a regular supervision meeting.
- 1 August SW4 records: *“Meeting with Ms Malcolm and Mr Alec Ness at Maternity Hospital. Explain the reasons for convening a CC which the parents accepted. Ms Malcolm also confirmed that her home address remains (as before).”*
- 3 August SW4 records: *“Visit to hospital – present Shirley and Alec. Shirley now more involved in feeding of Caleb. Ward staff encouraging her to do this. Further reassurance re Case Conference.”*
- 6 August Dr2 having left her job, Dr1, a Consultant Psychiatrist specialising in drug addiction, takes over Shirley’s file at the CDPS. He had previously been supervising Dr2, but had never met Shirley.
- 8 August Alec Ness fails to attend Astley Ainslie Hospital appointment. The letter reminding him of the date was sent to his sister’s house on 30 July, so he probably did not receive it.

- 9 August Child Protection Case Conference is held at Simpson's. See 3.1 to 3.11. It is chaired by SW3, a part time Senior Practitioner, and the Minutes are taken by a newly qualified social worker, SW10.
- 9 August HV records: *"Case Conference at Braids Seminar Room, Royal Hospital for Sick Children. Kalib's name placed on the Child Protection Register because Ms Malcolm's background indicates severe difficulties in the past in terms of parenting and maintaining consistent approach to child care. Ms Malcolm's partner, Mr Ness, has recently suffered a severe head injury which apparently involves Ms Malcolm caring for him and ensuring he takes his medication as prescribed. Ms Malcolm is under the care of Dr1, Consultant Psychiatrist at the CDPS and takes a daily medication of Methadone and Valium. Kalib is in the Neonatal Unit at present with neonatal abstinence syndrome. It is expected he will remain there for a further one to two weeks. Health Visitor plan: to do initial assessment after discharge and liaise on contact with other agencies."*
- 11 August Shirley is discharged from hospital, following "basically straightforward" post-operative recovery.
- 13 August Neonatal Social Information Record (Nursing Notes) records: *"Mum, Dad visited both sweating, sleepy, attending to Caleb under close observation."*
- 13 August Caleb is formally entered on the Child Protection Register, as being at risk. His name is given as 'Kalib Malcolm', written in such a way that it looks like 'Kakib' (sic), by SW4.
- 14 August Shirley and Alec register Caleb's birth, naming him as "Caleb Alexander Ness".
- 14 August SW7, who has just returned from holiday, notes: *"Telephone call to SW4. Child Protection case conference held at Simpsons on 9 August. It decided that the child (Kalib 30.7.01) should be placed on the Child Protection Register, initially for a three month period to monitor the care offered to the child. SW4 says that Alec is living at the Hotel through Homelessness Assessment at the Housing Department. He attended the hospital on a daily basis and SW4 is of the opinion that the relationship between Alec and Shirley is very much alive. Telephone call from Alec and Shirley in the afternoon. Alec is living in the Hotel (address given)."*
- 15 August Dr1 reports to the GP with whom Shirley is registered that Shirley's drug dependency is being managed by way of the prescription of Methadone 70 mg daily, and Diazepam 15 mg daily. The "script" is issued three times a week from a particular named pharmacy.



- 16 August SW7 records: *“Office appointment at Giles Street SWC yesterday. Alec remains confused about his future plans but I have clarified that Shirley does not wish to be housed with Alec, at the moment, so his application for housing should be single. Telephone call today to (an official) at Housing. Once Alec is housed we can concentrate on constructing a support package with the help of Medical Services. Telephone call to Alec (mobile number given) to let him know about today’s developments. I couldn’t get through as the number is not valid. Telephone call to Shirley to also let her know what’s happening. She is clearly in the process of distancing herself from Alec and is questioning his commitment to Caleb.”*
- 16 August SW4 records: *“T/C from Simpsons – Caleb discharged this week. Shirley was discharged a few days ago – has been visiting. T/C to Shirley Malcolm – agreed home visit 20/8/01.”*
- 16 August SW2 and SW4 discuss Caleb during the course of a regular supervision meeting. It is noted that Caleb is still in hospital, and that the Social Work Department files require to be reorganised, although the brief entry is confused about names.
- 16 August Neonatal record: *“Dad in to visit for most of the day – waiting for Mum to arrive. Requires close supervision while attending to care. Mum arrived and very sleepy and sweating.”*
- 17 August Neonatal record: *“Mum and Dad visited, managed to feed and change baby quite well. Mum very sweaty and slightly slew and bit sleepy.”*
- 17 August Neonatal record: *“Mum and Dad visited quite sleepy at times while in visiting.”*
- 18 August Neonatal record: *“In to visit late afternoon. Mum very pale and sweaty. Dad letting us know his problems!”*
- 19 August Neonatal record: *“Mum, Dad and (another person) visited. Mum and Dad attended to care. Mum sleepy, speech slurred, but attended to Caleb’s needs.”*
- 20 August (Comment: This date is probably incorrectly recorded - the correct date is not known.)
- SW4 records: *“HV present, Shirley Malcolm and Alec Ness: Caleb asleep during visit, Shirley speaking very positively about the future. Mr Ness continues to speak of getting a tenancy together and is being supported in this by Housing Department.”*

- 20 August HV records: *“Caleb progressing well for possible discharge later this week. Shirley to room in on the unit before discharge. Care review planned 21/8/2001. HV to be informed of discharge.”*
- 21 August Alec Ness fails to attend the Astley Ainslie. Dr3 reports to his GP. *“As stated in my letter on 18 July, I think it will be more appropriate that this man is referred to a drug rehabilitation clinic rather than continuing follow-up at my clinic. Certainly if the range of substances found in his 17 July sample are typical, then this would make further sub-acute rehabilitation of his head injury futile.”*
- 21 August Neonatal record: *“Mum and Dad rooming in with Caleb.”*
- 22 August Caleb is discharged from hospital. He is demand bottle feeding.
- 23 August HV records: *“T/C liaison H. Visitor SMMP – mother and baby discharged on 20/8/2001 (sic), follow up at SMMP for limited hip abduction. Feeding on full term formula. Plan to contact family by phone to arrange home visits.”*
- 23 August HV records: *“T/C – no reply.”*
- 26 August HV records: *“T/C + home visit – no reply.”*
- 27 August HV records: *“T/C + home visit. No reply.”*
- 28 August HV records: *“T/C arranged to do home visit, address checked.”*
- 28 August HV records: *“Home visit. See schedule. Maternal health reported to be coping well with care of the baby. Give support to partner who visits daily. Has contact with friend and her baby. Taking medication as prescribed. To see Dr.1 in one week. Reports to be very thirsty, drinking larger amounts than usual. Shirley to discuss with Dr.1 antibiotic therapy for infection now completed. Sterilisation of bottles discussed using steam method. Also has Milton method. Caleb – weight measured increased to 6.8½ oz (2.96). Appeared healthy. SIDS/safety discussed. Also care of infant and winding periods. Advised to give occasional drink of cooled boiled water to settle. Client Visit Report completed. Advised of service and contact number. Plan to see in 5/7 days or by client initiation.”*
- 28 August SW4 records: *“T/C from SW.9 (distant) Social Services: SW9 is SWR for Shirley’s two older children. She visited Shirley with her son (name given). Found Shirley in good spirits. She expressed (illegible) concerns re Shirley’s care of Caleb during the visit.” (see 5.6)*
- 30 August SW2 and SW4 discuss Caleb, but the relevant supervision note has been lost.

- 3 September Shirley fails to attend an appointment with Dr.1, but telephones to say that she has difficulties with the baby, and he sends her prescription to the chemist anyway.
- 4 September SW4 records: *“HV present, Shirley and Alec: Shirley reported Caleb is gaining weight, Caleb in no distress during visit. Shirley is having regular contact with HV. She feels she is coping well. She spoke of contact with a friend who has a baby of a similar age and how this is helpful to share experience. No concerns.”*
- 5 September HV records: *“Home visit. Mum and baby present. Caleb reported to be well remains windy but settling better. Feeding: offering 5 oz taking between 1 to 4 oz on demand. Baby weighed – naked 7-4½ oz. Appeared hydrated. Skin intact. Discussed feeding use of different teats, positions for winding. Continues to wind frequently during feeds. Shirley – reported mix-up with appointment at CDPS for medication. Awaiting Alec bringing Methadone. Had not taken today. Shirley has appointment a.m. at Community Drugs – with Dr1 Anxious about taking Caleb on bus. Shirley has support from friends. Alec dependent on Shirley for help with medication times. Discussed local support group. Shirley expresses not keen to attend at present. Reports to be coping well with care of baby not too tired able to manage night feeds. Flat appears clean and tidy. Problem with pram discussed – awaiting new wheel for pram. Recent contact with Social Worker SW4. Plan. Aware of HV contact number. Plan to see 12/9 at home.”*
- 7 September (Date unsure) SW9 telephones SW4 to say that she has spoken to Shirley on the telephone. Shirley denied being Shirley, and pretended to be a visitor. SW9 recognised Shirley’s voice. Shirley was very significantly under the influence of drugs. SW9 tells SW4 that she has serious concerns about Shirley’s fitness to care for a baby.
- 11 September An Occupational Therapist at the Astley Ainslie notes: *“I have been seeing Mr Ness sporadically over the last few months. We have tried to investigate with him the possibility of independent living separate from his partner, but he is insistent that he would prefer to remain with Shirley for the time being. At this time, he needs regular prompting to carry out daily living tasks. He needs monitoring for his daily medications and he remains very labile emotionally. He is capable of independent self-care, but has very poor memory and retention, even of regular routines. He has not as yet a permanent address of his own, and is still in temporary accommodation whilst his Social Worker continues to pursue the possibility of a permanent address. This creates a difficulty in planning further support for Alec, as we have no permanent address to refer to.”*
- 11 September SW2 and SW4 discuss Caleb. For the first time, the Social Work Department computer print-out lists Caleb in his own right, but still as “Malcolm, Kalib” i.e. under the wrong name. A rough note records that Caleb is *“putting on weight, no concerns”* and that Shirley is *“doing well”*. There is a brief reference to a home visit to Shirley by her older kids.

- 12 September HV records: *“Home visit – message left on window to HV – Gone out – emergency. Will contact HV for next visit. Plan to discuss progress with SW4.”*
- 13 September Alec Ness starts to attend sessions of the Brain Injury Group at the Astley Ainslie, and attends five out of seven of the sessions until 18 October. He is reported as being *“tearful, emotional”* and *“unable to relate to the content of the group session.”*
- 13 September SW7 records: *“Letter to Alec with appointment for 21 September”*
- 13 September HV records: *“T/C SW4 – no concerns – reports Shirley and baby progressing well. Last contact with family one week ago. Shirley also has frequent contact with Social Worker in (distant area) in relation to older child. Plan to await client contact.”*
- 14 September SW4 records: *“T/C (name) HV. Has missed a couple of appointments with Shirley, though when she has seen Shirley and Caleb she has had no concerns. Said she felt Mr Ness was at times a strain on Ms Malcolm’s patience, given his difficulties due to his head injury, he appears very dependent on Shirley. Otherwise Caleb continues to thrive and no concerns re care.”*
- 19 September HV records: *“T/C – no reply.”*
- 20 September Psyc fills in a Disability Living Allowance Claim form, to assist Alexander Ness. He notes that Mr Ness has *“Problems with balance – falls and clumsy”*: *“Has reduced traffic sense in general self-management. Might put self and other people in danger. Is prone to fall. Could not be trusted on unfamiliar routes. Reliant on taxi or hospital transport. He “is at obvious risk of injury through falling. Lacking normal self-protective reflexes, and slow reactions.””* He is noted as being *“currently homeless, living in hostel accommodation, visiting partner’s house.”* He *“needs constant light supervision and assistance when falls or in difficulty.”* He *“needs help with laundering, and organisation of clothing and personal appearance.”* It is said that Mr Ness *“could not plan or carry out meal preparation. Forgetful and disorganised. Could not be trusted with a cooker, or hot materials. Could carry out simple tasks with supervision. Could not organise personal shopping effectively – memory impairment and self organisation.”* It is noted that he *“Cannot remember to take his (essential) medication, and would be unlikely to organise himself to renew his prescriptions. Poor memory for attending appointments, understanding advice.”* He is said to need someone to keep an eye on him: *“He cannot organise his own day. Needs constant supervision and reminders. Can only cope with one directed simple task at a time, otherwise “lost”. Partner describes him as “like looking after a baby”. Gets confused, emotional, agitated. Needs organisation till he sleeps. Poor sleeper – wakes, sleepwalks, confused through the night.”* His post-traumatic epilepsy is said to have been controlled so far on medication, but

he “has dizziness” and “is prone to episodes of agitated confusion/sleepwalking at night.” It is noted that he is “Abnormally emotional. Labile – apt to become tearful, over-excited, agitated. Poor self-control and insight. Social rapport poor. Lacking judgement, impulsive. Consequence of severe brain injury – frontal lobe syndrome. This is a constant state. Cannot stay on track of one topic when speaking and not a good listener – attention problems. Cannot express thoughts adequately, or understand.” Help with childminding costs is sought, “so partner does not have to look after baby and him simultaneously, constantly.” In the summary, Psyc has noted: “Mr Ness sustained a severe brain injury in January 2001. He has subsequently shown very significant problems in personal confidence, and is a vulnerable person. As stated elsewhere in this form, he is highly forgetful, and has limited ability to follow or remember advice. He can cope with a single task, but requires constant reminders and light supervision. He could not, for example, cope with this form. Looking after him is extremely wearing, owing to his impulsiveness, emotionality, agitation and lack of insight. One is never confident that he has absorbed what he has been told, with justification. He suffers overall from a severe “executive dysfunction” secondary to brain injury. Although some improvement may yet be expected the extent of symptoms and difficulties at this stage indicates a highly guarded prognosis.”

- 20 September SW4 records: “HV present, Ms Malcolm and Caleb: Shirley appears very attached to Caleb who was feeding during the visit. Shirley said she appreciated being able to talk without Alec being there who she acknowledged could at times be a strain because of his sometimes repetitive focus on housing issues. Alec is living at the Housing Department temporary accommodation at (address given). Shirley continues to ensure he takes his medication on a daily basis, since Alec arrives every morning around 9-ish and spends the day with her and Caleb. She feels his handling of Caleb is not a problem, and that he has taken Caleb out in his pram on a few occasions, and she has appreciated the brief respite this offers.”
- 21 September SW7 records: “Office appointment at Gilles Street SWC. Alec failed to attend. Telephone call later from Alec saying he missed me by five minutes and that he was well. He remains at the Hotel at night and with Shirley and Caleb through the day. Telephone call to (official) at the Housing Department – no change.”
- 21 September HV records: “T/C – no reply. Plan to contact.”
- 24 September SW6 (a senior criminal justice social worker) is temporarily redeployed to cover for a sick colleague, taking over supervision of SW7 from SW5. He did not see the Ness file before Caleb died.
- 27 September SW7 records: “Office appointment at Gilles Street SWC yesterday – Alec failed to attend. Letter sent to Alec with new appointment.”

- 28 September HV records: *“Home visit by appointment. Caleb feeding 5.6 bottles of formula mainly 5 oz on demand. Weight 8.15½ (see centile). Reported to be well today. Movement symmetrical. Fontanelle (illegible). Skin pink. Appears hydrated. Bowels/bladder frequent nappies. Immunisations discussed in detail. Shirley reported feeling low – not going out, not answering phone. Continues to take medication as prescribed – daily Methadone. Has not seen Dr1 in last month. Reports to be caring for Caleb without difficulty but finding partner Alec extremely difficult to support. Shirley expressing thoughts of finishing relationship. Has seen Social Worker SW4 for short period now requesting more support. Discuss Shirley’s appointment with Dr1 – 1/10/01. HV agreed to contact SW4. Plan to see 2/10.”*
- 28 September HV records: *“T/C. SW4. Advised of above. Plan to see early next week.”*
- 28 September SW4 records: *“T/C from (HV): Saw Shirley and Caleb yesterday, no concerns re Caleb’s care, is gaining weight. However Shirley has confided in her that she is feeling low about her relationship with Alec. She indicated that Shirley is considering ending their relationship, as it exists at present, with Alec. Informed (HV) I was due to visit Shirley on 2/10/01 and would try to discuss this with her.”*
- 2 October HV records a thorough review of Caleb at the clinic. He is given various immunisations. HV gives Shirley Malcolm a questionnaire to complete, and assesses her as scoring 27 (a high score) on the Edinburgh Postnatal Depression Scale. HV ensures that Shirley Malcolm sees a family doctor (GP) that day, but Shirley refuses to take the antidepressant medication which the G.P. recommends. HV notes: *“Observed Shirley handle baby well. Quite irritated with Alec’s interruptions. Agreed to contact Dr1 as Shirley failed to keep CPDS appointment yesterday. Advised of HV coverplan to liaise with social worker”*. This is the only occasion after discharge from hospital that a doctor sees Caleb.
- 2 October HV records: *“CDPS – no reply.”*
- 2 October SW4 records: *“HV – no-one at home. Phoned Shirley on her mobile later in the day, said she had not received my letter, rearranged visit for 10/10/01.”*
- 3 October HV records: *“CDPS – T/C. Message left for Dr.1 contact HV”*
- 3 October HV contacts SW4: *“Advised of Shirley’s EPDS score and her reports of feeling low. SW4 to visit today. Will see over next week during HV holiday. Telephone conversation to Dr1. Shirley’s background information since birth given. Dr1 has appointment to see her 4/10/01. Made aware of HV concerns.”* There is no record of a visit by SW4 to Shirley on this date.

- 3 October Extract from Citizens Advice Bureau record: *“(Alec Ness) came in concerned regarding girlfriend who has just had a baby and is very depressed. She apparently is not treating him well. And causing a great deal of problems – lost his drug prescription – just wants to end his life, very “black”, mood low, has a Social Worker (SW7 plus phone number).”* The volunteer, P2, advises Ness to go to the Royal Edinburgh Hospital i.e. a psychiatric hospital.
- 4 October SW7 records: *“Office appointment at Giles Street SWC. Alec phoned to confirm on Tuesday and told me that he and Shirley wanted to be considered for a joint tenancy. In the absence of any confirmation of this I have done nothing to change the basis of his application. I’ll try to find out more when I see him.”*
- 4 October Shirley attends an appointment with Dr1 at the CDPS. She reports that she is feeling isolated, and that problems remain with Alec Ness. Dr1 notes that the brain injuries were “severe and chronic”, and that there are “major issues about the future, feeling trapped”. Shirley admits to buying extra illicit Methadone, and Dr1 suggests that she take Caleb and go to stay at Brenda House, a respite facility run by a charity. However, it becomes clear to Dr1 that the concern for Shirley was not the baby, but Alec. Shirley describes herself as looking after two babies, one being Alec Ness. Shirley tells Dr1 that she wants to live alone with her child, but she feels that she could not do this, as he has nowhere to go where he would be looked after. Dr1 increases her Methadone prescription from 70 mg to 90 mg. Dr1 does not report this to SW4.
- 5 October HV hands over to Health Visitor colleague in another practice, and arranges holiday cover, drawing her colleague’s attention to this case.
- 5 October SW7 records: *“Office appointment at Giles Street SWC. Alec was clear that he and Shirley wanted to be housed as a couple. I said I would write to Shirley and arrange to see her to confirm the arrangements. Telephone call from SW4 to say that Shirley had told her Health Visitor she was feeling very low. The Health Visitor decided that this was related to her wishing to be free from the responsibility of looking after Alec. Telephone call from Citizens Advice Bureau. Alec has appeared saying he is very down and wants to end it all. The worker (P2) is an ex-Psychiatric Nurse and was extremely worried about him. We spoke for some time and I recommended that she advise him to go to the Royal Edinburgh Hospital. Letter sent to Shirley with appointment for 11 October.”*
- 8 October Extract from Citizen Advice Bureau records: *“(Ness) - stated that there was a meeting on Friday re what is happening re his housing. The girlfriend does not want him to move in with her and the baby.”*
- 8 October SW4 records: *“T/C to (SW.7) – Social Worker for Alec Ness. Informed SW7 about recent contact with Health Visitor and the information that there appeared to be difficulties in Alec’s relationship with Shirley. He acknowledged that he had an awareness of this and had discussed it with*

*Shirley in the past. SW7 said he planned to visit the couple at home but not sure when. Will update me following this.”*

- 9 October SW7 records: *“Telephone call from P2 at Citizens Advice. Alec has been attending there and they have helped him with his DLA application. Unfortunately, Alec has also been helped by the Astley Ainslie Hospital staff with the same task. P2 has contacted the Benefits Agency who will only deal with their application which is in the process of being dealt with. Unfortunately (again), Alec has told everyone that he and Shirley wish to be housed together. I said I would confirm with Shirley on Thursday and phone her back.*
- 10 October SW2 and SW4 discuss Caleb at a supervision meeting. The scribbled note indicates that SW4 is linking in with the HV, and that there are *“No concerns re care.”* There is a reference to *“Re-housing problems – wants him out”* relating to the demands of caring for a *“head injury victim.”* There is a reference to a Social Worker being involved, based at Murrayburn Gate (i.e. SW7). The entry suggests that SW4 had spoken to him about this.
- 11 October SW7 records: *“Home visit to Shirley. No reply when I rang but Alec arrived as I was leaving. We went into the flat but Shirley was asleep. As I wanted to see Shirley on her own and she had just awakened, I left saying I would phone later. Alec phoned later saying Shirley had not received my letter. I phoned her later but could not get through.”*
- 12 October Extract from Citizens Advice Bureau record, by P2: *“(Ness) came in for a chat re his housing allocation with girlfriend and baby? Rang Social Worker the meeting had not taken place. But girlfriend still did not want Alec back. Alec very tearful re his whole situation also his brother’s death (years ago). After a friendly chat Alec settled and went away quite happy.”*
- 15 October HV colleague hands over at the end of the holiday, and advises in writing that no contact had been initiated by Shirley over the holiday period. HV records this.
- 16 October HV visits home. Shirley had forgotten *“event, day and time.”* Caleb is seen, reported to be well, and responding well. HV sees him smiling. His weight is taken: 10.2 oz. Caleb had not been seen at the hospital since discharge, and the Health Visitor undertakes to check this. His safety in relation to sudden infant death syndrome (cot death) is discussed, along with the inadvisability of three adults smoking beside him. *“Shirley reported to be coping – good support from friend present. Medication – now taking daily Methadone at chemist – this reported to be inconvenient – dosage now increased to 75 mls. Difficult to discuss health in front of Alec and friend, Shirley expressed at the door. Shirley had recent contact with Social Worker to discuss housing situation with him again. Shirley now going out appeared brighter in self. Remains focused on body image and muscle tone.”*



- 16 October SW4 records: *“HV – present Shirley and Caleb. Shirley was feeding Caleb when I arrived, and he slept. She was aware that Health Visitor had told me of her concerns about her relationship with Alec. She spoke of the strain she experiences in relation to Alec’s dependency on her. She would like it if he did not visit every day, even when he is not there he phones her frequently. She spoke of her source of guilt following Alec’s injury and how she felt she had to maintain the relationship at that point. She spoke of her concern about his obsession about getting a house together and how she does not want this. We discussed her own past and involvement in the sex industry and drug history, she hinted that on occasion she has supplemented her daily script, but that the CDPS had recently increased her daily amount to 90 ml, which she must go to the chemist to take. Shirley spoke of her hopes of the future and the relationship with her older children in (distant place), though we returned to the issue of her relationship with Alec and how she could discuss this with him. I asked if the leader of the head injury group, (Psyc), could be of assistance, and Shirley said she may speak to him about this. Reassured Shirley that whatever she chose to do in this respect my involvement would continue whatever the outcome. She asked me if I could write a letter to DSS explaining her current circumstances since she indicated she had some difficulties in her benefit circumstances, agreed to this. Concluded our lengthy meeting by asking Shirley to inform me if she took any steps as regards her relationship with Alec, and she agreed to do this.”*
- 18 October Alec Ness telephones the Astley Ainslie in the morning, to say that he would not be attending his brain injury group later that day, *“owing to the weather conditions”*.
- 18 October **13.28** Caleb is pronounced dead soon after admission to the Royal Hospital for Sick Children. He is eleven weeks old. The medical cause of death given on the death certificate is: *“Blunt force trauma”*. At autopsy carried out the same day, it is noted that there are, in total, fourteen definite rib fractures, with three categories of age. Some fractures are new, without having any evidence of healing. Some fractures are approximately one week to ten days old. The original fracture of the left fourth rib was several weeks old. It is concluded that there have been at least three separate episodes of trauma to the chest, probably caused by shaking. There is also a tear in the frenulum of the upper lip, which is recent. Examination shows no evidence of natural disease, and confirms that the baby had been developing normally. Bilateral subdural haemorrhages and retinal haemorrhages strongly suggest a shaking type of injury to the unsupported head of the baby. The conclusion is that: *“The person shaking the baby has grabbed the baby tightly by the chest, squeezed the chest to the extent of producing several fractures of the chest wall.”* The rib fractures could not have occurred accidentally, and could not have been produced by resuscitation at the time of death. They are not birth injuries. It is suggested that the recent rupture of the upper lip’s frenulum might have occurred if a bottle or dummy teat had been pushed forcibly into the baby’s mouth.

Both Shirley and Alec confirm that Caleb had been left alone with Alec for a short time, while Shirley took a taxi to the chemist to collect her Methadone in the middle of the morning of 18 October. Both report that the baby was well when she left the house. When Shirley returned from the chemist, she found Caleb apparently lifeless, and summoned an ambulance. Shirley told the telephone operator that the baby was blue, and that he was not breathing.

18 October Blood taken from Alec Ness on 18 October tests positive for Diazepam and Desmethyldiazepam.

19 October Alec Ness is arrested, and subsequently charged:

*“(1) On various occasions between 22 August 2001 and 18 October 2001, both dates inclusive, at (address given) you did assault Caleb Alexander Ness, your son, born 30 July 2001 and repeatedly compress his body all to his severe injury; and*

*(2) On 18 October 2001, at (address given) you did assault Caleb Alexander Ness, your son, born 30 July 2001, and did force the teat of a bottle or a dummy teat into his mouth, seize hold of his body, compress same and repeatedly shake him all to his severe injury and you did murder him.”*

24 October SW2 records that SW4 *“Will arrange independent counselling which is paid by Department likely to be three sessions. (SW4) has arranged to take some days off. SW4 and SW2 to meet with Shirley to go over SW4’s role and need to begin separation from her – she appears fairly dependent on SW4 at present.”*

## **2003**

20 January The trial eventually commences, after several postponements. Alec Ness incriminates Shirley Malcolm, and initially pleads not guilty to both charges. Evidence at the trial reveals that DNA tests for the Crown suggest that it is highly unlikely that Alec Ness was Caleb’s father. After the trial has run for several days, there is a change of Counsel representing Ness. A solicitor advocate is instructed to defend him.

5 February Alexander Ness’ plea of guilty to culpable homicide on the grounds of diminished responsibility caused by a brain injury is accepted. His not guilty plea to the first charge is accepted by the Crown. Sentence is deferred for the preparation of psychiatric, neurological and social inquiry reports.

11 February Man1, Head of Operations in Edinburgh Social Work Department, makes a brief report to the City of Edinburgh Council, which includes the following statement: *“It is also normal practice for the notes of a case*

*conference to be sent out to all attendees, affording an opportunity to verify what was recorded.”*

- 17 February Man1 makes a further statement, correcting this. He says: *“It is now apparent that the Minutes were not distributed in this case. This information was made known to me personally on Wednesday, 12 February after I had reported to the Executive. Rather than making any further comment on this serious omission, I suggest that this too should be a matter for the review into the circumstances of this case.”* (see Appendix A, (e))
- 20 February The City of Edinburgh Council passes a resolution to instruct the Lothian Child Protection Committee to organise an independent inquiry into the circumstances surrounding Caleb’s death.
- 12 March The trial judge, Lady Cosgrove, sentences Alec Ness to eleven years imprisonment.
- 20 May First day hearing witnesses for the present Inquiry.
- 30 May When the Inquiry team interviews Alec Ness in prison, he informs them that he has lodged an appeal, claiming that he pled guilty to culpable homicide as a result of defective professional representation. He has also lodged an appeal against the length of his sentence.
- 4 July Last day interviewing witnesses for the present Inquiry.

### **3 THE CHILD PROTECTION CASE CONFERENCE**

#### **3.1 Preparation for the Conference**

3.1.1 In accordance with usual practice, SW4 decided who should be invited to the Case Conference. SW2, as his senior, should have reviewed this preparation, and probably did so, although she could not clearly remember what had happened. In accordance with usual practice, SW4 issued written invitations to the people detailed below. They were posted on 3 August. One of the invitations was corrected in draft, as it was originally addressed to PC4, a Police Juvenile Liaison Officer who was well known to the Social Work team. Before the invitation was sent out, it was changed so that it was addressed to PC2, a Senior Officer, as the police had requested that all such invitations be addressed to PC2. The police produced the actual invitation to the Inquiry Team, and it is important to note that it made no reference whatsoever to Alexander Ness, or to the name “Ness”. The invitations to all the participants followed a standard pro forma, and we reproduce a copy in the Appendix. One of the people invited was SW7, the Criminal Justice Social Worker attached to Alec Ness. He told SW4 that he would be unable to attend, as he was going to be on holiday until 13 August. A written report was not requested (see also SW7).

#### **3.2 Report for the Conference**

3.2.1 In accordance with usual practice, SW4 prepared a written report for the Child Protection Case Conference. In order to protect the anonymity of the older siblings we are unable to reproduce the report prepared for the case conference, and we therefore confine ourselves to making the following observations:

- The report records the previous involvement of Leith Social Work Department in arranging contact visits with older children, and the later referral caused by confusion with another person who was about to be evicted.
- The history of Shirley’s existing two children is narrated over three full pages, in a fair attempt to summarise the bare bones of the information which had come from the (distant) Social Work Department. It continues: “*Ms Malcolm’s most recent contact with Criminal Justice Services relates to a Community Service Order which resulted from a shoplifting offence in 1998 and this Order was completed in January 2001. During this period, Ms Malcolm moved to her present address and met her present partner, Mr Alec Ness.*”

- The report, which extends to 6 pages, goes on to deal with the background of Mr Alec Ness in eight lines: *“Mr Alec Ness is currently involved with a criminal justice worker from the Murrayburn Gate social work centre, who was invited to today’s case conference. However, at the time of writing, I have now been informed that SW7 is currently on annual leave and will not return until 13 August 2001. I have little knowledge of Mr Ness’ background, other than he has a history of offences related (to) the misuse of drugs. More recently, Mr Ness suffered a severe head injury which has had a considerable impact on him and Ms Malcolm has been heavily involved in caring for him, and ensuring that he takes his medication on a regular basis.”*
- The report confirms that SW4 had visited the couple in June, and carries on: *“It was noted that the house was in particularly good condition, comfortable and well maintained. Ms Malcolm and Mr Ness informed me that at this time they were pursuing a tenancy through the City of Edinburgh Housing Department. During this visit, Ms Malcolm openly acknowledged her previous difficulties with drugs and stated that she had been in contact with the CDPS for over a year and was currently on a prescription of Methadone and Valium. I also contacted the CDPS in June of this year, who confirm their involvement with Ms Malcolm over the past 18 months. I was informed that she had been reliable in making appointments and there had been no unexpected substances in recent urine samples. The CDPS also agreed that at that time, Ms Malcolm’s circumstances were settled.”*
- The report went on to disclose the fact that Community midwives had been trying to trace Ms Malcolm, but had been told that she had moved house, before she gave birth. In the paragraph entitled “Conclusion” the report continues:- *“During my contact with Ms Malcolm and Mr Ness, both in the community and in the hospital after the birth of Kalib, they presented as motivated to settle down, and parent their new baby. Ms Malcolm’s background clearly indicates that there have been severe difficulties in the past in terms of parenting and maintaining a consistent approach to childcare. Ms Malcolm has pointed out to me that this was quite some time in her past. I have no evidence to suggest that Ms Malcolm should not assume the care of Kalib, when he is ready to leave the hospital. However my view would be that Ms Malcolm’s motivation and ability to parent in the community needs to be closely monitored and that during this period, Kalib’s name be placed on the Child Protection Register for the time being.”*

### 3.2.2 We have the following observations to make about this report:

1. It plainly conveyed the impression that in the future Shirley and Alec Ness would live together as a couple, and jointly look after Caleb.
2. It provided virtually no information about the extent of Alec Ness’s head injury; however, it does alert the reader to the suggestion that Mr Ness required care himself.
3. Shirley’s long history of prostitution is not mentioned, and the full extent of her history of criminal offences is not disclosed. There is no discussion of the couple’s income.
4. Shirley’s drug use is disclosed, but there is no analysis or evaluation of the current situation and its implications in the context of her previous history.

5. It fails to identify the risk factors in relation to Caleb's care, and conveys the message that the writer has reached the view that the baby should be discharged to the mother's care. It fails to ask the key question- what evidence of change in Shirley's behaviour or lifestyle is there, which suggests she will be a safe parent?

3.2.3 It is worth noting that the report is dated 8 August, and no doubt allowances should be made for a delay between dictation and typing. Although there is no record to vouch this, we are clear that SW4 and SW7 spoke about this case by telephone before the end of July, as SW7 explained that he would not be able to attend the Case Conference because he would be away on holiday, and he placed the conversation before Caleb's birth.

### **3.3 The Case Conference itself : Preliminary**

3.3.1 We have had real difficulty in establishing exactly what happened at the Case Conference. At first sight, this may seem surprising, as Minutes were drawn up, and the "Summary of Discussion" extends to two closely typed pages. Much of that summary reads as though it has been noted verbatim. However, numerous inaccuracies on the first page, which merely records who was present, who was absent etc, alerted us to the unreliability of the Minutes, and then we discovered that some witnesses claimed that a key decision was made, which was not recorded. The alleged decision was that Alec would not be left alone in charge of the baby. We therefore have to examine the evidence in some detail.

### **3.4 The Minutes**

3.4.1 Firstly, we should note that the Minutes were drafted by SW10, who had just qualified weeks before the date of the Conference. She had once attended a Child Protection Conference to observe it, and had never before taken Minutes in this format. She was given some verbal guidance beforehand by the Chairperson, SW3, and she told us that the draft Minutes were checked by SW4. They were not checked by the Chair, SW3, despite the terms of the Guidelines. Strangely enough, there is no place in the sample form for the Chairperson to sign the Minutes for authentication purposes, and we therefore **RECOMMEND that the CPCC minute format is changed, so that the Chairperson has an opportunity and obligation to sign the Minutes.** SW10 told us

that she thinks that she dictated the Minutes within days of the Case Conference, but she could not remember this clearly, and we remain unsure about when the Minutes were typed up. One witness suggested that they were only typed after Caleb had died. However, we thought that SW10 was a truthful witness, hampered by a poor memory, and she assured the Inquiry that she handed the final version of the Minutes over to SW4 before she left the Leith office several weeks before Caleb died. The date given on the face of the Minutes, 4 September 2001, is therefore probably correct.

3.4.2 On the first page, the Minutes give the wrong date for the Case Conference, saying that it was 11 August 2001, whereas in fact it was 9 August 2001. The subject child is given as “Kalib Malcolm”, SW10 having taken the spelling of ‘Kalib’ from SW4, and having heard Shirley Malcolm say that the child would be known as Malcolm. The Minutes correctly record the following witnesses as being present:

Dr1  
Nurse2  
HV  
Nurse1  
SW4  
Shirley Malcolm  
Alec Ness

3.4.3 They correctly record that the Chair was SW3. In the section entitled “Absent/Unable to attend”, the Minutes say that a named Consultant Neonatologist was unable to attend, we will call him “Neo.2”, but the narrative mentions Neo2 arriving late, and giving the Conference some information. This was an error. In fact, Neo1, another Consultant Neonatologist, did attend late, having been detained in a clinic. Neo1’s name is accordingly never mentioned. A Consultant Obstetrician is correctly recorded as unable to attend, and the Juvenile Liaison Officer from Leith Police Station, whose name had been deleted from the invitation before it was posted to the Police Station, is named and listed as absent. That individual, the JLO, had no involvement in Caleb’s case. The fact that SW7 had been invited, but was unable to attend, is not recorded.

3.4.4 The Summary of Discussion is detailed, and reads fluently. We heard evidence from all the people who participated in this Case Conference, including Neo1, with the exception of Shirley Malcolm. All agreed that what they were recorded as having said was roughly what they said, although Nurse 1 thought that what she had said about

Alec Ness handling the baby had been recorded as a less serious concern than she was in fact attempting to communicate. Many quite small details were confirmed as accurate. Accordingly, we have to conclude that the Summary of Discussion is reasonably accurate, despite the mistakes on the first page.

### **3.5 Discussion immediately prior to the Case Conference**

3.5.1 SW3 told us that she was given a little background information on the day of the Case Conference by SW4. Like everyone else, she appears to have received SW4's report dated 8 August on the morning of the Case Conference itself, 9 August.

3.5.2 SW10 also remembered some kind of discussion taking place prior to the Case Conference, to which she was not a party. She thought that the people involved were SW4 and Shirley. SW4 did not mention this in his evidence to us. The importance of this discussion is that it is the only time when an understanding could have been reached that Shirley would be caring for Caleb, and that Alec Ness would never be left alone with the child. In the absence of any information from SW4 that this happened, we reject this suggestion as untrue.

3.5.3 When the Case Conference was commenced, in accordance with the guidelines it started with Shirley and Alec being excluded from the room. The professionals present were asked if they had any restricted information to make available i.e. information they wanted to communicate, which could not be discussed in front of Shirley and Alec. The answer was 'no', and this was appropriately recorded in the Minutes.

### **3.6 What was decided in fact**

3.6.1 The difficulty for us was to ascertain exactly what was decided at the Case Conference. The narrative does not read as an assessment of risk to Caleb, although many factors which might give rise to risk are discussed. They are never pulled together and focussed. The Minute nowhere states that the meeting decided that Caleb should go home, as a matter of principle, although that is implied throughout, as though the decision had been made somewhere else at another time.



3.6.2 It is plainly unsatisfactory that people attending such a CPCC should be left with the impression that a key decision (whether to send the baby home, or not) has already been taken somewhere else. While the first purpose of the CPCC was to assess the risks Caleb was going to face in life, the decision that it was safe or unsafe to let him go home must flow from that risk assessment. We accordingly **RECOMMEND that an explicit discussion and decision as to whether or not the child should be discharged to the care of the parent should always be part of a CPCC for a newborn baby**, including full discussion about who will be in the household.

3.6.3 We very much regret the fact that we cannot publish the Minutes in full, partly because they repeatedly name the witnesses to whom we promised anonymity, and partly because they go into detail about Shirley's older children. However, we do highlight the following points:

- a. Several passages in the Minutes appear to assume that Alec and Shirley would be living together, or at least working together to care for Caleb. For example:-

*SW4 "spoke to his report. He stated that he was conscious that it was all historical information regarding Shirley's other children. He stated that (her first child) had been in to see Caleb and that there had been fairly positive feedback from the previous worker (SW8) and probation officer (SW7). They had considered Shirley and Alec to be presenting as motivated to care for Caleb. He stated that this was a new start, but there was a process that needed to be gone through. He stated that although they were not entirely clear of past problems they needed to look to the future to look at risks and support. SW4 stated that Alec is now needing some care himself and that there would be lots of stress around when Shirley was back at home. It was therefore important to look at what support they would need and what risks were there."*

3.6.4 As already discussed, his report dated 8 August had presented Shirley and Alec as a couple, living together. Regarding Shirley's statement that in the future she would like to get off drugs entirely, "*Alec stated that he would give her all the support he could and that he hated drugs.*" Another extract: "*SW3 said to Shirley that she*

*sounded like she had a lot on her plate. SW4 stated he was confident about Shirley's motivation, but that he thought there needed to be a period of monitoring and therefore a period of registration to allow him to get to know Shirley and Alec better and to see how they are coping. Then they could come back for a review."*

3.6.5 The Minutes do not explicitly state that Ness was living outside the home, although this had been the case since 17 July. The only inference from the Minutes themselves, read cold, is that Alec Ness would be living with Shirley and that he would be involved in the baby's care.

3.6.6 Taken together, the Minutes and the Report suggest that Alec would be involved in Caleb's care in the future. However, in the evidence we heard from the witnesses who were actually present, it is clear that most understood that Alec was not physically living in Shirley's flat on 9 August. They were all clear nonetheless that he would be involved with Caleb on a day to day basis for the foreseeable future. Some, such as the Consultant Psychiatrist Dr1, could see that Shirley wished to distance herself from Alec Ness, and anticipated that Ness would become more peripheral as time went on. Almost all the witnesses commented on the irritation which Shirley displayed every time Alec Ness interrupted inappropriately. It is therefore perfectly reasonable to say that there was an understanding at the Child Protection Case Conference that Shirley would be the main carer of Caleb, and that Ness would not be involved round the clock. However there is a difference between understanding that as relevant factual background, and saying that the Case Conference took a decision to discharge Caleb to his mother's care at home, on the basis of an undertaking that she would be the sole carer of Caleb. We are absolutely crystal clear in concluding that no such decision was reached by the Child Protection Case Conference.

3.6.7 The only note of caution was sounded by Nurse1, a neonatal sister at Simpson's. She stated that: *"Feeding has been Caleb's only problem, but that he is keeping his food down now. Nurse1 confirmed that Shirley had been actively involved in feeding Caleb and SW4 stated that regarding present circumstances, he had been in their house and it was well prepared for Caleb coming home."* Later, it is recorded that Nurse1 stated: *"... that Shirley handles the baby well, but that Alec needs practice. She repeated that there were some concerns there, though Shirley keeps him right at the moment."*

Nurse 1 also is reported as having said: “*She said that she could only assess Shirley in the hospital and that she does care for the baby. She stated that her concern was if Alec was on his own with Caleb. Nurse 1 asked SW3 that when Caleb is ready to go home, i.e. when feeding properly, was it appropriate for them to arrange a normal discharge*”. SW3 replied: “*Yes. And we’re making sure it is supported.*” We see this passage as confirming Nurse 1’s evidence to us that she had been reluctant to see Caleb going home, in circumstances where Alec was left in charge of Caleb. We believe that what happened is that several of the listeners genuinely misinterpreted what Nurse 1 was saying, as it is a fairly common problem that a father may not hold a baby confidently, or support its head. We believe that Nurse 1 may have been too tentative in the way that she phrased her concerns, and she accepted in evidence to us that she did not stick to her guns and insist on further discussion of her view that Caleb should not be permitted to go home at all. She told us that at the time she was relatively new to Case Conferences, and had received no training about them. This has been partially remedied since Caleb’s death, she told us, as she has now received some training on what to expect from a CPCC.

3.6.8 Because Nurse 1 was not assertive, the Conference did not appreciate that in fact she had observed the clumsiness and forgetfulness induced by his brain injury in Alec Ness. She did not appreciate at that time that she should ask for her dissent to be recorded. Now she would feel confident that she could challenge decisions and know that she should ask for her dissent to be recorded. (There is a box in the pro forma Minutes which encourages dissent to be recorded.)

3.6.9 The one thing that the Minutes and all the witnesses were clear about, was the fact that the Chair asked whether anybody dissented from the decision to place his name on the Child Protection Register. No-one indicated any dissent and Caleb’s name was placed on the Child Protection Register. We could not ascertain that the Chair, SW3, had summarised the potential risk factors for Caleb, or agreed the category of registration. On the form, which demands an answer to the question “*Area of abuse*” SW10 filled in: “*Physical neglect*”, and gave the “*Level of certainty*” as “*Possible*”. (See further 7.4).

- 3.6.10 The Conference did decide that the case should be reviewed in three months, dating from the date of Caleb's discharge from hospital. It was decided that SW4 would organise the date of the meeting, which was not fixed on 9 August. Three months was earlier than the standard review period of six months.
- 3.6.11 The Minutes correctly record that the Case Co-ordinator (previously referred to as Key Worker) would be SW4, and that the other "Core workers/agencies involved" was HV. It is important to note that SW7 was not named there.
- 3.6.12 The Minutes also fail to record any detailed child protection plan, apart from mentioning that SW4 stated: "*That his contact will be at a fairly high level.*" All the witnesses agreed that no details were discussed at the Conference. We comment on this at 3.7.1.
- 3.6.13 The witnesses also agreed that there was no discussion about the absence of information which ought to have been made available, before the Case Conference could reach a decision. The most glaring omission is the absence of information about Alec Ness' head injury. Every witness commented on Alec Ness' inappropriate behaviour at the Case Conference, and at Shirley's obvious irritation at his interruptions. SW4's report had made the brief reference to brain injury already quoted, yet there was no-one at the Case Conference who knew anything about Alec Ness. They knew that he had convictions, but no details were available. Everyone knew that he was fiercely proud of the baby, deeply interested in his welfare, and that he would be visiting frequently, as in fact happened.
- 3.6.14 Unfortunately the Chair, SW3, did not pause, and attempt to find out more. SW3 had never chaired a Child Protection Case Conference before. She had no specific training on how to chair Case Conferences, although she had attended many. We are clear that she should have identified this massive gap in the information available about the circumstances in which Caleb was going to be brought up, whether or not she thought that Alec Ness would be directly involved in his hands-on care. Had she identified that information gap she could have considered reconvening the case discussion to allow this information to be gathered.

3.6.15 There were other gaps. SW4's report said enough about Shirley's two older children to alert the Chair to the fact that more information would be appropriate. We accept that neither she nor the people attending the Case Conference knew the details of Shirley's neglect of her two older children, most of which we cannot disclose in this report. But SW3 could and should have reconvened the Case Conference in order to obtain either the attendance of a Social Worker from the (distant) local authority, or an up-to-date report. Less obviously, but nonetheless thought provoking, is the absence of information provided to the Case Conference about Shirley's offending behaviour in the past. She has an extremely lengthy schedule of previous convictions, and by 2001 she had been a prostitute for about 15 years. That information should have been available, as it had a bearing on the risk that she might neglect Caleb. We discuss the absence of evidence from the police at 4.5. It is a significant fact that no one at the CPCC knew Shirley or Alec Ness well. Caleb was suffering from neonatal abstinence syndrome on 9 August: the CPCC did not discuss its implications for his care at home.

3.6.16 Shirley's drug use was obviously a central concern for the Case Conference. The Minutes record that Dr.1 told the Case Conference that Shirley had used drugs intravenously from about 16 years of age, and he made reference to her traumatic childhood background. He said that Shirley took drugs as a way of coping. He told the Conference that Shirley had *"problems with engaging in treatments in the past, but that since this pregnancy, her engagement has been better and tests prove that she is sticking to her prescription drugs. He stated that this was a material change but that monitoring would need to be continued. He stated that he would be her support worker from now on."* We asked Dr1 about this, and although he could not remember clearly what he had said, he accepted that the Minutes were substantially accurate. In fact, if one examines the detail of Shirley's drug treatment in the recent past, the picture was not as positive. What Shirley was telling the Case Conference is that her lifestyle had changed. When asked if she was well connected with people who took drugs, Shirley replied that most of them were dead. *"She said that she has very few friends now and that most of them are straight."* She admitted that she was offered drugs a lot in Leith, but said that she had not taken heroin since the 1980s. While she thought that it was more realistic for her to be on a script at the moment, Shirley said that in the future she would like to get off drugs entirely. Dr1 stated *"that it was unrealistic for her to be drug-free within the next two years, considering her history of*

use.” The actual picture of Shirley, of repeated attempts to come off drugs, and repeated relapses, was obscured. We believe that the minute taker and other listeners did not fully understand what Dr1 was telling them, as they did not have enough background knowledge about chronic addiction.

3.6.17 All the witnesses agreed, and the Minutes correctly record, the fact that the Case Conference decided not to refer Caleb’s name to the Reporter to the Children’s Hearing. So far as we can make out, there was very little discussion of this, and no real reasons are recorded. In the box marked “Reasons”, it is simply recorded: “*Unanimously agreed that referral not necessary at present.*” but the minutes fail to record any discussion of this issue. Some muddled reasons emerged in the evidence of some witness (see Summaries) but we would like to record our astonishment that this decision was made. With a history of two children taken into long term care, it was entirely appropriate to involve the Reporter.

### **3.7 The Child Protection Plan**

3.7.1 In terms of the Guidelines, a Child Protection Plan “*must be agreed*” at the Case Conference. The Minutes do not outline a Child Protection Plan for Caleb. In fact, no Child Protection Plan was discussed at the Case Conference, beyond vague indications that there would be a high level of monitoring once Caleb went home. The HV understood that she was to make an initial assessment, liaise with other services, and carry out an ongoing assessment of the baby’s growth and development. No plan was made for her to meet SW4, for example for review meetings, and nothing was said about exactly how often she should visit. SW4 understood that his task would be “*some real assessment of the circumstances and their ability to parent the child*”, and that he should liaise with other professionals. Speaking of the time between Caleb’s discharge from hospital on 22 August, and his death on 18 October, SW4 said that he should have made five visits to see Shirley, but that “*one appointment was missed.*” The timescale is eight weeks. The Chair, SW3, told us that SW4 should have visited weekly, and it was planned that HV would keep in “*close contact*” with Shirley, after discharge. None of the other witnesses remembered a plan for weekly visits by SW4, and we do not accept SW3’s evidence on this point.

### **3.8 Review and re-evaluation of risk**

3.8.1 There was a vague plan to re-evaluate risk before the review date some time in November, although in fact no initial assessment of risk had been undertaken. No review date was actually set. No meetings were arranged between the two case workers, SW4 and HV, to discuss progress, nor to re-evaluate risk. As can be seen from the Chronology, there were occasions on 4 September, 20 September and 16 October when SW4 and HV together visited Shirley, each time by arrangement. There is no evidence of a re-evaluation of risk for Caleb, whether formal or informal, by SW4 and HV working together as a team. There does not even seem to have been a discussion when Shirley was not present, when information was shared and the case reconsidered.

### **3.9 Supervision of the case Co-ordinator**

3.9.1 Although we accept that Caleb was mentioned during supervision sessions between SW4 and SW2, on 30 August, 11 and 26 September, and 10 October, it is absolutely plain to us that these discussions were routine and superficial. The notes recording these sessions, which we asked to see, were scanty and inexact. SW2 did not ask the questions which might have jolted SW4 out of his complacent expectation that Shirley would cope.

### **3.10 Co-ordination of child protection**

3.10.1 SW4 was perfectly clear in his evidence to us that Alec Ness' Criminal Justice Social Worker, SW7, had a role in assessing risk for Caleb. SW4 also saw it as part of his own role to contact SW7, and to keep on top of what was happening with Ness. There were some telephone contacts between SW4 and SW7, both before the birth and after the birth, although they never once met. Significantly, however, SW7 did not appreciate that he figured in any Child Protection Plan. In Social Work terms, he understood that SW4 was the case co-ordinator, but did not in any sense see himself as having a role in the protection of Caleb.

- 3.10.2 Bearing in mind the fact that the Minutes of the CPCC were never circulated while Caleb was alive, only the persons attending the Case Conference (and their Line Managers, where appropriate) could have known anything of the risks to Caleb's safety. Dr1 appreciated that he could and should pass on any concerns to SW4, but did not in fact do so. For example, he did not report her failure to attend appointments, nor the increased prescription on 4 October. Moreover when he recommended that she should consider admission to a mother and baby facility, he did not discuss this with the case co-ordinator. We discuss this further at 9.1.16 and 9.1.17.
- 3.10.3 Nurse1 and the Midwife (in Simpson's) knew that they could and should pass concerns on to SW4, although plainly their involvement ceased on 22 August. In fact, information did come to light between 9 August and 22 August, which should have been communicated to SW4. On several occasions Shirley appeared to be under the influence of drugs, to a degree likely to impair her ability to care for Caleb, when visiting the baby in hospital. Nurse 1 told us that she did pass this information on to a Liaison Health Visitor within the hospital, but there is no record of this. We think it unlikely that this information was fed back either to SW4 or to the HV.
- 3.10.4 HV told us that she received information about Caleb's discharge on 23 August and believed that this was a couple of days after the event. The Liaison Health Visitor at Simpsons told her that the mother and baby had been discharged on 20 August, and the HV was surprised as she had telephoned the nursery on 20 August and been told that Shirley was to "room in" at the hospital, before discharge. ("Rooming in" is an arrangement where the mother stays overnight with the baby in a private room, and is quietly observed in her handling of the baby.) In fact, the discharge did take place on 23 August, after Shirley had roomed in at the hospital. The "Health Visitor Liaison Summary" prepared by the hospital on 1 August, and sent to the HV, recorded the baby as a girl (sic), but did at least give a clear summary of the baby's initial problems with particular neonatal abstinence syndrome symptoms. We discuss this further at 9.1.6 and 9.1.7, and 6.8.34.
- 3.10.5 As can be seen from the Chronology, the HV was the one person who made a serious effort to pass on information relevant to risk to Caleb, and to alert other professionals



to her concerns. See in particular the entries for 14 September, 28 September, 2 and 3 October. In short, she appropriately communicated her worries to SW4, more than once.

In her “Child in Need” record HV summarised the “relevant issues” as follows:-

1. Maternal health in relation to drug issues.
2. Past history of parenting skills with two children in long-term care.
3. Partner recent head injury dependent on Shirley for initiation to take medication.
4. Relationship difficulties.
5. Post-natal depression EPDS score 27, 2/10/01.
6. Shirley difficulty keeping appointments CDPS.

In all the paperwork relating to Caleb, this is the only written attempt to identify issues which might be relevant to Caleb’s development and safety anywhere, apart from SW4’s Report of 8 August.

### **3.11 Conclusion**

3.11.1 Having reviewed the whole evidence, we have reached the view that the risks to Caleb at the point of discharge from hospital were far greater than those identified at the CPCC. Individual agencies had information which would have greatly informed the assessment of risk, and this would have been readily available on request. If this information had been gathered up effectively, we believe that the case conference would have decided that Caleb was at risk of significant harm through physical neglect by Shirley, and also at risk of physical injury and neglect by Alec, in consequence of his brain injury. The level of certainty was probable rather than possible or certain. The consequence of a properly informed assessment of risk might have been either (a) a decision not to discharge Caleb home, or (b) a decision to discharge him into his mother’s care, but only subject to a high degree of support and monitoring, by which we mean daily contact by various support agencies, co-ordinated by SW4. Referral to the Reporter should have followed, on any view.

## **4 COMMENTS ON SOME THEMES**

### **4.1 The Community Drug Problem Service (CDPS) and Drug Addiction Generally**

4.1.1 The CDPS came into existence in 1986, and treats approximately 1,000 patients a year, who are referred to the service by general practitioners in Edinburgh and the Lothians. It deals with the most demanding cases requiring “substitute prescribing” in the area, e.g. prescribing Methadone instead of heroin to heroin addicts, and the like. In 2003, it was treating approximately 4,000 people in a shared care model with general practice. Once a stable pattern of prescribing is established, the patient will often revert to the general practitioner for repeat prescriptions. Other patients receive their prescriptions direct from the CDPS, and the G.P. is simply informed by letter about what is happening. The CDPS is run by Lothian Primary Care NHS Trust, and is based at 22/24 Spittal Street, Edinburgh. It currently employs about 25 clinical staff, along with administrative back-up.

4.1.2 Most of the referrals to the CDPS are for opiate drug dependence, but sometimes the referrals relate to Benzodiazapine drug dependence, cocaine, or (rarely) cannabis. At first patients go through an assessment process, mostly with nursing staff, and the majority require stabilisation on a substitute prescription. While the patient is chaotically using drugs, he will usually present with multiple psychological problems, but after stabilisation the underlying psychological issue can be identified and addressed. Psychiatric care is then offered by the CDPS, sometimes by psychiatrists, and sometimes by nurses with specialist training in mental health.

4.1.3 In order to prevent the addict from taking too much at once, arrangements are routinely made for the patient to pick up the prescribed drug from a particular designated chemist daily, or perhaps three times a week. The danger is that the patient will take three days’ supply all at once on the first day, with the consequence that he will revert to seeking drugs on the street on days 2 and 3. The prescribed drug or drugs (often more than one is prescribed) is referred to as the “script”, and the aim in

theory is to reduce the amount of each prescribed drug gradually, until dependency is ended.

- 4.1.4 A further danger arises from prescribing drugs 3 or 4 days at a time, namely that the addict will sell his prescribed drug, often in order to finance the purchase of his preferred illegal drug on the street. Methadone is therefore available on the black market.
- 4.1.5 The CDPS takes urine samples from its patients from time to time, but they are seen as having limited use. Drugs such as Methadone and Benzodiazapine will stay in the body for approximately a week, and cannabis can be traced in the urine for approximately a month after use. It is commonplace for addicts to top up the prescribed drugs, such as Methadone, with drugs which they buy on the streets. If a Methadone user tops up with heroin or Dihydrocodeine, the top-up drugs will show up in the urine samples. However, if a person is receiving Methadone on prescription, and goes on to top up with extra Methadone, the urine sample will not reveal the fact that the patient is topping up the prescribed Methadone with more bought on the black market. Similarly, some patients are prescribed heroin, and if they use street heroin on top of the prescription, urine tests cannot identify this.
- 4.1.6 The class of drugs known as Benzodiazapines, which includes Valium, Diazepam, Temazepam, and Nitrazepam, all test positive in the urine without any specific indication of which drug has been used.
- 4.1.7 Women who become pregnant are often motivated by the fact of the pregnancy to reduce their drug use, and many chaotic drug users can stabilise for a while during pregnancy, hoping to protect the baby. However, reduction of the dose can only be done gradually, without incurring risk to both mother and baby. A stable drug habit is more likely to achieve wellbeing in the mother and good parenting, than rapid attempted withdrawal.
- 4.1.8 A pattern of withdrawing from the addictive drugs, followed by relapse, is common. It is very rare for people who have to withdraw from heroin in prison to stay off the

drug when they are released. Opiate drug abuse is a condition of relapse and recovery, and the aim is step by step recovery, with a gradual progression towards health.

4.1.9 Methadone itself causes sweating, so that if a regular user of Methadone takes more than usual, he will appear to sweat. Paradoxically, people on Methadone also sweat if they have not had enough of their regular dosage of the drug. Increased drowsiness is often a sign that a Methadone user is topping up with illegal drugs.

4.1.10 Drug users who take Diazepam generally believe that it calms them down, and makes them easier to live with. In fact, in high doses and over the long term, it has the opposite effect, and makes the user more difficult and moody. Dr. 2 told us that she spent a great deal of time trying to persuade drug users that Diazepam was not doing them any good, but they frequently did not believe it.

4.1.11 The majority of addicts inject into their arms, but some use the back of their hands, or their forearm. Once the veins are particularly badly damaged, addicts often move on to inject into their groin, the muscles of the bottom, or sometimes the neck. It is commonplace for addicts to get together in someone's house, in order to "shoot up" and "get stoned" in company. It is well known that a child in that house will tend to be neglected. There is a further potential risk to a child, as many drug abusers have a history of sexual or physical abuse. Some victims of abuse become perpetrators of physical or sexual abuse, giving rise to a higher than average risk that a drug addict may abuse a child. Often the people invited in to a home to join the group are unknown to the host.

## **4.2 Neonatal abstinence syndrome**

4.2.1 Babies are born with neonatal abstinence syndrome because they have become accustomed to the drugs which their mothers were using during pregnancy. Characteristically, they have a "very piercing, very irritating" cry, and they cry a lot and demand a very high level of attention. The experienced Consultant Paediatrician whom we interviewed (Ne01) told us that she could walk onto a ward, and identify such a baby immediately, by his crying. The babies are irritable, jittery some of the time, and "sometimes shaky" when they are disturbed. Feeding difficulties are very

common. Although they want to feed all the time, when they are actually offered food, they are often uncoordinated in their approach to feeding. They may vomit, or may start to suck well, but fail to take very much at each feed. They will often not last very long between feeds, before they start crying again, the first feed having failed to satisfy them. They often develop intestinal hurry, and sore bottoms in consequence - despite every effort, they often develop very severe nappy rash, which causes pain in its own right.

- 4.2.2 Not all of these babies require drug treatment. The drugs used will replicate the effect of the drugs which the mother had been using during pregnancy. The opiates metabolise very quickly, and the babies tend to develop symptoms in the first few days after birth. The baby might then be given morphine orally, on a gradually reducing dose over 7 to 10 days. Where the mother has used Benzodiazepines, such as Diazepam or Temazepam, only, the symptoms may not be apparent for the first 5 to 7 days, and the baby's withdrawal will then take place during the second week after birth. A similar approach is taken with reducing doses of Benzodiazepines, but the process takes longer. The criteria for leaving hospital are that the babies are able to gain weight on oral feeds, off medication, and settle sufficiently that an ordinary mother can look after them.
- 4.2.3 In hospital, these babies are so difficult to look after that a single trained nurse giving one-to-one care to such a baby requires relief, and cannot cope on her own for a whole shift. Hospitals try to minimise light, minimise noise, and reduce all sources of irritation for the baby. Often a baby is carried around all the time, in the nurse's arms. Sometimes a baby is comforted by being swaddled.
- 4.2.4 When these babies leave hospital, they are not the same as ordinary babies. Experienced foster mothers, who are accustomed to caring for small babies, regularly report that these babies are particularly difficult to care for. The babies don't sleep. They do not settle. They tend to scream a lot. This irritability can go on for months, although the baby is gaining weight and developing more or less normally. They often present at clinics as being irritable many weeks after birth.

- 4.2.5 The extent of babies' withdrawal symptoms is not directly related to the intake of drugs by the mother. Some mothers, who are using drugs heavily, have babies with minimal symptoms, and others, who have used drugs much less during pregnancy, have babies who are seriously affected. The baby's state in hospital does not always allow staff to predict accurately how he will be at home.
- 4.2.6 Caleb presented typically with hypoglycaemia (low blood sugar), and intermittent vomiting, within hours of birth. His feeding difficulties meant that he required nasogastric tube feeding, and he had a slightly small jaw which might have contributed to his feeding difficulties. He was not as badly affected as other babies, and was not treated with drugs such as morphine. Nurse 1 remembered him, and remembered that when he woke up he would cry immediately, but when fed he could be pacified, whereas others would scream so desperately that they have to be fed first, changed, and fed some more, in order to be pacified. This is still, however, quite unlike a normal baby, who will spend some time waking up, and then start to cry with quite a different level of need expressed in the crying.
- 4.2.7 Our Consultant Paediatrician witness, Neo1, gave evidence about mothers on the Post Natal Ward who were so drowsy that they could not manage to handle the baby. She described them as "just not with it, really stoned". She did not observe Shirley in this state. On the contrary, she thought that Shirley appeared to care for Caleb well, and she had no concerns about Shirley's ability to care for Caleb. Neo1 did not meet Alec Ness, but heard at the time of the concerns expressed by the nursing staff about his inappropriate behaviour, unlikely stories which he told etc.
- 4.2.8 Currently, the Neonatal Unit has very few contacts with these babies after they go home. If the baby does not turn up for a clinic booking, the Unit will contact the Health Visitor, and ask her to check on what is happening. These babies are usually seen 4 to 6 weeks after discharge, or earlier if the babies were premature or underweight. Thereafter, typically, the baby may only be seen once more, a month or two months later.
- 4.2.9 There is no Joint Protocol between the Social Work Department and the relevant Health Trusts which recognises and plans for the special needs of babies with neonatal

abstinence syndrome, although we understand that one is in the course of preparation. In case we have misunderstood this, we **RECOMMEND that a Joint Working Party prepares a Joint Protocol to inform the treatment and care of babies born with neonatal abstinence syndrome**, within an interagency framework. We were concerned to realise that these babies could return home without any Social Work involvement, although Neo1 made it clear that consideration would usually be given to referring such a baby to the Social Work Department, depending on the circumstances. (See 6.8.22 and 6.8.23; 9.1.4). We are concerned that these assessments necessarily involve observation of the mother in hospital, where she will be prescribed drugs such as Methadone, but may not have access to all the illegal drugs which she would use if she were at home. The snapshot of a mother caring appropriately for a baby in a Special Care Unit may not be a true guide to the reality which the baby will face at home. We therefore **RECOMMEND automatic referral to the Social Work Department of any baby born with neonatal abstinence syndrome, who has not been identified pre-birth**. This could be incorporated in the Joint Protocol just mentioned.

### **4.3 Lothian University Hospitals NHS Trust**

4.3.1 Originally, National Health Service Trusts were set up under the National Health Service and Community Care Act 1990 (c19), with the objective of assuming responsibility for the ownership and management of hospitals. There have been changes since then, including the formation of Primary Care Trusts (see 4.4.1). In 2003, Lothian had three Trusts: the Lothian University NHS Trust, which is an acute trust; the Lothian Primary Care Trust, and the West Lothian Trust. The three are grouped together as part of one regional National Health Services organisational unit for the Lothians, Lothian Health. The same structure was in place in 2001. The Lothian University Hospitals NHS Trust runs various hospitals in the area, including the Simpson's Maternity Pavilion, where Caleb was born. Simpson's relocated along with the Royal Infirmary to new buildings at Little France subsequently. The Astley Ainslie hospital, where Alec Ness went to recuperate, is part of the Lothian Primary Care Trust.

4.3.2 When we wrote to LUH NHS Trust, we asked them to identify a suitably senior person with responsibility for Child Protection, to come and speak to our Inquiry Team. They identified HosMan, a Consultant Paediatrician who is the Lead Clinician for Child Protection. After taking over that role in 1994, she further developed the Child Protection Service within the Trust, and runs a dedicated Child Protection Office which is available to assist anybody working for the Trust. The office ensures that 24 hours a day, 7 days a week, there is a Senior Paediatrician, either of Consultant status or a Senior Clinical Medical Officer, on call to give advice about issues arising when a child is perceived to be at risk. The Trust also operates a Child Protection Committee, which is chaired by the Director of Nursing. It meets approximately 4 times a year, but the nurses are better attenders at meetings than the doctors. A Lothian wide subcommittee is considering training issues, but HosMan expressed her frustration about the level of training available throughout the Trust, and the poor attendance at such training sessions as there are.

4.3.3 The Trust has formulated a policy relating to child protection, which can be seen on the web, but HosMan was the first to acknowledge that far more needed to be done. We quote: “I would like a much higher profile of Child Protection within my Trust. I know that the Chief Executive nominated me to come. I would dearly have loved him to come with me so that he can learn, and I think one of the recommendations has to be that it is not enough nominating or devolving responsibility. They have to at least have some idea of what’s going on. If he had come with me, he might have learned a fair amount, and it’s not enough just to have policies and procedures in place and on the web. There has to be a mechanism of ensuring that staff are reminded that they exist, and then amidst 500 other guidelines you need to make sure that Child Protection is important and has a high profile. I would like a recommendation about mandatory training in Child Protection for all levels, at all levels for all staff in the Health Service from level 1, which is awareness raising, to much more detailed level 3 or 4 specialist courses. They have to be properly resourced and funded.” We endorse that as a formal **RECOMMENDATION that the Trust organises and funds mandatory child protection training, as identified by their own specialist.**



4.3.4 The implications of what she is saying is that there is a lack of clarity within the Trust about management accountability for ensuring best practice in child protection matters. We refer to this further at 9.3.16 and 9.3.17.

#### **4.4 Lothian Primary Care Trusts**

4.4.1 The Health Act 1999 (c8) retained Health Boards in Scotland (cf Health Authorities in England), and established publicly funded Primary Care Trusts which unify community health, mental health services, and primary care within a single organisation. Usually, there is one Primary Care Trust in each Health Board area. Health Boards continue to exercise delegated functions from central government to ensure the provision of various services, but it is the Primary Care Trusts which have day to day operational responsibility for them. Lothian Primary Care Trust extends geographically from Dunbar in East Lothian through Edinburgh and stops at the boundary of West Lothian. It has 213 sites, from which many different kinds of services are delivered. The Trust employs approximately 8,000 people, half of whom are nurses, and it has substantial influence over people who are not employed by it. Examples are general practitioners, dentists, pharmacists, and ophthalmologists.

4.4.2 The Trust has employed a Child Protection Adviser since approximately 1994, whom we interviewed (PC Man 2). He is line managed by a General Manager, and also by the Nursing Director of the Trust. We did not interview the General Manager, “who does all the pay and rations”, but we did interview the Director of Nursing (PC Man1). The Trust delegated her to attend this Inquiry. She sets the career objectives, and appraises the achievements, of PC Man2, jointly with the General Manager. PC Man1 herself has no training in Child Protection. Some time before Caleb’s death, PC Man2 set up a special recording system, the “Cause for Concern Record”, for any child where there was a possible concern related to Child Protection. It is up to the individual Health Visitor to open the file, and to keep it up to date, and there are detailed requirements for the keeping of each file. PC Man2, assisted by a part-time worker, reviews all of the Cause for Concern Records every six months, and the Health Visitors are supervised every six months in relation to these cases. In Caleb’s case, the HV did open a Cause for Concern Record immediately, and kept it meticulously.

4.4.3 PC Man2 confirmed that if a Health Visitor reached the point where he or she was very concerned that a baby was at risk, the appropriate course of action was to contact the Social Worker concerned. The Health Visitor was also able to contact PC Man2 for advice, at any point.

4.4.4 The remit of this Trust extends far beyond the surgeries of general practitioners, and includes the CDPS and the Astley Ainslie. The Inquiry Team wrote to the Director of the Trust, seeking a high level, senior witness who has responsibility for Child Protection in the Trust generally. Initially, we were referred to PC Man 2, whom we had already interviewed, and who appeared to think that his own remit extended to Health Visitors and Nurses, and no further. The Trust settled on PC Man1, and we reproduce part of our interview with her here:-

#### **PC Man1**

Q: “Let’s imagine that a doctor in the CDPS had concerns that the mother’s drug use was going out of control or that she was much worse than she had been. What would you expect him or her to do about alerting somebody to those concern?”

A: I mean, the Health Visitors call Case Conferences if they’re worried about children, and have a multi-disciplinary debate about that.

Q: I’m moving on to the CDPS now.

A: Well, they would do the same thing and, I mean, they would alert the same people if they were worried about a Child Protection case. I mean, I think in relation to CDPS and trying to work out whether or not the CPNs and folk there have an awareness of who they should call in specific cases, it would be worth speaking to the Clinical Director there, if you haven’t done so already.”

Q: We haven’t spoken to her, but I am concerned about the communication arrangements within the Trust as a whole, and what the understanding is within the Trust about who should communicate with whom when there’s an urgent Child Care referral.

A: I suppose ... mhm hm.

Q: You see, we also have involved in this story with this baby the Astley Ainslie, because they were treating the father, who had suffered brain damage in an assault.

A: Mhm hm.

Q: They are part of your Trust aren’t they?

A: Yes they are.

Q: And the doctors we’re talking about, a Psychiatrist, and there’s a Psychologist involved, are aware that a baby is coming and are aware that a baby is born, and are definitely concerned that this man that they’re treating is not suitable for being close to a baby. What would you expect them to do about communicating their concern about the baby being at risk?

- A: You see, in the hospitals there is a Social Worker attached to all the wards, you know, and if there was ... I mean, if there was a patient in where there was ... they wouldn't be discharged without Social Work involvement. There's a Social Worker who would be involved in the Care Planning, and that would be in both the Mental Health set-up and the Astley Ainslie as well.
- Q: But would you expect that Social Worker to call a Case Conference, refer immediately to the Reporter, do something in an emergency when the situation is bad?
- A: I think if a nurse had information where they were worried about child abuse, they would contact the Social Worker that was allocated in the ward. If that's a Community situation, I'm sure that the practitioners, the Health Visitors, the CPNs, the Learning Disability folk, know who they should be contacting if they're worried about that.
- Q: Well, why are you sure that they know? What are they told?
- A: Well, I don't know what they're told, but what I do know is that, in terms of training for the Trust, we've got different levels of training. We've got elementary training; we've got more in-depth training and we've got Link Health Visitors and other Link Nurses.
- Q: Well, sorry to interrupt you, but you've moved on to training and I'm still on something else.
- A: But your question was how do I know that they have been told.
- Q: No, my question was how do you know that they know who to go to. Now, let's look at my Psychiatrist in the Astley Ainslie.
- A: Right.
- Q: Who is he supposed to go to with his Child Protection concerns?
- A: In relation to the question about how do I know that they - who they should go to, I mean, I know that people have had training to do with the new Child Protection, the Area Child Protection Guidelines.
- Q: Every person employed by the Trust?
- A: No, but about 800 people I know have had training, and everyone has had the opportunity to go to the training, and the training that we routinely offer in the Trust is on the Internet. It's on our Trust Training Directory Brochure. We've got training offered by ... about what to do if there is disclosure about sexual abuse. He's one of the Psychotherapy guys at Colinton Road. I would assume that the training includes that. PC Man 2 does an update about the Child Protection Guidelines to new staff, that comes out.
- Q: To all new staff in the Trusts, including ... ?
- A: Health Visitors.
- Q: Well, never mind about Health Visitors. I'm not really concerned with Health Visitors at the moment. I'm looking at the Trust as a whole, looking at all the people.
- A: We don't have that routinely in place for all Trust staff. There's no question of that.
- Q: Whose responsibility would it be to organise that?
- A: Well, what we're doing at the moment, the Health subgroup, which is a subgroup of the Area Child Protection Committee, refers to work being done by the interagency Lothian and Borders Area Child Protection Committee. And they've produced a paper which I know has gone to the Chief Executive in Lothian saying that this is what they're going to do and that the training needs to be improved and developed.

- Q: So just to go back to the question of who would organise delivery of it, whose responsibility is it within your Trust? Where would that go?
- A: I would make sure that the recommendations of this Health subgroup are put in place ...
- Q: Does (PC Man2's) remit actually extend beyond Health Visitors?
- A: Well it has increasingly done so, not least because of the Child Protection Guidelines being interagency. He is there wearing a Nursing hat and very much a Health Visitor hat because we deal with Child Protection. As I say, we've got link nurses who are from other specialisms now.
- Q: No, but I'm just trying to get hold of his remit.
- A: Well, his remit ... he doesn't do the Audit and Case Supervision and all the rest of it for other staff. We've got other systems in place for that. Generally speaking, I'm wearing my General Nursing hat and trying to get Clinical Supervision in place, and we've got policies and protocols for that, generally speaking, but that's not specifically to do with Child Protection.
- Q: Well, just thinking about training, the Psychiatrist at the Astley Ainslie is an example, would you see that as something that would ever come under PC Man2's remit?
- A: Well, how I would see that come about is that PC Man2 feeds back to me and ultimately he would feed back to me the proposals that come from that Health group, and I will take them to my Management Team, which includes the Medical Director and, if we have to do something special for doctors, we will do that
- Q: I'm just concerned about the assumptions here. You've just said that you would assume people know. We're in the unhappy position of finding that people don't know all sorts of things, and often we've had witnesses who have said to us "Well, I thought the Social Workers were involved. It's not my piece of cake anyway. I just assumed somebody else was dealing." That's the message we're getting from a number of people, and they haven't been trained to do anything else. They haven't been told to do anything else. They haven't, it appears, been given protocols or guidance on where to go if they have some concern.
- A: Well, all I can say is that we do have policies and protocols to do with Child Protection. They've been developed by the Link Health Visitor and PC Man2's system, and they're in our Clinical Nursing Manual. Now, that's all very nursingy.
- Q: Well, I'm leaving the nurses out of it. Leaving the nurses out, what do you say? For example, looking at the CDPS, what about the situation – when should they breach confidentiality which they would owe normally to a mother who's a drug addict, to raise a concern that because of her addiction or whatever her child is at risk?
- A: You see, I think we do it immediately we are worried, and I think CPNS.
- Q: Why do you say that?
- A: Because I've been there. I've done it. I've been a CPN. I knew who to contact at that time when I was a CPN, and I would know who to go to and know who to flag up with the concern with, and the CPNs I know
- Q: Let's keep away from the nurses. I'm not really interested in the nurses.
- A: Yes, but the CPN people ... I mean, maybe you need to talk to the Medical people about what they would say and do because it's mostly CPNs that work in the CDPS service.

- Q: You understand we've asked for a witness from the Trust because we've been talking to people, and what we're seeing is a very mixed message and confusion, so what we're trying to establish is whether there's any real guidance to medical staff, for example a protocol for medical staff where a Child Protection issue arises. Do they know where to go and what to do?
- A: I think you should ask that question of somebody like ... who is the Associate Medical Director in Mental Health, about what the Psychiatrists would do in that situation and whether there is a Care Policy and Protocol for them. I mean, I'm pretty sure that they would know what systems to enact if they were worried. You're maybe finding out otherwise.
- Q: My confusion, because I come from outer space with all of this – I don't understand the Trust structure – my confusion here is that if ultimately they're all working for the same Trust, I would have expected somebody in the Trust to be able to pinpoint exactly, first of all, who is responsible for Child Protection and, secondly, what are the systems in place?
- A: Well, what I'm saying, I mean, the systems in place are enshrined in the Area Child Protection Guidelines, which people have training on, both new people coming into the Trust and permanent staff. There's a Training Needs Analysis goes on. I'm talking Nursing. I'm talking Nursing actually.
- Q: I'm really trying to move beyond the Nursing.
- A: You see, the Medical Director is a GP. It would be very interesting to know his view on that. It would be worth asking him his view on that. I mean, I've come here because I manage PC Man 2 professionally and because I flag up various issues to do with Child Protection, largely through my senior Nursing forum networks, but I do flag things up to ...
- Q: We did write to the Director and ask for somebody who would take an overview and explained that we were looking for an overview, and were not particularly concerned with PC Man 2. We're trying to get the bigger picture, because obviously, with PC Man 2, we've interviewed him and we know what he sees as his area of responsibility. It appears to me from what you're saying that you're not actually sure who the person with the overview would be.
- A: Well, I have the overview of the Child Protection work that PC Man 2 was doing.
- Q: But, beyond that, Child Protection for the Trust?
- A: We don't have ... I mean, it would be me.
- Q: It would?
- A: Yeh. Mhm hm."

### **PC Man 1**

- Q: "I mean, do you think you have a responsibility across the areas within the Trust, the Primary Care, the Health Visitors in terms of the Primary Care, the Astley Ainslie and the CDPS?
- A: I would say that I'm professionally accountable for Nursing. I would say that it's not clear that I've got a responsibility Trust wide for Child Protection because the emphasis in my work is to do with Nursing issues, and I've got it very embedded in nursing practice.
- Q: Who does have that responsibility then, if you don't, do you think? Does anybody have it?
- A: I think my boss would say I do, which is why he wanted me here."

## PC Man 1

- A: "I told you we've got 8,000 staff in the Trust. Half are nurses. We've had road shows in relation to the Child Protection Guidelines and only 800 people went, so there's only 800 have gone. We do monitor that, but they don't all go.
- Q: I was going to ask you that. I mean, in terms of monitoring your work post and these other parts of the Trust and Health Visiting, have you got information about what the sort of level of knowledge and training is?
- A: We've got information about who has been, so we know how few people who are non-Health Visitors and non-Community people have been.
- Q: Have you collated that in terms of looking at these areas ...
- A: Yes.
- Q: ... and considering whether or not there are people in these areas that have those skills?
- A: Yes we have. Yes I've just received at the end of May my annual report from PC Man 2 and, of course, this whole inter-agency thing has recently been highlighted because of the "It's alright" report, and we are aware we're going to have to do something about it because we're aware of how few people have been trained.
- Q: So currently it's not possible really to give a clear answer on what the sort of level of knowledge is in those two areas, the CDPS and the Astley Ainslie?
- A: No. No it isn't."

## PC Man 1

- Q: (Referring to the Astley Ainslie and the CDPS):  
"Would you accept if they've not had any training in Child Protection that it might be quite difficult for them to flag up the right issues or maybe to say it in an assertive enough way, apart from just a phone call maybe that says "I'm a bit worried"?"
- A: Well, I mean, what I would say is that there is training available for people like CDPS who routinely deal with situations of family chaos and potential child abuse. I think they're very *au fait* with the Guidelines.
- Q: Why do you think that? I mean, how do you know that?
- A: I suppose I don't know it because we don't monitor the fact, I know from going into the wards that they are aware that people like PC Man 2 are available to give advice and support, and I know the training is well advertised, and people either decide to take up that training or not.
- Q: Are there any elements of training within your Trust that are mandatory?
- A: Not in relation to Child Protection.
- Q: No, I was just thinking more widely. Are there some areas of work that you think are so important that everybody is fully aware about it, that there's training?
- A: Well, things like lifting and handling, fire lectures, the statutory training is mandatory, and we've got updates for them. We've got updates for Child Protection every year as well, but it's optional rather than mandatory that people go.
- Q: Are there any clinical areas of work that are mandatory?

- A: No.
- Q: So they don't have mandatory resuscitation training?
- A: They do have updates, sorry. That's annual.
- Q: Right, and that would be mandatory?
- A: Yes, it is.
- Q: Is that the only one?
- A: I think it is.
- Q: Would you feel that maybe Child Protection should be a mandatory area of training for staff, at least for new staff who are working with Children and Families?
- A: I think it needs to be prioritised. I don't know."

When we interviewed PC Man2, who has various Nursing and other qualifications, including specialist training in Child Protection, he said:

### **PC Man 2**

- A: "My day to day activities involve being available to all our staff, to give them advice on any matters relating to Child Care Protection Safety that they may have. So it could mean that they have very minor concerns about child rearing or parent/child relationships or family environment, in which a child has been brought up and they have concerns or the family are a bit difficult to work with. So this would be the core of my activities.
- Q: Does that mean that you are at the end of the phone for people on the front line just to phone you up any time?
- A: I'm available on a phone form whether it is in an office or on mobile, I'm available to the Trust, the Trust have to contact me when they encounter any situation. That's the Foundation level. I'm also involved in providing staff with regular training at Foundation level and their basic knowledge in identifying what is the indicator of abuse or neglect, and what action to take when they encounter such a situation.
- Q: So when you are saying you provide training for staff, what kind of staff are you dealing with?
- A: Most of our staff are Health Visitors.
- Q: And does your remit extend beyond Health Visitors?
- A: It extends to staff of the Trust so I have dealings with Psychiatric Nurses, Community Psychiatric Nurses, Learning Disability Nurses, GP Practice Nurses, especially those that are employed by our Trust, also other Health staff like Dental Health staff, Drug Teams, they too access my services.
- Q: Now if you were doing let's say a training day for Community Psychiatric Nurses for example, would you also invite in Community Psychiatric Nurses who were based with other Trusts in the area, Hospital Trusts and so on?
- A: If they are based in our Trust area the invitation is open to them as well. There is very little separation between Hospital Psychiatric Nurses and Community Psychiatric Nurses nowadays, in that they tend to dip in and out of the Community and the Hospital.
- Q: I am just trying to get the picture for people who are not employees of the Lothian Primary Care Trust, you would be involved in teaching them and so on as well?

- A: For the hospitals for our Trust. I tend not to go beyond our own Trust staff essentially, not because I don't want to or don't wish to, it is just the circumstances are such that we have such a large population of staff who need our service and there are so little of us to do that, it is restricted in area.
- Q: What sort of numbers are we talking about then, what are the numbers of staff you are dealing with?
- A: Now, that's a good question, it's in the thousands, but the front line staff we have about 200 Health Visitors and maybe about 100 Community Nurses of other descriptions and these people are people who need our services more frequently than other groups of people."
- Q: "I just wondered if you could clarify for us your own role within the Primary Care Trust in relation to training, because I think you talked about Foundation training and then you talked about what you recognise is a big gap really I think in multi-agency training. So can you just clarify for me what the bit of training is that you are doing?
- A: Right, for our Trust we run, every month for half a day, we run Child Protection Update Training. The Child Protection Update Training is targeted for Health Visitors to come for the half day ...
- Q: ... What I think I'm interested in is to what extent is that multi-agency training that you were delivering to them or to what extent you are bringing in people from other agencies to take part in that training?
- A: We haven't done that.
- Q: You haven't done that?
- A: No, we haven't done that, apart from the seven sessions we ran.
- Q: The Roadshow for the Guidelines?
- A: Yes, yes, that's the one, and we have brought in experts from outside for that to just present to our staff one specific topic.
- Q: Yes, but in terms of facilitating your own Health Visitors working in the joint partnership way with Social Workers, Education, Police on the ground you are not doing that kind of multi-agency training with Health Visitors, is that what you're saying?
- A: We're not doing much of that, no. The only place we did one session was in South Central where we invited Social Work, Police, Education staff, and PC Man1 was involved with that.
- Q: Yes.
- A: But that's a one-off thing almost.
- Q: Okay, and to go back to Ms O'Brien's question about the Psychiatric nurses, obviously we are particularly interested in the sort of nurses which were coming out from the Astley Ainslie to work with families in the community, and I think there's a lot of involvement across the hospital community boundary in relation to nurses of all kinds now, isn't there?
- A: Yes.
- Q: Would you see yourself within your role within the Primary Health Care Trust as having a responsibility to those other groups of nurses?
- A: I do.
- Q: Is there some difficulty then in engaging them, is that what you're saying?
- A: It is the problem of releasing them to come, firstly for staff who are not working with Children and Families *per se* in the community, they have not come on board to think that they have rules and responsibilities for protecting children so I would like to change that attitude.



- Q: What have you done to try and change that attitude?
- A: Time and time again I am making recommendations that all our staff should be involved in training, and this report has that recommendation in it as well. So I am trying to get the Managers to release the staff to come to the basic training, foundation level training. I saw a gap for other staff like Nursery Nurses, like Ancillary staff, like Staff Nurses, who are in the Community, they don't have any training but they're all going into homes, so I brought them into the training bundle as well, so all those people are getting annual training now.
- Q: Right, so those other groups are?
- A: But they weren't Health Visitors.
- Q: Right, yes.
- A: I tried to get District Nurses, Psychiatric Nurses, and they are a bit more reluctant to come in, but gradually I think some of them are coming in."

The Inquiry was told that the average case load of a full-time Health Visitor is about 200 pre-school children, and the numbers of children identified as giving Cause for Concern varies by area. In some areas, less than 1% of that case load will be registered as Cause for Concern, but there are other areas where 20% of the case load are registered as Cause for Concern.

#### **PC Man 1**

- A: "In our Trust we have pockets where we have a very large population of children identified to be vulnerable to harm, risk or neglect and we do have, yes, a few Health Visitors who have a very large population while others haven't as much. As to whether anything could be done about that in terms of manpower is not within my control.
- Q: No, but it seems to be a resources question, doesn't it?
- A: Yes, it is a resource question. From my point of view if I have identified a member of staff who has got a large population of children vulnerable in their case load, I will see them more frequently for their case supervision ...".

#### **PC Man 2**

- Q: "So just looking, going back to my query about whether as a society we are overloading our Health Visitors with Child Protection concerns, would you be in favour of the recommendation of more money being put into the system to allow for more Health Visitors with Child Protection expertise to be employed?
- A: I think that will only help to protect children, yes, indeed. However, the operational dynamics of Health Service is moving along at such a pace, the changes are so fast, that there are other dimensions coming into it so now we have a lesser number of Health Visitors, qualified Health Visitors doing that

job, we have more of a skill mix coming into it, whether that's an economic argument or not, I don't know.

Q: Now when you are talking about a skill mix, are you talking about other nurses?

A: We are talking about other groups of nurses coming in, maybe Nursery Nurses coming in, maybe Staff Nurses coming in, people who haven't had Community training, or people not qualified, ancillary staff joining in, to make a bigger team, and so all these have diluted the amount of time Health Visitors *per se* visit or have contact with clients and children.

Q: Now is that going in a welcome direction from your point of view or how do you view that change?

A: Traditional thinking will not welcome that, in the proactive way there are room for both, but I think when you look at Child Protection and look at the quality of experienced or knowledgeable staff seeing children at a time when there needs to be some action taken, perhaps there's a risk that if those people who are seeing the children and the family in those circumstances are not as well trained or have not had the knowledge base, then they may not refer or identify those children, so there is that risk.

Q: They may not know a problem when it is presented to them?

A: Indeed."

4.4.5 Most GPs and Health Visitors in Lothian are linked up by a computer software system, known as "G-Pass", whereby information can be shared. However, the software does not allow for a page relating to Child Protection, so the Health Visitors' careful "Cause for Concern" records cannot be accessed through it. Moreover, although the Health Visitors' records are computerised, the GPs cannot obtain access to those records.

4.4.6 In general we were concerned about the keeping of separate records by different parts of the same Trust. Both paper and computerised records relating to children and their parents should be rationalised and cross-referred to ensure that practitioners working with a child are fully alert to potential child protection issues. We **RECOMMEND that the Trust carefully reviews its record keeping systems to facilitate effective sharing of information.**

4.4.7 Although PC Man2 organises training for Nurses and Health Visitors concerning Child Protection, it does not appear that he has given an overview of all the training which Health Visitors etc receive.

## PC Man2

- Q: "... around the specific issue of drugs, parental drug abuse and neonatal abstinence syndrome, how familiar do you think the Health Visitors on the ground are with these issues and how they might impact on the management of the baby and its safety?
- A: That's a good question. Honestly I don't know how much training our staff have on the effects of drugs on children.
- Q: How would they get training if you weren't aware of it?
- A: Well, there is a training department that does this all the time and they probably have some training.
- Q: Sorry, sorry, you'll need to explain that, which training department?
- A: Lothian Health, not Lothian Health, Edinburgh Primary Care Trust has a Training Department, an independent Training Department, that sets out training in various things, it could be anything, it could be diabetes, it could be wound management, it could be drug misuse.
- Q: Would they set up training which related to risks to babies?
- A: No, certainly not.
- Q: Without letting you know, involving you in that?
- A: If, no, if there's any Child Protection connotations then they will talk to me and we'll decide, but if it is the general training for everyone, drug use, then they will not pass that by me.
- Q: No, but this would be very much relating to?
- A: Well, actually I don't know if they have had any training because I haven't been party to the planning.
- Q: And if your Health Visitors were going off on that kind of training would you not be aware through their study leave requests?
- A: We will get, someone will hear about it, but I'm not aware of things that have come back that we have had any training whatsoever.
- Q: So is the likelihood then that the Health Visitors have not had any training?
- A: It is very likely."

4.4.8 Our conclusion, from the evidence made available to the Inquiry, is that the Primary Care Trust is completely failing to discharge its duty to inform and train its own staff about child protection. There is an exception to this: it is doing a good job of training and supervising Health Visitors. However, important as they are, health visitors are only a small proportion of the staff employed by the Trust who have an opportunity to protect children. Caleb's brief life story illustrates the actual or potential involvement of two psychiatrists, one psychologist, two General Practitioners, and one Outreach Nurse, all of whom are currently untrained in child protection. It is imperative that the Trust remedies this, firstly by clarifying exactly who is responsible for child protection throughout the Trust, and secondly by ensuring that the responsible person actually knows about child protection, or at least is in receipt of regular advice from a suitably qualified specialist. We **RECOMMEND that Lothian Primary Care Trust**

**urgently allocates resources and skilled staff to institute mandatory child protection training for staff at all levels, which must include advice on the extent to which a patient's right to medical confidentiality can be breached when a child is at risk.**

## **4.5 The Police**

4.5.1 Since April 2003, a major reorganisation of the Police Force in the City of Edinburgh has resulted in a single administrative division, which has unified the Police approach to Child Protection. The Family Protection Unit and Child Protection Officers are based at St Leonard's Police Station, and a Detective Chief Inspector with overall responsibility for Child Protection reports to a Detective Superintendent at Police Headquarters at Fettes. The Inquiry Team interviewed the Detective Inspector (DI) with hands on, day to day responsibility for Child Protection at present. In 2001, the Police Force was still split into geographical divisions, and we also interviewed the Detective Chief Inspector (DCI, on temporary promotion) who then had responsibility for Child Protection in D Division, which included Leith. We further interviewed the Detective Constable (DC) in the Family Protection Unit at Leith who dealt with the invitation to Caleb's Case Conference, and who has since transferred to work in the Family Protection Unit at St Leonard's.

4.5.2 In 2001, D Division received hundreds of invitations to attend Child Protection Case Conferences each year. All of the invitations followed a pro forma format, which was exactly the same as the format used by SW4 when he sought Police attendance at the CPCC for Caleb in August 2001. We reproduce a copy of that invitation, with names deleted, in the Appendix. In common with all such invitations, the invitation relating to Caleb did not identify the nature of the case, the severity of the matter being dealt with, or the reporting officer involved. As CPCCs are held for children of all ages up to 16, the issues involved can vary considerably. All of the Police witnesses complained that it was an unnecessary drain on time and resources to start with so little information: often the Social Work Department would be dealing with a case where the Police had been involved, perhaps investigating assault of a child, and the Social Worker concerned knew this. Sometimes a CPCC has to be arranged as a matter of urgency, for good reason, but no explanation is ever given. As a matter of

routine, the invitation letters would arrive at the last minute, within a day or two of the Case Conference, adding to the pressure on the Police to identify the appropriate information sought. The DC, who impressed us as a sensible woman who had considerable competence in Child Protection, said that she had contacted “a couple of Senior Social Workers in Edinburgh,” to say that this pro forma required to be re-examined, as more information should be supplied at the outset. She also thought that one of her colleagues had written to the Social Work Department (at what level, we do not know) to make the same point, but nothing had changed. The DC’s initiative took place probably in 2001, and was unrelated to Caleb’s death. We have no hesitation in **RECOMMENDING that the pro forma invitation issued by Social Work Departments throughout the City should be reviewed, in consultation with the Police, and a new pro forma drawn up, which offers the Police far more information.**

4.5.3 In Leith in 2001, the routine was for letters to be addressed to the DCI, who passed it on to a Detective Sergeant, and then to a Juvenile Liaison Officer (JLO). If a Reporting Officer had been involved with the child’s case before this, perhaps because the child was a victim of a crime, the invitation would be passed on to the appropriate Reporting Officer. This could be a uniformed Constable, or a member of the CID, depending on the gravity of the matter concerned. The Minutes for Caleb’s CPCC name and identify the Juvenile Liaison Officer in Leith at that time, and suggest that he had been invited to attend, but that he was unable to do so. In fact, as the invitation letter left the Social Work Department, the original draft letter by SW4 which had been addressed to the JLO by name, was changed (apparently at the instigation of SW2) so that the invitation was addressed to the DCI, in accordance with preferred Police practice. We spoke to the JLO by telephone, but did not interview him: although he dealt with hundreds of these cases, he was away at the time of Caleb’s CPCC. The invitation, dated 3 August, landed on the desk of the DC. She clearly remembered it arriving so late that it reached her hands either the day before the Case Conference, or the day before that (7 or 8 August). She did not think that it had been held up in the Police Station: the procedure for passing the letter down the line there was relatively straightforward and quick. She believed that the Social Work Department posted these invitations, despite being sited next door to the Police Station, and we surmise that the invitation might have been posted second class.

- 4.5.4 The reason the DC remembers the invitation to Caleb's Case Conference is that she already knew Shirley Malcolm. SW4 had added Shirley's name and address at the bottom of the invitation, in his own handwriting. (So far as the DC was concerned, this was a welcome clue: most of the invitations did not give the parents' names.)
- 4.5.5 At an earlier stage in her career, when the DC was a uniformed officer in Leith, she had dealt with Shirley Malcolm, generally because Shirley was working as a prostitute outside the tolerance zone which was operating in Leith at that time. The DC remembered speaking to Shirley from time to time, and also remembered seeing Shirley when she was pregnant with Caleb, and remarking that she looked much healthier than usual. However, what really stuck out in her mind was the fact that, on one occasion, the DC was asked to carry out a strip search of Shirley, and Shirley shouted abuse at the DC, and kicked her. She therefore had no difficulty in immediately recognising the name on the invitation.
- 4.5.6 Significantly, the invitation did not mention the name of Alexander Ness. It gave Caleb's name as "Kalib Malcolm", with his date of birth.
- 4.5.7 When the invitation letter reached the DC, there was a note at the top right hand corner from the DCI to the Acting Detective Sergeant, instructing her to attend the CPCC. The DS delegated the matter to the DC.
- 4.5.8 The DC asked her DS whether she knew "Kalib Malcolm", and of course the DS said no. The DC started carrying out background checks, following standard procedures, against the names "Kalib Malcolm" and "Shirley Malcolm". She turned up Shirley Malcolm's extensive list of criminal convictions. She told us, and we accept, that she telephoned the Social Work Department, and asked to speak to SW4, who had signed the invitation. She could not remember whether she had spoken to him, or to his Senior, but her normal practice would have been to speak to the Senior Social Worker if she was unable to reach the writer of a letter. The DC told the Social Work Department that the Police knew Shirley Malcolm from her history of prostitution and drug abuse, but she thinks that that was all she really said about Shirley's record. She assumed that if she mentioned drugs and prostitution, the Social Work Department

would understand that there was a list of associated convictions, for offences of dishonesty and the like. By reference to the Guidelines, the DC thought that she was at liberty to share information that was relevant to Child Protection, such as assaults on a minor, Schedule 1 offences, or a history of known abuse. She was less clear about how much could be passed on when the convictions were not specifically child related.

4.5.9 In her telephone call to the social worker, the DC also offered to dig around for more information, and said she would write a report if need be, but at the moment she had nothing more to say. She also said that there was no-one available from the Department to attend the CPCC. She says she was told “That’s fine”, and that no report was needed.

4.5.10 We found the DC to be a credible and reliable witness, and believe that she passed this information back to the Social Work Department. As one of the witnesses attending the CPCC remembered waiting for the arrival of the Police at the outset of the Conference, it seems likely that the DC did not speak to SW4, and that instead she spoke either to SW2, or a Duty Social Worker, and her message did not get back to SW4. Given the timescale, this is not surprising.

4.5.11 We asked the DC what she would have done if Alexander Ness’ name had appeared on the invitation. She confirmed that she would have checked him up in the same way, and once she had discovered his criminal record she would have sought more information from the Social Work Department. If she had discovered that he was living in the household, or visiting the household every day, she would probably have attended the Case Conference herself. Police Officers from Leith regularly did attend Case Conferences at that time, particularly the JLO. If a Reporting Officer had particular knowledge of the case, he would be sent along, provided that there was enough notice for this to fit in with his shift duties. When that was not possible, the Social Work Department quite often asked for a written report, and this was provided. The DC was clear that she was not asked for a written report for Caleb’s CPCC.

4.5.12 The DCI at Leith at that time told us that he would have recognised the name of Alexander Ness, if it had been mentioned in the invitation letter when it crossed his

desk. He knew that Alec Ness was a man with a reputation for violence, and that he had been involved in drug dealing.

4.5.13 The DCI told the Inquiry from information gathered after Caleb's death that Alexander Ness had had two marriages, and three children, but that there was no "indication whatsoever of ill-treatment or any ill-feeling towards the kids."

4.5.14 It is worth recording that the DCI handed us a copy of the "Child Protection Initial Case Conference Agenda", which had been prepared for Police Officers attending a CPCC for the first time, in order to explain the procedure so that they would know what to expect.

4.5.15 The DI gave evidence to the Inquiry about current procedures, having himself had no involvement in Caleb's case. The new Family Protection Unit at St Leonard's has 14 Child Protection Officers, who report to 3 Sergeants, who in turn report up the line. The Unit deals with domestic abuse, juvenile crime, sex offenders who have been returned to the community, missing persons, etc. Children who are victims of sexual abuse are part of the Unit's remit, but physical abuse of children is dealt with by uniformed officers elsewhere. There are some exceptions, for example where the abuse takes place within the family, or if it is ongoing or historical.

4.5.16 The DI described the same pro forma letters reaching his office in 2003, and said he had been seeking a meeting with the Child Protection Co-ordinator since May 2003 to speak about these letters.

4.5.17 When shown the invitation to Caleb's Case Conference, he described the checks which would be done against Caleb's name, but said that he would be surprised if his office would check against the name of the mother, i.e. Shirley Malcolm, if such an invitation arrived in his office today. They would, however, telephone the Social Work Department to obtain more information as a matter of routine, and also to see whether it is really necessary for a Police representative to attend the CPCC.



4.5.18 He said that if a search were to be done, and a lengthy record such as Shirley's turned up, that would not in itself mean that he would organise attendance at the CPCC. The information would be passed back to the Social Work Department verbally.

An example of this approach:

Q: "Would you see a long history of previous convictions of the kind I have described – fraud and uttering and dishonesty and prostitution and so on – as having a bearing on Child Protection such that you really wanted to make sure that the Case Conference knew that that history was there, or would you say, well, that's not terribly important?"

A: I would say it's not terribly important."

For the DI, the alarm bells would ring where there was a history of sexual crime or violence.

4.5.19 The DI spoke of plans for a joint unit with the Social Work Department, as has happened in some other areas of Scotland. We think that it would be inappropriate for us to comment on that, on the basis of one case.

4.5.20 The Inquiry Team had some difficulty in understanding the current process of allocating cases, with the result that physical abuse ends up with uniformed officers who are undertaking a whole range of other duties. While the uniformed officers receive joint investigative interviewing training, most would have no Child Protection training, and we are concerned that they might not know what to look out for, for example in a situation where physical abuse is part of the grooming for sexual abuse. The uniformed officer might end up at a CPCC, and he would have received no formal training process in connection with that. The DI said that many of the inquiries related to minor assaults, where for example mum had slapped a 10 year old. We think that there is room for closer consideration of this, and **RECOMMEND that the Police review the detail of their approach to physical and sexual abuse in collaboration with Child Protection specialists from outside the Police. Thereafter, we recommend that they re-examine their internal procedures for allocating cases.**

4.5.21 We are also concerned to learn that it is not and was not automatic that a parent's name would be checked with the Scottish Criminal Records Office, on receipt of an invitation to a CPCC. We may be wrong about this, but we believe that Social

Workers have long operated on the basis that such checks are automatic, where the parents' names are given. **We RECOMMEND that a clear understanding is reached between the Police and the Social Workers on information sharing prior to the CPCC.**

#### **4.6 Telephone calls to the Social Work Department about Caleb**

4.6.1 In common with other Social Work Departments, Leith operated a system of logging telephone calls into the office. It still does this. At the time of Alexander Ness's trial in 2003, P1 came forward to the press, and said that she had tried to telephone Social Workers to warn them that Caleb was at risk. (See Introduction 1.1.4). In evidence to us, P1 confirmed that she had made two telephone calls to the Social Work Department. She could not place these in time at all, beyond saying that they related to the time after Caleb was released from hospital, and before his death. She said: "The first office I phoned was the Leith office and I spoke to the receptionist there and asked for the Duty Social Worker. They told me there was nobody available. I left my name and telephone number and asked for the Duty Social Worker to phone me back. I didn't go into why I was calling but normally I would have done, because I was at that time, myself, I was completely exhausted. So it was very short but direct." On the second occasion, she phoned the Craigentenny Social Work Department, in connection with a family matter. "Again there was nobody there and I left my contact details and asked somebody to call me back." She did not say anything about a Child Protection referral or concern. To quote her: "I remember I was just so tired, so exhausted I couldn't bear to speak to a receptionist and go through the whole rigmarole and then speak to a Social Worker and go through it again."

4.6.2 We did attempt to trace the log of telephone calls. SW1 confirmed in evidence to us that when she heard of P1's allegations in 2003, she tried to trace the records. They had been destroyed long before then. She also went round the office, and spoke to the Support Workers, and Social Workers, to see if anyone could remember the call. No-one had any recollection of it. Even when informed that P1 had not mentioned the name of a child, the fact that she was calling on a Child Protection issue, or given any clue about the reason for the call, SW1 said that she would still be "really really

surprised” if the message had not been passed on to the duty Social Worker at the time.

4.6.3 We had some doubts about P1’s reliability as a witness, as discussed at 5.12. Her evidence about making the calls was corroborated by P4, who remembered discussion about the first call at the time, and said that she was actually in the office during the course of the second call.

4.6.4 We find that P1 made two telephone calls to the Social Worker Department, with the intention of alerting them to her concerns about the care of Caleb. We consider that it was bizarre to telephone Craigentiny, with the intention of adding information about Caleb to a wholly unrelated request for information concerning a family matter. P1 knew perfectly well that the appropriate Social Work office to call was Leith. We conclude that it is unfortunate that the message was received, but then lost. In the whole circumstances, we cannot attach any serious blame to the Social Work Department for vague messages which went astray.

## **4.7 Edinburgh and the Lothians Child Protection Committee**

4.7.1 Child Protection Committees do not have a statutory basis. They have been set up throughout Scotland to monitor and review interagency Child Protection procedures in the locality concerned. Similar arrangements exist in England. The intention is that each participating agency improves its understanding of the role of every other participating agency, in order to improve interagency function in Child Protection matters. The remit of the Edinburgh and Lothians Child Protection Committee stretches from the city to East Lothian, through Midlothian, to West Lothian, and therefore includes representatives from each of those four Social Work Departments, as well as representatives from Education. Health interests are represented by a Consultant in Public Health, Consultant Paediatrician from West Lothian Health Care Trust, and a senior nurse from Lothian Primary Care NHS Trust, respectively. There is also a representative from the Scottish Children’s Reporters Association. There are representatives from Children 1<sup>st</sup>, SCIS, the Army Welfare Service, and the Procurator Fiscal’s Office. There is a delegate from Lothian and Borders Police.

- 4.7.2 One individual was appointed as Child Protection Co-ordinator for Edinburgh and The Lothians in 1997. His employers are the four local authorities within the Region, Lothian Health, and Lothian and Borders Police (i.e. six in total). He has a Social Work background, with appropriate specialist experience of Child Protection. He has a surprisingly small staff and budget. As an employee, his line manager is the Head of Operations in Edinburgh Social Work Department.
- 4.7.3 A predecessor to the current Child Protection Committee, the Lothian Regional Review Committee, first issued Guidelines for the Region in April 1977. The Guidelines have been reviewed from time to time, and we discuss some of the provisions applicable in 2001 at 7.1 to 7.4.
- 4.7.4 Legally, the Guidelines only have the force of instruction, as there are no statutory provisions relating to their promulgation or enforcement. It is important to note that the Guidelines for each Region of Scotland are separately drafted, and there can be significant differences in practice as outlined by the Guidelines from one area to the next.
- 4.7.5 The Committee itself elects a person as Chair of the Committee, and also a Vice Chair. In 2003, the Chair happened to be the Head of Operations with City of Edinburgh Council Social Work Department.
- 4.7.6 The extent to which the Child Protection Committee can oversee and examine what happens in its own area is limited by its staff, its resources, and ultimately by its lack of statutory powers. Ideally, the Child Protection Committee should have the legal power to set up a multi-agency review, in a case like this. We believe that since Caleb's death child death reviews have been instituted on a pilot basis in Lothian. However there is no statutory process for Child Protection Committee's to follow to set up a more far reaching independent inquiry.
- 4.7.7 Man1, the head of Operations of the city's social work department did have the power to investigate his own staff, and we understand that he did so. A few procedural changes followed, in 2003, as described in the Introduction. However, any person in his position does face a potential conflict of interest in such circumstances. For

example, in Caleb's case, did Man1 identify and remedy the lack of seniority of Chairpersons of CPCCs drawn from the Leith team? We do not know, as our remit did not extend to asking such questions. However, it is obvious that he could not tread on the patches of the relevant health professionals, and certainly could not look at what happened in the round.

4.7.8 We believe that the remit of the Child Protection Committee should be re-examined, and that consideration should be given to providing it with statutory powers to investigate child protection practice in its area moving freely across agency boundaries. We think it requires statutory status. We understand that the Scottish Executive is currently looking into this as part of the Child Protection Reform Programme. One disadvantage which we have suffered is the inability to compel the attendance of witnesses or the production of documents. We see no policy reason to justify this when the lives of children are at stake. In addition it has been difficult for witnesses to recollect events two years down the line.

4.7.9 We recognise a real problem where the child protection co-ordinator, who is working on behalf of the committee is line managed by the very person who may be failing to provide adequate services.

4.7.10 In considering the way forward we aware that we are looking at only one case, which we hope is wholly unrepresentative. We see this line of thinking as requiring informed debate by people professionally involved from many different angles.

## **5 COMMENTS ON SOME WITNESSES**

### **5.1 SW2**

5.1.1 SW2 was supervising SW4 in 2001. She had qualified in 1984, spent time as a main grade worker with children and families, and then five years as a senior practitioner in Leith. She has the Certificate in Child Protection studies from Dundee University, and had recently been promoted to Senior social worker. She was experienced, and as a senior she was line managing five main grade social workers, and had other roles to play within the office.

5.1.2 She discussed the case with SW4 from the time when it was allocated to the children and families' team, and understood from SW4 that "Ms Malcolm's lifestyle had changed". It does not appear that she gave any thought to the possibility of arranging a pre-birth CPCC. At the time the CPCC was discussed at the end of July, she thought that SW4 had "had made a few visits to Ms Malcolm and Mr Ness", whereas he had only met them once. She checked over the list of invitees for the CPCC: we did not discover whether she knew before 9 August that SW7 was away on holiday. It may be that she saw the list before this was known, and assumed that he would attend. She did not, however, suggest that someone should be invited from (distant) social work department, apparently relying on SW4's chat with them by telephone, and the terms of the old report which had been sent in. We think it was important that the CPCC was given full information about Shirley's longstanding failure to parent her two existing children. She did not apparently think of adding the GP, and it should be borne in mind that HV did not know Shirley at that stage. She knew Ness had suffered a brain injury, but thought it was enough to rely on SW7's information about that, whatever that might be. Given the similar lack of knowledge of other senior witnesses, we can hardly criticise her for failing to add the Community Child Health team via the Child Protection office to the list. (See 9.9). Nevertheless, she and SW4 should share some of the criticism for failing to convene the right people to attend.

5.1.3 Much more criticism must be voiced of her failure to supervise proactively after the baby went home. She should have been up to speed about the factual circumstances: instead, she told us that it was her understanding that Shirley had moved into her flat

“just shortly before she had the baby” (wrong) and that Alec Ness had “a tenancy in the Granton area they had their separate tenancies certainly”(very badly wrong). She should have been asking to see the Child Protection plan (written down), and she should have discussed the level of monitoring required with SW4. She should have caught up with the fact that there was no coherent plan almost immediately, and remedied that grave defect. She should have been asking what had happened to the Minutes. She failed totally to do these things. We accept that Caleb was mentioned at her routine supervision meetings with SW4, on the dates which are given in the Chronology. We do not accept that there was sufficient discussion to satisfy a minimum standard of professional competence. Each time, SW4 appears to have said that everything was going well, that Shirley was coping, that the baby was thriving. It may be partly his fault that knowledge which he had, such as Shirley developing post-natal depression, was not fed back, but it must also be the fault of the Supervisor who is not asking questions. She left it to SW4 to identify areas of concern, and did not attempt to discuss the case in such a way as to help him realise that there were things to worry about. Both stopped asking the questions which might have identified risk, allowing themselves to be reassured by the apparent co-operation of the couple. Over and over again she emphasised this.

- 5.1.4 SW2 told the Inquiry: “My view would be I think that things were done correctly and we did as best we could for the baby at that time. There was nothing to suggest that the baby couldn’t go home with Shirley.”

## 5.2 SW3

- 5.2.1 In 2003, SW3 had been a Senior Social Worker for one year. In 2001, she started the year as a Social Worker (at what used to be called the “Basic Grade”), but in June 2001 she was promoted to being part-time Senior Practitioner, while remaining a part-time Social Worker. She had been a teacher, and trained as a Social Worker late, and in the course of both careers she had attended Case Conferences for about 20 years before 2001. She had the Specialist Child Protection qualification from Dundee University. Aside from Caleb’s Case Conference, she had no involvement with Shirley or Caleb, beyond asking SW4 in the passing how they were doing.
- 5.2.2 She said that just before Caleb’s CPCC, SW4 informed her that “Shirley and Alec weren’t together any more, he was living somewhere else and that the main role appeared to be she was the carer and he would visit every day because she administered his pills. His brain damage meant that he wasn’t able to do this himself. I can’t remember whether this was before or during the Case Conference that he said that his Probation Officer couldn’t come, but from what he had been able to find out Alec had children by a previous relationship and there had been no child care concerns, that he had been somebody who was known to be violent, involved in drugs, but his brain damage had made him placid.”
- 5.2.3 It was her evidence that the Case Conference explicitly discussed the fact that Caleb should not be left alone with Alec Ness. She described him: “Mr Ness’ presentation at the Case Conference was really of somebody who would need cared for, but he was inappropriate in the way he would keep interrupting and saying things like “Oh I’ll keep Shirley off drugs, I’ll do this, I’ll do that, but as I say he was also very biddable, if you asked him not to interrupt he would not interrupt. There was no signs of aggression even when we were discussing the fact that he shouldn’t be allowed to be caring for Caleb, and he wasn’t impatient”. She said that “It was discussed with Shirley directly, I do remember saying to her did she understand that, and did she understand that Alec should not be left with Caleb alone and she said yes and that she had no plans to do so. I also discussed with her, although it’s not elaborated in the Minutes, the fact that that gave her an additional stress and that she was not only



looking after a baby but she was also having to look after Alec, and that was a concern.”

5.2.4 With regard to the decision-making process, we quote the following extracts:-

A: “But what was being presented at the Case Conference was a much more positive picture of Shirley, that she was motivated, that she had been up and about feeding the baby, the Report from the CDPS was good, better than I thought, I had actually assumed that with a long-term drug user it would be a much less favourable report but they were saying quite clearly that this was the best that she had done.

Q: When you say “they” who is that?

A: Dr1, and again he is working from records. She had established what appeared to be a good working relationship with the Social Worker, she was co-operating with him and at the Case Conference she was saying she was prepared to work with the Health Visitor.

Q: So you mean having read the report before you arrived you had thought before you arrived there would in the end be a decision to make a referral to the Reporter?

A: I certainly thought that was possible, yes.

Q: But when the discussion took place at the Conference the view became brighter and more positive, would that be a fair way of putting it?

A: Yes, it wasn't a Case Conference where your worries were raised, it was actually a Case Conference where they were lowered, surprisingly.”

Q: “Did you have any information about his own problems with abstinence from maternal drugs or anything like that?

A: That he had withdrawal?

Q: Yes.

A: Again that was expected.

Q: So you knew he had withdrawn?

A: Yes because she was on a script.

Q: And did you think that that would affect how easy it would be for the mother to look after the baby?

A: Obviously yes, but again the reports were she was doing well.

Q: And those were based on her visits into the hospital when he was still there and she had been discharged?

A: And also I knew the Health Visitor involved was a very experienced Health Visitor and I knew she would be very attentive. To me that was a very important factor, Shirley agreeing to work with the Health Visitor.”

A: “(Midwife's) contribution was obviously she had concerns I think the first day because of the incident with the Methadone, being an allegation of smoking hash in the toilet which Shirley denied she was doing. I checked out about the Methadone and Shirley admitted to doing so.

Q: What does that mean, taking extra Methadone?

A: Yes, on that day and that was discussed and also she denied smoking cannabis in the toilet, she said it was just a cigarette, but then the midwife went on to say that after that she had been impressed with the progress she had made and her commitment to the baby.”

A: “Dr1 had just taken over and he had Shirley’s medical records there, so we had to get Shirley’s permission for him to share what was in the medical records, which she gave, and his contribution was that she did appear to be on this occasion sticking to the Methadone programme which she hadn’t in the past. She had made more progress over this particular period than she had in the past.

Q: And how long was that particular period do you remember, how long a period are you talking about?

A: He was talking about the year, eighteen months period from the records and it did seem to be a more settled period for her. His view was that she was motivated on this occasion.”

Q: “And you have mentioned Nurse 1’s concerns about Alec holding the baby. Do you remember her making any other contributions?

A: No, I have wracked my brains for this, but she didn’t.

Q: Why have you wracked your brain, is that because of the publicity?

A: Yes, and she didn’t mention anything about him being impatient with the baby or tending to be angry. The example she gave is quite a normal one for new fathers, you know particularly in fathers, but it didn’t trigger any, not in me I don’t think anyway, no, she didn’t bring up anything and she agreed with the decision not referring to the Reporter.”

Q: (Referring to the Report of 8 August):

“During my contact with Ms Malcolm and Mr Ness, both in the Community and in the hospital after the birth of Caleb, they presented as motivated to settle down, and parent their new baby.” You will agree that suggests ...?

A: Yes, I definitely agree that suggests that he was living in the house full-time.

Q: But at the Conference you were all clear that he wasn’t actually living in the house?

A: Yes I was, and that was my understanding.

Q: Did you understand that there had been any relationship difficulties between Alec and Shirley before the baby was born?

A: No.

Q: No. There was no information that would suggest that Shirley had thrown Alec Ness out and ended the relationship in July, or anything of that kind?

A: Not that I can recall, no.

Q: You know that you mentioned that, and we read the passage that said, that SW7 couldn’t attend because he was on holiday?

A: Yes.

Q: Did it give you any concerns that there was nobody from Criminal Justice there to speak about Alec Ness and his circumstances?

A: Yes, but the Social Worker had had some discussion with somebody and they were feeding him the information I suppose, I think I told you earlier it was about Alec and about his changed circumstances.

Q: So you are talking about? From the offending point of view, Ness wasn’t regarded as at particular risk of offending in the same way as he had been in the past?

A: Not because of his brain damage.

Q: Well, you say not because of his brain damage, do you mean the brain damage had changed him?

- A: Yes.
- Q: And therefore you felt the picture in the future would be different?
- A: Well yes, I mean yes I suppose that's right, I mean the effect of the brain damage was such a major change both to him and to the relationship."
- A: "... according to the Guidelines I most certainly did (have a responsibility to check the Minutes), and I suppose there is a difference between guidelines and habit and practice.
- Q: Under the Guidelines what were you supposed to do?
- A: Try to get them out within two weeks.
- Q: And what about checking their accuracy and so on?
- A: Eventually once they are typed they would have come to me. They weren't typed though until actually Caleb was dead.
- Q: So you remember them coming eventually?
- A: I didn't get to see them, they were really just typed and because Caleb had died they went into the review process."
- A: "I suppose if anything good could come out of this it would be that Social Workers actually get more training, and more training in not just sudden death syndrome, you know, talking about neurological stuff, you know there are now huge variations in Social Work experience and knowledge and it is increasingly a very young, inexperienced workforce and the training just isn't there, it isn't happening and I don't think it's happening for the other agencies to be honest."

5.2.5 SW3 also urged the Inquiry to recommend that every agency invited to a CPCC puts in a written report. We consider this is not a practical suggestion.

## 5.3 SW4

- 5.3.1 In 2001, SW4 was a Children and Families Social Worker, whose Line Manager was SW2. Although he was at the basic grade in the Social Work hierarchy, he was well qualified, with several years of experience. It was clear to us that he had been given a considerable degree of autonomy by his senior, and that he was quite confident that he knew what he was doing. After the chance discovery of Shirley and her pregnancy, it was appropriate for SW1 (the Team Manager, and senior to SW2) to make this an allocated case, and for the case to be allocated to SW.4. At the time when this happened, he was not overloaded with work. We were struck by the fact that he never suggested that he had been unable to carry out a particular task because he was overburdened with work.
- 5.3.2 The Guidelines are silent on the detail of how risk should be assessed in anticipation of a baby's birth, but we were told by Man2 that he would have expected weekly visits for the last few weeks before the birth, where (as here) there had not been significant recent contact with the Social Work Department. It is an extraordinary fact that SW4 met Shirley only once before she gave birth, and thereafter only twice, on the maternity ward, before the CPCC on 9 August. Appropriately, he obtained information from the (distant) Social Work Department, from Alec Ness' Criminal Justice Social Worker, SW7, and from the CPDS. The vague telephone information from Dr.2 at CPDS on 12 June was not followed up with a request for a written report. Shirley had a history of drug addiction stretching back for more than 20 years, so we consider that this level of investigation of her current degree of dependency was casual in the extreme. We believe that SW4 formed a favourable impression of Shirley on his visit of 12 June, and that he allowed this to cloud his judgement. Shirley, of course, was only too well accustomed to dealing with Social Workers, and certainly knew how to put on a good front and say the right things.
- 5.3.3 In evidence to us, and from the tenor of his report, it became clear that he regarded Shirley's failure with her two earlier children as a question of history. *"I mean, I was judging the situation based on what I was being presented with. I mean I would have had an awareness of that history but I was also making judgements based on what I was being presented with as well. The flat was in good condition and they seemed*

*well prepared for a new baby coming along, there was a lot of baby equipment in the house, new things, they both spoke very positively about the birth of the child, she spoke quite openly about her involvement with the CDPS and her previous difficulties and about how she was trying to move on from that. (She) presented quite a positive picture of her situation acknowledging that there had been difficulties and she was still using drugs.*” Based on his experience, SW4 suspected that she was using illegal drugs as well as her “script” (i.e. prescribed drugs), but he thought that she was functioning well.

5.3.4 It was SW4 who went on to prepare the background report for the CPCC. (See 3.2.1 to 3.2.4.) Inevitably the perspective of that report carried great weight with the CPCC.

5.3.5 Its conclusion is also discussed elsewhere, and it was a central problem for this Inquiry to understand how there was a leap from the perspective of the report: (“... *(Shirley and Alec) presented as motivated to settle down and parent their new baby*”) to a decision taken by the CPCC the next day apparently with knowledge of the fact that Alec Ness had moved out of Shirley’s flat. The Minutes for the CPCC do not record this as a fact, and there were even some witnesses who attended the CPCC who did not remember it being said. One would therefore have expected SW4 to explain the situation to us in evidence, but he did not. He indicated that the Minutes were “*fairly accurate*”, and never suggested that he had explained to the conference that Alec Ness was no longer living in Shirley’s house. Although he was the Case Co-ordinator from 9 August, he did not suggest to us that there had ever been a decision that Alec should not be left alone with Caleb, in contrast to the evidence of others. On the contrary, the impression he gave was that he expected Alec to be so involved that, in an emergency, he could even theoretically have become the main carer for the child, although he would then have wanted to know more about Alec’s brain injury.

5.3.6 With regard to the care plan after the baby was discharged from hospital, he said that: “*In terms of my case load Caleb would not have been one of my major concerns at that time.*” According to him, there should have been 5 appointments after discharge, and before Caleb’s death, but “*one appointment was missed*”, and he saw no cause for concern when he did visit.

- 5.3.7 He said that if he had developed any concerns about Caleb, and had thought that the risks had changed for some reason, he would have discussed that with his senior at his regular supervision meetings. Supervision took place every two to three weeks.
- 5.3.8 Although we consider that he was attempting to be honest with the Inquiry, he was not a reliable witness, having forgotten things which we regarded as proved by reference in contemporary notes. However we have to single out for mention the phone call by SW9 warning that Shirley was high on drugs, and incapable of looking after a baby. She was clear that she had spoken to SW4 about this, and her recollection was backed up by contemporaneous formal notes kept by the (distant) Social Work Department, which we saw. SW4 not only failed to mention this, but also insisted that the entry on 28 August which could have been read as meaning that SW9 had expressed her concerns about Caleb, in fact should be interpreted as meaning that she said that she had “*no concerns*”. In that context, he denied any concern having been expressed. We prefer SW9’s evidence, to the effect that she did pass concerns on to SW4 by telephone, probably on 7 September. We use “concerns” as Social Workers do, to refer to serious reservations about the baby’s safety.
- 5.3.9 Looked at in the round, we believe that SW4 proceeded on the basis of his impressions, and sometimes very superficial impressions at that, rather than on the basis of evidence. Because of the favourable impression that Shirley made on him, he dismissed her truly appalling history of past parenting (as disclosed in the report he received from the distant social work department), and later he did not really listen to the concerns of others, namely SW9 and the HV. HV was clear in her evidence to us, which we see as borne out by the contemporaneous records and her actions, that she did perceive heightened risk for Caleb, once Shirley had serious post-natal depression for which she refused to take treatment. When she passed this on to SW4, as the system expected of her, he did nothing.
- 5.3.10 We do not accuse SW4 of wilful neglect. We do not accuse him of culpable disorganisation – meaning to do something, but never getting round to it, for example. He seems to have drifted along, secure in his own first impression that all would be well. He was happy to rely on Shirley to be his main source of information about Ness. It is even more concerning that he accepted without challenge what she said

about herself. Because he was not critical, he did not respond to the increasing level of risk in Caleb's environment. He simply did not listen.

## 5.4 SW5 AND SW7

- 5.4.1 SW7 had pre-qualifying experience of child protection when he worked in the residential service between 1979 and 1990. He went on to qualify as a social worker in 1992, and thereafter he worked exclusively in criminal justice. His training in child protection was accordingly basic, and he was very clear about this in his evidence to the Inquiry. His focus was on seeing Alec Ness through the period of compulsory supervision on licence after his release from prison.
- 5.4.2 The primary objective was to prevent Ness from re-offending, and to that end the first priority was to find Ness somewhere to live. On release, Ness went to stay on his mother's sofa, but she was very old and frail and it was at once clear that the arrangement could only be a stop gap. A friend who was going abroad offered Ness a three month let, which he took with SW7's consent. Temporary addresses followed until hospitalisation in January 2001.
- 5.4.3 After Ness was discharged from the Astley Ainslie, SW7 visited him several times in Shirley's flat. He knew, because Shirley told him, that Ness was clumsy and uncoordinated to the point of falling over, and he knew, because he could observe it himself, that Ness could not concentrate or focus for long on any topic. He was, he says, in regular contact with CN, the outreach nurse from the Astley Ainslie, and he asked her for a "prognosis" for Ness. He never asked a doctor for that information, or any other information about the nature or extent of the brain injury. We criticise that elsewhere, and we should make it clear that the criticism extends to SW5, his supervisor from December 2000 to September 2001. However, we note in her defence that she was extending her own job responsibilities to provide supervision of SW7 and others because the Practice Team Manager was off sick long term, and the office was overstretched at the time. In September 2001 she was relieved by SW6, another very experienced Senior, but again he was only covering while the colleague was off sick, and he told us he had not opened the Ness file before Caleb died. He was doing several tasks, and this was a low priority at that time.
- 5.4.4 SW5 had qualified as a social worker in 1981, and did generic social work (including child protection) until 1992. Since then, she has concentrated on criminal justice



work. She impressed us as a sensible and experienced witness, so it gave us pause when she defended SW7's approach. He set out first to find the house, and then to set up a package of care when a given address could allow applications to be made to a given allocation of resources in that area. We think that this puts the cart before the horse when there is a possibility that the housing applicant might not manage on his own in mainstream housing. SW5 explained this approach by saying that the waiting list for supported accommodation was so long, that it was no good expecting a vulnerable single male to hold on and wait for it. She hinted that a medical assessment which confirmed that Alec Ness needed supported accommodation might have interfered with his application for mainstream housing. We see the difficulty in practical terms, and much regret that housing is so inaccessible for so many, but we cannot accept that this approach was good practice. Even leaving child protection issues to one side, we should have thought that the chance of a brain damaged man re-offending must increase if he is left on his own in a new flat where he cannot cope with day to day living. The approach of SW5 and SW7 depended on their impressions that Ness was docile, not too bad, and so forth. Brain injury is complicated, and they should have proceeded on the basis of medical evidence, if only to protect the public from a possible risk.

5.4.5 SW5 told us that she would have arranged to send a written report to Caleb's CPCC if she had known that it was taking place when SW7 was on leave. We accept that she would have done this in accordance with standard practice, and believe that a written invitation did not reach the Murrayburn Gate office to alert her to the need to provide information. We think the written invitation to SW7 was not posted, as SW4 learned by phone that SW7 would not be able to attend. The question is why neither SW4 nor SW7 thought of requesting a written report. We do not know what happened with SW4, who did think that Ness had a continuing involvement with Shirley, but we suspect that SW7 dismissed the thought as he was sure that the relationship had ended before he left to go on holiday.

5.4.6 When SW7 returned and heard about the CPCC, he did not think of querying what was happening, even when he knew that Ness was involved in day to day care of the baby. He knew that there might be a risk to Caleb. "I suppose the things that were alarm bells for me were if he (Ness) was falling and if he was holding the baby". Yet

he did nothing to bring this to anyone's attention then because "These things had been said and spoken about", referring to his telephone conversations with SW4. In other words, because he had passed on the information which might have a bearing on risk, he thought his job was done in child protection terms. Looking back, he told us, referring to SW4. "...we would talk it through and we would talk about our perspectives. We talked it through on the telephone and talked it through. I would go through my perspective of what was happening. SW4 would sometimes, as I say, be saying, "That's not my understanding of it". My understanding or belief was that I had gone into those details, but it would be in the context of a discussion. It may be that I said something that wasn't picked up on or maybe SW4 said something I didn't pick up because I was making another point, and things like that could have happened. I certainly remember being shocked by him saying that he felt that the relationship was still going on. That was a shock to me. I thought "Well, it's very clear that they're both saying to me individually that the relationship is over," and that surprised me and I remember making that clear to him."

- 5.4.7 This is one example of several where we can only conclude that things were said which were not heard or absorbed by the listener. Teaching people to listen and to hear what they do not want to hear, or perhaps what they simply disagree with, is what is needed. But how can it be achieved?

## **5.5 SW8**

5.5.1 The Team Leader of the Children and Families Team in (distant) Social Work Services, and Manager of three Social Workers (including SW9) over the past seven years, also gave evidence to the Inquiry. She was one of the authors of the Report, dated 22 January 1998, sent to SW4 in June, before Caleb's birth. Again, we cannot reproduce most of the information which she could offer. However, we are clear that the decisions at Caleb's CPCC would have been different if those present had heard her evidence, based on many years of contact with Shirley.

## **5.6 SW9**

- 5.6.1 SW9 had come to work in the (distant) Social Work Department just before Caleb was born. She took over responsibility for Social Work involvement with Shirley's two elder children, and had continued to work with those children until she gave evidence to the Inquiry in May 2003. She was a basic grade Social Worker, with no specialist training in Child Protection procedures. She impressed us as an intelligent and reliable witness, and we note her evidence for three reasons.
- 5.6.2 Firstly, she had clear recollections of telephone conversations with SW4, particularly on 30 July 2001, 28 August 2001, and 7 September 2001. She had contemporaneous records which confirm these calls. The first concerned communication of the fact of Caleb's birth to the other two children, and was non-contentious. The second matched the record in SW4's files, reproduced in the "Chronology". She agreed with SW4 that she had not expressed concerns about Shirley's care of Caleb on that date. However, on the third date, probably, SW9 had telephoned SW4, or alternatively she telephoned the duty worker at Leith and subsequently spoke to SW4. What she was clear about was that she rang to report the fact that she had telephoned Shirley to speak to her about the children, and had spoken to a woman who denied that she was Shirley, and said "I'm a friend of Shirley". However, SW9 had met Shirley, and recognised her voice. SW9 thought that this was Shirley at the end of the telephone "certainly under the influence of some drug, heavily under. It was very slurrish, the conversation". SW9 took the initiative and telephoned SW4, "because, in my opinion, she wouldn't have been in a fit state to have cared for her child." We did not know about this telephone conversation when we interviewed SW4, but he specifically denied the suggestion that SW9 had ever expressed any concern about Shirley's ability to care for Caleb. We had no hesitation in believing SW9 on this matter.
- 5.6.3 According to SW9, SW4 told her at some time (she could not place it by date) that Alex Ness was "a known drug dealer in Edinburgh" and "had associations with many inappropriate people". He also told SW9 on 18 October 2001 that Shirley was obtaining half of her Methadone legally, 90 ml by prescription, and another 100 ml illegally on top of that. (This may have coincided with an increased usage because of Caleb's death.)

5.6.4 Secondly, SW9 gave her evidence about the older two children, which we cannot disclose here.

5.6.5 Thirdly, we asked her what she might have said, had she been invited to attend Caleb's Case Conference. At that stage, her information would have come from the file, rather than first hand knowledge, but we reproduce her replies:-

“Q: But if you had been invited, what sort of information would you have thought was relevant from the files that you inherited?

A: Certainly the background information with regard to Shirley. Shirley at that point had a 21 year drug history that had not changed, despite numerous attempts for her to accept drug rehabilitation to try and assist her in maintaining her drug habit. That hadn't changed. Her lifestyle in terms of who she socialised with – inasmuch as I could gather and certainly my contact with her subsequently hasn't told me anything different than that – was that she still was associating with many inappropriate people.

Q: You mean in connection with drugs and what? Criminals as well?

A: Yes, criminals. I think she has been part of quite a wide circle of people, and certainly what she was telling me was that she was still associating with people who were allegedly up for offences against women, so it was all around her kind of behaviour. I think the big one for us has also been that Shirley has been inconsistent throughout these children's lives and, on an emotional level, that has been extremely damaging to these two children. She's not been able to provide them with consistency, and at times she has got them involved in inappropriate conversations about her lifestyle.”

Later:

“Q: So all of those things, what would they have pointed you towards saying to a Case Conference for Caleb?

A: Certainly I have a very high level of concern, and I think I can only speak for (distant) Council, and my view currently is that I wouldn't allow the two children that I work with, whom I know very well, to be having any unsupervised contact with Shirley.

Q: Do you mean not even for an afternoon?

A: No, we don't allow it.”

## **5.7 SW10**

- 5.7.1 SW10 is now a Senior Social Worker, but in 2001 she finished her CQSW (Certificate of Qualification in Social Work) in July. In the run-up to qualifying, she had spent five months as a student in a placement with the Children and Families Team at Leith. After a month's gap, she returned to Leith for a two months locum job, from early July until September 2001. She had no formal training in Child Protection procedures, beyond what she had learned in the CQSW course, and she had once attended a CPCC as an observer, when she was a student.
- 5.7.2 SW4 asked her to attend Caleb's CPCC as Minute-taker, because she had time to spare. SW3 (herself brand new to the job of chairing Case Conferences) "went through the procedure with" SW10, and SW4 had been SW10's a practice teacher during her placement, and he also explained what was required. She had gone into Social Work after doing other things, and was confident from the experience of taking Minutes in other contexts that she would be able to do the job. She did not know shorthand. She took notes during the meeting, and thought that she had been present when SW.4 had some kind of discussion with Shirley prior to the meeting, which she did not minute. She was unsure about this part-recollection that a pre-meeting discussion had taken place. After the CPCC, she dictated the Minutes into a dictaphone, and her hand-written notes were shredded. She thought that she had dictated her notes within the next few days, no later than that. She said that she passed the Minutes over to SW.4, to check.
- 5.7.3 While we believe she was trying to be truthful, we were very unsure about how much reliance we could place on her memory, which had been refreshed by "someone from Shrubhill" (ie the social work department), accompanied by SW3, shortly before she spoke to us. It is regrettable, to say the least, that her evidenced was tainted in this way.
- 5.7.4 After the draft Minutes had gone to SW.4 for checking, SW.10 could not remember exactly what had happened.

- Q: “So after that did he suggest to you that you should do anything with the Minutes?”
- A: I don’t remember. I mean, there was a process to follow and there was times when I had to tick names. I don’t remember what the process was now. I’ve only done this one, so ...
- Q: Well, do you remember clearly that you were supposed to be following through the process for the Minutes?
- A: I don’t remember what amount of the process was mine. I don’t really remember, I’m afraid. I have tried to, but I can’t.
- Q: Other people have asked you this before, have they?
- A: Yes, because SW.3 asked me that, and I said, “I don’t remember what the process was”.
- Q: When did SW.3 ask you this?
- A: When she gave me the Minutes, because it was a few weeks ago but SW.3 and somebody from Shrubhill – (first name) somebody – came just to see me, and they were just sort of ... sort of ... you know ... you know ... to tell me what was happening really, because I didn’t have a clue. I just had a phone call from the PTM just to say that I was going to have to speak to someone at that point, and then SW.3 and the guy came along. They gave me a copy of the Minutes and ... well, before that they’d asked me what I could remember, and it was pretty much the same, you know. It had not changed at all. What I could remember then is the things that I could remember now, and she asked me about the process, and I just couldn’t remember.
- Q: Did you ever give the Minutes to SW.3 for checking?
- A: I don’t remember.
- Q: No, because I think if you look at the Guidelines, the Minutes should have gone back to the Chair for checking, shouldn’t they?
- A: I probably did then because I would have looked at the Guidelines, you know, at the time because, you know, I was following them.”
- Q: “Alright, so you can’t remember whether you gave the Minutes to SW.3?”
- A: I just know I gave them to whoever I was told to give them to.
- Q: What about circulating the Minutes? Did you understand that the Minutes should be circulated to people?
- A: Oh yes. Aye.
- Q: You knew that?
- A: Mhm hm. The Minutes should always be circulated to people that were there.
- Q: So whose responsibility was it to circulate the Minutes?
- A: I can’t remember.
- Q: You see, it’s been suggested to us it was your responsibility to do that.
- A: It might have been. I might have done it, but if it had been my responsibility and I was aware of it, I would have done it. That’s all I know. That’s all I can say really.
- Q: Yes, because the information we have is that the Minutes weren’t circulated.
- A: Yeh, certainly if it was something that I had known it was my job to do, I know I would have done it because, you know, I did these really quite well. I wanted to make sure it was as good as possible and I did it alright, you know. It was my first one.
- Q: So you’ve got no explanation for the fact that the Minutes weren’t circulated then?
- A: No.

Q: And did you see the Minutes after you finally had them typed up?  
A: I would have checked them over before I ... I've noticed a couple of wee mistakes in this, typos. I would have checked them before I gave them to SW.4 or SW.3 or whoever I gave them to afterwards, you know, just for obvious mistakes, and they would have checked them for content, you know.  
Q: Are you sure you didn't just put them on the file?  
A: Oh I wouldn't have done that, no.  
Q: So you are clear that you gave them to SW.4 or SW.3 or somebody?  
A: Oh aye.  
Q: Now you've talked about SW.4 checking things and ...  
A: I think they had the file, sorry, so SW.4 would have had the file, not me.  
Q: You've talked about SW.4 checking things and telling you things in the story you've told me today. Who was actually supervising you during the time that you were at Leith over that Summer doing the locum job?  
A: SW.2.  
Q: Did you talk to her about this case at all?  
A: I can't remember. Probably.  
Q: Did she give you guidance on what to do about the Minutes?  
A: I don't remember.  
Q: Did she tell you how to take Minutes before you went along?  
A: I think I checked these things out with SW.4 and SW.3, I would imagine, you know. I would have gone to them normally."

SW.10 believed that SW.3 was experienced at chairing CPCCs, so SW.10 was confident that SW.3 knew what she was doing.

5.7.5 SW.10 has worked in a hospital since November 2001, and she told the Inquiry that she did not realise, when there was publicity about Caleb's death, that this was the baby whose CPCC she had attended. She only discovered her own involvement "a few weeks ago", when contacted by someone at Shrubhill.

5.7.6 The Inquiry Team deeply regretted the fact that "someone from Shrubhill" saw fit to take her through the evidence, in the company of SW.3 whom she knew and liked, a few weeks before the Inquiry heard her evidence (on 5<sup>th</sup> June 2003). Although we felt that SW.10 was basically trying to be truthful, we also thought that her poor memory might have been tainted by discussion of the events which she was struggling to recall. It is one thing to interview Social Workers in the Team immediately after a baby's death to find out what has happened, and quite another to interview a person who has left the City's employment a few weeks before an independent Inquiry ask her for her best recollection of events some two years previously. These are not adversarial proceedings, and we find it difficult to understand what justification there can be for



pre-interviewing this witness, particularly with another critical witness in attendance.  
**We RECOMMEND that the Social Work Department refrains from interviewing witnesses where an inquiry has been set up.**

## 5.8 HV

- 5.8.1 The Health Visitor assigned to Caleb was highly trained and very experienced. She had moved to the GP practice where Shirley was registered in August 2000, and did not know Shirley until after she was contacted by SW4 and told of the social work department's interest in the pregnancy. She asked SW4 to encourage Shirley to make an appointment to meet at that time. Shirley made the appointment, but failed to attend. hereafter, the HV was aware that midwives were trying to see Shirley, and that one had concluded that Shirley had moved to another address. Here was a suggestion that Shirley had put one of her neighbours up to telling the midwife this story, in order to avoid seeing her.
- 5.8.2 HV attended the CPCC, and knew what to expect. Her memory is of SW4 doing "most of the talking", and realising that "quite a few members of that team hadn't actually met the parents." She knew that she should liaise with SW4 in connection with the child protection plan, such as it was. She noticed that she had not received the Minutes well before Caleb died, and said that she had already complained to SW1 about the failure to circulate Minutes in connection with other cases. She had noticed that she had not received Minutes from 4 CPCCs soon after starting her job in Leith: in fact, she says she never received those Minutes. This contrasted with her experience in another practice in Edinburgh, which was much less busy, where the Minutes always arrived.
- 5.8.3 HV only discovered that Caleb had been discharged because she phoned the ward at the hospital: the usual warning in advance does not seem to have happened. We think this is quite unacceptable for a child on the Child Protection register. HV had trouble visiting Shirley's flat at first, as there was no reply on several visits. Shirley's doorbell had been disconnected, she later discovered, and she was able to visit thereafter by tapping on a window. All her visits were pre-planned, i.e. Shirley knew in advance that she was coming, and we consider that it would have been better practice to intersperse the planned visits with the odd unscheduled spot check. Clear records were kept of the visits, and of the dates of telephone contacts with Shirley, in the special recording system organised by the Lothian Primary Care Trust. We have no criticism of what HV did when she did see Caleb: on the contrary, she was

checking him appropriately. Fractured ribs would not necessarily be apparent on examination, even by a doctor alerted to the possibility of their presence.

5.8.4 When HV went on holiday in October 2001, the other HV in the practice was also off, and cover was arranged with Health Visitors in a neighbouring practice. We saw written records relating to this, and are satisfied that adequate arrangements were made, contrary to what was apparently said at the trial. We also saw confirmation in a written record kept by one of the covering health visitors that the people who made contact did not include Shirley or Alec Ness also told us in evidence that he knew of no attempted contact with a health visitor which had been frustrated by the absence of holiday cover. We think it might have been good practice for HV to have suggested proactive intervention by her colleague during the holiday, given her concern once she knew Shirley had post-natal depression, but we do not know if such a suggestion would have been practicable in terms of workload.

5.8.5 Although the Child Protection Plan for Caleb was conspicuous by its absence, and we certainly do not criticise the HV for failing to follow it, we do consider that the frequency of her visits to Shirley could and should have been higher – at least once a week – simply as a matter of good practice. The evidence of PCMan2 supports this. However, the evidence also suggested there was a relative shortage of HVs in this practice with a high number of child protection cases, and we therefore do not criticise HV herself. She impressed us as competent and caring.

5.8.6 We conclude, in fact, that HV comes out of this investigation well. Her analysis of the risks in Caleb's home environment at the beginning of her file is the only contemporaneous written evaluation of risk that we have found. It is sensible and accurate. Moreover, she did try to alert others, and crucially SW4, to her perception of heightened risk at the beginning of October. She played her role in the system as it is supposed to operate in Edinburgh and the Lothians: the fact that she could not trigger increased concern and intervention is the fault of the system. We say more about this in our conclusions, and end with her evidence on this:

SW4

A: "... the information that I was getting from the Health Visitor ultimately was that you know, that Caleb was thriving and that the Health Visitor didn't have any concerns, and in my subsequent visits to the family home I didn't see anything or I wasn't told anything that would have made me, you know, unduly concerned you know, about their actual just day-to-day care of the child."

HV

Q: "So going back to the time when Shirley presents to you and you were concerned about the post natal depression, you told G.P. and you know that she had refused the antidepressants, you contacted Dr.1 and you told him of your concerns and you contacted SW4 and told him of the concern, is that the situation?"

A: Yes.

Q: Now is that taking the steps that you understood were appropriate for you to take when you thought that there was an increased level of risk to the baby?"

A: Yes. That was the GP, the Consultant Psychiatrist, the Social Worker and the person that was going to be covering my case load."

## 5.9 GP

- 5.9.1 In 2001, Shirley was registered with a GP, who never saw her or the baby during Caleb's lifetime. She had fallen out with him when he discovered that she had forged one of his prescriptions, and he sent her on to the CDPS for substitute prescriptions in the autumn of 1999. Thereafter, the CDPS would report on drug issues to that GP. She attended the surgery infrequently, and tended to move around and see different doctors each time. Shirley failed to take Caleb for his 6-week check-up, but she did bring him in for that check-up when he was 9 weeks old.
- 5.9.2 We interviewed the GP who did that check on Caleb, and who also saw Shirley at the same time, on 2<sup>nd</sup> October. The HV had already interviewed Shirley, and formed the impression that she was suffering from post natal depression. She saw the doctor for a moment before he saw Caleb, and "put me in the picture that Caleb's mum had been a drug user. That the father had had a head injury. And that I think there had been a Case Conference in the hospital." Without this proactive intervention by the HV, the GP would have known nothing of this, because the mother's notes were not brought along to the clinic for a developmental check of the baby. The baby was examined, and completely undressed for the examination, but there was no sign of any abnormality. When asked about the post mortem findings of old rib fractures, the GP said: "I would have thought that when I held the child to assess its posture and tone that he would have been in discomfort. I would have expected the child when it was looking at me to maybe be a little bit distant and haunted. Children that are abused often have a kind of stare about them. This was a happy child in every way. ... If there were any fractures they must have been some time back, maybe more than 5 or 10 days or something, or maybe sometime after I saw the child, because as I say the thing that really struck me about this child is how happy he was sitting on mum's knee." He did find Shirley was low in mood, and was keen to get her started on anti-depressants, but she refused to take them. He made a definite diagnosis of post natal depression. He told HV to keep a close eye on her. However, there were no concerns about Caleb's health on that date. An appointment was made for Shirley on 11<sup>th</sup> October, but she did not attend.

5.9.3 The GP told us that, after Caleb's death, his own practice reviewed their method of computer coding children at risk, and the mother's notes are now taken along to the child's developmental check-up. However, although he would like to see the Health Visitor's notes combined with the child's notes, in the child's file, he thought that there was "resistance to combining the notes". He understood that there was a requirement on Health Visitors to maintain separate notes, apparently from the Trust. He also observed that it was "Never terribly helpful when one of the parents is actually with another doctor, another practice." He thought that it would be reasonable to ask the Trust to give people priority to go on the list of the GP practice where their partner was already registered, in the context of a couple with a baby on its way.

5.9.4 What is significant is that, as a matter of fact, the GP did not know about the concerns expressed at the CPCC (for example relating to Alexander Ness' handling of the baby), and although he knew in general terms that Shirley was a drug user, he did not know her history or her actual current intake of Methadone. Through a combination of defects in his practice's recording systems, and the failure of the Social Work Department to circulate the CPCC Minutes, the implications of the diagnosis of post natal depression as an extra risk factor for Caleb were not apparent to the GP who diagnosed it.

5.9.5 The GP expressed the opinion that Health Visitors are currently overloaded with Child Protection cases. We quote part of this evidence:-

Q: "From what you are saying it would be perfectly possible for there to be far too many new babies on the At Risk Register to be looked after by the Health Visitors in your practice, and yet your practice and the Health Visitors themselves can do nothing about it.

A: We would have difficulty doing anything about it because of the constraints of the budget and because of the constraints of the ... yes, because of the constraints of the budget and constraints of ..... funding. I am of the belief in relation to all Health professionals who work in ... Edinburgh, that really the number of nurses, the number of doctors, the number of Health Visitors should relate to the workload and specifically in relation to Health Visitors. If you are a Health Visitor in Barnton you'd probably, although not necessarily, you may have got many fewer At Risk families than if you are in the heart of Restalrig, and Restalrig has definitely undergone a demographic change in the last 5 to 10 years. Basically what's happening is that the old worthies of Leith have

been slowly dying off and a much more chaotic influx of youngsters has come into the area.

Q: And often drug use must be contributing to this?

A: Yes, we are ... our practice is in the top 10% of practices for drug misusing populations.

Q: So are you saying that your practice is allocated Health Visitors in the same way ..... as if it happened to be situated in Barnton?

A: Yes, again it's changed because of this PMS because we have had a significant rise in the number of nurses as a whole in the practice."

A: "I think it would be very useful to recommend that the number of Health Visitors is directly related to the number of children at risk or families at risk. But that should be seen as quite separate from other nurses, members of the Nursing Team."

## 5.10 Dr 3

5.10.1 Dr3 is a Consultant in Rehabilitation Medicine at the Astley Ainslie, and Ness was under his care from 26 February to 9 March. At that time, the next of kin, and the family to whom he spoke, were Alec Ness' grown-up daughters, and Shirley did not attend the ward at all, to his knowledge. He then saw Ness at Outpatient appointments on 25 April and 18 July, and on these occasions Shirley attended with Ness. He did not see either Shirley or Alec after Caleb was born, as Ness failed to attend his clinic on 21 August and he decided that it would be better if he were referred "to a drug rehabilitation clinic" thereafter. He made this suggestion to the GP with whom he thought Ness was registered in west Edinburgh, to whom he sent reports.

5.10.2 Prior to discharge, Ness was assessed as being able to make a simple meal, to make a drink, and to go out shopping on his own. It was anticipated that Ness' ability to plan, and to remember things for even a short period of time, would cause problems, but improvement was expected. Typically, learning new things, coping with new problems, and doing two things at once, would put such a patient under stress. After Alec' brief admission to the Royal Infirmary in July, Dr.3 saw him, and said:

*"When I saw him he was definitely a different person, you know, he was totally distracted and focused on his partner Shirley, you know, you would think she was coming to my appointment, not him. Alec was kind of distracted, fiddling with his mobile phone, looking you know, slightly slurring his words and not sharp at all and I wondered whether he had actually been taking something, and obviously the prescribed drug he was taking from us was an anti-convulsant which I noticed he was taking in a slightly lower dose than recommended, but he was being prompted to take that. And the difficulty about housing came up again but it was clear, I really picked up at this stage that, you know, Shirley and him weren't really getting on very much and that Shirley was getting fed up with this kind of behaviour and I definitely got the impression, I mean when she was talking to me you wouldn't think Alec was there, she was more or less telling me that they were going to separate and I got the impression for the first time Alec had really thought about this, or even come to be aware of it, and she said that Alec was going to live with his sister and I think he went almost to argue with that and then didn't. On examining he had pinpoint pupils which I*



*couldn't quite work out why, and I wondered whether he was actually taking Methadone which Shirley was being prescribed, and, you know, he acted like someone who clearly wasn't drunk, he didn't smell of alcohol but he certainly was someone who had been taking some sedatives of sorts."*

5.10.3 In view of that suspicion, Dr.3 arranged to have Alec' urine tested, and it tested positive for Benzodiazepines, Valium and Temazepam. There was a possibility of a trace of Methadone as well. These drugs "clearly would account for his change of behaviour and would fit the opiates and the Methadone would fit with the pinpoint pupils." This also provided an explanation for Alec falling around, vomiting, bumping into walls etc. Ness was warned not to take any more of these drugs, or alcohol, but "he didn't accept that he had taken anything, and there was this story about his nephew spiking his drinks".

5.10.4 Dr3 had no concern about the baby which Shirley was expecting, as he thought that the relationship had ended.

## 5.11 PSYC

5.11.1 Psyc is the Head of Neuropsychology at the Astley Ainslie Hospital, and is a Clinical Psychologist. When Alec Ness was transferred there from the Western General, Psyc was in charge of the Neuropsychological aspects of his multi-disciplinary care, and made various formal assessments of the extent of his brain injury between 26 February and 6 March 2001. He estimated that prior to the brain injury, Ness had been “quite a bit brighter than the average”, partly on the basis of his occupational history, which included working as a foreman in a brewery many years previously. On testing, it appeared that Ness had moved from “a normal average level to in many instances clinically alarming levels” of functioning. He defined this as being when a person was at, or below, the tenth percentile, i.e. functioning worse than 90 out of 100 people, and in some cases Ness actually went below the fifth percentile. Some scores even went into the second percentile, i.e. “The stage where a person would really require outside help to cope in day-to-day functioning”. All the results were typical of the injury sustained, and Alec was assessed as having a “clinically significant degree of cognitive impairment” at the time of his discharge from hospital. Psyc told us: “His perception wasn’t good, he didn’t look carefully at things and didn’t assess situations visually in a good way. His speech functioning was grossly normal. Looking at him subjectively, he was extremely disorganised, inattentive, rather inappropriate and forgetful, he behaved a bit like an old lag, he was extremely deferential, he looked institutionalised.” He knew that Alec had been in prison for a fairly lengthy sentence, and that it had something to do with drug dealing, but no more. Since Caleb’s death, his team has started asking for more information about criminal records, as a clue to the potential for rehabilitation.

5.11.2 Ness was “completely lacking insight”, and he “was really deaf to all advice, even fairly direct advice”. It was anticipated that his recovery time would be long, and that it would take a year or more after discharge before his final state could be assessed. However, in fact his condition deteriorated.

Q: “So at the time you saw him in July had he changed from what he was like when you saw him at the time of discharge?”

A: At the out-patient appointment he was much the same as he had been when we discharged him in March, he hadn’t improved, but when we saw him on

24 July at his sister's house when he was under duress, he had really fallen to pieces, and in fact his overall condition appeared to have deteriorated and we imagined it was partly the domestic stress and partly the fact that he appeared to be taking drugs again, because if you damage your brain drugs and alcohol have a disproportionate effect.

Q: Can you tell me a little more about that? What about the effect of taking the drugs that he tested positive for ?

A: (referring to Methadone and Diazepam) Well, both of these drugs are essentially sedative drugs and they would be such as to reduce the functioning of what brain cells he was left with, it would be such as to depress his functioning, and they are in a secondary way, you know, people tend to react badly when they are over-stressed so if somebody is given more than they can cope with that's when they are likely to lose their temper or to do something radical or, you know, very poor, so that the drugs would have reduced his ability, already damaged ability, to cope with the pace of life and thereby would have made him also more prone to react, to explode, because you know, he could cope with that much less while he was under the influence of drugs like this.

Q: Did you see any sign in him that he could explode when under pressure like this?

A: None whatsoever, he was as I said always extremely deferential and on the surface biddable, amenable. Underneath he was simply doing exactly what he wanted but he never showed any sign of irritation or even inclination to debate a point, would always say "Yes yes yes", and then "but". So there was no evidence of a sense of standing up for himself or a sense of ... that he might lose his temper, I never saw any sign of violence in the man.

Q: Alright, so what I was asking about originally was the deterioration from March/April through to July?

A: Yes.

Q: And you are saying there was a deterioration?

A: Yes, there was."

5.11.3 Psyc and CN, the Outreach Nurse, had a long visit to Alec on 24 July 2001, before Caleb was born. Shirley had made him leave her flat, and we asked him about this:

Q: "You have described mixed messages and I'm just wondering – is the story really that she had told him she didn't want him, she had put him out and he refused to listen to this, or do you think she was saying one thing one day and another thing another day?

A: I think there was something to do with, he, as you know, it's perhaps clear by now that he was very bullish and single minded in what he thought should happen, and so at times she might have despaired of actually getting the message over to him and just said, oh, right, okay I've been defeated.

Q: Yes?

A: There was also an issue of their future housing because the house she lived in was unsatisfactory and there was some, I think she had given one of the team a hint, or some reason to suppose, that if they were perceived as a family they would get better housing, and it might have been that he was, his presence and the baby and herself was a means of getting a better living arrangement.

Q: Yes?

A: So there were material and psychological issues at play there, as well, and she may at times, given his apparent devotion to her, it didn't seem, yes, it was almost a devotion but in a kind of deranged, a deranged sort of devotion, it wasn't a responsible or clear-sighted sense of responsibility, it was more of a dependency, an obsessive sort of dependency, and she may have felt that his devotion would prevail, you know that in the end it was probably, he might be of some use, although she complained bitterly about how clumsy and emotionally abject he was, that he burst into tears for no real reason and was very clumsy, knocked things over, forgot things, was just hopeless.

Q: Now, you say she complained, did you hear her complaining?

A: I did not hear her complain but heard it through CN, the Nurse, who was keeping me briefed on their situation."

5.11.4 After that, Ness "kind of vanished from the scene, was very difficult to contact, didn't turn up for appointments", and the hospital in the end went to considerable trouble to ensure that he attended their Brain Injury Group, which he did haphazardly. Speaking of Ness in that group, Psyc said:

A: "He was really very, very disorganised, his problems just, and these were all patients with severe brain damage but he had no concept whatsoever of sitting in a group, of turn taking, of following a topic, had no social awareness that we could discern, and would interject with completely irrelevant remarks or ask questions (no matter) what particular theme might be being discussed, - and he would just announce to the room at large something completely different, he was really, really hopeless socially, all we could ascertain about him was that he was staying in the Hostel, he was going to the house in Leith where his partner stayed with the baby, so he wasn't staying there overnight, he was being allowed to make feeds for the baby and to dangle the baby on his knee and things like that. He said some things about the baby which were just completely implausible, for example that the baby was upset when he had to go back to the Hostel at night, and the baby would at this time be about two or three months old, and other things like that. But from what we could see he was visiting the mother and the baby, taking a very limited part in the care of the baby and was desperate to get a house for his partner and himself and Caleb, he saw that as his first priority and really whatever other topics were being discussed in the group were of no interest to him, most of his interjections and concerns were about this getting a house.

Q: Did you get any impression that he was sometimes doing things alone with Caleb, like looking after him for short periods of time?

A: None, none at all."

5.11.5 When he learned of the baby's death, Psyc said:

"I mean I felt obviously very, very distressed at this, you know, we in a sense being party to this, hadn't been able to help this baby, and I can't really blame Alec because in a way, I really think he was so clueless he just didn't know what he was doing, and had he been more with it I would have held it against him and really come to dislike

him a lot but I just thought it would be like, you know, putting him in a stable with a horse, you know, that he would just bump it and bang it and make a mess of it and wouldn't, just through sheer ignorance rather than through malice. So we were very sad, felt, you know, all of us thought a lot and discussed a lot about what could we have done, what have we missed out, something has gone wrong, why have we not, you know, why did this happen. I doubt he, I don't think he, I mean I wasn't there but I doubt he would be shaking the baby in a kind of fury, I think it would have just been kind of tetchy and you know, he just didn't realise how little it takes to injure a baby, you know, I just don't think he was violent or malicious in an extreme way and just perhaps lost his temper and forced the teat into his mouth, that sort of thing through his just sheer lack of knowledge and his rather clumsy, forlorn sort of style."

5.11.5 When asked whether he could suggest recommendations for the future, Psyc said:

"... If there has been evidence of mental illness or instability in the carers of the child they (the CPCC) should be duty bound to take evidence from those clinicians who have looked after the parent or the member of the household who might represent a risk, because I think that, just as we weren't really very well able to assess the maternal coping capacity or something, they weren't really in the best position to assess the severity of his brain damage and its potential for causing chaos and I think there must have been a gap there somewhere in their perception of how bad this was."

## 5.12 P1

5.12.1 In 2001, P1 was acting as the Director of a charity which had an office in the same street as Shirley's flat at that time. Her own house was at the same address. Some of her evidence concerned things that she had seen in the street by chance, for example (speaking of Shirley): "I've seen her in the street a few times and she was obviously under the influence of alcohol and drugs and arguing with males and females at the top of their voices, throwing bottles of beer in the street, and I didn't go out of my way to find out exactly what was going on." This referred to the time when Alec was in hospital. She saw Shirley in the street with known drug dealers, and was quite clear that Shirley was taking illegally purchased drugs (on top of the Methadone) during her pregnancy. She reported that, after the baby was at home, Alec Ness complained that Shirley was in charge of his medication, but not giving it to him. Instead, Shirley was using it, in particular 100 Paracetamol tablets, which she melted down and injected. At that time, she says, Ness said that he was worried because she was injecting these drugs and other illegal drugs into her neck. Alec Ness gave us the same information when we interviewed him in prison. We have difficulty in evaluating this evidence, as we have not seen Shirley, but on balance we concluded that it was probably true.

5.12.2 We did accept her evidence of what she saw of Caleb when Alec brought him to the office, and note that much of that evidence was corroborated by P4. We select the following extracts:-

5.12.3 When she was asked about watching Alec handling Caleb, she said: "On many occasions he had great difficulty. We'd always have to say: "Alec, you have to support the baby's head". Always having to remind him, you know, to support the baby's head. He seemed quite heavy handed on many occasions but very, very loving. He would make major mistakes like, you know, the baby would be sleeping for instance and he would be trying to wake the baby up, play with the baby and change the baby's nappy when the baby was sleeping and we tried to gently say, you know, "This is baby's sleeping time" etc."

"He was quite anxious, you know, to be doing things for the baby. He was always, you know, I have to do this or Caleb needs a new baby bottle. I have to go and get

Caleb, he's needing nappies and I have to go down and bathe baby Caleb which we were very concerned about. I gently said: "Alec, you should not be bathing the baby" and, "You know Shirley should be doing that".

"It was always Alec that did the shopping, went to the shops and seemed to co-ordinate everything which surprised me at times because he did do some of these things very well considering the brain injury but at other times was very, very poor."

"The baby came into the office and the baby was sleeping and I made Alexander Ness a nice cup of tea and a sandwich and I think we were just about finished the sandwich when the baby started to cry, so I picked the baby up and said to Alec, "Is the baby due to be fed Alec?" and he didn't know. "When was the last time the baby was fed Alec?" and he said he didn't know. I said "Did you feed the baby Alec?" He said "Yes, I fed the baby." "When did you feed the baby?" He didn't know when he fed the baby and I said, "So how did you feed the baby?" because I was concerned, "How did you feed the baby?" "I just mixed up some powder and ran it under the cold tap" and it horrified me."

5.12.4 P1 quite often assisted Alec in feeding and changing the baby, and did not see anything unusual about the baby. "So when Alec would come out with the baby he would have difficulty pushing the pram. There is quite a high kerb in the street. He would have difficulty in co-ordinating that high step and the pram was always in the front between cars pushing it about and this was happening about 5 or 6 times a day. Sometimes I used to try and ignore him." "I'm not going out. I'm not going out." And each time I would have to go out and take Alec Ness across the road with the baby in the pram because I just thought there is going to be a car and kill both of them... We had to count his bus fares out sometimes. He would be very confused when he was leaving Shirley Malcolm early evening to return to the hostel. He had great difficulty counting his bus fares and we used to make his money up in small bags with "Monday, Tuesday, Wednesday" etc." "He had concern that drug addicts were coming to the home at night time and I gave great weight to that because I did see that on many occasions at night." (On 25 September, or thereabouts): "I was out, it was a birthday and Alexander Ness had called me on my mobile. He was very, very distressed and said there was no money, there was no nappies for the baby and there was no milk for the baby and I said, you know, just stay put and I would be with him. I asked him why there was no baby milk and I said "You get your tokens to collect your baby milk Alec, where are the tokens?" He told me that Shirley Malcolm had swapped the tokens for cannabis."

5.12.5 “I think there was long periods of time when Alec had no contact with anybody at all. This is when I couldn’t understand who was taking responsibility. I knew that as soon as Alexander Ness got out of hospital I thought there would be a team of different agencies there, maybe someone from the Head Injury, maybe a Social Worker for Shirley Malcolm and Alexander’s Probation Officer. What seemed to me in my line of work I think there was a lack of continuity of structure between the services. It didn’t seem like anybody was talking to each other.”

After Alec Ness came out of hospital, he took to visiting P1 more and more frequently. He was often in her office “5, 6, 7 or 8 times a day”. Sometimes he turned up dirty and smelly, P1 would tell him to go home and shower, and change his clothes. Previously, he had been an extremely well dressed man. She said that she tried to get him into a simple routine, and there was a slight improvement after time. However, Alec’ personal hygiene and wellbeing deteriorated approximately a week after the baby came home from hospital. He continued to visit the office several times a day after Caleb was born, often bringing Caleb in his pram.

5.12.6 We should record the fact that P1 wrote a lengthy letter to the Inquiry Team, immediately after there was a public announcement that this Inquiry was being set up. The letter ended with an allegation concerning factual circumstances on the day of the baby’s death, which the Chair of this Inquiry thought should be passed on to the Lord Advocate. If true, the allegations might have had a bearing on the safety of the conviction of Alec Ness. The Lord Advocate in turn passed P1’s letter to the police. A decision was later taken, following police inquiries, to take no further action.

5.12.7 P1 was insistent that she knew Alec Ness in her personal capacity, and not in her capacity as a Director of the charity. She was not candid with us about the original link between herself and Alec Ness, which was a family connection, and we were troubled about the extent to which we could rely on her evidence. We concluded that she was unreliable in some respects. Certainly, what she was quoted as saying to the press at the time of the trial was not the same as what she said in evidence to us.



## 5.13 P2

5.13.1 P2 is a volunteer at the Citizens' Advice Bureau, who happens to have Registered Mental Nurse and Registered General Nurse qualifications. She never met Shirley, but saw Alexander Ness three times when he came to the CAB for help. (See Chronology.) She asked his permission to ring his Social Worker, and did in fact call SW7. SW7 told her not to be concerned, as "Mr Ness was not connected with the family group, it was only mother and baby." He told her not to bother trying to obtain housing, as this was already in hand. On the second visit, Alec Ness "had his hands on his head and said: "It's terrible, you don't know what's going on. Nobody knows what's going on. It's terrible." He became so worked up, that P2 advised him to go to the Royal Edinburgh, and see a Psychiatrist. The third meeting, like the others for roughly an hour, involved Alec Ness saying that Shirley had "the baby blues", which made her think "Well, there's something not right here, but I never for one minute actually thought that or still don't think that he would have harmed the baby because he was so much in love with the baby and was much in love with having a family unit." What he said about Shirley made P2 think that she might have "a puerperal psychosis".

5.13.2 Oddly, she told the Inquiry that SW7 asked her not to intervene until after a meeting, between "the Social Worker for the baby and her Social Worker and SW7 himself". This was scheduled for 18 October. This meeting was to replace a meeting which had already been cancelled.

5.13.3 She said that each time she had seen Mr Ness, she had telephoned SW7. After the baby died, she contacted the police to tell them of her involvement, but people in the CAB did not like this. She told the inquiry that she got "in terrible trouble from the CAB for being concerned about this baby", because "they said they didn't want the CID in the CAB because it caused a bad reflection on the CAB with the police coming into the CAB." (Referring to the Head Office of the CAB.) Someone senior in the CAB seems to have complained to her about breaching the client's confidentiality, but she refuted this by saying that she had received Mr Ness' permission each time.

5.13.4 The truthfulness and reliability of this witness was difficult to assess. SW4 and SW7 made no reference to a meeting to take place just before Caleb died, and the records which we saw made no mention of such a meeting. We wondered if they had deliberately decided to conceal this fact? However, paradoxically, we should have been more impressed to hear that they were taking an active interest in the increased risks evident in October 2001: what is so worrying in this case is that the risks stacked up with no discernible reaction from the Social Workers involved. We concluded that P2's evidence on this detail was not reliable.

5.13.5 We did not have an opportunity to pursue her evidence about the attitude of the CAB to her disclosure of her involvement to the police. If what P2 says is true, and we stress that we have not verified this, it reflects very poorly on the CAB's approach to child protection.

## 5.14 P3

5.14.1 P3 contacted the Inquiry directly, and asked for an opportunity to give evidence. He is a friend of Alexander Ness, and he thought that the independent Inquiry might have something to do with the guilt or innocence of Alexander Ness. He told us: “I know for a fact the death wasn’t committed by Alec Ness, it was committed by Shirley Malcolm”, and tried to give more evidence along the same vein. We explained to him that the criminal courts, specifically in this case the High Court which may hear an appeal on behalf of Mr Ness in the future, deal with these issues, which could not concern the Inquiry. He made allegations about various crimes committed by Shirley, up to and including April 2003, and claimed that she was never charged because she was a police informer. He is so indignant about this alleged miscarriage of justice that he has emailed “every MP in Scotland, the Lord Advocate” and others, to complain that Alec Ness had been forced into pleading guilty on the basis of a false understanding that he would receive a lenient sentence.

5.14.2 However, his descriptions of Mr Ness were illuminating. Speaking of the brain injury, he said: “I knew Alec Ness before and after and Alec Ness is basically the same person. He can sit and have a conversation like I could have a conversation with you, but if he has any more than one thing to deal with in his brain, if you ask him a double barrelled question, he can’t answer it. He comes up to a wall of confusion.” Before the accident “Alec Ness could count money backwards you know, but now he can’t even count his bus fares.” In the old days, prior to the brain injury, Alec Ness had always had money, “He is a moneymaker”.

5.14.3 At that time, it was Alec’ intention to stop Shirley working as a prostitute, and she had looked forward to a life of financial support from Alec. P3 did not specifically say that Alec Ness was drug dealing prior to the brain injury, but that was the implication we drew from his evidence. After the brain injury, which P3 was clear was a mugging by someone who knew that there was £7,000 in Ness’ pocket, everything changed. Alec Ness had to learn how to do simple things, like going to the shop, and the more often he did something routine, the more likely he was to be able to manage it. “If it was to go and cash his pension book he could go and cash his book, or if it was to cash her book, you know, he could do it once he had started to get into the routine, but if

you said 'go up to the town on a bus to Woolworths and get me this' he would get lost.”

5.14.4 Ness was devoted to the baby, but he thought of himself: “Alec would play with Caleb whether Caleb was awake or whether Caleb was asleep, he didn't know any different, he just wanted to play with his kid, it was his kid, he loved it to bits, you know.” He took the baby out in the pram “all the time”, and P3 only saw Shirley with them once. Alec “wanted to take it out in the pram, he wanted to go and show it to everybody, you know, this is my little boy, you know”.

5.14.5 P3 often saw people visiting Shirley's flat: “What used to happen is because Shirley Malcolm was a junkie, I don't know if you understand the junkie culture but they don't do it themselves, they usually do it in gangs, there's usually about four or five of them and they will all sit and either smoke it or bang it up or however they want to take it, but it wouldn't happen when Alec was about, it would happen during the night or when Alec went back to the (hostel).” When asked why it did not happen when Alec Ness was around, P3 replied: “Just because he didn't like it, you know, and I don't think she wanted him to know because she is keeping him on a string basically at this time, you know.”

5.14.6 He was indignant because, although he was on the Witness List for the defence for the trial, no-one had come to precognose him or his family. He commented about this Inquiry: “But I don't see how somebody can have an Inquiry regarding something when there is that much doubt on the conviction, because if it had been the other way round, if it had been Shirley Malcolm who had been convicted for killing Caleb Ness, I think the people involved in looking after Caleb would have been in a lot more trouble. You know, it is easy to convict, it is easy to turn round and fit an idiot up for it, rather than get the real person, because who gets into trouble then?”

## 5.15 P5

5.15.1 P5 is a member of the public, who is related to P1. She visited the charity office as a volunteer once a week during 2001, and often saw Alec Ness. She described him “like a dog with two tails, he honestly was. He was so proud. He would be there every Wednesday with his baby in its pram showing it off, telling me if they had a good night or a bad night or how much he was taking to feed, and Alec was the one that was very much caring for the baby because I know Shirley has been described as an ex-drug addict but that’s not the case, it’s not the case”. Shirley’s window had been broken, she had stolen a bottle of Methadone from somebody in a pub on the corner. P5 described Alec handling the baby as “Clumsy. He was clumsy but very caring, always very caring.” Speaking of Shirley, she said: “I heard that she was stealing drugs. She would buy drugs. Her drug addiction, there was no improvement at all and she would sleep all day and Alec would take care of her and the baby.” She thought that Alec and Shirley wanted to claim that they were living together for the purpose of getting a house, but to say that they were living apart for the purpose of getting DSS Benefits. She could see long before the baby died that Shirley was trying to finish off the relationship with Alec, but from Alec’ point of view, “She was a new beginning for Alec. He wanted to help her, the baby was the beginning of the new family and he could see all this happiness in her eyes and in the future for him and it was never going to happen. Everybody knew it was never going to happen.” He was unable to accept that Shirley wished to end the relationship: “I think he just had the picture in his mind of this happy family and he didn’t want to let go.”

5.15.2 She described Caleb as being clean, and thought he seemed well cared for. But she thought he looked a bit peaky.

## 5.16 NURSE1

5.16.1 Nurse1 is a Neonatal Sister in the Neonatal Unit, and she is also the Special Care/High Dependency Nursery Co-ordinator. She told us that up to 2001 she did not have any formal training in Child Protection procedures, and had learnt as she went along. She meets the Hospital Social Worker once a week, and raises issues or concerns about the babies in her care at that meeting. She takes a special interest in the babies of drug abusing mothers, and makes a point of meeting the mothers, and sitting and talking to them for some time. Some of the mothers already have Social Workers, but “if it’s just a new case that’s been highlighted, they won’t have a Social Worker”.

5.16.2 She remembered Alexander Ness quite clearly. “I remember he wanted to talk at length to all the nurses. He would come right up close and you would have to step back or say to him “Move back” - he was never threatening or anything but he told us a lot of things about himself, whether they were true or not true, things like ... he said he was a drug counsellor. Often we had to direct him back to the baby because that’s why he was there, but he liked to come and relay his life story to people.”

5.16.3 This is what she told us about his care of the baby: “He was interested in the baby because he helped to feed the baby and do the care for the baby but when Shirley was there she was inclined to do it. She was good, she was good with the baby unless she was very sleepy. If I remember rightly you had to keep him at the cot with the baby, but he certainly wanted to feed the baby in the nursery but he wasn’t good at handling the baby, certainly he appeared unsafe and had to be reminded a number of times about how to hold Caleb. I can remember he didn’t support his head and he wanted to walk about and he wanted to sit in a high chair, these things. Sitting in a high chair, we don’t like, we prefer parents to sit on a lower, safer chair. The high chairs are for the nurses or parents to sit with babies in incubators. We don’t like parents walking about with a baby. That particular nursery was a big, busy nursery, people moving around, nurses moving cots, toddlers, siblings running around, it wasn’t appropriate to walk about with the baby, plus the fact he was never holding the baby securely anyway. Most parents would probably be safe enough to walk about but he wasn’t. He usually did what you wanted him to do, but maybe five minutes later he would be on the move again.” “He constantly wanted to be talking to the nurses and he just

didn't, he would be holding Caleb and talking to somebody and he wouldn't notice that the baby's head was dangling. He reminded me of when the siblings come in and you say to the parents "Do you want them to hold the baby" and you position them and you have to say "You do this, you do that and you hold them like this". She agreed that he compared to a big brother of seven, holding the new baby. Speaking of that, she said: "He will learn, that's right, after the first time he usually manages to hold the baby but Alec just didn't seem to – he was obviously unsafe from the beginning, there was no question and everybody agreed with that."

5.16.4 Speaking of Caleb's CPCC, and what she was trying to communicate about Alec Ness to the Conference, she said: "I honestly just thought that he would, I thought he might just have let the baby fall if he was nursing him or something, or just not handle him properly. I never thought he would deliberately have harmed him, I never ever thought that, I just thought he would just have been careless with him and maybe not just handled him properly."

5.16.5 In her view, she tried to tell the CPCC that this baby should not go home with these parents: "I can remember telling them about, obviously it was fresher in my memory than it is now – I can remember telling them about what happened in the nursery and about the parents' behaviour and handling of the baby and we felt Shirley was able to handle the baby and was quite good when she wasn't sleepy but we had concerns about if she was sleepy, but her general handling was okay but we had grave concerns about Alec' handling of the baby. I distinctly remember saying if Alec was left alone with the baby, and because I felt the person who chaired the meeting was sort of, I don't know if dismissive is the right word but I really felt she wasn't taking on board what I was saying and I remember sort of again bringing it up and asking "Is the baby going home?" I then got the general impression that the baby was going home but that hadn't actually, as far as I was concerned, been decided. I felt this is what they were saying. So I then sort of said "When the baby is being discharged, is he being", something like "is he being discharged?" I don't remember if it was to that effect, and then she said "Yes", and I just felt it was quite dismissive, "Yes of course" sort of thing, and I thought – "They're not really listening to me here".

5.16.6 She told the Inquiry that, after discussion of “certain support systems” which would be put in place when the baby went home, she said that she would agree, but that she was concerned if the baby were going to be left with Alec. She told us: “I don’t think I strongly disagreed, I just felt that the baby shouldn’t have been going home with them but I didn’t stand up and say “I definitely don’t agree with this”, I didn’t say that.

5.16.7 Nurse1 confirmed that she had not asked the CPCC to minute her dissent to the decisions made by the CPCC, but that with the benefit of hindsight she would have been more assertive. At that time she was not familiar with CPCCs, and did not feel confident about asserting her views. She has received some training since then.



## **6 MANAGEMENT UNDERSTANDING OF GOOD PRACTICE**

**In this chapter, we have selected extracts from the evidence heard by the Inquiry, in order to give the reader an understanding of the basis for our conclusions. The extracts are grouped loosely under nine themes, but inevitably there is some degree of overlap. These highlight the gaps between management understanding and actual practice.**

- **Contact with the family before birth, and preparation of the report for the CPCC**
- **Who should be invited to a CPCC, and when should the CPCC be adjourned because it lacks sufficient information?**
- **Who should be Chairpersons of CPCCs, and what should they do?**
- **What should have been the real issues at Caleb’s CPCC?**
- **Referral to the Reporter**
- **Circulation of the Minutes of the CPCC, and their importance**
- **The Child Protection Plan and review of risk**
- **Health Professionals, their role, and confidentiality issues**
- **The role of the Criminal Justice Social Worker in Child Protection**

### **6.1 Contact with the family before birth, and preparation of the report for the CPCC**

#### **6.1.1 Man2 (Man2 is the Child Protection Co-ordinator)**

Q: “How much contact would you expect the Social Worker to have had with the family prior to the Case Conference?”

A: By the family you are meaning Shirley herself or Shirley and Alec?

Q: Well perhaps you could answer those two questions.

A: If Shirley and Alec are living together, if they are living together my expectation is that the Social Worker should have in order to arrive at assessment, frequent contact with both parents separately and together.

Q: Frequent?

A: Yes.

Q: Now in this case the Social Work Department doesn’t tumble to the fact that Shirley is expecting a baby and that there’s an issue even to be addressed until about May. So let’s say that they start actively pursuing those questions at the beginning of June and the baby was born on 30 July.

A: Yes.

Q: How many contacts would you expect the Social Worker to have with Shirley at that time?

A: Well I’m going on the previous history of this family because two children have already been removed, there’s a brain injury here, and the guy is still around if not actually living in the house and my expectation if I was the Social Worker, and I can only talk from my own judgement, if I was the Social Worker in that case I would want to talk to them weekly.

Q: Weekly?

A: Yes, in the latter stages of the pregnancy.”

### 6.1.2 **Man2**

- Q: “What would you expect the issues to be for the Case Conference when Caleb was in hospital?”
- A: The fundamental issue is, is it safe for Caleb to be at home, cared for by those who have parental responsibility for him, that is the fundamental issue.
- Q: Would you expect the Chair to make that clear?
- A: Yes absolutely.
- Q: Would you expect a recommendation in the Report prior to the Case Conference to focus on that one way or the other?
- A: Yes I would expect the Social Worker’s Report to be predicated on the issues of the risks and vulnerability, these are the two key issues. By that I mean the vulnerability of the child, those factors implicit in the child which indicate vulnerability, and by risk I mean those factors present in the child’s environment, that includes the care givers, which exposes a child to danger.”

### 6.1.3 **Man4 (currently Operations Manager in Children and Families social work)**

- Q: “On the one hand there’s the woman with the issue of the drugs, and, on the other hand, the man. Just assume that the man has the contact with the baby that I’ve told you about every day for several hours a day. Would you expect the key Social Worker to get information from a doctor about the extent of the brain injury in writing, for example?”
- A: I think it might depend on your own observation of the person. I have worked with people with brain injuries. They vary from violent to passive, and I suppose it might depend on how that person was relating to you. I don’t know if it was a serious brain injury or whatever. If it affected his behaviour, then I think you need to understand what that’s about and what the implications are.
- Q: Isn’t that a bit dangerous to say you leave it to an assessment by a Social Worker relating to how he seems on the occasion?
- A: It may seem like that. I suppose it does seem like that, but I don’t know. I mean, I don’t know this man, but if I observed someone who was quite strange – and I’m saying this in a layperson’s way because I think that’s important – then I think I would be seeking medical advice because I would be concerned about the impact, especially on a small baby.
- Q: Yes. Here, never mind how Mr Ness presented, the information that he had been in a coma and in hospital for weeks and had then gone to the Brain Injury Unit at the Astley Ainslie, would that not be enough to trigger off the duty of a Social Worker to inform himself about the extent of the brain damage when he knows that the baby is going to be in contact with this person?
- A: Yes, and I think that’s ... I suppose that’s yes. I think the other part of that is that the Case Conference should have informed themselves.
- Q: Well, I was just moving on to that. You’re agreeing that the Social Worker should have found out and, therefore, by extension, the Supervisor should have been prompting the same inquiry from the Social Worker. Do you agree with that?
- A: I do.”

#### 6.1.4 SW4

- Q: “How many times do you think you saw her before the birth?”
- A: I don’t know if I did see her again before the birth actually when I think about it.
- Q: Well just have a look at the records to remind you.
- A: Because I went on holiday, I think I may have seen her once – no, I went on holiday on 15 June and came back on 9 July and, you know, it was a telephone call from the CDPS that told me that Shirley was actually in Simpsons and had had the baby.
- Q: So between the 9 of July and the time she had the baby you don’t remember seeing her?
- A: No I wasn’t, I didn’t see her.
- Q: No?
- A: I spoke to, as it says here I spoke to the HV who thought she had moved house because she hadn’t been able to get Shirley in but I phoned CDPS just to see if they had had any contact with her and they told me she was in Simpsons.”

#### 6.1.5 REP

- Q: (Looking at the report prepared by SW4 relating to Caleb:) “There is obviously a huge record of background of instability in relation to Mum’s background with concerns which have led to children to be received into care, so compulsory measures of supervision were required right up to, through the 1990s in respect of the older children. I suppose it is interesting the way the report is written in, in the light of what we now know that there is many paragraphs and pages on Ms Malcolm and one paragraph on Mr Ness, a paragraph which I hope if I was a Reporter I would be picking up and enquiring further into.”

## 6.2 Who should be invited to a CPCC, and when should the CPCC be adjourned because it lacks sufficient information?

### 6.2.1 Man1

- Q: “What about the role of the Chair in deciding who was attending the Case Conference?”
- A: Prior to, yes, I would have thought that the Chair should have been involved in the process of ensuring that the key professionals were either going to be there or in their absence that information from them was going to be made available to the Case Conference.
- Q: You see this Chair personally couldn’t be involved in advance, but when she arrived did she have a responsibility to ensure that she had all the information that was necessary for Caleb’s assessment?
- A: I would have thought that the Chair should have made sure that all the information was available to the Case Conference to allow them to come to a reasoned decision and if that information either in the shape of people being there or of reports weren’t available should have pended that discussion to allow that information to come forward.

- Q: You see the Criminal Justice Social Worker allocated to Alexander Ness was invited, not that one can see from the Minutes, but we know that he was invited, he couldn't come because he was on holiday, would you have expected the Chair to hesitate and allow the conference to proceed to a decision in the absence of information about Mr Ness?
- A: Well, from what I know about Alec Ness I would have thought that information was crucial.
- Q: So you would have expected the Chair to have postponed the Case Conference in the absence of any information about Ness?
- A: Yes.
- Q: Would you have expected the Chair to consider that information about the extent of Ness' brain injury might have a bearing on whether Ness should be left with Caleb?
- A: Yes."

### 6.2.2 Man2

- Q: "First of all can I ask you about the people listed as invitees, would you expect the Chair to have input on whether all the right people were there or not?
- A: Yes, the Chair has to be satisfied the right people have been invited.
- Q: Now if the Chair wasn't satisfied that the right people were actually there, whether they were invited or not, what should the Chair have done?
- A: Prior to the Case Conference or on arrival at the Case Conference?
- Q: Either?
- A: Okay, my expectation would be that a Chair some time prior to the Case Conference should contact the Social Worker for the case, who is normally the person who is processing the invitations, and satisfy themselves that everybody has been invited that should, and to try and satisfy themselves about who is actually going to be there on the day. Now the reason that I do that isn't just academic, the reason is because if I was going to chair a Case Conference it would affect how I chaired the Case Conference knowing who was going to be there.
- Q: Well this has all been done in a terrific rush, I don't think the Chair knew she was chairing it until the day before, or perhaps it was the day.
- A: Well again that is a procedural issue, I would clearly say that was not satisfactory.
- Q: Anyway having appeared at the hospital and had the benefit of perhaps only a very short time looking at the Social Workers' Report, would you say it was up to the Chair to think about who was there and whether the people there were appropriate and sufficient?
- A: Yes absolutely. The Chair needs to ensure, particularly for an initial Case Conference, that all protagonists are people who have contributions to make about the issue of risk. Now if I noticed that there were people not present, or not going to be present who really had an important contribution to make on that issue then personally I would be asking for the Case Conference to be adjourned.
- Q: Alright. Now looking at the Minutes still, No. 2, you will see that there is no Criminal Justice Social Worker who knew Alec Ness listed in the Minutes. Now you can take it from me that the relevant Social Worker had been invited to attend but was unable to attend because he was on holiday. Can you

comment on whether somebody else should have attended from the Criminal Justice Social Work Department, given Alec Ness' history of being out on parole and so on?

A: My expectation is that Alec Ness, there is no question of it, was an extremely important person in the life of Caleb. Given his history, given his antecedents, given his current circumstances, i.e. Criminal Justice supervision, my expectation is that the Criminal Justice Service would have been represented at that Case Conference. I am also dismayed to see the Criminal Justice Social Worker's name doesn't appear on the list of those absent or unable to attend. I am assuming that the Criminal Justice Social Worker told the Social Worker prior to the Case Conference that he couldn't come?

Q: He did.

A: Then I would have expected the Social Worker to have said, well I think then somebody from your Team ought to be there, preferably your senior.

Q: Right, so your expectation would be in short that somebody else from the Team would have attended in his place?

A: Yes."

### 6.2.3 **Man3 (Criminal Justice Services Manager)**

Q: "Now, in this case a Case Conference is called while the baby is still in hospital – the baby hasn't got home yet – and SW7, your Criminal Justice Social Worker is invited but he can't go because he's on holiday, so nobody attends.

A: That's unfortunate.

Q: Would that be usual? Would you expect him to pass the request on in the office and ask somebody else to go for him?

A: Yes. Yes, if that were possible, and certainly as a minimum a written report to be available or a reorganisation, a rescheduling of the Case Conference, which is often not possible and not practical. Now I don't know the availability of staff at that time in Criminal Justice terms specifically, but what I can tell you is that it's only now that we're getting very close to full establishment, and so we had it these times ... we were under-established. That's a common position for Social Workers across Scotland."

### 6.2.4 **Man4**

Q: "In circumstances where families are known to other authorities and where there is a Case Conference happening, would it be standard to think about inviting a representative from another authority who might have valuable information?

A: You mean another local authority?

Q: Another local authority who may have worked with another part of the family previously, historically.

A: Yes, one would hope so.

Q: That would be something that you would consider to do?

A: The whole point of it is to get as much information as possible at that initial stage."

### 6.2.5 SW3

- Q: “Okay, so you have the report from SW.4, how long before the Case Conference did you have the report?  
A: Either the day before or at the Case Conference, I really can’t remember.  
Q: You see I think the report is dated the 8 August, Wednesday the 8?  
A: I think I probably got it the day of the Case Conference.  
Q: You can’t really remember?  
A: I can’t really remember, reports often came in at about that time, you are lucky if it is the day before but it’s often on the day of the Case Conference.  
Q: Right, so that was quite common. Did you have time to read the report and think about it before you went to the Case Conference?  
A: A little.”

### 6.2.6 SW3

- Q: “You didn’t have much information about the brain damage itself, did you?  
A: No.  
Q: Did you think of holding things off to get more information?  
A: I have to be honest and say no.  
Q: I mean looking back .....
- A: Oh looking back, yes.  
Q: Do you think you should have done?  
A: Possibly, but again I don’t know, there were no indications that Alec Ness was a risk to Caleb that came through. Possibly yes if there had been more information about the brain damage that indicated he could be impatient or could get angry suddenly then, yes, but that wasn’t there, he is obviously very limited but caring towards Caleb.
- Q: But were you really relying on SW4 to give you all this information?  
A: Yes, normally we would rely on the participants at the Case Conference if there had been concerns about Alec being aggressive, impatient, then the hospital where the people observing how he was with the baby, so you would expect that bit to come in.
- Q: Looking at the other people who didn’t attend, there was the JLO from Leith Police Station, did you think it would have been important to have information from the police about the couple?  
A: Yes. We didn’t know he wasn’t going to attend, we actually waited on him coming for quite a while and then it was agreed to start. We had some knowledge, you know SW4 had some knowledge of his previous convictions.
- Q: Of Ness’ previous convictions?  
A: Yes.  
Q: What about Shirley’s previous convictions?  
A: Again there was the report which indicated she had been on probation, she had been stealing from, various drug related crimes and obviously we had that.
- Q: Did you have enough information about her previous convictions, do you think?  
A: I think we possibly did, it’s quite a lot of detail in the report. Obviously there would be a lot more, but her previous convictions wouldn’t necessarily indicate anything more than she had a chaotic drug use pattern which would

affect her care of the baby, and what we were being told was that that wasn't the case at that point in time.

Q: And you were getting this from Dr1?

A: Yes.

Q: That the chaotic drug use was in the past, is that the view you were taking?

A: In the past, yes.

Q: If she had a past when she was in and out of prison a lot, would you have seen that as relevant?

A: Yes, but again Social Workers are heavily involved with her and the plan was that the Social Worker and the Health Visitor would be heavily involved. We were doing an early review to monitor how that went because at the Case Conference all we had was historical concerns. The reports since birth were actually reasonable from the hospital and she was co-operating with us."

#### 6.2.7 SW3

Q: "So as the Chair did you feel it was your responsibility to take a direction on who was there?

A: I would now, then, no. I mean I would have if there had been particular circumstances like if for instance there had been concerns raised about Alec Ness then yes, I would have wanted to wait for the probation person and the police, but there weren't, so I mean on reflection yes, I wish things had been done differently."

#### 6.2.8 SW3

A: "No, I actually think I chaired the Conference properly because I was new to doing it and was practically following instructions of the format.

Q: So you don't think there was a lack of training behind that at all?

A: No, at that time it would have been extremely rare for somebody not to go ahead with a Case Conference either because the police weren't there or because somebody else wasn't there. It would happen now.

Q: Would it?

A: Yes, but it didn't happen then, or in the twenty years that I have been ...

Q: When did it change?

A: I don't know if it has. It's changed for me ..."

#### 6.2.9 SW3

A: "... It was two years ago and there's lots of Case Conferences go ahead without the police being there, even if there are convictions. Equally probably they would have the Case Conference rather than wait for somebody who was not considered to be a main carer, probation officers, and I think that probably still happens."

#### 6.2.10 SW4

- Q: “And what about any Social Workers from (distant area), did it cross your mind to invite somebody from (distant) Social Work Department?”
- A: No.
- Q: I’m just wondering why not?
- A: I don’t know, I can’t remember.
- Q: No?
- A: I can’t remember any discussions about inviting anyone from (distant area) at all, it may have been talked about in conversation, I don’t know, I can’t remember.”

#### 6.2.11 SW4

- Q: “Now did it occur to you to get someone other than SW.7 since he was away?”
- A: No, no.
- Q: Did you think you needed any more information?
- A: Not at that time, I mean again and this is my opinion, the sort of the number of quite senior Health Care people who were at this Case Conference was quite unusual.
- Q: Was it?
- A: Yes and also the mix as well of professionals who were at that meeting was in my opinion quite good.”

#### 6.2.12 SW4

- Q: “Looking at it with the benefit of hindsight I was struck by how little is said about Mr Ness’ head injury, if you look at page 5 (of the Report of 8 August).”
- A: I didn’t have a lot of information about Mr Ness’ head injury at that time, I knew he had a head injury and I knew he was recently out of hospital, I didn’t know any of the details of how he sustained that head injury, I had, you know, anecdotal information about that, falling on a set of stairs or something, but other than that, no, I didn’t have a lot of information about that at that time, but that would have been, you know, as time went on, you know, after the Case Conference it would have certainly been something I would have tried to find out more about but obviously it was overtaken by events.
- Q: Yes, but you didn’t think it was important to get any more advice about the head injury before the Case Conference could reach a conclusion?
- A: Whether it was important to get advice or whether I had time to get advice, that’s two different things.
- Q: Yes.
- A: No, I mean obviously I didn’t, obviously I didn’t. In hindsight perhaps, you know, if I had been able and had the time and had, you know, the right route to go down to get that information it may have been helpful, I don’t know.”

#### 6.2.13 SW4

- Q: “Do you think that the meeting had all the information it needed to make a judgement on that (i.e. sending the baby home) because I think you said to us



that perhaps a Risk Assessment hadn't really been completed, would you normally expect that, you know, in a sense that's slightly back to front?

A: No, I don't think it was back to front, I think there was sufficient information on the table and also you know, the professionals who were there had a sense of Shirley, we had met with Shirley, there was sufficient information to make a decision on whether he should go home or not.

Q: Of course, but if members of the meeting hadn't that information in front of it that would be very difficult to know, for them to know what information they hadn't got, and who would you see as having the role of making sure the meeting had all the information it needed in front of it?

A: That's a good question. I don't know if that's my role or not.

Q: Because that's a very important question.

A: I think it's a very important question, I think perhaps maybe the Chair of the meeting, I don't know, it is quite an important question, you are right, you are right."

#### 6.2.14 SW5

Q: "What did you know about (Alec Ness') brain injury?

A: Very little, only what SW7 had told me.

Q: Why didn't you find out more?

A: Why didn't I find out more, because I wouldn't have seen that as my role to find out more, if I had needed to know more I would have got SW7 to find more.

Q: Right, well, you were supervising him, why didn't you think that you needed more information?

A: Because we thought we had enough to be able to assess his needs at that point in time and that once we had him into accommodation we could look at what was going to be I would have thought a fluid situation anyway.

Q: Now, what do you mean by a fluid situation?

A: Well I think that it looked like his circumstances or his brain injury or whatever were the factors that were influencing his behaviour at the time wouldn't be static. I suspected that and my suspicion was that the situation might have got worse, that he would have developed some kind of mental health problem or he would develop some kind of emotional volatility." (Referring to 22 June 2001.)

#### 6.2.15 SW5

Q: "I am just a bit puzzled about why you didn't get medical advice about the extent of the brain injury?

A: I think probably because I didn't think we needed it at that time.

Q: But why, how did you know?

A: Right, I don't know if I can answer that one. I mean yes, I mean what I would say is that I didn't think we needed it, I thought we could get him re-housed, we could then get enough, enough information to be able to look at the package of care. I might say that I mean with hindsight I might have been concerned that we wouldn't have got him re-housed.

Q: In what way?

- A: In that what we had done was landed between two stools with the normal housing stock saying that he required specialist housing stock and us having to wait for a long time to get him something.
- Q: Certainly one of the things that was behind all this was the fact you knew that for specialist housing stock there was a very long waiting list.
- A: Yes.”

#### 6.2.16 SW5

- Q: “Did you know that SW.7 was invited to attend (Caleb’s CPCC) and he couldn’t because he was on holiday?”
- A: That I don’t know either.
- Q: No. Would it have been practice, normal practice to send somebody else along from the Criminal Justice Team if one person couldn’t attend?
- A: Oh it would be prioritised, if possible, if it was at all possible we would send someone, if not we would make sure that a full report was given to the Convenor of the Conference.
- Q: And when you say a full report are you meaning a written report?
- A: Yes.
- Q: And are you aware that there was no such written report in this case?
- A: No I am not.”

#### 6.2.17 SW6

- Q: “In this case we have a Criminal Justice Worker invited to a Child Protection Case Conference, and he can’t go. Fair enough. When an invitation has been issued, would it be normal practice for someone else to go or a report to be sent in or what?”
- A: Well, I would say that it should get the highest priority for anyone who is invited to a Child Protection Conference to go to it but, hand on heart, I cannot say that under every circumstance everyone who is invited to a Child Protection Case Conference would go, and I can give examples from the prison where it is simply just not possible, under the terms of the contract, to send a Prison Social Worker, say, for instance, up to Aberdeen to attend, because part of Edinburgh Prison is a national facility and, therefore, I couldn’t say that under every circumstance we would send a Criminal Justice Worker to a Case Conference. We would always submit information in the form of a written report about what we knew about the person and, wherever possible and wherever reasonable, we would attend it. Now, what you are talking about here – I am just thinking this off the top of my head – what you are talking about here is a Child Protection Case Conference about someone who, as far as I am aware, was not deemed to be a risk to children and therefore it wouldn’t have quite the same high priority as a Child Protection Case Conference where the personal supervision was deemed to be a risk to children.”

#### 6.2.18 SW7

- Q: “Were you aware that a Case Conference was held?”
- A: Yes, SW4 invited me to it, but I was on annual leave at the time.
- Q: Right. Now, did you get a written invitation to go?

- A: I don't think so. I think when SW4 told me about it, I told him it corresponded with my annual leave."
- Q: "In terms of looking at the kind of Case Conference process and about the information that was available to Case Conference, obviously you weren't able to go, you were on holiday?"
- A: No.
- Q: Would it be normal for your senior to go in your place to a Case Conference?
- A: It may well have been, but certainly at that time I didn't really think I had a lot to add. That wasn't ... I felt that it would have been useful for me to be there as being involved with Alec, but I think by that time I was seeing, you know, him separating and I really thought that was for the Children and Families to be involved with what was going on."

#### 6.2.19 PC Man 2

- Q: "Actually we should tell you the GP wasn't invited to the Case Conference.
- A: No.
- Q: Does that surprise you?
- A: Yes, it surprises me, it doesn't surprise me. Again, it's this sort of calling wolf too often, if you invite somebody often and they don't turn up you don't invite them. It could be part of that, I don't know, but I think that as a standard, as an inter-agency working expectation he should have been invited whether he turned up or not, that would be my expectation.
- Q: I think to be fair it is a Child Protection Guidelines expectation that he should have been invited?
- A: He should have been invited."

#### 6.2.20 HV

- Q: One thing I'm wondering about is whether there was any suggestion at the meeting that more information was needed, that the meeting didn't have all the information that it ought to have, do you have any recollection of that?
- A: Yes, well SW4 was quite clear about that, that he didn't have any information really on Alexander Ness, Alexander Ness' Criminal Justice worker was on holiday I believe and he hadn't attended the Case Conference and there wasn't a Report handed in from the office and that was made quite clear that there was very little information on him apart from what he had observed and gleaned on his contacts before Caleb's birth.
- Q: Was there any suggestion about postponing the decision until there was information from the Criminal Justice people?
- A: No.
- Q: Nobody suggested that the meeting would have to wait until it got more information?
- A: No
- Q: The Report that SW4 prepared referred to Shirley's two previous children both of whom were cared for elsewhere, do you remember that?
- A: Yes.
- Q: Was there any suggestion that there should be more information about what had happened to them and how her parenting had gone wrong with those two children?

- A: I don't recall any, no.
- Q: And we see from the Minute that the police didn't attend, they were invited to attend but they didn't attend. Was there any suggestion that information from the police would be useful and should be waited for?
- A: No, no, I don't really remember the police being mentioned at all.
- Q: Did you know that Shirley Malcolm had a lengthy record of previous convictions?
- A: There is a brief reference to it here.
- Q: That's right.
- A: But I didn't really know the nature and extent."

#### 6.2.21 HV

- Q: "Was there any discussion about whether she had been working as a prostitute prior to the pregnancy or during the pregnancy?"
- A: No.
- Q: Any suggestion that her criminal behaviour, offending behaviour would have any impact on Caleb's future?
- A: I didn't know at that point that she had a recent criminal past at all."

#### 6.2.22 Dr3

- Q: "Now let's imagine a Social Worker has come to you in August when the baby was in hospital and said: "We're going to have a Child Protection Case Conference to discuss what should happen with the baby when he is ready to leave hospital, give us any advice or input from your point of view." Can you imagine what you might have said to help the Case Conference reach its decision?"
- A: I would have said that at the stage I last saw Alec in July that obviously he wasn't a competent carer for a baby, but I mean it wouldn't require a Consultant in Rehabilitation Medicine to be able to decide that, it was quite obvious to a layperson, you know.
- Q: You knew his head injury was there and if you had been asked, you know, is it safe to leave this baby with this man even for a few hours a day, what would you have said?
- A: Unsupervised care of the baby would be out of the question. Obviously as an attendee he wasn't a man who was rampaging around being aggressive or whatever, that would be somewhat different, but unattended supervision of a baby would be out of the question."

#### 6.2.23 Psyc

- Q: "Now we know that in this case there was a Child Protection Case Conference on the 9 August and I appreciate that you weren't there. Are you aware of any invitation being sent to the hospital for anybody to attend it?"
- A: No, no.
- Q: Now imagine that you were being asked to attend a Case Conference to consider Caleb's future just at the stage he is in hospital, he has never got out of hospital after birth yet?
- A: Yes.

- Q: What would you have said to the Case Conference?
- A: I would have said that the baby should have been kept in care, should not have been released to either the mother or the father.
- Q: Did you know much about the mother?
- A: I knew that the mother had a very big opiate habit and although she was on Methadone, prescribed Methadone, these folks do a lot of trading and extra dealing on the side, and she was also taking a huge amount of Diazepam every day, enough Diazepam to fill an ox.
- Q: How do you know how much she was taking?
- A: Well, she said at one point she was taking eighty milligrams a day and two milligrams would make you feel dizzy.
- Q: When did she say that?
- A: At the appointment where she turned up with ... and me.
- Q: And that was in July was it?
- A: Yes, that was July 13, and she was doing really very well because she had got down to 30 or something a day which was still a very big dose of Diazepam. So I thought that on the ground there was no, she wouldn't have come off this habit by the time, by August, that's for sure.
- Q: Yes?
- A: So in effect I think she was heavily drug addicted and intoxicated for quite a lot of the time, and he was not able to cover those periods at all, so in effect the baby was going to be in the care of people who weren't fit, in a fit state to look after a baby, so I would have said not.
- Q: Well just to concentrate on what we know about Alexander Ness because obviously he was your primary concern?
- A: He was my concern, yes.
- Q: If you had been asked whether Alexander Ness could have assisted Shirley with the care, what would you have said about that?
- A: This is, sorry, would this be based on the supposition that Shirley was competent?
- Q: Well, yes, for the moment let's just assume that Shirley was competent.
- A: I did not think he could really assist, my personal opinion and I am not an expert on child care, I did not think he could assist Shirley in the care because from what I could see of her she wasn't competent enough to supervise him.
- Q: Alright, let's just assume on the hypothesis that she was a competent mother, then what would you expect?
- A: Then he could assist her, yes, under her direct supervision, as long as she checked what he was doing and kept an eye on him at all times with the infant.
- Q: What would you have said about the proposition that he could have been left alone with the baby for let's say half an hour?
- A: I would have said that was just unthinkable. He did not perceive things properly, his social awareness was poor, so that looking at a baby he would not know if the baby was in distress, choking or simply cooing happily. I think he was clumsy and precipitous in his movements, he wouldn't have known how to handle a baby properly, he was sort of euphoric and he would have been likely to pick up a baby roughly and not handle it in a proper way, he seemed just in all his movements and his concerns to really not have any clues about how he would look after a baby, even for half an hour. I think he would have to be watched at every moment if he was with a baby.
- Q: What about making up the feeds, I think you mentioned that?

A: Well, I think he would probably be taught how to do it but I would always want to check that he hadn't used a dirty bottle or that the temperature of the bottle was at the right temperature, and that if he was actually applying the teat to the baby's mouth to make sure he wasn't, you know, causing the baby to choke or you know, perhaps squeezing the bottle so as to inject more milk into it. This would be the sort of thing he would do, he was really quite gung ho in his approach."

#### 6.2.24 MN

Q: "With the benefit of hindsight is there anything that you personally could have done differently, or you can see should have been done differently?"

A: I probably with hindsight, you know, I would have phoned up Simpsons and checked exactly what had, you know, or said can one of us be at the Case Conference, I mean we weren't aware that there was one being arranged.

Q: Yes.

A: But I think, you know, in hindsight I would have said that there should be somebody, a representative from our Team there, especially if Alec was going to be taken in as part of the care package for Caleb."

#### 6.2.25 HosMan

A: "... we had put in place the policies and guidelines. We had all these flowcharts, that again sit on the web, about what to do if you're worried about an unborn child, as in Caleb's case, pre-birth Case Conferences, numbers to phone. That didn't happen. So I might have expected, having had these policies in place, promulgating through these people on the Child Protection Committee, that I might at least have had a call from Social Work, if nobody else, to initiate the initial referral discussion about a pre-birth Case Conference. Now, I don't know what happened here, but they're usually not too bad at inviting us to pre-birth Case Conferences because, although it's directly with the Neonatologists and the Midwives, they know that the Office for Child Protection is my office.

Q: And while you say "they", who do you mean by "they"?

A: The Social Worker who was calling the Case Conference should have invited us.

Q: Yes, so that would be the Children and Families Social Worker? It's just to spell it out for the record.

A: Yes, Children and Families, whoever organised the Case Conference.

Q: And would you expect that Community Child Health would be on the checklist really for them in thinking about who should be invited to the Case Conference?

A: It would have been nice if there was a formal checklist but, as you know, it's a hit and a miss. We do get invited to some pre-birth Case Conferences, but I would love to know whether that's the tip of the iceberg that we're invited to. I want to know the denominator I think.

Q: Well, from the evidence we've heard so far, I think it will be the tip of the iceberg."

#### 6.2.26 **HosMan**

“... I don’t know how many medical people were at the Case Conference and what level of seniority, because I’ve also been aware of, you know, Case Conferences being attended by SHOs and Registrars who (a) have no idea why they’re there and they don’t know how to contribute.

Q: It might be useful just to think through with you actually who you would have expected to have been at that Case Conference?

A: We need senior people with the knowledge and understanding of the Child Protection process to ask the right questions. I mean, if you give it to some poor junior member of staff, they will be completely at sea.

Q: So from what you know from what you heard from Susan at the beginning about our knowledge of the case, could we just quickly go through those, the Health people that you would have expected to be there?

A: It would have been nice to have had a Community Child Health senior doctor, the Consultant Neonatologist, maybe the Consultant Obstetrician who has been involved with the mother, and the midwife, and then the Neonatal Nurse to speak about all the observations that she made of mother’s drug use and all the signs and symptoms of mother’s drug use.

Q: ... from outside the hospital, who would you have expected to have been called in for that?

A: The drug worker; if we had known about the father’s problem, somebody who was looking after either his mental health or his physical health – and we have problems when we talk about mental health – the GP.”

#### 6.2.27 **REP**

Q: “Is it practice in this area for Reporters to attend Case Conference, is that something that they can and do do?”

A: Yes, but there is a time limit in terms of how many we can attend. We would not attend a Case Conference unless it was a child who had been referred to us obviously because of us taking on board the decision, but if it, if it is a case like this, this is almost an ideal type of one to attend.

Q: This is what I was wondering, yes?

A: Particularly if it is a child who has been referred to us pre-birth, and I have examples from my own professional practice of this sort of situation where the child is referred to us pre-birth, there have been pre-birth Child Protection Case Conferences which have enabled us to attend, hear from the participants directly. The major part of the Reporter attending a Case Conference is to be able to assess evidence quite frankly, and that’s it, we are assessing evidence both for compulsory measures of supervision and what factual evidence there is to support a ground. You know, we are more listeners rather than contributors. We would not play a part in the decision of the Case Conference as to what happens.”

## **6.3 Who should be Chairpersons of CPCCs, and what should they do?**

### **6.3.1 Man1**

(Issues having arisen as a result of the death of Caleb and another baby, instructions were issued on 19 February 2003 as follows.)

A: “Firstly that the Chairpersons of Child Protection Case Conferences must have due regard to those who attend the Case Conference not only in relation to deciding who should be invited, but in following up and seeking an input from any individual agency who is invited but who is unable to attend, or does not attend. The second thing was that Chairpersons must ensure that at the end of every Case Conference a Child Protection Action Plan must be discussed and subsequently recorded with clear actions identified and responsibilities for undertaking agreed actions clearly assigned. The third thing was that the Chairpersons must ensure in relation to decisions about whether or not children be returned to the care of their parents or parent and/or removed from care of their parents or parent, the pros and cons of either course of action to be fully discussed and the legal grounds for removal openly and thoroughly explored and recorded.”

### **6.3.2 Man1**

A: “... I also understand that the Chairperson both came from within the practice team and was not at a level of seniority that we advise is required, so that is something that I think needs to be considered in the future. It may be that we have senior practitioners whose wealth of experience is actually much greater and we may be, through the requirement to have a Senior Social Worker undertaking the task to chair a Case Conference, denying people with considerable experience and skills to do it, but generally speaking we require a Senior Social Worker to do that.

Q: Now if you hadn't looked into the facts here, would you have expected the Chair to be a Senior Social Worker?

A: Indeed.

Q: So it was a surprise to find out it was a Senior practitioner?

A: Yes.

Q: What about any training for a person chairing these Conferences, would you expect that person to have training on how to chair a Case Conference?

A: Indeed.

Q: Because we heard she hadn't had any.

A: I didn't know that.

Q: But you would expect the person to have training?

A: I would have, yes.”



### 6.3.3 **Man1**

Q: “And we have talked about the fact that the Chair was not a very senior person, but would you have expected the Chair to have been consulted in advance about who was to be invited to the Case Conference?”

A: Yes.

Q: Because the picture we have here is of the Chair being picked at the very last minute and going along with practically no information and certainly no input in the invitations which were being sent out. Is that not in accordance with what you would expect?

A: No.”

### 6.3.4 **Man2**

Q: “... Now in this situation we have the Case Conference convened, what’s your understanding about the selection of the Chair for the Case Conference?”

A: My understanding of the selection of the Chair is that the local authority Social Work Department involved has the responsibility for hosting, convening and supplying the Chair for a Case Conference. The Chair of a Case Conference is a delegated responsibility from the Child Protection Committee. It is not an agency function, it is a Child Protection Committee function delegated to one agency to undertake. The Chair of a Case Conference should be a senior member of staff, and by senior that will clearly or explicitly, on my understanding or reading it should be that it would be above Senior Social Worker level.

Q: Above senior?

A: Above.

Q: In this case the person who chaired the Conference was a senior practitioner, a recently appointed senior practitioner not actually a senior. Would that suggest that the Chair appointed was not falling within what you would expect?

A: Yes, does not fall within what I would expect. A senior practitioner would not be a level I would expect to chair a Child Protection Case Conference.

Q: We have had evidence that lots and lots of them are chaired, certainly in the Leith area, by people at that level.

A: That surprises and dismays me.”

### 6.3.5 **Man4**

Q: “You said earlier that the Supervisor would not normally chair the Case Conference. Does that happen?”

A: Occasionally that does happen. We have a system in Edinburgh of independent chairing but, on occasion, that doesn’t happen and, as I understand it, it would happen more in a case that wasn’t seen to be of great difficulty or whatever.”

### 6.3.6 **Man4**

Q: “Can you confirm what level of worker would chair a Case Conference and what worker then would have chaired a Case Conference or whether it may be the same; it’s simply not changed?”

- A: It's the same. The Guidelines are nearly the same as they were. It would be the Senior Social Worker or Practice Team Manager or above obviously.
- Q: How often is it normally a Senior Social Worker who does it, is it the Practice Manager maybe only steps in if ...
- A: No. Well, for instance, the area I came from, it's on a rota basis, so everybody takes their turn."

#### 6.3.7 Man4

- Q: "SW3 was at the time a senior practitioner. It's just maybe getting an understanding of what the difference is, the roles and responsibilities?
- A: There are actually very few of them left. A senior practitioner was brought in so that a person who has got a lot of experience – and that's the first thing – would get a chance to have a more ... to get a clear development in the post that weren't necessarily wanting to manage staff, and that's why these posts were brought in, so it would be an experienced staff who would take on this role and either work or whatever. They would not at that time supervise staff. That's all changed, by the way. We actually have very few senior practitioners because we don't have enough people to manage the work. We need the seniors, more senior practitioners.
- Q: Were they the same grade or were they different grades?
- A: No, a senior practitioner is paid slightly less than a senior."

#### 6.3.8 Man4

- Q: "Would you have thought at that level (i.e. senior practitioner) a worker chairing a Case Conference would have had the authority ... maybe if I start the question the other way. In terms of the chairing of the Conference, overall what do you think they have in terms of responsibility to make the final decision about a Case Conference? Do they ultimately have the power to say "This is what is going to happen" although some people may disagree with that, or do they really take the consensus view of what the group is saying?
- A: I would have thought if someone is chairing, then I can only assume they were given that role because someone thought they were competent to do it. They should take the role of the Chair and be clear of their authority in that.
- Q: What's the answer to the question? What is the role of the Chair?
- A: The role of the Chair is that they take the authority to obviously take into account everyone's view but, at the end of the day, everybody to be clear about the decision that's made and make sure that that's minuted in a correct way.
- Q: Can they make a decision which is contrary to the view of everybody else in the meeting?
- A: That would be extremely unusual. In fact, I've never actually met a case like that. I've certainly met cases where there's been a difference of view and the Chair has had to form a view out of that, and I think that's right.
- Q: But would you see the Chair as having the authority to say "I've listened to everything you all say, but I still think we should take course A rather than course B?"
- A: I think that would be ... I think that would be difficult because you're expecting medical staff, teachers, whatever, to go away and implement a Care Plan that they don't agree with. In that circumstance I would, personally, I

would reconvene a meeting or have a discussion and come back to it and decide how we're going to do that in a proper way, and if I was a Senior Social Worker I would certainly go and see my Practice Manager and make sure we dealt with it, and maybe go to a higher agency. I don't think it's right to leave it in that way."

#### 6.3.9 SW3

- Q: "Now at the time that we are concerned with, which is 2001, what were your responsibilities at work at that time, generally speaking?  
A: Well I was part-time Senior Practitioner, part-time Social Worker.  
Q: And can you explain to me what do you mean by Senior Practitioner?  
A: Well basically Senior Practitioner is when you Chair Case Conferences, Looked After Reviews and try to do developmental work in the Team.  
Q: And part-time Social Work was doing what?  
A: That was just carrying a normal case load. At the time it was just changing because I still had a full case load, I was just changing and I was starting up Senior Practitioner work.  
Q: So when did you actually start the Senior Practitioner load?  
A: June.  
Q: Of 2001?  
A: Yes."

#### 6.3.10 SW3

- Q: "... is there any kind of induction course for seniors, or Chairs of Conferences?  
A: No  
Q: So you take on the role having had no ...  
A: There is an instruction book.  
Q: But there is no kind of ...  
A: It divides it up but there's no training.  
Q: So there's no half-day course?  
A: No.  
Q: In Lothian again, how does the rota for chairing conferences be drawn up, how were you chosen to chair Caleb's Conference?  
A: There is a rota but because there's not enough people on it to cover every day, particularly Case Conferences like this, if it's your day then people will phone you up and you'll have to do the conference that day. If however a worker needed a conference quickly then basically they have to phone around, or go around and find somebody to chair."

#### 6.3.11 SW3

- Q: "There is not clarity, or there wasn't at that time in terms of the Chair's role? Ultimately the Chair has the final decision in terms of need to register or not?  
A: No, the Chair's role was to be independent and as you say you take in all the information but not – unless I have got this wrong it wasn't the Chair's role to decide on like the practice issues like a Child Protection Order, that would be decided by the team, by the worker, the Senior Practice Team Manager. The

Chair could certainly suggest that they did that. I don't know because I have no experience of that happening."

## **6.4 What should have been the real issues at Caleb's CPCC?**

### **6.4.1 Man2**

Q: "On the facts you did know would you expect this Case Conference to be asking first of all whether the child should go home to the home environment, and then move on to the question of whether the child should have his name on the Child Protection Register, or do it the other way round, or what?"

A: Well the Child Protection Case Conference couldn't really make a decision whether a child went home or not, that's another matter altogether. That's an issue that needs to be done within the context of the law usually by a local authority, or the Children's Hearing, but you would expect them to address it because the issue of whether a child goes home is based on whether it is safe for a child to go home. The issue of registration follows on from that. In my view the purpose of a Case Conference is not to discuss whether a child should be registered or not, that's a mechanical issue. The fundamental issue is about risk and any other decisions flow from that. In other words if a Case Conference decides that a child would be at an unacceptable level of risk were it to return home every other decision should flow from that, including registration."

### **6.4.2 Man2**

Q: "Even if (Alec Ness) wasn't living in the family home and even if he wasn't caring for the child on his own, it was also clear to everybody present that he would be visiting often and taking an interest in the baby. Does that put him in a situation where people should have been asking questions about whether he was an appropriate person to have in this environment?"

A: Absolutely. I fail to understand how the Case Conference could address the issue of risk without addressing the issues you've just described.

Q: You see we have had several witnesses who have said, oh well, he was on the periphery, Shirley might have been finishing her relationship with him, he wasn't even living in the house by the 9 August, but equally everybody is clear that he was visiting the hospital, he actually visited the baby in the hospital and so on. Is it acceptable that that should be recorded as a reason not to look really hard at him?"

A: No it's not. The decision of a Case Conference, like every other decision in these matters, or any other process in these matter has to be evidence led. I would want a Minute to tell me what the evidence was about all the statements that have been made, about whether Alec is going to be living in the house, not living in the house, what the level of contact was going to be, what his attitudes were, what his demeanour was, what the factors were about Alec that may or may not have made him a safe person to be with Caleb, or to care for Caleb. All of these matters should have been discussed and the evidence for any opinion given.

- Q: Would you expect there to be an explicit evaluation of risk to Caleb somewhere in the Minutes?  
A: Absolutely.”

#### 6.4.3 HV

- Q: “So when you went to the Case Conference what did you understand that it would deal with before you arrived?  
A: Assessing really the risk of Caleb being with both his parents in the home environment, and assessing whether or not Caleb should go on the Child Protection Register and then if that was agreed that he should indeed, then formulating a Care Plan for his care after his discharge from hospital.  
Q: So before the Conference started what did you think the possible outcomes could be, going on the Child Protection Register, anything else?  
A: Well, either being registered or not, whether there would be a supervision if he went on the Register, if indeed he was going to be referred to the Reporter’s office, and whether there was going to be supervisory care from Social Work or indeed of him not going to his parents at all, going into care.  
Q: Okay what information did you bring to the meeting?  
A: I don’t recall that I brought much actually at all because I hadn’t actually met the couple, the information I had gleaned beforehand was very much from the Social Worker and from what I had actually read in the GP records.”

#### 6.4.4 HosMan

- Q: (Asked about the value of observing mother with baby in hospital.)  
A: “I think we know that any parent who comes to visit, who knows they’re being watched and observed, will do the best they can because they do not want to be seen to be failing.  
Q: ... so how valuable are those observations for a Case Conference?  
A: They may be valuable inasmuch as, you know, some parents who are not in entire control whether they’re observed or not, will do what they do. I think we have to take it with a pinch of salt.  
Q: There’s a risk of false reassurance then isn’t there?  
A: Yes.”

#### 6.4.5 REP

- Q: “One of the things that doesn’t seem to have been discussed (at the CPCC) was whether or not this child should go home.  
A: Yes.  
Q: Would you have expected that to be explicitly discussed?  
A: I would have been expecting it to have been discussed prior to the child being born.  
Q: Yes, that’s why I was asking that question.  
A: That’s where I was indicating where we could have had a role prior to birth, you know, I wouldn’t have left it until the child was born for that decision to have been taken.”

## 6.5 Referral to the Reporter

### 6.5.1 Man1

Q: “Now in the Minute of the Case Conference we are told that there is a decision not to remit to the Reporter?”

A: Yes.

Q: Can you comment on the circumstances whether Caleb should have been referred to the Reporter?

A: I think every Case Conference looking at registering a child in need of protection should give consideration to referral to the Reporter and the decision either to refer or not to refer should be clearly recorded as to the reasons why that decision has been taken. From my recollection of the Case Conference Minutes I couldn't tell why the child wasn't referred to the Reporter.

Q: That's because there is no reason given?

A: No, and I should be able to read a Minute and understand why that decision has been made.”

### 6.5.2 Man2

Q: “Would you expect a discussion to take place about whether or not Caleb should have been referred to the Reporter?”

A: Well I would expect it to be addressed flowing from the issue of risk.

Q: Are you aware that Shirley Malcolm had two earlier children taken into care?

A: Yes.

Q: Could you comment on how appropriate it would be to refer to the Reporter in those circumstances?

A: I can first of all comment on whether that would be further indications of risk and the answer to that is yes. If parents have two children removed then the circumstances of the permanent removal have to tell us something about potential risk to a third child. These factors are taken into account in combination with other current factors.

Q: ... So the issue then once you have decided on risk, what do you do about it?

A: Well one of the things that you can do about it is to refer to the Reporter. It's only one thing but it is one of the things that you can do.

Q: You see here we have in the Case Conference Minutes ... “SW3 then asked if people felt it was appropriate to make a referral to the Reporter and all agreed it was not.” And then in the box schedule the reasons are given as “Unanimously agreed that referral not necessary at present”. Now is this sufficient?

A: No.

Q: ... To record the reasons for not sending this matter to the Reporter?

A: No, no, but there should be within the narrative of the Minute, actually not within, clearly laid out an assessment of risk and what all the risk factors are and that should tell you why the Case Conference thought the child should not be referred to the Reporter?”

### 6.5.3 **Man4**

- Q: “If the agreement of the Case Conference is not to refer to the Reporter, then the Minutes don’t go to the Reporter, is that right?”  
A: Yes.”

### 6.5.4 **Man4**

- Q: “What about referral to the Reporter? When would you expect the Case Conference to make a decision to refer to the Reporter?”  
A: When you feel that other avenues need to be taken. I mean, often that would be the case if people felt that the Children’s Hearing needed to look at the information involved and make a different decision, because it goes into a different decision making place, as it were. It’s another place for people to look at the information and the evidence.”

### 6.5.5 **SW3**

- Q: “Do you remember discussing that, whether there should be a referral to the Reporter?”  
A: Yes, it was discussed and whether the registration, about whether a referral should be made to the Reporter to consider compulsory measures of care and I explained to Shirley what that meant, it would be ranging from the possibility of a supervision order to perhaps Caleb having to come into care and it was unanimous, there wasn’t anyone in that Case Conference thought that a referral should be made the Reporter.  
Q: And did you agree with that decision?  
A: On the basis of what we had, yes, because had we referred to the Reporter we had a mum who was co-operating both with us and saying she would co-operate with the Health Visitor, she had her drug use under control and was co-operating with the CDPS, I didn’t think on the basis of the information that we had at the Case Conference there were grounds for a Child Protection Order and I thought that had we referred to the Reporter the chances of a No Order principle were high because even if we had, the Reporter had gone to court and back, got a supervision order, all it would have been would have been a Social Worker and a Health visitor, exactly the same services as were already in place. The idea of three months was to monitor how all that went in to give more information.”

### 6.5.6 **SW3**

- Q: “(What should have been the reason stated in the appropriate box?)  
A: Basically it was there was no basis for a referral given, she was already working with the Social Worker, had agreed to work with the Health Visitor, she was working with CDPS, her drug use was controlled, reports from the hospital were positive about her care of the baby.”

#### 6.5.7 SW4

- Q: “Now as you said there wasn’t a decision to refer the case to the Reporter, do you remember why it was?”
- A: I can’t remember the word-for-word discussion but my impression is that, you know, that meeting reached a conclusion that there wasn’t sufficient grounds, there wasn’t sufficient information at that point that would justify, you know, making a referral to the Reporter.
- Q: Did you agree with that?
- A: At that time, yes. At that time, that might have changed, I mean, because my, I was perfectly well aware that I would be involved and that this was a precautionary measure and that you know, some real assessment of the circumstances and their ability to parent the child, that would be my task and it may have been that at some point further down the road, you know, there might have been sufficient concern to refer it to the Reporter.”

#### 6.5.8 SW10

- Q: (Looking at the Minutes relating to Caleb’s CPCC):
- “You see it says ‘Child(ren) be referred to the Reporter? NO’, and then “If NO state reasons why” and it says “Unanimously agreed that referral not necessary at present”. Do you see that?”
- A: Mhm hm.
- Q: Now, why were no reasons put in there?
- A: I thought that was a reason.
- Q: And did SW4 help you with that entry?
- A: Possibly. I certainly, you know, talked to SW4 and SW3 about how to do it, and I had a sample one, you know, for writing it up.
- Q: You see, I would suggest to you that that doesn’t give a reason. It says that there is unanimous agreement, which is fair enough, but it doesn’t say why this agreement had been reached.
- A: Yeh.
- Q: Can you comment on that?
- A: No. I mean that’s probably similar to what the sample I was given had.”

#### 6.5.9 HV

- Q: “We understand that the decision was made not to make a referral to the Reporter. Do you remember the reason for that?”
- A: Mainly I think it was because SW4 was quite, he was the one that had done the most assessment in the community and he was quite positive about the parenting. However, although the decision was made not to, the decision was made to send the Reporter the Minutes of the Case Conference.
- Q: To the Reporter?
- A: Yes.
- Q: Is that right?
- A: That’s what I seem to remember.”



#### 6.5.10 PC Man2

A: "... I mean we don't like to go to the Reporter obviously but once we go to the Reporter he accepts the referral then his first reaction is to ask for a background report.

Q: Can I interrupt you there just for a second, because you said we don't want to go to the Reporter, what did you mean by that?

A: I think there is a feeling that we would like Social Work and Health to work together on issues that could be handled at that level, and it is perceived that going to the Reporter is sort of going above the head of Social Work colleagues, that is the feeling we have, and Social Work probably feel that as well, maybe you have that experience, I don't know. But that feeling we have is, if we try to negotiate a passage of care with the Social Work Department and we are not getting anywhere and we feel that, "Okay, we tried everything we can with you, you are not giving us the support we want, we feel that we need to go to the Reporter", so we go to the Reporter with a view of making a referral for him to consider whether he wants to call a Hearing, and if he thinks that maybe he has something to take forward, the first thing he will do is he will come to the local Social Work Office that is referred from the Health Visitor, "I want a report from you", and that again creates a bit of more tension between working, because we don't want to have any tension working in Child Protection with our colleagues, but okay over this case we have maybe disagreed but over a long period of time we still have to work together.

Q: Do you think that would get in the way of your Health Visitor referring a child on when she really felt there was a need to?

A: It could do, it could do, because if individual differences can come into play and we have situations where a case is referred to a Social Work colleague and that colleague feels that, dash I don't have anything in here, I worked with this family before, the situation is nothing I can take on board and we do not agree with that or we feel that yes, there is an indication here, we want you to reconsider your decision, and they maybe think that "Well in this case we don't want to, we have made our decision", so we can come to an impasse, and for us to take it forward we have to go to the Reporter."

#### 6.5.11 REP

A: "... The Reporter is an independent official, that's one of the key aspects, our independence, and we are there to investigate all children referred to us who may be in need of compulsory measures of supervision. Any person may refer a child to the Reporter. Our job is to collate as much information as possible from all the relevant agencies, to assess whether we have the evidence to prove a ground of referral from the Section 52 to the Children (Scotland) Act 1995 and determine whether to bring that child before a Children's Hearing or refer for voluntary measures or not to take formal action."

#### 6.5.11 REP

A: "There has been a huge growth (in referrals to the Reporter) and it's not just in my area, it has been across Scotland ... and it indicates two things, I suppose it indicates that agencies are more aware of the need to do something about it. I

think in certain areas it does indicate in my view a confusion about what action to take in terms of referral processes.”

#### 6.5.12 REP

Q: “Now it would help us if you could indicate what kind of case you would expect to be referred to the Reporter bearing in mind that this is a new baby where there are concerns about the parents.

A: Absolutely. There is a specific referral protocol, I don’t know if you are aware of it, and which was created through the blueprint.

Q: No, that may be very useful, a referral protocol?

A: Processes of referrals.

Q: Right?

A: In particular you will find at Appendix 3C a specific protocol governing referrals to the Children’s Reporter from Social Work.

Q: Alright, now, perhaps you could help me by giving me the exact reference to this, that’s from the blueprint?

A: This is a code of practice which has been developed from the time interval work which is an inter-agency group, initially chaired by the former Chair of Scottish Children’s Reporters Administration but under appointment from Scottish Executive, and the remit of the group was to try to identify a means of reducing the timescales for processing of cases in the Children’s Hearings system. That started from a recognition that timescales were too long. So work was done and each authority has a local authority review group which specifically looks at time intervals, and it looks beyond time intervals, it looks at sort of standards of processing, it looks at protocols, protocols between, protocols for police warnings for instance are covered here, protocols for referrals from the police to the Reporter, protocols for referrals to the Reporter by Health professionals is also covered. (It was established for the record that this was a Scottish Executive publication called: “Blueprint for the Processing of Children’s Hearings Cases Inter-Agency Code of Practice and National Standards, Second Edition, 2001.)”

Q: You see I’m wondering whether it was out and in circulation by August of 2001?

A: I wouldn’t have a clue, my guess, my instinct would be that it was out. (Mrs MacKinnon) It was.

A: Certainly even if the blueprint was not in its final version the referral protocols have been agreed prior to the final publication of the blueprint.

Q: The question is how widely known that would be?

A: The referral protocols were drawn up by our Scottish Children’s Reporters Administration and Association of Directors of Social Work, and were made available to all the local authorities.

Q: And roughly when would that have been?

A: I would guess it would be 2000. The protocols that were formed are replicated exactly.

Q: Alright. So it is exactly the same protocol replicated in the Scottish Executive document as other protocols which involve other situations?

A: Indeed, and in my view what they do is replicate what should have been good practice anyway, I don’t think this changes anything dramatically, I would be

surprised if anybody looked at this and said – oh gosh, I’ll have to start doing this a different way now.

Q: Now, perhaps you could help us with what the protocol says.

A: The protocol is intended to try to concentrate agencies’ minds and looking at the Social Work one in particular in terms of when to make a referral to the Reporter and recognises that, you know, the first principle may be looking at preventative services to see whether children can be looked after appropriately, balancing what needs of intervention are appropriate and referring to the principles found in the Children (Scotland) Act at the paramountcy of the welfare of the child, the need for intervention only to take place where necessary to promote the child’s welfare, and the local authority’s statutory duties to safeguard and promote the welfare of children. The referral protocol stresses the need for referrals to be made where there may be a requirement for compulsory measures of supervision, the protocol lists the different grounds of referral but makes it clear that Social Workers must not take into consideration whether they believe there is sufficient evidence for grounds of referral to be established. The protocol really stresses that the question of sufficiency of evidence is a matter for the Reporter and that the issue for the Social Work Department and indeed other agencies to address is may there be a need for compulsory measures of supervision to make the referral. An issue which isn’t within the protocol but certainly has been covered by practice in the past is that we don’t require a child to be born to make a referral.

Q: Yes?

A: We have received a number of referrals for children who have been identified as potentially at risk should they be born.

Q: Yes?

A: And that has in fact been helpful to us because it has enabled us where there has been a referral to make early and full investigations so that we know what we are doing when the child is born.”

#### 6.5.13 REP

A: “If one is looking at the demands of a new child and looking at the sort of ability of the mother to cope in the past with children and one is looking at that additional pressure upon mother and that alone would give me rise to concern. I have to say that even if one was taking those two paragraphs out (i.e. relating to Ness in SW.4’s Report) the level of concern about Ms Malcolm would have made me very surprised at the case not being at least run by us or indeed being referred. By and large if there have been children previously referred to the Hearing system then unless there has been an absolutely dramatic and positive change in circumstances it has been a normal course of events for subsequent children to be referred to us and surely the Reporter then still has a discretion as to whether to bring it to a Children’s Hearing but it allows an independent person to make an inquiry, to gain information from all the different agencies at one step removed, that’s what I see as our value as Reporters, that we are not people who are in the middle of the family who, which can sometimes, can sometimes blind objectivity I suppose.”

#### 6.5.14 REP

A: (Looking at the Minutes of Caleb's CPCC:) "... I suppose what I would have been expecting is a very detailed summary in terms of the, if a referral was not being made with those sort of, that sort of background, I would have been expecting a detailed summary of the degree of voluntary contact, the sort of co-operation of both parents, a sort of Care Plan that would be in step to ensure that the child would be adequately protected without compulsory measures."

#### 6.5.15 REP

A: "... my own view is that at least in this region and I suspect nationally that the issue of what constitutes a referral to the Reporter is one which needs addressed, because there is a lot of information which I suspect we are not getting which we should, and equally there is a lot of information which we are getting which quite frankly I don't think we should and in particular many of our, the vast majority of our referrals from non-offence cases come from the police. The percentage of referrals we get from the Social Work Department is very, very small, at least in the Edinburgh area, I think particularly in the Edinburgh area.

Q: The care and protection, that would be care and protection?

A: Absolutely. Now, that partially is, indicates good work done by the police who are very quick off the ball in terms of making referrals to us in areas that they come across. So an awareness of what constitutes a referral, an awareness of the ability to consult with the Reporter prior to referral, an awareness of the ability to involve the Reporter prior to the birth of any child who may be at risk are key elements for me which from what I am reading today makes me wonder if they have been properly understood. There is a principle in the Children (Scotland) Act in Section 16 which talks about how the Children's Hearing will not make an Order unless it is better than making no Order at all, and I have been aware that that principle has received a number of different interpretations, and it has been a source of concern to me seeing one or two cases and I am not saying it necessarily applies here, as to a sort of minimum intervention, keep out of the system at all costs, and I think there is a danger in the application of that principle too rigidly, particularly in relation to whether to make referrals to the Reporter."

#### 6.5.16 REP

Having read verbatim what SW3 had told the Inquiry about the reasons for not referring Caleb's case to the Reporter:) "I mean one obvious thing is that it is all about she, it is full of comments upon, it is very focused on Mum.

Q: Yes?

A: It doesn't seem to need to provide the entire picture of the family, it doesn't seem to take account for me of the whole previous history, in a way it is looking at today, without necessarily encompassing the whole degree of difficulty that Mum has had in the past which led to two children being removed which is hugely substantial. I mean my own gut reaction to all of that even taking account of being wise after the event would have been that a

referral to us would have allowed a bit more investigating out of that, and what it talks about is the supports, it talks about Mum's co-operation, it talks about supports, but what I am not picking up is the relationship between that and the child's safety."

#### 6.5.17 REP

Q: "... I have some experience myself of cases, of being told that actually if the child is referred to the Reporter then the depth of the assessment and the speed with which it is undertaken would be hastened, and again it comes back to the question of work issues.

A: Absolutely, and certainly people use our system sometimes to almost bring a child to us to ensure that something is done quickly and gets the service where they may think otherwise that child won't get a service, and again if we are looking at the blueprint then strictly speaking there should be a 20 working day limit on when reports are produced in the Social Work Department. So there is an expectation that things will move quicker."

#### 6.5.18 REP

Q: "Here we are talking about somebody who has got a drug dependency history of more than twenty years?

A: Absolutely.

Q: Many occasions when she has attempted to withdraw from drugs and has failed. The story which was being presented to this Case Conference was that there had been a reduction in her drug dependency in the sense of Methadone used during the pregnancy, but also that she had got nowhere near being clear of her drugs?

A: Yes.

Q: The Case Conference wasn't discussing whether she was buying drugs on the street as well but there was certainly clear evidence that she was still significantly dependent on the Methadone. Would that in itself have given rise to the prediction that this child was likely to lack parental care in the future?

A: It could without question. If I slightly caveat that it is because I am aware there are many parents I suspect whose children have not been referred to us.

Q: Yes?

A: Who are getting by.

Q: Indeed.

A: Without the need for compulsory intervention. I suppose I would be looking at the other sort of supports, the monitoring, the other factors in the background, you know.

Q: Well, just to be clear, that sort of scenario can be referred to you, you would then look at the supports, you would look at the things you are talking about, that might result in you deciding to take it no further, is that the case?

A: Indeed it might well do. Many referrals, as everyone will be aware, we do not end up bringing to the hearing. I don't think, and I have given my caveats about some of them which I think are made inappropriately where there is no intention of compulsory measures of supervision being needed, but I think if there is an issue about it then it does no harm making a referral to us and there is no harm for us to take no further action at the end of the day."

## 6.6 Circulation of the Minutes of the CPCC, and their importance

### 6.6.1 Man1

(Referring to instructions issued on 19 February 2003.):

“ ... (We asked) each Practice Team Manager ... to check that there was a Case Conference Minute.

Q: So it's up to the Practice Team Manager to check?

A: Yes and that Minute should contain a Child Protection Plan in place for each child currently on the Register, to ensure that it had been sent to all agencies and signed up to.

Q: What do you mean 'signed up to'?

A: Agreed for the Case Conference, for the Child Protection Plan to have been sent out with the Minute and for that to have been agreed to by signing to it.

Q: Do you mean physically a signature?

A: Yes, physically. I can see that in asking the question, asking for it to be signed up to could be misconstrued so perhaps this isn't as explicit as it should be, but my understanding of it was that it should be signed by the person.

Q: Alright, you understand that if the person signs this Minute on receipt he really is, he not merely is agreeing that he has received it but he is also agreeing to do what he is asked to do in terms of the Care Plan?

A: Indeed, and to report to the Practice Team Manager or report to their Service Manager on this position on a case by case basis.”

### 6.6.2 Man1

Q: “And what about the selection of the Minute taker, how should that have happened?

A: Again I don't have the guidelines to hand but my expectation would be that the Chairperson would have been involved in that. The Minute taker would be someone who was independent from the circumstances around and someone with some experience and knowledge in doing these things.

Q: What sort of training is given to people about taking Minutes?

A: I don't know.

Q: Do you see the Minute as being important, playing an important role in the management of the risks to the children involved?

A: Very. I think there is a great danger in leaving to individual recall what has and hasn't been said at a meeting. The Minutes for me would reflect the record that one would go to, to recount or recall what decisions had been taken, how the process had been gone through to get to these decisions, who was allocated which task, and how these were going to be undertaken.”

### 6.6.3 Man1

A: (Speaking of looking into Caleb's case later.):

“Equally there were a number of other cases where Minutes had not gone out and hadn’t been agreed to, or whatever, and I have to say I was shocked that this Minute had not gone out. I was even more shocked to find that in a small amount of cases that was also the case, but it just shouldn’t have happened.”

#### 6.6.4 **Man2**

A: “Well I think that the distribution of Minutes is there to assist professionals to carry out their functions. I still think a Health Visitor should know what they need to do even if they don’t receive the Minutes but that, you know, what a Health Visitor does or anyone else isn’t entirely contingent on receiving a Minute, but nevertheless the distribution of Minutes and the guidelines for it are there for good reason and that is to ensure that the written information, the result of the Case Conference is on record of every agency, because it could be for example a Health Visitor was off sick, or whoever, and somebody else needs to carry on the work, therefore they need on the file all of the contemporary up-to-date information, and that’s why the turnaround of the Minutes is so important.

Q: Whose responsibility was it to get these Minutes out?

A: The responsibility of the local authority Social Work Department because they are responsible for taking the Minutes.

Q: Well, who was the person?

A: The Case Co-ordinator has to ensure that the Minute is sent out. The Chair ...

Q: I thought it was the Chair?

A: Well the Chair has a responsibility to check the Minute to ensure that the Minute is accurate. The Chair should also check that it’s done. I think that the Case Co-ordinator has got a role to ensure that it’s done, rather than just check it’s done, if you get my drift. My assumption would be of course that most Chairs would be independent of the Team, therefore not necessarily on site to ensure that Minutes are issued, but nevertheless it is probably an academic point, at the end of the day the Chair has a role to make sure that the Minutes go out.

Q: Would it be a matter of concern to you that we have heard evidence that Minutes routinely at the time were not issued for months, held up for ages, people didn’t even think it was remarkable that they hadn’t received the Minutes, it was just normal not to receive the Minutes?

A: I think the word “concern” is again an understatement, yes it would be a matter of serious concern to me if I had known that.”

#### 6.6.5 **Man2**

Q: “It was just to check with you, how does anybody who reads that Minute actually know that the Chair is happy with the Minute?

A: Well again ... my expectation is there is a sheet here which actually has on it a part where the Chair confirms that they have read it, confirms that it is satisfactory and signs it and dates it. Now I know because I have chaired some Case Conferences in other authorities that they have a page on their Case Conference Minute and it’s automatically sent to the Chair who has to do that

and that means actually re-reading it word for word. I'm sorry, I'm actually surprised to see that it's not the case in this.

Q: But there is an expectation that the Chair ultimately has, the responsibility for the content of the Minute lies with the Chair in its accuracy.

A: Yes.

Q: Not with the Minute-taker who is responsible to gather and put together, but ultimately the Chair would sign off that they are satisfied with the contents.

A: Exactly.

Q: And the form should have something, this is just maybe missing a page, but normally the Minute would have a page that allows the Chair to sign off and say I agree.

A: My expectation would be that the Minute should have that page, yes. Now whether Edinburgh Council's format for Minutes has it on it, you may be right, maybe it doesn't, I've just never understood that, in which case I am amazed.

Q: It is important that we are clear that the Chair has that responsibility to ensure the content, but I think also others need to know that the Chair has signed it off in terms of the content.

A: Exactly."

#### 6.6.6 Man2

Q: "Do you think they get copies, or do seniors get copies as a matter of course of Child Protection Minutes, or do they ever see Minutes, especially those seniors who maybe have not attended a Case Conference, do you think they see that Minute?"

A: No but they should, and again it's down to the responsibility of the senior. I think the senior should hopefully check, that is one of the things they should always do, that's not about implying the Social Worker is not doing their job but it's a gatekeeping mechanism, it's a quality assurance mechanism, a senior should check every report that's been written and likewise the senior should check the Minutes of any Case Conference that their worker has been involved in."

#### 6.6.7 Man4

Q: "I presume the Minutes get sent to the Chair?"

A: Yes.

Q: To sign off its contents?"

A: Yes, that's formal. (*sic.*)

Q: And sign it before it's circulated?"

A: Yes."

#### 6.6.8 Man4

Q: "Is there any process and would there have been a process again in 2001 about any kind of sampling of the quality of your Minutes and the quality of CP1s? Is there any mechanism or was there a mechanism to spot check?"

A: No. This is one of the things we're looking at. There's not a formal system to do that. I think that the Service Managers – that's the layer between me and the Practice Team Managers who would manage each area – I think they need



to do a spot check type of situation and we need to bring that into play, but it's not there at the moment. The Practice Manager would take that role, and often does."

#### 6.6.9 HV

Q: "Now you told us you didn't receive a copy of the Minute after this took place in August, did you actually notice that you had failed to receive a copy of the Minute or not?"

A: Yes.

Q: You did notice?

A: Yes.

Q: Did you do anything about that?

A: Well there was four Case Conferences I attended round, well within a relatively short space of time and I hadn't received the Case Conference Minutes for any of them and I did raise it with my Child Protection Adviser, and I raised it with the Senior Social Worker at the Leith office, whose name escapes me for the moment.

Q: Was that SW2 or ...?

A: SW1.

Q: And the Child Protection Adviser is the person whose name you gave us a few minutes ago?

A: It was (a person then assisting PCM2), she was a deputy at the time. I actually wrote a letter and I have a copy of that somewhere, and I think it was to SW1 I actually wrote to and (the deputy) herself said she would follow it up. I never ever received any of the Minutes for the four, well those four that I attended.

Q: And you knew that you were expected to get them sooner or later did you?

A: Well I expected them, because they were more or less the first Case Conferences that I had been to at that practice, and I hadn't been to that many before although obviously some few and this was a much busier practice and I expected to get them within fourteen days because of what the guidelines said. It was unusual, in the last practice you did get the Minutes very quickly, you know there wasn't a delay, so that was very, very unusual for this to happen because you depend on the Minutes obviously to recap on what everybody said and if you don't get them soon enough you can't remember anyway, especially, you know, at this particular time because there had been quite a few and they were all complex cases and you are relying very much on the Minutes."

#### 6.6.10 SW3

Q: "Did you get a copy of the Minutes after the Conference?"

A: No.

Q: ... So did you notice that you didn't get the Minutes?

A: I have to say no. Minutes came at varying times for Case Conferences.

Q: We have heard that it was a bit of a problem in Leith at the time that Minutes were ...

A: Yes, we have got a typing problem as regards the notes. The normal system would be for the Minute taker to give a note to the worker to check and then they would go for typing. I just have to be honest and say no I didn't. I mean I

remembered the case and I knew we were having a three month review. I wasn't surprised I hadn't got a copy of the Minutes, that would have come, eventually I would have checked, but I didn't, I have got to say that I didn't.

Q: So you as the Chair didn't have any responsibility to check?

A: I did, I know I did.

Q: Did you, I'm asking deliberately, I don't know?

A: Oh no, according to the guidelines I most certainly did and I suppose there is a difference between guidelines and habit and practice.

Q: Under the guidelines what were you supposed to do?

A: Try to get them out within two weeks.

Q: And what about checking their accuracy and so on?

A: Eventually once they are typed they would have come to me. They weren't typed though until actually Caleb was dead.

Q: So you remember them coming eventually?

A: I didn't get to see them, they were really just typed and because Caleb had died, they went into the review process."

#### 6.6.11 SW3

Q: (Looking at the Minutes relating to Caleb):

"How do you feel about the summary of the discussion, is that an accurate summary of the discussion so far as you're concerned?

A: It's reasonably accurate, it would have been useful if it had been padded out in bits, but then the range and quality of Minute taking within the Social Work Department is, I don't know, is as long as a piece of string, it really does vary and up until recently as long as the Minute was reasonably concise and got the main point in, that was acceptable. These Minutes get the main points in, there were obviously other bits of discussion which were not minuted."

#### 6.6.12 SW3

Q: "Has the practice of taking Minutes changed in any way?

A: Yes certainly locally for us, we now have a system of tracking them which we didn't have before and what we found was we still can't put them out within two weeks, but the period varies considerably. We still haven't got the typing support, the Social Worker's priority is direct contact and if a crisis comes in the Minutes go to the bottom of the pile, although we are focusing on trying to get them out, we are certainly clear now, and we are clear about having a separate Care Plan rather than a Care Plan that just feeds into the Minutes.

Q: Have you done this before, had Care Plans that fed into Minutes?

A: Yes, I mean these Minutes are normal Minutes for that time.

Q: At that time it was nothing special, there was no written down separate Care Plan, but that's changed?

A: It's certainly changed for us, I don't know that it has changed for other teams."

#### 6.6.13 SW4

Q: "Did you receive a copy of the Minute after the ...?"

- A: I know there is a lot of debate about this, I can't remember.
- Q: You can't remember, okay. Who's responsibility is it to copy the Minutes round?
- A: Personally the way the system works or worked, it's probably been looked at since then, was that if you were a Minute taker at a Case Conference and the Social Workers, you know, were note takers, you know, we had a rota in Leith because there was always a lot of difficulty sometimes about spreading the load of Minute taking – some people would end up doing it more than others, you know, in Team meetings there was always grumbings about such and such is doing it or not doing, so we had a rota and quite frankly it was, and again this is opinion, something I don't think Social Workers should have been doing, was taking Minutes at Case Conferences, but the understanding was that the person that took the Minutes you know, presented the Minute for typing and ensured that the administration around that was done.
- Q: Now in this case who should that have been?
- A: SW9.
- Q: Right, so when you left the Case Conference was it your understanding that SW9 would deal with the paper work and circulate the Minutes to the right people?
- A: Mhm hm.
- Q: But you knew that the Minute should be circulated?
- A: Yes absolutely.
- Q: So you say you can't remember whether you received the Minute, would you have noticed it if you hadn't received it?
- A: Possibly not, possibly not."

#### 6.6.14 Nurse1

- Q: "Do you want to have a look at the Minutes now to remind yourself? From what you have said you have obviously seen them before.
- A: I would get a copy after Caleb left but I don't normally keep them, I just return them. I remember reading them and thinking "That's not accurate." I didn't do anything about it because we no longer had the baby, and that's something I've learnt, but I just, well I just thought – "That's it."
- Q: Do you remember when it was you got the Minute, do you have any idea?
- A: No, and I just normally return them to the Social Work Department, I don't normally keep anything like this."

#### 6.6.15 REP

- A: "I think the first issue is that this Minute if it had been referred, if a decision had been made to make a referral to the Reporter encompassing this Minute then it is fair to say that this would not have given us any help in determining whether to proceed and that we would have had to make a fairly detailed investigation to get the evidence which doesn't come out of here."

#### 6.6.16 REP

- Q: "Would guidelines on what should be said in the Minute be helpful or would they just clutter up an already cluttered area?"

- A: Guidelines exist already within the sort of Child Protection Guidelines which I thought up to now should be sufficient in terms of doing that, I mean there may be a role for the Child Protection Committee to be looking at that, but we have quite recently reviewed the Child Protection Guidelines and I would have expected if they had been followed to have further deep information on this. We have noticed in recent months coincidentally or not a vast improvement in speed with which Case Conference Minutes are getting to our department which I have to say has been a problem for quite a period of time.
- Q: And when you say the speed at which they are reaching you, how quickly are they reaching you now?
- A: I haven't done any overall assessment but just speaking to people informally it seems to be very near the target reached in the Time Intervals Report.
- Q: Was that the five days?
- A: The five working days.
- Q: Yes, we are told that the Minutes of Caleb's Case Conference hadn't been circulated by the time he died on 18 October?
- A: Right. I believe there is a degree of urgency in Case Conference Minutes. I can fully understand that they are given to Social Workers who have many other things on their plate, that that is a struggle, but I would want to make one general comment if I may about the Leith Social Work Centre which is the office that relates to this, and that is that in general terms our office has been impressed by the quality of work provided by that Social Work Centre. I have to say that in general terms. We are aware that as with other Social Work Centres it has come under increasing pressure of work and resources, but I think it only fair to record that in general terms it is an office that we have been able to enjoy a good service from."

## **6.7 The Child Protection Plan and review of risk**

### **6.7.1 Man1**

- Q: "... There is no detailed Care Plan for Caleb involved in these Minutes. At that time what would you have expected to happen?
- A: Sorry?
- Q: Well I'm talking about the actual details of the Care Plan for Caleb, how would you expect that would have been worked out?
- A: At the Case Conference I think they should have been agreeing who was going to fill what roles and clearly I would have expected to pick this thing up and see that SW4 had been identified as the Social Worker, that he would have been visiting on a weekly basis and that the Health Care visitor had agreed that she would do joint visits. The ascribing of roles and what people will do within these roles from the Social Worker, the Health Visitor, the Police if they are involved, Doctors, from Shirley and from Alec Ness, stating very clearly this is the plan that we are going to have to work towards.
- Q: ... But you would have expected it to be decided at the Case Conference and recorded at that time?
- A: Yes.

Q: Just to be clear about this, you wouldn't have expected the Case Conference to simply identify the core workers and then ask them to convene perhaps very quickly afterwards to identify the details of the Plan?

A: Well I think that as a practice leaves open, leads to difficulty ... I'm not expressing this right. If you are not going to agree at the Case Conference who is going to do what, you are leaving it for others to decide that and there is no guarantee that that will happen, and I think the Chairperson's authority and accountability is beginning to be removed from them and you should be looking at these things within the meeting if only to be able to say to the parents, and the child if they are old enough to understand it, that this is what is going to happen and you have to be on board with this, if you're not on board with it, then X, Y and Z is likely to happen."

### 6.7.2 Man1

A: "I would expect as a young child for his milestones to be getting checked by the Health Visitor, his weight to be getting checked, for them to be doing the normal developmental stuff to see how he was doing and I would expect the Social Worker to be visiting regularly.

Q: How often is regularly?

A: I was about to say that by that I mean fortnightly, depending on who else and what other visits were taking place, and that should be worked out in my view at the Case Conference and agreed timescales that the people are going to be working to that there should be regular contact between the identified core workers, in this case the Health Visitor, the Social Worker, and there should have been links and liaison formalised between the two Social Workers, the Criminal Justice Social Worker and Shirley Malcolm's Workers.

Q: So would the Criminal Justice Worker have been a second Worker?

A: Yes, with Ness, but I would also expect that either – as Ness and Malcolm were meeting up frequently I would have liked to have seen two joint visits being undertaken by the two Social Workers with both people present with a "policing function" to ensure that the contract that had been agreed, or should have been agreed, was actually being undertaken.

Q: What about the Community Drug Service who were treating Shirley Malcolm's drug dependency, should somebody from that have been involved in that as a core worker?

A: Certainly should have been involved – I'll come back to the question of core worker. I think they should have been involved, clearly the Health inform the core workers that Shirley was actually drug free, or she wasn't drug free because that clearly has an implication for the care of the child."

### 6.7.3 Man2

Q: "Now would you expect the Minutes to reflect a detailed Care Plan in a situation as here where it was decided the baby would be going home?

A: No.

Q: Why not?

A: I think that a Child Protection/Care Plan as you describe it, and Child Protection Plan should be recorded, it certainly should be discussed and agreed, but not necessarily within the Minute of a Case Conference.

- Q: Alright, where would you expect it to be then?
- A: I would expect it certainly to be on the records of all the agencies who are participants in the Child Protection planning, these are normally the key front line agencies.
- Q: Who would be drawing up that Care Plan?
- A: The Case Co-ordinator, if a child was registered the Case Co-ordinator, the Child Protection Case Co-ordinator who is normally, according to the guidelines the Social Worker responsible.
- Q: Yes, now let me just draw your attention to page 6 of the Minutes. Now do you see the core workers agencies and the key co-ordinator is given as SW.4 and the other core workers are given as SW.4 and HV, do you see that?
- A: Uh huh.
- Q: Are you saying that the person who would draw up a record of what the Care Plan was intended to be would be SW4?
- A: Yes.
- Q: And you would expect him to draw that up and circulate it to the other agencies when?
- A: I would expect SW4 as the Case Co-ordinator to convene immediately following the Child Protection Case Conference, to convene rather than to hold it immediately following the Case Conference, a meeting of the core, the identified core agency workers. These people are of course identified at the Case Conference, who is going to be the core people. They should then get together either immediately after the Case Conference or at a time as soon as possible thereafter to arrive at a Child Protection Plan.
- Q: Now was this the practice in 2001?
- A: It should have been the practice in 2001.
- Q: Because not a single witness has mentioned this to us, and we have interviewed many now involved at the various levels – and not a single witness has suggested this to us.
- A: I would be interested, although I presume I can't ask you, I would be interested to know how the Child Protection Plan is arrived at in that case.
- Q: The expectation seems to have been that there was a discussion at the Case Conference, which may not be fully reflected in the Minute it is conceded, but from then on everybody knew what to do because of the discussion at the Case Conference.
- A: Well that would be a view I would disagree with.
- Q: Well ...
- A: The issue of the Child Protection planning again is crucial, the risk assessment is one phase of it, the decision about registration is an important decision to make on the back of the risk assessment. That leaves further crucial work to be done, a further phase of the work and that is Child Protection planning. If I can make a very general statement, my conclusions as to what is happening in Scotland is that often Child Protection planning is the weakest part of the whole process, and that may also be the case here. It certainly would not be my view that you can undertake effective Child Protection planning within the context of the Case Conference. Partly because the parents are there but also because the Case Conference has a different focus and that is on the assessment of the risks.”

#### 6.7.4 **Man2**

A: "... The next stage is before these people leave the Case Conference they commit themselves to an arrangement to sit down and draw up a Child Protection Plan, my expectation is that is done as soon as possible after the Case Conference, that could mean immediately after the Case Conference. The core group with the Case Co-ordinator then sit down and lay out a plan of what is actually called a Child Protection Plan but essentially it is a plan to do what I have just said, two things, to continue to monitor the level of risk and minimise the risk. There's no point in just monitoring, the whole point of being involved in the life of children is to change their circumstances and that means in terms of Child Protection lower risks and dangers. So in drawing up that plan every agency has to bring to the table what it's going to do to fulfil these two objectives. That will mean as detailed as it needs to be, how often particular people are going to visit, what the objective of these visits are, how communication between the core group is going to take place on a regular basis, what the criteria will be for a further Review Case Conference and how that will be convened, all these arrangements, and also maybe setting out other professional tasks with individual members of the family, or indeed others as needs be, and that ought to happen, it ought to be written down.

Q: Is there a form or is there a document that somebody writes that onto?

A: There are in some authorities ...

Q: In Edinburgh they don't have a specific Child Protection form?

A: I am not aware of a Child Protection Plan form. It needs to be written down and it needs to be owned by the core group who are committing themselves to this Plan. The Case Co-ordinator role is to have an overview of the implementation of the Child Protection Plan as well as undertaking their own statutory professional functions."

#### 6.7.5 **Man2**

A: "... A core group can't be two people, I am not sure that that is a core group."

#### 6.7.6 **Man2**

Q: (Should SW7 have been named as one of the core group monitoring Caleb?)

A: "Well, first of all let me start by saying I think he should have been. I think SW7 belonged to the list of core people in the Child Protection Plan.

Q: Yes.

A: And that's not there just to make up the numbers, he's there because he's got a role to play, he is a key professional with one of the care givers, either intermittent or full time, we don't know, of one of the carers for Caleb Ness, so he has got a key role to play in Child Protection planning, and indeed the implementation of a Child Protection Plan. What has gone wrong? Well clearly SW7 has not understood his role, or function in relation to Child Protection and that might be a general issue in relation to Criminal Justice Workers, I don't know, it might be that Criminal Justice Social Workers don't see themselves as part of the role in terms of Child Protection planning or risk assessment or risk management."

### 6.7.7 Man2

- Q: “Coming back to the Child Protection Case Conference, you talked about people arranging a Review Child Protection Case Conference if something significantly changed. Do you think that that is something that happens frequently across Lothian at the present time, do you think that that is something that people see as a tool that they can use in that situation?”
- A: No. No I don’t. Do you want me to expand?
- Q: Yes.
- A: I think that that’s for a number of reasons, I think primarily there is a fundamental problem here and that is that there is no framework for assessing risk, so in other words sometimes the change in circumstances is speculative, it’s to do with people’s individual interpretation of what is going on and it’s not located within any conceptual framework, now that’s missing and I think that’s really quite important. The second thing is, and I don’t know if it is understood, but everything should not be contingent on reconvening a Review Case Conference, it should be contingent on people’s understanding of what needs to be done because factors have changed. So I wouldn’t ever like to think that people would think, “I can’t do anything unless we have had a Review Case Conference”, that’s not the intention, it’s not there to replace individual agencies’ responsibility to protect children.
- Q: I think that the question that we have been getting from the workers that we have spoken to in the Inquiry is the opposite of that, but that in some senses the Child Protection Case Conference is almost seen as something that stands to one side in the process and makes a decision about registration or not, but doesn’t actually make a fundamental decision about whether the child should go home and how that child might be protected. Would you like to comment on that?
- A: Yes, because I would be interested in knowing in the absence of that who does make these decisions because the corollary of that assumption is that individual agencies make these decisions. If that is the case then I would want that to be explicitly demonstrated that they are making these decisions.
- Q: The problem is though, is it not, that nobody is making the decisions?
- A: Apparently.
- Q: It’s not that people are making decisions which they shouldn’t be, the problem is everybody is waiting for somebody else to make a decision.
- A: Yes, that’s about authority and I think the responsibility of the Case Co-ordinator is to ensure that information is pooled together and action is taken on the back of that information as necessary.”

### 6.7.8 Man3

- A: “If I wasn’t at the Case Conference and I submitted a report, I would expect communication between the lead actors, the lead officers, and that would be between the Children and Families’ Social Worker and the Criminal Justice Social Worker. I would expect common sense to prevail as well as good practice in actually both understanding what action or any action plan that was in place being understood and being implemented.”



#### 6.7.9 Man3

- Q: “SW7 is away on holiday. He knows the Case Conference is taking place. He comes back from holiday. He hears nothing. What would you expect him to do?”
- A: I’ve just answered it I think. I would expect to follow it up. What was the outcome of the Case Conference? There should be a written record of the Case Conference. It should be distributed to the parties concerned, and any actions would be outlined therein. I would expect him to say “Why haven’t I received the outcome of the Case Conference” and to be following it up in that way as a matter of some urgency.”

#### 6.7.10 Man3

- Q: “We have a bit of a dispute here between the Criminal Justice Social Worker and the Children and Families Social Worker about just who was involved in monitoring the situation for this baby after the baby came back from hospital. Is your answer to “What should have happened” the answer you’ve just given us, that it should have been clear from the Case Conference Minutes?”
- A: Yes.
- Q: And if there wasn’t clarity in the Minutes, then what?
- A: Then there should be clarity.
- Q: And who should have found that out and established the clarity?
- A: Well, I would have expected experienced Social Workers to have the nous to do that, but if not, then their senior Social Workers, their Line Managers.”

#### 6.7.11 Man4

- Q: “In Edinburgh when the Case Conference takes place and there’s major decisions that can be taken, one being registration, how is that registration then transferred into a monitoring and an action plan? What’s in place at the moment to actually then monitor that process of registration?”
- A: Well, as I said earlier, a Case Co-ordinator would be appointed – it is often a Social Worker – to oversee the case, but they would be ... well, there’s two things. There’s the supervision of a professional’s work, and it wouldn’t only be Child Protection work obviously, but there’s that supervisory worker relationship but there’s also ... I think there’s an issue here, to be quite honest with you, about how the work is overseen, and my expectation would be that the Chairperson may, you know ... would have a role, but there’s also a role for the direct supervisor of that person who, in a day-to-day way, would be overseeing the case, making sure the Care Plan is in place, ensuring that other agencies are playing their part in that.
- Q: So that would be your Case Co-ordinator that you would identify?
- A: Yes.
- Q: Who is normally a Social Worker?
- A: Yes ... but their supervisor is obviously playing a key role in that, although they’re obviously not often the Chairperson. That’s their care role I think.”

#### 6.7.12 Man4

Q: “What is the outcome of a Case Conference in Edinburgh – what is drawn up? There’s a Minute which is circulated. Is there a Protection Plan, a Care Plan? Is there something that’s produced that allows Workers to use that “This is what we have to do over the next three months”?”

A: There’s a Care Plan with ... it’s really not a separate document, and it’s something we’ve agreed to do something about. There are certain Care Plans, and I’ve looked into quite a number of these recently since all of this, to be honest with you, because I think it’s important we improve our practice. There’s always improvements to be made, but I think we need to have separate documentation for a number of things, and I think that’s one of them, so people are clear what they are doing. The ones I’ve seen and the ones I’ve been involved with, there is a Care Plan and people can sign up to that and know what they’re signing up to, but I think we maybe need to take that a step further.”

#### 6.7.13 Man4

Q: “If circumstances deteriorate within a family, is there an expectation in terms of current procedure that an early review would be convened or would the Senior and the Social Worker hold and work with that situation until the review date came along or would you expect them to ask for an early meeting and reconvene early?”

A: I would, but obviously it depends on the severity of the circumstances, but I think if there are concerns, then a review would be the right thing to do because you would then be involving other agencies and, as I understand that case, there are a number of agencies, adult agencies as well as child care agencies, that might be involved, so I think that’s the best way of formalising the situation. That doesn’t mean to say that people aren’t in daily contact with each other about the issue, whatever the problem is.”

#### 6.7.14 Man4

Q: “... what would your expectations have been in relation to the frequency of visiting a child who was on the Register, a newly discharged baby from hospital on the Register?”

A: ... certainly a few times a week.

Q: A few times a week?

A: Especially if you’re talking about someone who’s got a drug problem that’s maybe unstable.”

#### 6.7.15 Man4

Q: “We’ve got the Criminal Justice Social Worker, we’ve got the Children and Families Social Worker; in the particular case we’re concerned with, there’s an Outreach Worker from the hospital because of the brain injury; there’s people involved in the Drugs and Methadone Programme. We’ve got people from all over the place. Who is actually doing anything to ensure co-ordination between all these different agencies?”

- A: Well, I think the Social Worker is, if that's who's been deemed to be the Case Co-ordinator, and I assume that's what happened, with the formality of a Case Conference at the back of them. They're not just going out saying "I'm a Social Worker". I think they've got the authority, and they have the authority from all our agencies to do that.
- Q: Alright, so in a particular case you would say it was the key Social Worker who had the responsibility to ensure co-ordination?
- A: And their Senior. I don't think you can divorce that."

#### 6.7.16 Man4

- Q: "After the Child Protection Case Conference several weeks go by and then there are signs of problems: the mother develops signs of post natal depression; her drug dependency seems to be growing; the father is reported to be distressed, nearly suicidal – things like that. When these signs of distress and problems arise, who actually should be pressing the button and causing something to happen in the arrangements following a Child Protection Case Conference like this?
- A: Anyone and everyone, I suppose. Whoever sees the concern, because you don't need to just wait for ... you know, to arrange another review. You might feel in a case like that that something more serious needs to be done.
- Q: Meaning what?
- A: You may have to decide that the baby should be in care.
- Q: But what we seem to see here is a lot of people, each telling the other about something happening, passing the information round in a circle, pass the parcel, but nobody actually taking control and saying, "Right, that's it. The alarm bells are ringing." Can I just be clear from my point of view that the person you would say ought to be taking control is the key Social Worker, is that right?
- A: I would say the key Social Worker should be taking control because that's who works for me, but I think if other agencies are involved, then they should be getting asked the same question, I suppose. I don't think ... you may have a key Social Worker who is on holiday for three weeks – you know what I mean – but I think, from where I sit, the Managing Social Workers; I would expect them, yes.
- Q: You see, if you have a Health Visitor who is sounding the alarm bell, what exactly would you expect the Health Visitor to do?
- A: I would expect her to get on to the Social Worker, yes, and that's what normally would happen, I've got to say. If she feels that she's not getting a proper answer, then I would expect her to take that further.
- Q: To where?
- A: To her own Line Manager or to a Line Manager in the Social Work Department."

#### 6.7.16 SW3

- Q: "So the plan was exactly what, to have a review in three months you have mentioned. Was there actually a Care Plan?
- A: Yes, well the Social Worker was going to visit weekly and the Health Visitor was keeping very close contact, Shirley was to keep close contact with the

CDPS and the Social Worker was going to look at support once she was home with the baby and what was needed.

Q: Now was there a Care Plan drawn up, or anything in writing about the care question?

A: No.”

#### 6.7.17 SW3

A: “What would normally happen, the normal thing that would happen after a Case Conference like this is that the assessment would be ongoing, it would be what you would call a comprehensive assessment, so part of that would be the Social Worker finding out the information that wasn’t available at the Case Conference, which would be the bit of contacting, is that the Probation Officer who wasn’t able to be there, and that would be an ongoing assessment.

Q: So it was your understanding that SW4 would go away from that Case Conference and seek further information?

A: He would, he would automatically have contact with the Probation Officer and talk to the Probation Officer and things like that.

Q: What do you mean “talking to”?

A: That’s part of what we do, that would be part of our normal way of operating in a case like this.

Q: Let’s say SW4 had gone away and found information which gave him concern that the risk to Caleb was greater than had been thought at the time of the Case Conference, whether because he got that information from another person, or whether because things change, like Shirley got post natal depression?

A: Yes.

Q: Who was going to pull this case together and change the decision-making?

A: That would be the Social Worker and the Senior, it would be line managed.

Q: So the Social Worker had the obligation to go to the Senior and say the risks are growing in my opinion?

A: Yes.

Q: And what then would have happened?

A: They would then have taken the decision on whether or not Caleb needed to be accommodated if the risks were such.

Q: Was there any expectation that the Case Conference would be brought forward?

A: That wouldn’t happen, no, the Case Conference would still happen at the three month mark but it’s not unusual for children to go into care between one Case Conference and the next. It doesn’t involve the Case Conference, the Case Conference is updated on what happened in the time in between.”

#### 6.7.18 SW4

Q: “So did you ever in the time after Caleb came back from hospital, did you ever consciously reassess risks for Caleb at any point in time?

A: Not to any significant degree, no.

Q: Right.

A: If it is helpful in terms of my case load Caleb would not have been one of my major concerns at that time.

Q: You knew other babies and children who were more at risk, is that what you're saying?

A: Yes, based on the information I had."

#### 6.7.19 SW4

Q: As I understand it, reading the guidelines, there is a task then for the Case Conference to put together a Child Protection Plan when they put the baby on the Register, is that your understanding?

A: Mhm hm, well, the plan generally is that the Social Worker, I think it's mentioned in the Minutes that there was going to be a period of monitoring, you know, looking at what the family circumstances were and me liaising with, you know, other Health Care professionals.

Q: And were there any? There is nothing recorded as I can see it in terms of how frequently that monitoring would take place?

A: No, no.

Q: So that there wasn't an agreement?

A: There wasn't an agreement reached about that."

#### 6.7.20 SW4

Q: "In terms of your role was there a clarity or did you feel the Case Conference gave you that clarity about what that role of monitoring or assessment and monitoring actually meant, was there a specific task went with that?

A: There was no specific task as such but you know, you know yourself monitoring can mean anything.

Q: Sure, depending what the task was.

A: Yes, there was no specific task, you know, speaking personally I was aware that my task was to (a) monitor the care of the child, (b) be aware of any other significant information you know, as it presented itself, but unfortunately events overtook me in that respect."

#### 6.7.21 SW4

Q: "Did you have any kind of case meetings or planning meetings, workers meetings, in relation to the family where yourself and SW7 and maybe the Health Visitor could have come together to kind of share?

A: We hadn't at that point, we hadn't at that point, that may have come up prior to, you know, the three months having elapsed, but again overtaken by events.

Q: In a broader context, not necessarily for this case, is that something that happens, I suppose more for my information, is that something you could clarify, you could have a planning meeting?

A: Oh yes, absolutely, if there are sufficient concerns around, I think that's the significant bit of this, if there was sufficient concern around you would do that, have a professionals meeting but, you know, those concerns weren't being raised and I didn't have any kind of sense that I would've needed to do that."

#### 6.7.21 SW4

- Q: “What did you understand that other people had to do after the Case Conference, you mentioned the HV and you mentioned yourself, did you see any other people having a role to play?”
- A: SW7 would certainly continue to work with Alec who at that point, you know, wasn’t living in the family home.
- Q: So did you see him as having a role and as assessing risk for Caleb?
- A: Yes, I mean I would have hoped, you know, if he became aware of anything that was significant he would be passing it on to me, he certainly knew of my role in the case.”

#### 6.7.22 SW5

- A: SW7’s role would be at that point in time to continue to liaise with all involved agencies with regard to the care of Caleb and to alert whoever had been designated as the responsible Child Protection Officer with any concerns that we would have.
- Q: So would you see him in Social Work terms as the second Worker?
- A: Probably not, no, not in terms, in Social Work terms, because our role with regard to the young person would be secondary to all the Health Visitors they see or any other responsible medical or child care person, that they would be supplementing our role.
- Q: And would you expect there to be a record of SW7’s involvement in the Child Protection Plan after the Case Conference?
- A: If there had, if there had been an agreed task given to us then I would expect that to be logged.
- Q: So you would have no trouble seeing a Criminal Justice Social Worker having that role of reporting every month or keeping an eye on the position with a thought about the child’s needs?
- A: I think we would, what I wouldn’t have a problem with would be the reporting back in terms of the parents’ behaviour, anything that the parent or the person we were supervising would do to cause concern, I wouldn’t, I would have more of a difficulty if it was an assessment about the child’s behaviour because we are now not trained to do that.”

#### 6.7.23 SW5

- Q: And would you see it as appropriate for the Criminal Justice Social Worker to meet the Children and Families team Social Worker to discuss the situation perhaps after the Case Conference?
- A: If there was enough concerns to warrant it, yes.
- Q: What if there were no concerns?
- A: Probably I would think not as a matter of course.

#### 6.7.24 SW7

(After the CPCC)

- Q: “When you saw Alec did you talk to him about Caleb?”

- A: Yes.
- Q: And anything about how he felt about Caleb?
- A: Yes. Yes.
- Q: What was the story there?
- A: He told me he was delighted, he was laughing and he said very appropriate things.
- Q: Did you have any impression that he was involved in helping Shirley look after him?
- A: My understanding was that he was going there every day to help. He said he was fully involved when he went on a daily basis.
- Q: Well, when you realised that Alec was going to see Caleb during the day and was involved with that, did that worry you in any way?
- A: I think I felt that there were a few things. One, I felt that the Children and Families Team were involved, so that may have made me feel a lot ... well, certainly my focus was never Children and Families, if you like. It wasn't about ongoing supervision as a family. It was about Alec and the supervision of his licence, and already my involvement would normally be doing, if you like, structured work in addressing offending behaviour and looking into avoidance of offending behaviour. Already I was well further over into the welfare side of looking after Alec than I would have liked to have been because it's not an area I'm skilled in. Although I was talking to SW4 on a relatively regular basis, my view was "Children and Families are involved and they'll supervise the Child Care side of it".
- Q: So did you express any concern about Alec being with the baby?
- A: I didn't really have any concern. I knew he had had previous children and knew that he had an ongoing involvement with them. I really didn't see it coming. I didn't see ... I really didn't have, if you like, any worries about Alec and any wilful harming of the child or any abusive behaviour. I suppose I had some concerns that were echoing Shirley's concerns about his being unstable or if he was falling over, but my understanding was that that was well known and I felt that there were agencies involved who were monitoring the child. My view was then as Alec was separating from Shirley anyway, it was about getting him back on track and moving Alec into his house and to getting back to doing what I was supposed to be doing.

#### 6.7.25 SW7

(Referring to early-October)

- Q: So it would be fair to say you were never assessing risk to Caleb at this stage, in any event?
- A: No, I wasn't involved with Caleb at all. I was involved with Alec and Shirley and trying to distance, if you like, trying to get Alec. I was involved with Alec, but Shirley was there in so much as I was trying to find out what her views were and what she wanted to happen, but really it was "Get Alec his own tenancy as quickly as possible".

#### 6.7.26 SW7

(When you came back from holiday, and spoke to SW4)

- Q: “During that conversation or any subsequent conversation you had with him, was there any kind of discussion about how this case was going to be monitored and what your role might be in relation to that monitoring process?”
- A: I thought I was very clear with SW4 saying that my role was with Alec and that Alec was moving out of the relationship. I think it would be about getting back on line. Now, that’s my feeling of it. That’s what I believed to have been the case.
- Q: Did he suggest, or have you had cases in the past, where you’ve actually been a second worker in a Child Protection case where you’ve been a Criminal Justice Worker and you’ve worked with another colleague from Children and Families who have been involved in the Child Protection process or is this the first time you’ve kind of dual managed a case?
- A: I didn’t see it as dual management. As I say, I really didn’t see it in that way. I think I saw it as Children and Families were involved; a Child Protection Case Conference had taken place; Caleb was going to be placed on the Register and, therefore, when Alec moved out of the household ... well, he had moved out of the household but was spending still a lot of time there but, in the future, was going to be away, so I really didn’t see a focus for me in that house. As I say, it was about working with Alec separately, so I foresaw less involvement with Children and Families in the future.”

#### 6.7.28 PC Man2

- A: “Yes, in this case I would expect (HV) to have at least weekly contact if not more with Mum and child.
- Q: Can you describe to us what kind of contact that would be?
- A: I would expect her to at least see them at home, also to see the child at the clinic set up where the child would be weighed and measured in terms of looking at his, if he is thriving or whether it is jittery or whether there is any neglect emerging, but certainly the home visits will have been the most important part of her contact.
- Q: Yes, we would agree with that. Can you just tell us for the record why home visiting would be so important?
- A: Why, well, first of all to monitor all the aspects that is already recorded here, to see whether mother/child bonding is growing, to see that child care is appropriate, to see whether the relationship issue with that child identified is an issue that needs to be looked at more closely, to look at whether the parents’ chaotic drug use is in any way impinging on their ability to care for the child. She will also be able to see the environment in which the child is brought up, whether there is consistency in care or whether there is a deterioration. So all these markers will give her an inkling as to whether this family is coping adequately or not.
- Q: Yes, and are you saying these things are all easier to detect on a home visit, are they?
- A: Absolutely, yes.
- Q: Would you expect those home visits to always be made by prearranged appointment or would there be some value in dropping in?



A: To a degree dropping in would probably be more valuable, but if the family live in a flat or maybe have a security door, then you have got this kind of barrier.

Q: So in the ideal world, what would you have expected, a bit of a mixture?

A: A combination of both, yes, yes.”

#### 6.7.29 Dr1

Q: “(Do you see yourselves as part of the process of compiling an assessment of needs for a baby placed on the Register?)

A: We are involved in the process and we attend Case Conferences, I mean various members of the team will attend Case Conferences and part of the planning will be further monitoring of a person’s drug misuse problem and that would be where our area of expertise lies, and that’s how we report back to a Conference to say a problem has progressed in this way.

Q: And if you were part of that monitoring team offering that information to the Case Conference, the Review Case Conference, a follow-up, would there be an expectation that you would have regular contact with the Social Worker who had responsibility for Mum and child?

A: Not formalised, necessarily. What we would expect is that we would be, we would give information back into the Case Conference at its next, six months later or whatever, or three months. We would expect that if we had concerns about the child we would inform directly, we would encourage the client to inform in the first instance but if they refused we would break confidentiality and inform the Social Worker if it was required to do so, if we felt there was a risk.”

#### 6.7.30 HosMan

Q: “What is your general experience and expectation of Case Conferences in Edinburgh in relation to drawing up a Care Plan for a child going on the Register?

A: The ones I’ve been to certainly have a Plan drawn because, otherwise, it makes the Case Conference laughable, that you actually come away, after a lot of professionals get together sharing information, and come away with no plan, so that is my expectation, and certainly the ones that I go to generally come away with a plan.

Q: How detailed would that plan be? Would it, for example, say how often the baby would be visited?

A: It can do. It’s variable. It goes from just naming key individuals to specifying what the expectation is and the frequency of the meeting.

Q: And in an anxious case like this, would you expect there to be some formal agreement for those key professionals to actually come together on a reasonably regular basis to monitor that plan?

A: Yes, absolutely ...”

#### 6.7.31 Nurse1

Q: “Do you remember what the Care Plan was for Shirley?

- A: I think there were support systems being put in place for when the baby went home and it was visits by the different professionals.
- Q: Do you remember how often they were supposed to be?
- A: I got the feeling they might have been daily to start with.
- Q: Really, right. Well who was that to be by?
- A: Well it would have been the Midwife, Health Visitor and the Social Worker, I don't know if she had other support people, sometimes from the Drug area they have support."

#### 6.7.32 Nurse2

- Q: "How frequently do you think, from your knowledge of Shirley and the baby and the risks that were around, what sort of frequency of professional support would you have expected there to be there for her?
- A: I think initially when she first went home, then there should have been quite a high level of care to make sure she was coping with him 24 hours a day.
- Q: What sort of level?
- A: I would expect 2 or 3 times a week maybe and then gradually breaking off from that.
- Q: In response to?
- A: In response to, "yes she's coping and we can withdraw such intense monitoring of her and the baby"."

#### 6.7.33 REP

- A: "(What is absent is) the sort of rounded picture in terms of looking at it in all aspects of the case, looking at the Care Plan in terms of what supports would be offered to the child, what supports would be offered to the mother, what supports would be offered to the father, and some sort of proper risk assessment to determine that those supports would be sufficient, and what I see an absence from here and I am not sure if this is just confined to this particular case, is an absence of using a proper framework of risk assessments to help determine degree of risk."

#### 6.7.34 REP

- A: "The other area which I am conscious of and I have talked about briefly, is the whole sort of risk assessment tool to aid decision-making which is an area which our agency is trying to develop at present for our own decision-making, but also in conjunction with other areas. I am conscious that areas such as Fife, and Perth, have developed risk assessment decision-making tools for exactly this type of case.
- Q: And are they in the form of what, kind of checklists that people can run through?
- A: Certainly.
- Q: So that there is a conscious effort to run through each of the issues?
- A: To identify the risk factors.

Q: You see we have here a baby who was certainly diagnosed as suffering from neonatal abstinence syndrome when he was born and he was going home to Mum who was on Methadone.

A: And the father with head injury?

Q: The father with head injury who Mum was doing some looking after. Would they appear to be risk factors which should have been taken into account?

A: Yes.”

### 6.7.35 REP

A: “... I have to say that the whole issue of training in Child Protection law applies as much to Social Work Departments as well as others, that’s the general across the board bit. I think there is a training for us as Reporters which we require to develop more in terms of use of risk assessments as tools in Child Protection training and that is something as an agency which we are looking at, although I don’t think it would have affected any decision which we would have taken in this case had it been referred to us. I am sure you are aware more than anyone that one can’t escape looking at the sort of impact of Social Work and Social Work in the current climate of the lack of resources which we see day in, day out, in terms of the delays in assessments being made, the non-allocation of supervision requirements, of reports that are often waiting months and months and months and which, you know, I am putting no blame on the Social Work Department for in terms of what is there and what staff shortages may be, but they inevitably create pressure.”

## 6.8 Health Professionals, their role, and confidentiality issues

### 6.8.1 Man1

Q: “What about neonatal abstinence syndrome, is that a matter which a Case Conference should have been concerned about in your view?

A: Neonatal?

Q: Neonatal abstinence syndrome.

A: I don’t know what that is.

Q: This is a heroin addict mother who was on Methadone and so on, whose baby had trouble withdrawing from the drugs to which he had been exposed when he was *in utero*.

A: Right.

Q: Are you aware that babies in those circumstances may give rise to particular care needs?

A: I understand that Caleb was in Intensive Care for some time, yes.

Q: Well would that have been a matter of concern do you think to the Case Conference, how needy a baby he was going to be?

A: Well I would have thought so.”

## 6.8.2 Man1

- Q: "... Let's say for the sake of argument that Shirley's drug prescription had been increased after Caleb was born, should the Community Drug Project have been obliged to tell the key worker that?
- A: I think there is a growing awareness amongst our profession that the link between drug abuse and child abuse.
- Q: Yes.
- A: And in Glasgow – Glasgow's guidelines are far in advance of the guidelines that are in our guidance there, but we realise in Edinburgh we need to update and upgrade them. Because of the linkage I think there should have been information passed, to protect the child.
- Q: Well you haven't answered the question.
- A: Have I not?
- Q: No. Did you see the doctor who was treating Shirley as having a duty to inform somebody if Shirley's drug use changes dramatically for example?
- A: I am not sure if the law says that they have a duty or not. I would expect that in good Child Care practice would allow people to share information.
- Q: Well, leaving the law aside, we have as one of the people who attended the Case Conference from CDPS, Dr1.
- A: Yes.
- Q: His input on her drug abuse was an important factor with decision making obviously?
- A: Yes.
- Q: Would you have expected him proactively to link in with the Social Worker if he saw a change to the drug use of Shirley?
- A: Yes.
- Q: Would you expect him to do that without being told that he should do that?
- A: Yes.
- Q: You would expect him to just do it off the top of his head, would you?
- A: No, no.
- Q: Well what makes you think that he would lift the phone, or write a letter if Shirley's drug use changed?
- A: Well, I'm assuming that the doctor would understand that if there were drugs, if the use of drugs were interfering with Shirley's lifestyle then that would interfere with the care of a very young child. Now maybe that's an unfair assumption on my part. I want to go back to this issue, you said do they have a duty, should the doctor have a duty, and I am confessing to an ignorance of the law in relation to that. That might well be a question that should be addressed – should there be a duty to inform?
- Q: There may be a lack of clarity about that.
- A: Maybe. However if the doctor was at the Case Conference and had heard the circumstances around the care of the child and the arguments for and against the child going home and then subsequently discovered that the drug use was different and on the increase, then I would have thought common sense would dictate that the information should be shared.
- Q: He has a duty of confidentiality to his patient however, so common sense is not always going to be considered, is it?
- A: Was Caleb his patient?
- Q: Caleb? His patient is Shirley.

- A: Was Caleb his patient as well?
- Q: No. I'm talking about a drug specialist, an addiction specialist.
- A: Okay, can I ask a question here?
- Q: It rather depends.
- A: Does the duty of confidentiality excuse the non-sharing of vital information?
- Q: Well, I think actually you should be telling me the answer to that question.
- A: Well, I wish I'd never asked it then.
- Q: I mean, given your position in this whole Child Protection scenario, that's a question to which you should know the answer, isn't it?
- A: I have my own views on it, I'm not sure that I know the precise answer in law.
- Q: Never mind the law, let's just look at the world that you are operating in.
- A: Okay.
- Q: And watching over. Do you think that the doctors in Lothian are sharing information when they think information might have a bearing on Child Protection, or do you think that they are not?
- A: That's a very good question because I can only assume that they are because I can't think of any research or work that has been undertaken that would help me answer that one way or the other.
- Q: ... Never mind auditing, I'm looking at a situation I think here with Child Protection Conferences taking place round Lothian and Edinburgh on a weekly basis where many agencies are involved at these Conferences routinely.
- A: Yes.
- Q: And where routinely the child's safety is going to depend on the input from people like Health Visitors, Doctors, all sorts of people in the health field, that would be fair, wouldn't it?
- A: Yes.
- Q: Are you saying to us that you don't know whether these people are actually reporting in any concerns about Child Protection when they have them?
- A: I would have to agree with that because I don't now - ... well, I don't know."

### 6.8.3 Man2

- Q: "... Clarify for us the moment your understanding about training of health professionals in the Simpsons and the Astley Ainslie and in CDPS.
- A: My understanding would be that they would have some information during their professional training and that once in employment, professionally trained, that there would be opportunity for, during their induction, opportunity for further training. Now the difficulty here is my understanding is that Child Protection would be a component in training rather than training on Child Protection. So I think we have got to be careful here when you talk about Child Protection training, some people might mean a full course essentially solely about child abuse and neglect and those issues surrounding the protection of children. Professional training for hospital staff I think is often getting information about Child Protection procedural information as well as some diagnostic information, amongst other ongoing professional development and training."

#### 6.8.4 Man2

A: "... Pre-birth Child Protection Case Conferences as they are called are reasonably frequent events, perhaps arguably not as frequent as they ought to be but certainly reasonably frequent events, if one predicate Child Protection issues following the birth of a child, or indeed there are Child Protection issues pertinent to the pregnancy. There are difficulties around that and the difficulties are partly to do with information sharing, I would guess that information concerning a pregnancy for example is to be shared, would need to be done on a need to know basis and I think one would need to demonstrate very clearly that there were Child Protection concerns before agencies would be confident about sharing information about pregnancies. Sharing information about living, breathing children is another matter altogether and I would hope that agencies would automatically share information in those situations.

Q: ... Is there an understanding between all the relevant agencies that information relating to children should be shared on request?

A: Your use of the word 'understanding' is very interesting. My expectation, for what that's worth, yes there is an understanding between agencies and that sides in with the Child Protection guidelines, both within the spirit and the letter of it. It certainly ought to exist within single agency procedures that information is made available. It is clear that, for example, exception to confidentiality will include matters of Child Protection, that's my expectation, and it's also my expectation that every member of staff of key agencies in Child Protection would understand that. Whether that actually happens or not is another matter altogether. My expectations I know are sometimes not met, I know there are difficulties occasionally in sharing information, I know that some staff may not fully understand their responsibilities, I know that some agencies may not fully understand the law of procedures.

Q: I was just wondering about the law, is there any legal protection if you like for people who are being asked for information and who are sharing patients' confidential information with another agency, do they have any protection from the law?

A: Well, the Data Protection Act primarily I suppose would offer some protection, but again as in any piece of legislation there are exceptions and the Data Protection legislation is exactly the same.

Q: (Example given of Dr1 from the CDPS saying that it was difficult to breach client confidentiality, when there was not a clear cut issue of risk to the child.)

... But you can see the difficulty when information about the mother is information which might have a bearing on risk to the child, but which might not. Is there enough protection for doctors and other professionals in those circumstances?

A: I don't think there's enough clarity, I don't think there's enough clarity. My view would be that in relation to the Data Protection legislation there is enormous scope for that to be clarified, to be exclusively set out in a way that is understandable for every agency and every professional and that's not currently the case. I also think that probably the protocols, the procedures, the policies relating to the sharing of information probably could be explained

better, and better understood. So the answer to your question is I think there is a lot of scope for improvement there.”

#### 6.8.5 Man2

A: “... I think most of us agree that the greatest benefit in training on Child Protection is to do it jointly between agencies, rather than just as a single agency. That doesn’t remove the responsibility though from single agencies to ensure that their staff is trained, even to the most basic level and if that’s not happening then I have a serious worry that people are coming to interagency training without even having the basic in place that should be put in place by their own agencies.”

#### 6.8.6 Man4

Q: “Does Edinburgh have a model of assessment that they use? Is there an assessment framework or something?”

A: No. No, we’re looking at that at the moment actually, but no. We have guidance about risk assessment in the procedures, what people should be taking into account, but it’s not a risk assessment framework like you would know in Criminal Justice.

Q: Have you anything in particular to pregnancy? Do you have any protocols in place that are actually specific about assessing risk in those scenarios?

A: Yes, and that obviously involves people from the medical profession as well in the main, so there’s other people involved as well, but we would take into account – and whether it’s an assessment tool in the way you mean, I’m not sure – but I think it’s more about taking into account a history of a person’s lifestyle as well as their past life and how they’ve lived and all the rest of it, because just because you have a baby doesn’t mean to say you become a miracle mother.

Q: Do you have a protocol in relation to that?

A: No.

Q: Not at the moment?

A: We have a protocol with Simpsons, which I’ve got to say has got more difficult with the new Royal Infirmary because of the fast turnover of mothers, but we work in this hospital and I’ve been very keen to make sure our staff work with the hospital. It’s got more difficult with the new Infirmary being up there.

Q: And that protocol would have been in place in 2001?

A: For a Senior Manager.

Q: And do they have a close working relationship with the Medical staff?

A: Yes, very.

Q: The hospital team?

A: Yes.

Q: Can I just clarify that. Was there a substance abuse protocol for the assessment of babies born to mothers who have ...

A: There is not a written protocol in the way, I don’t think, you would mean it, but we have local protocols – I suppose that’s the way to put it – within the Simpsons Hospital, for instance, that our staff are linked towards and the Senior oversees the work, and they’ve always worked very well. The staff

know when to refer. It has got more difficult since we've moved up the road to the new Infirmary just because of the changes. ...

(Later). Most mothers are out of hospital in 24 hours these days, so I think the Community Health Visitors are actually becoming the key role, the key link, I should say, to us, not to the hospital, so it's quite an interesting change."

#### 6.8.7 **Man4**

Q: "You see, we've had psychiatrists and psychologists and people like that concerned with Mr Ness' head injury, who knew the severity of the injury and knew that he was abusing drugs on top of the head injury, and were in a position to say without doubt that this man should not have been left with a child. But they felt that this was all up to the Social Worker, that there was a Social Worker in place and they knew there was a Social Worker in place; it was all up to them. What would you say about that?"

A: I would say they'd never been trained in Child Protection."

#### 6.8.8 **Man4**

Q: "The implications for us are complicated because if we were to make a recommendation that every person who might conceivably be involved, from any angle down to the Consultant Psychologist and the brain injury, should actively be doing something every time there was the faintest whiff of a Child Protection issue, you might be deluged with silly calls and neurotic calls from people when, in fact, everything was well under control.

A: Yes, I take your point, and I think I know from speaking to colleagues in Community Health that they're clear because they are the people that meet most of these young children, sick children and so on, and there are issues there for the medical staff and the training in voluntary and mandatory training and all of that, and I think we need to be clear. That would be a view I have personally, that I think for certain groups of staff this training should be mandatory. There's no doubt about it. For people you are talking about who may only face this once a year, I think there's a different issue and I think its about awareness training. I couldn't expect these staff to be trained the same way my staff are trained in Child Protection issues, but I suppose it's about awareness training – if they do face it, what do they do – and maybe we haven't got that message over very well."

#### 6.8.9 **SW3**

Q: "What do you think the people going away from that Case Conference thought the risk to Caleb actually was? We talk about risk, what was in people's heads do you think?"

A: Possibly that the risk lay around Shirley not sticking to her drugs programme.

Q: And what impact would that have on Caleb in reality?

A: That would impact on her physical care of Caleb and her ability to both assess and meet his emotional needs.

Q: Emotional needs?



- A: Yes, his emotional needs. If she was completely doped out of her head she wouldn't be meeting his emotional needs.
- Q: Would she be meeting his physical needs if she was doped out of her head?
- A: No.
- Q: So what down the line might happen to a baby who is sent back into a situation where his mother is abusing drugs and trying to care for a disabled man, what is the reality for this baby, what could happen?
- A: If she was not staying on her programme then the reality would be very serious and that is why the CDPS is part of that monitoring, you know, that she was staying on the programme."

#### 6.8.10 SW3

- Q: "Did you and do you think other members of the Case Conference had an understanding of a state of withdrawal from drugs, what is the impact of that for the baby in terms of difficulties that the baby might present in subsequent care at home?
- A: I think the Health Visitor would and I think the hospital staff would.
- Q: Was that discussed openly at the Case Conference?
- A: No, not by the staff.
- Q: So do you think then that ...
- A: I certainly don't, I don't have an intimate knowledge of babies' withdrawing, if you see what I mean. I don't know what the Social Workers' knowledge is, but the rest of the people there were medical people.
- Q: They might have individually had that knowledge?
- A: Well possibly, certainly the midwife and Nurse1.
- Q: Yes, were the potential implications of that to Caleb's care though shared with the Case Conference?
- A: No."

#### 6.8.11 SW5

- Q: "So were you aware how much contact Alexander Ness was having with the Astley Ainslie team over this period? (i.e. at 22<sup>nd</sup> June 2001).
- A: I had some awareness of it.
- Q: So would you have thought that it might be useful to have somebody from there?
- A: I would have thought, what I would have thought probably was that we would have a meeting with them at a later date in order to look at what the requirements would be for settling him into any accommodation that we had managed to identify for him and look at their involvement in more of a Community Care perspective rather than a Criminal Justice perspective, but the difficulty sometimes we have with regard to working with other service providers who are not from a Criminal Justice background is how much information we can actually share with them with regard to a person's previous convictions etc. and that the review is primarily a Criminal Justice matter where we're looking at people's previous history in terms of their offending behaviour often and that sometimes is not what the service user would want to have shared and sometimes it isn't what we're allowed to share with people .....
- Q: And the absence of Shirley at the Review, was that because she didn't attend or does that go back to what you were saying about the confidentiality?

A: That goes back to what I was saying about the confidentiality to allow us to focus on the Criminal Justice.”

#### 6.8.12 SW5

Q: “Is there help given for people with brain injuries and so on to enable them to register with GPs ahead of ordinary members of the population do you know?”

A: Well the best that we can do is to write either through now, it used to be in the Northern, I think it was Drumsheugh and say someone has moved and they require a GP, and we do that for most, for many service users.

Q: Yes?

A: And if they are required and if there is a problem with somebody registering within a particular practice we can only ask, point it out and say “Look, would you consider taking this person on?” We can only advocate on their behalf, that is about the best we can do in terms of ...

Q: Does that usually work?

A: It depends, it depends, there are many reasons why practices don’t particularly want to take on certain service users, it doesn’t always work. The best you can do is say this is the situation, you will always get a GP but you might not get the one that, or in the area that somebody particularly wants to be in, and I think that’s maybe why people are sometimes reluctant to change. So what you will find with many of our service users that their GPs, they live in one area, and the GP1, doesn’t know they’ve moved because they won’t tell them in case they take them and strike them off the list. So many of the GP records in terms of someone’s address are not accurate.”

#### 6.8.13 SW7

Q: “Now, obviously in dealing with Alec up to the time the baby was born, you are dealing with a man who you know has come out of hospital after a brain injury?”

A: Yes.

Q: How did he seem to you compared to what he was before?

A: I suppose I could qualify that by saying I knew I was dealing with someone who’d had a bang on the head and had come out of hospital. I was not clear at all about the extent of his injuries; nor were the people who were involved with him medically.

Q: Who do you mean by that?

A: Doctors, nursing staff. I mean, it was ...

Q: Which doctors?

: Well, I spoke to MN, and when I say doctors, I say that on second-hand evidence. She was the person who Alec was seeing at the Astley Ainslie and was involved in his ... sorry, I’m not sure about the term ... convalescence. Would that be the right word?

Q: Well, she told us she was an Outreach Nurse.

A: But she was the person that I was given, the name I was given, and I spoke to her, and I suppose my concern at that time was Alec appeared relatively normal at some times and other times he appeared quite forgetful and quite emotional. There were various other things that came out round about that time which would explain some of the mood swings and some of the problems.

Q: Like what?

A: Like I was informed that Alec had been tested positive for, I think it was, Temazepam and Valium, which came as a real shock to me. It wasn't something that I had been on the lookout for. I was aware that alcohol could have been a problem and I was aware that he had been involved in cannabis, but I wasn't aware of any ...

Q: Did it occur to you to ask the Astley Ainslie for some kind of medical report to help you?

A: That would have been ... in hindsight it would have been much clearer, but I didn't. The majority of my work with Alec, he was lucid, clear and fine. What I was hearing was that occasionally he was very upset, and I suppose my view was that he was in the break-up of a relationship, he was about to have a baby, he would be upset, but I didn't put the three together and see a hugely disabled man in the community. I saw someone who was separating from a partner, who was potentially violent."

#### 6.8.14 SW7

A: "I foresaw, if you like, quite a lot of pain for Alec. I thought it was going to get difficult. I thought that Shirley had come to realise that the reality of living with Alec was going to be too much for her and was really backing off at a tremendous rate, so I saw the future as Alec perhaps continuing involvement with Shirley but probably not, but that was a supposition on my part at that time, but that was really the way I saw it. It was about getting something in place for Alec, find a house.

Q: Yes, but she was complaining that he was hard to look after, wasn't she?

A: Yes.

Q: That he was dependent on her and that he needed looking after?

A: Yes.

Q: Yes, so that doesn't sit too well with the idea of a guy who is coping alright, does it?

A: Well, no it doesn't, and I agree, looking back on that, that may be right, but I suppose my focus was ... it's very ... my focus was to find a house, get him there, locate services to come in and support him in the house and move on. I knew he was going to the house all the time. I knew he was there all day. Yes, you're right, there is a conflict there that perhaps I should have picked up on more."

#### 6.8.15 SW7

Q: "All these letters from the Astley Ainslie are going to a GP?

A: Yes.

Q: (GP named), and of course, Alec was nowhere near there?

A: He didn't have a GP. There was a problem. He tried to get in touch with the GPs in Leith. He was having problems getting his records changed, so that was confusing as well. I had difficulty contacting anybody. When I contacted, was it Hill Street? That's just off the top of my head. That might be wrong. It was very complicated. It was very difficult to get any information, I found, at the time but, on looking back on it, I probably could have worked a lot harder to get information from the records.

Q: I just wondered if that was part of the package of things you would do when someone was being released from prison, needing housing and so on, whether you would check to see that they were registered with a GP?

A: Well, we would suggest that people do that, but my assumption was Alec was aware. He knew what to do. He had gone to (named doctor), who had said he was no longer a patient, and he tried to register with the GPs next to it, you know. The feedback I was getting was that he had been aware of this in doing it.”

#### 6.8.16 SW7

A: “I think clearly looking back on it, I think more contact with the medical side and more structured contact with the medical side, but again the focus was Alec and about Alec’ needs, so I suppose, yes, that would be one thing, much more contact with the medical side. I suppose better communication with everybody involved all round. It’s hard not to be horrified looking back on it, but at the time it didn’t feel that unusual. I felt the level of contact I was having with people was relatively normal, and I keep saying the focus was for me to get Alec away and move on to the housing. Certainly in Social Work, once someone has an address, the services are supplied by that area. The fact that he didn’t have a permanent address was very difficult.”

#### 6.8.17 PC Man1

Q: “Do you think again there are particular difficulties for staff working in any particular areas within the Trust, for example within the Mental Health Services and within the CDPS, in terms of breaching confidentiality?”

A: Well, I think ... I think these issues are almost a regular debate in Teams, Mental Health Teams and places like the CDPS, because the whole issue of breaking confidentiality ... it happens a lot.

Q: There is very frequent debate about the issue, but are you confident that as a result of that debate the outcome is what you’ve just said, which is that if they were concerned that a child was at risk they must share that?

A: Yes, I would be confident about that, I have to say.

Q: And do you know that for a fact?

A: How can I know it for a fact?

Q: Well, that’s what I mean, are you ...

A: Well, I’ve been part of the debates when I was doing Clinical work.

Q: A very long time ago?

A: Yes, it is a long time ago. We’ve got somebody in the Trust who deals with medical records, and she’s also done training to do with Caldicott. We haven’t had any specific guidance about – that I can think of – about confidentiality *per se*, and Nursing and Child Protection that I can think of.

Q: I mean in response to Caldicott which you’ve just mentioned?

A: Yes.

Q: There hasn’t been a multi-disciplinary group within the Trust developing?

A: No, we’ve got that, and (named person) takes the lead ... (she) has organised training, and we’ve amended our policies and protocols.

Q: So why are you confident then that the guidance in that new document for the Trust reflects your understanding that there is no problem with breaching confidentiality?

- A: Yes. Yes I am confident about that and our local Child Protection Guidelines Policies and Protocols are in our Clinical Nursing Manual, and it's back to this business – they're in our Clinical Nursing Manual.
- Q: Yes, but even though they're in your Manual, it's difficult, isn't it, to be 100% confident that people have read them, absorbed them and know that that's what they would do in that situation?
- A: No, I can't force people to read them but, you know, I've got dual trained people who work in the Community and in hospital settings, you know. They're going to be aware of policies that they're using. Maybe not!"

#### 6.8.18 PC Man2

- Q: "So, just to make sure I am following this, you're wanting to strengthen the ability of the ordinary Health Visitor who has Child Protection concerns to raise them and bring them to the attention of the Social Work Team, is that it in a nutshell?
- A: Yes.
- Q: So that when they do raise the issue the Social Work Team takes it seriously and does something about it?
- A: And also feedback as to what the decisions are.
- Q: Alright, are you finding in practice that Health Visitors raise concern and then weeks later they have no idea what has happened?
- A: Exactly. The system is that we have, when we make referrals it goes to the Duty Team.
- Q: Yes.
- A: Now the Duty Team is quite a, it is a rotating team and in that rotation there might be five people, six people involved and each phone call will come to different people who are concerned about the same issues, and each one will go into a loop somewhere. So the first level of concern is taken by Social Worker A, level of concern 2 which is slightly higher is taken by Social Worker B, but they don't marry up, so that gets lost somewhere, and then people start making assumptions – oh yes, she did phone me about that.
- Q: So you are saying the concern can be expressed by two different people to two different Social Workers?
- A: Yes, in the same team.
- Q: In the same team and yet the match is not made?
- A: The match may not be made, and then the concern will just stay there.
- Q: Stay there?
- A: Yes.
- Q: So you have situations where there's actually no action taken by the Social Work Team?
- A: Very often, yes.
- Q: Now is this talking about new cases which you're bringing to the Social Worker Team's attention for the first time?
- A: Both new cases and cases that are going on and off, yes."

#### 6.8.19 Dr1

- Q: "(Is breaching confidentiality a big issue?)

- A: We deal with people committing, breaking the law every day and if it became known that we would break confidentiality too easily we would, you know, people just wouldn't tell us anything and we wouldn't be able to work with them. So we are left with, you know, being very clear that there has to be something active that, I mean the most recent example was two days ago and a mother said that she had stubbed a cigarette out on her child, that was clear, no problem at all. So we're going to tell Social Work, do you want to do it or do we?
- Q: No choice?
- A: But you know if there had been any concerns about Caleb where I would have told her that, you know, we have to inform on this, and that wasn't an issue in this case.

#### 6.8.20 Dr2

(Not actually involved after Caleb's birth: asked what role she would have played if she had still been in post):

- A: "I mean I would see my primary role in meeting with Shirley and hoping that I could build up and have a good enough relationship with Shirley that I could talk to her about what was going on, so that would be where my focus was, providing I knew other supports were in place at home, but feeling then that I would liaise with Social Work where necessary if I had concerns, if they brought concerns.
- Q: Would you expect to have a regular dialogue with your colleagues and Social Worker would it be on an increased concern basis do you think?
- A: Up to now I mean anything like this has always been on an increased concern basis. I can see now if you are thinking about what might change there would be use for it being on a more regular basis, but these things can be months apart.
- Q: Yes.
- A: And inevitably it's always difficult, two people working to get hold of each other and that can add to it being months apart, that conversations take place. I think in a case like this thinking of the ideal, I think it would have been ideal if there had been a, in other words you knew everything you knew now and thinking of recommendations, I think in some way the professionals involved were going to get together to check that they all had the same story and that the picture was the same, that would have been ideal.
- Q: Related to that really is the link between CDPS and the Primary Care Team. Could you just discuss that a little bit?
- A: The Primary Care, you mean GP?
- Q: What expectation would there be for communication between CDPS and the Primary Care Team?
- A: Well, there would normally be regular letters going to the G.P. from CDPS. Letters don't usually go, well certainly if I was at the clinic now I certainly wouldn't expect to write every time, it fills up the notes, but at least every three months or when there was a change, or something significant to report. I have contact with the Health Visitors if I have concerns about children, especially initially, you know finding out, fact-finding I often do via the Health

Visitors if I have concerns so my contact would normally be with either the G.P. or the Health Visitor.

Q: In a situation like Shirley, approaching the time of delivery of her baby, would there be an automatic phone call between yourself and the Health Visitor?

A: No.

Q: Or would it really only be if there was a heightened concern?

A: Yes.”

#### 6.8.21 Dr2

Q: “And you would link directly to the child’s Social Worker at that point in time if you had specific concerns about a child on the Register?

A: Yes.”

#### 6.8.22 Neol

Q: (What would happen if the family didn’t have a Social Worker already?)

A: “We would want to know a bit about the home set up. We wouldn’t necessarily visit the home, but we would want to know about the home set up, how many rooms were there, who else was in the house, who would be looking after the baby, that kind of thing.

Q: And how would you expect to get that information?

A: We would get that information from the mother. I suppose it could be inaccurate but, yes, we would get that information on questioning.

Q: Right, and then you would make a judgement whether or not you were concerned?

A: Hopefully the Liaison Health Visitor would have been able to inform us from the practice whether there were other ... whether there were concerns in that respect because the Liaison Health Visitor would be at the meeting as well, so we would expect that if the GP had had concerns about the home circumstances, that we might hear back from that.

Q: Right, so is what you’re saying then that a decision whether or not to refer the baby for Social Work input would be based on that discussion in that Liaison meeting?

A: Yes.

Q: Between the Liaison Health Visitor, the Hospital Social Worker and the Medical Team?

A: Yes, yes.

Q: Is there always medical involvement at that time?

A: There used to be but there isn’t always now, but we would normally do so if there was a case that we were worried about.”

#### 6.8.23 Neol

Q: “You see, coming from outside, it seems to me obvious actually that if the baby has got neonatal abstinence syndrome, there ought to be Social Work involvement as a matter or routine, that there should be no exceptions.

A: And I think there almost invariably is, but it’s not routine.

Q: It’s not routine?

A: It’s not.

- Q: You don't have a standard practice where you would have a discussion following the birth of a baby and the baby may result in coming into the Unit?
- A: No.
- Q: There is not a Case Discussion, which is not even at Child Protection level, just a case of discussion with the professionals looking at what the risk might be, and whether there's a need to do anything or not?
- A: No. No. I mean, I think, to be honest, I think it's unlikely. I can't say this for a fact, but I think it's unlikely that a baby would go through a unit without having a Social Worker involved, but it may well be that on the postnatal wards, because they weren't that symptomatic, that could happen, and I know there have been occasions in the past where we've felt it might be necessary and the Social Work Department have not felt that it was necessary.
- Q: And what happened then?
- A: I don't know. We didn't have a Case Discussion, I don't think, on that occasion, but because the Case Discussion involves so many different professionals, many of whom are working in the Community, they're actually very difficult to organise.
- Q: Indeed, but in the instance where you felt certainly concern about the baby you just spoke about, where you felt it was important to have a Case Discussion and Social Work felt the opposite, was that satisfactorily resolved in the discussion, that you both reached a mutual agreement that perhaps, "No, we didn't need to do that", or was that much more the feedback from Social Work that "We weren't going to do it and that, therefore, is the end of the discussion"?
- A: We wouldn't have let the baby home if we had felt things were too ... as we perceive them, too dangerous, but I can remember feeling unhappy about not having a Case Discussion about at least one baby.
- Q: Did you know that you could refer the matter to the Reporter yourself?
- A: I don't ... me, that would seem to be a very extreme thing to do.
- Q: Why?
- A: To me, that would imply that a Child Protection Order needed to be taken out, so I maybe underestimate how many people use that, or overestimate. Maybe I had seen it more as a last resort."

#### 6.8.24 Neol

- A: "We don't have close feedback with the CDPS. We do have very good feedback in cases in which we are specifically worried, so in Case Discussion, it would get as far as the Case Discussion, we would have good feedback. We wouldn't normally ... remember we're looking after the baby and not the mother, and I think there are issues as to whether ... how easy it would be to access maternal ... for us to access maternal information. We've never been denied maternal access to CDPS, but I don't know to what extent they would protect the mother's confidentiality. I don't know because I haven't challenged it.
- Q: Would that be an issue do you think? If you were trying to make some judgement about whether or not you need to refer a baby to Social Services, for example, if it has neonatal abstinence syndrome and doesn't have a



Worker, do you think information from CDPS might be quite crucial in making a decision like that?

A: Information from CDPS would tell us what drugs the mother was on. They might be able to tell us a bit about the mother's ability to cope with herself and, yes, that would be helpful, but I'm not sure that I would see that as something that the staff looking after the mother could access very easily."

#### 6.8.25 Dr3

Q: "Now if the Inquiry Team were to make recommendations for the future can you think of any recommendations that we should be making?

A: Yes, I think whatever recommendation in terms of liaison with the Health Service, I think the decision could probably have been made without too much about Alec's past medical history on the basis of what we saw of him really in everyday life and his responses.

Q: Are you meaning that any layperson who saw him would realise he wasn't fit to look after a baby, is that what you mean?

A: I think that the average Social Worker would probably have noted that, assuming he saw him on the days when he had taken drugs. Now it is not inconceivable that they may have seen him on the day when he hadn't taken drugs in which case, you know, he may well have been reasonable to the layperson and it's almost, the issue is, which also brings into question not just Alec's judgement but Shirley's, because Shirley said to me in the clinic not many months before she was afraid to leave him alone in the house without a baby being there, and the fact she left him with the baby is odd, surprising."

#### 6.8.26 Dr3

Q: "If you had thought ... at that visit in July that (Ness) was actually going to be the male partner as it were in this new family with this new baby, what would you have done about that?

A: I think given that Mum was also a drug addict I would assume there would have been Social Work involvement with the baby, and they would have checked that, and also contacted them to see if they knew the background of Alec.

Q: And you wouldn't have had a problem with that?

A: No I wouldn't have had a problem with that, you know doctors don't make the greatest networkers I have to say but, you know we do contact other people where necessary and I would have done that given the severity of the issues arising from that I probably would have done that myself.

#### 6.8.27 Psyc

Q: Did it occur to you or any of the team to contact the Social Work Department or anything like that relating to Caleb?

A: As far as we understood it, it did, the thought did cross my mind but the, this is after Caleb's birth.

Q: Yes?

A: And I did think about it. My understanding was that the team had met, you know that this special panel had met and had taken evidence and had made this

decision, and I didn't, although I subsequently heard that Shirley had a drug addiction problem or knew that she had a drug addiction problem, it was all in a sense hearsay, and I didn't – she wasn't my patient – and I took it that the Panel, you know, a panel of experts had decided this, and while I was surprised at this decision having been made, they had had the evidence and the experience to make that decision and that it was my job simply if I became aware of anything that would maybe not have been available to the Panel, or any fresh development which would have raised the risk of concern about the infant, then I would have probably said something, but Alec had a Social Worker and the child we knew was on a Child Protection Register so we presume that this, the Panel had released the child to the parents' care taking the necessary, you know checks and precautions to make sure that all would be well.

Q: By the Panel you mean by that the Child Protection Case Conference?

A: The Conference which had decided where Caleb would go.

Q: But you hadn't been at the Case Conference and none of your team had been there?

A: That's right.

Q: Yes, you knew that?

A: Yes.

Q: Yes. Wasn't it a concern to you that the Case Conference didn't have all the relevant information?

A: I would imagine that the Case Conference, you know, with this specific remit would have taken note of all relevant factors including his health condition and the health condition of any other visitors, regular visitors to the house. It was just unthinkable to us that they wouldn't have said, "Well is it just mum and babe, or is there a man going to be coming, is there any other regular visitor? Who are they, what are they like?" because it was obviously a very risky situation, and we thought that they would take note of all the, all these factors, and it was inconceivable that they hadn't."

#### 6.8.28 Psyc

Q: "Had you any concept of what you might expect SW.7 to be doing in this situation, would you see him as having any role potentially?

A: Well he was Alec', yes he was Alec' I think Criminal Justice Social Worker and I would imagine he would have been acting something like a Probation Officer, checking on his housing arrangements and his, you know, state, trying to keep him as much as possible on the straight and narrow and listening out for any areas of trouble that might be cropping up, yes.

Q: It's a potential area of trouble with Alec?

A: Yes. You mean looking after the child was a potential area of trouble?

Q: Or maybe his relationship with Shirley, a lot of the things you describe perhaps.

A: The potential, yes I think that Alec had just described the child care as being really ideal, that we had a happy mum and he was popping in and doing his bit.

The Chair: But you knew he had no insight?

A: We knew he had no insight but I mean he was almost like a fool in paradise as it were, and we thought "Well, the mum is keeping an eye on things ... he

hasn't been kicked out of the house, and the mother isn't refusing to let him near it so things must be by and large going quite well.

Q: And yet you had those huge reservations you shared with us earlier about the mother?

A: Yes, yes, that's right but when a baby is sent back to a house, you know, you get, I would imagine that you know, if a mum is depressed or has some physical problem that you have the Health Visitors in some cases calling in daily. I mean when my children were little there was no call for them to do so, I couldn't seem to get into the house for Health Visitors, they were always, you know, they were calling daily for about a fortnight and after that weekly, but there was certainly no shortage, and I would have thought in this kind of situation where the baby is perhaps at risk of failing to thrive, post-drug addiction problems, that there would at least be a daily check, and on top of that there would have been the Child Protection Social Worker who would have been filling in the gaps ...".

#### 6.8.29 Psyc

Q: (Referring to learning of the CPCC's decision from MN):

"... we had actually told Alec when we had visited him at his sister's house the baby might not get home with you, and this came as a bombshell, "What do you mean?", well, because the house isn't right, you know, Shirley has problems and you are not well, and people who look after babies might well say this baby's not going to go home with you", and he was very cross about that, very disturbed, and MN said to me, "Well, the Case Conference says let the baby go home", and we just kind of looked at each other and I remember saying to her: "Well, they're the experts", you know, I don't know how the experts get to these decisions, because I just, we thought it was extraordinary at the time but they have obviously taken everything into account ...".

#### 6.8.30 HosMan

Q: "... we had a Neonatologist who suggested that she wouldn't be able to get information about the mother's drug use from the CDPS, she didn't think, but she wasn't sure?

A: Had she tried?

: She didn't, no.

A: Because I've had no problems getting information from CDPS workers.

Q: Alright, but the worry, of course, is that there are lots of Paediatricians out there, or Neonatologists out there, who think that there's no point in trying to get the information because it will be refused on the grounds of confidentiality owed by the clinician in the drug project to the mother.

A: Well, as I say, the "Getting Our Priorities Right" document came out for consultation in 2001. The final version was published this year, but it's been around since 2001 and, if people refer to it, they would know quite clearly what it says about confidentiality."

### 6.8.31 HosMan

- Q: “How much training have these Health Care professionals got about what they can and can’t do in a Case Conference? Thinking, of course, about a Consultant Neonatologist, would you expect him or her to know that he could and should say that?”
- A: Woeful training in Case Conferences. I think that’s part of the lack of training throughout the Trust.
- Q: Would you also expect him or her to follow that point to have an understanding about what the role of the Reporter would be in thinking about whether or not a referral to the Reporter should be made?
- A: It’s difficult to speak for other people, but my experience is that – and that’s also my concern – that the more people wash their hands of Child Protection in terms of the Consultant staff – there is a belief that, you know, ‘HosMan’s office will look after Child Protection’ – the more that is done, the less awareness there will be.”

### 6.8.32 HosMan

- A: “There’s no training in place, nor is the mechanism of the Case Conference in any way standard. Again I am speaking from my experience of the Scottish Audit, going up and down the country. The Chair of Case Conferences, the discussions made at Case Conferences, whether or not there is a Child Protection Plan, is a hit or a miss. Some areas you have a decision by consensus; some you have the Chair making the final decision, and my observation of Case Conferences the Chair can very cleverly, depending on what he wants, pick on the most senior person to kick off and then you’ll find that all the junior people go “Aha, I agree with that. Agree. Agree. Agree”, and that’s the way a decision is made. So whatever the experience of this midwife, she might have felt that “Well, you know, wiser and older heads have made a better decision”, and didn’t feel the need to take it any further, and I think that is a shame. She didn’t have the confidence or the courage to take it further, and people say to me, when I am doing some case discussion with colleagues, they might say “Well, it’s all very well for you” or “It’s all very well for Dr Hammond to say that”, but it shouldn’t be left to (myself) and Dr Hammond. People should be trained to that level of confidence that they can challenge. It’s about multi-disciplinary working, multi-agency working, not going in and being arrogant and, you know, riding over everybody’s decisions, as some medics tend to do, but understanding and respecting what we’re all there for, and the whole Case Conference process I think needs to be re-examined.
- Q: ... Have you raised these issues with Man2, your concern about the way the Child Protection Case Conferences work out in practice, for example?
- A: It’s all in that “It’s everybody’s job to look after me” Report. The Scottish National Executive Review, it’s all in that, one of the recommendations, so I would expect that, you now, Child Protection Committees were given a very clear role to restructure themselves and to look at their practices, so that that would be one of the issues that they should be looking at.”

### 6.8.33 HosMan

- Q: “There’s a reluctance among our Consultant colleagues to pass on or to recognise and pass on Child Protection concerns because of the possibility of being formally complained about or sued even because of sharing that ... breaking confidentiality. Has that been a significant issue, do you think, in any of the professional groupings round about Caleb?”
- A: I think in particular Mental Health professionals are particularly precious about the sharing of information. One of the recommendations from the Scottish National Inquiry : Audit and Review is that there should be in place a procedure in trust whereby the staff know when they can breach confidentiality because it’s all spelt out by the GMC, by our College, by the Scottish Executive, but, instead of using that as a helpful way to breach confidence, the term of confidentiality is used almost as a smokescreen: “I can’t do it because it’s confidential”, so I think the interpretation of the confidentiality rules and regulations needs to be addressed by many people who just use it as an excuse.”

### 6.8.34 HosMan

- Q: “Another thing I would like to ask your comment on: This is the document which was sent to the Health Visitor in the Community. This is how she opens her files. It’s a record sent to her from Simpsons, which actually starts with a baby girl being referred to. They haven’t even got a baby boy. The baby is called “Baby Malcolm”.
- A: That’s mother’s name?
- Q: It’s mother’s name, and I think this document is presumably written just after birth, from what one sees of it. It says, “HV Liaison Summary 1<sup>st</sup> August”. The baby was born at the end of July but, by the time the baby goes home, the baby has been named, registered, as Caleb Ness.
- A: Mhm hm.
- Q: Caleb Ness. The hospital records all started off as Kalib Malcolm. Now, there doesn’t seem to be any change in the paperwork I’ve got whereby the name which the hospital has ascribed to the baby at birth is corrected to the real name of the baby by the time the baby is released into the community. Is there anything you would like to say about that?
- A: My cynical view is welcome to the Health Service, but I understand what you are saying, it is a real issue. That’s why I said at the very beginning that I was disappointed this particular baby was not known to Community Child Health for all the reasons I have said. I would have expected a phone call either from Social Work, as part of their initial referral discussions, or from our Neonatal colleagues because they recognised that this child was going to need ongoing follow-up, that we would have then had a file opened on this child. The first thing I always do when I hear about any tragic death is “Can I see the file?” and I want to see the file to see where we did or didn’t go wrong, but we didn’t have one.
- Q: Well, just to tease this out, because I don’t understand it, coming from outer space, who was opening the Community Paediatrics file? Your office?
- A: Yes.
- Q: Not somebody in the system?

- A: No, and that's another thing that came out of the Scottish Audit. The number of Health records on a child is phenomenal. It's almost as if every department who deals with a child opens a separate file, so it wasn't unusual for us, when we went on our Audit, to find one child with 17 sets of records.
- Q: We have the picture, but the answer to the question, "Why is there no Community Paediatrics file?" is because your office never heard that Caleb existed?
- A: Exactly. Had we known, we would have started a file."

#### 6.8.35 Nurse1

- A: "... I don't think it comes over here how concerned I was actually about the baby going home, it doesn't really.
- Q: But you think you said enough to make your concern quite clear?
- A: I now know I could have made it a lot clearer.
- Q: But just remembering what you said, were you just making an observation that like many dads he's not very good with the baby?
- A: No, no. I was definitely concerned, because of the drug abuse as well.
- Q: Yes, the combination of the drug abuse and Alec's problems?
- A: Alec's, yes, that's right.
- Q: But you told us you didn't ask for your view to be minuted as being of dissent?
- A: No I didn't.
- Q: Well looking back with hindsight, is there anything you would do any differently?
- A: I think I would have been more assertive.
- Q: Doing what?
- A: Just speaking. I mean probably at that time I hadn't been to any Case Conferences and I am not familiar, I wasn't familiar as I am now with Child Protection issues. I know the Social Worker had to explain a lot of things to me before the Case Conference.
- Q: Is that SW4?
- A: No, our hospital Social Worker, I can't remember who he was at the time, you know and I have learnt a lot from the Social Workers in the two years."

#### 6.8.36 Nurse1

- A: "(At present) we're doing Child Protection training for staff and we are, when I say we, the Maternity Unit in the Community are compiling a leaflet for parents of the babies of drug abusers, how to care for them and I think we ourselves are trying to help parents to look after their babies by telling them what the babies are going to be like, that they are going to cry, and what methods they can use to pacify them, we're already doing all these things and I think if we had more training in Child Protection I think we might feel that we can speak up more at meetings."

#### 6.8.37 Nurse1

(Referring to concerns about Shirley being sleepy, sweaty, slurred in her speech when she visited hospital, after the CPCC):

- Q: “(Did you communicate that to anyone?)
- A: Oh, after the Case Conference, well I would have communicated that to the Liaison Health Visitor because I take these notes with me to the meeting each week and I would have communicated all this to her ...
- Q: Well, can we clarify, is that the Liaison Health Visitor, or the Liaison Social Worker, or both?
- A: Both, I meet them both on a Tuesday and I meet with the Liaison Health Visitor on a Thursday as well and any Social issues I just refer to it and read out the entries ...
- Q: So if you pass that information on to them what would you expect?
- A: I would assume she would pass it on to the allocated Social Worker, although I don't know if there was an allocated Social Worker. SW4 just took the case on, oh well these entries were made after the meeting, I assume she would be liaising with him.
- Q: So you wouldn't see it as at all your responsibility to do that, to say that this, this and this has happened since the Case Conference?
- A: I would now because we have improved dramatically in that aspect. Now when there is an allocated Social Worker I can deal direct with that person, as well as the hospital Social Worker, so that she knows who is in the hospital, but I now deal directly with the Social Worker concerned by phone.
- Q: But at the time of Caleb that would have been done through the Liaison?
- A: Yes, that's correct.”

#### 6.8.38 Nurse2

- A: “They would be referred to the CDPS if they were pregnant.
- Q: By?
- A: By whoever, the Community Midwife, the Hospital Midwife, who knows. Whoever discovers it can refer them to the CDPS.
- Q: And what would you expect the CDPS to do in that situation? You've got to remember we're ... treat us as if we know nothing.
- A: The CDPS, they're a drug withdrawal ... they take people through drug withdrawal, drug rehabilitation and, if you're pregnant, you can get referred automatically. If you're not pregnant, there's a big waiting list.
- Q: Right, so they have a higher priority?
- A: Yes. There would be a key person that we could contact at CDPS. We don't speak to them too often, but there would be a key contact in the mother's notes that we could contact at CDPS to discuss their drug regime.
- Q: Right, and I know it sounds pedantic, but how does that name get into the mother's notes? How does the information about who the Key Worker in CDPS ...?
- A: She has hand-held records and she would take them with her.
- Q: She would take them with her when she went?
- A: Yes. Her Community Midwife would write them in the notes as well. Her GP could write them in her notes. There's a particular sheet that they write on about their pharmacy, their drug abuse, their GP, their Key Worker, Health Visitors, CDPS Key Worker, Key Midwife.
- Q: So that shared record acts as their liaison document?
- A: Yes.

- Q: Okay. At what stage would you expect the Maternity Service or the CDPS to alert the Social Worker that it was felt that there were going to be concerns about the baby, or is there an automatic referral to Social Services in that situation, do you know?
- A: It would probably be through the GP and the Community Midwife or the Hospital Midwife, if she was attending the hospital, to alert the Social Worker where we had concerns about a particular mother.
- Q: Right, and what sort of understanding do you have about the threshold for that? You've said already you've quite a number of women coming through the ward who are taking drugs with a prescription or not.
- A: Yes, and they function perfectly well and look after their kids.
- Q: So what sort of thing might alert you to the fact that there might be concerns about the baby?
- A: If they weren't co-operating with you, if they were being secretive, or if they had erratic behaviour, if there was violence or if they were unable to function on a daily basis. If they can't look after themselves, then how are they going to manage themselves and a child?
- Q: And have you in some of these circumstances been the one to alert Social Services?
- A: I don't think I've ever phoned Social Services.
- Q: You've not been in that situation?
- A: No.
- Q: Where would you expect that referral to come from? Where is it most likely to come from?
- A: The GP or Community Midwife.
- Q: And is that written down anywhere now? We understand that it wasn't in 2001, but is there actually a formal written down protocol with thresholds and criteria?
- A: I don't think so."

#### 6.8.39 Nurse2

- Q: "Going back, you've told us about your half hour a year in Child Protection training. Has that included any training in relation to the expectation of yourself in a Child Protection Case Conference situation, what your role might be?
- A: No.
- Q: No. You haven't had any training with respect to that?
- A: No.
- Q: Do you think that would be useful.
- A: Mhm mm.
- Q: Are there other aspects of Child Protection where you think some further training would be useful?
- A: I do think about the Case Conference, yeh, it would be good.
- Q: Why are you saying that?
- A: Because, you know, I didn't feel well prepared to attend. I didn't know what was going to happen at this Case Conference, who would be there, etc."



#### 6.8.40 Nurse2

- Q: "Do you have a Social Work Unit in the hospital?"
- A: The women tend to have their ... we do have one in the hospital but, you know, if it's to do with a child, then they tend to go by area. Wherever the woman stays, there would be a specific Social Worker for that area.
- Q: So the Staff in the ward, you would probably contact the Area Team Social Worker as opposed to?
- A: Yes, as opposed to Hospital Social Work.
- Q: Are there times when you do have contact with the Hospital Social Work?
- A: If someone's not got a bus fare to get home.
- Q: Do you use them at all?
- A: Sometimes.
- Q: As a reference point around Child Protection or any of those things?
- A: No, not really."

#### 6.8.41 REP

- A: "I wonder, if one looks at the composition of the Case Conference how many of those who were in attendance have the detailed knowledge of the Children's Hearings system of the role of referral to the Reporter, and I know that we have provided Reporter training for Health Visitors in the area in the last year so I hope the Health Visitor would be covered and clearly Social Workers will have knowledge, but in terms of the midwife, consultant psychiatrist, neonatal sister, I do wonder to what degree they have the necessary information on the use of the legal system to be able to make that decision.
- Q: Do you think some training in that respect would be helpful?
- A: I have absolutely no shadow of doubt about that. You may feel differently but I have always felt that far more training is needed for the medical profession generally on the role of the Children's Hearing system and the use of the law to protect children. It's an area that we provide some input to partially when we are asked, so it is certainly something we need to do more on ...".

#### 6.8.42 REP

- Q: "You have talked quite a bit about the importance of professionals being able to contact you to discuss whether or not a referral would be appropriate, I would just be interested in your own experience and that of your team in terms of how often Health professionals actually take advantage of that and what sort of circumstances they might do that in?
- A: ... my impression would be that we do not get a lot of consultation from Health professionals. I can think offhand of at least two children whom I personally have referred to Hearings in consequence of Health Visitors making referrals to me despite the decision of the Case Conference not to, and certainly in the two cases I can think of, you know, those cases stick with you, and they were both cases which were entirely appropriate to have referred. That is one of the reasons why we have been trying to build up contacts with Health Visitors so we know where they are and how to get reports from them, individual localities, and so that they know who we are and that they, that

informal consultation with the Reporter is not about Social Workers alone, that anybody can do it.”

#### 6.8.43 REP

A: “Occasionally we have been used to obtain reports from psychiatrists where there has been a difficulty in other agencies obtaining information from psychiatrists and occasionally we have struggled to help them out, and I don’t know if that’s relevant at all in this case but it certainly has been an issue sometimes in obtaining information from psychiatrists about a parent’s medical condition and where there have been issues of confidentiality which have been raised which have delayed us getting information. We have talked about the General Council Guideline where a child is at risk and we’ve had a bit of debate on that and sometimes that has been sufficient and sometimes we’ve had to ask for parents’ consent and sometimes that has not been sufficient ...”.

#### 6.8.44 GP

A: “I think HV certainly expressed to me on recurrent occasions difficulties with the Social Work Department in getting the kind of support that we would like.

Q: What sort of thing are you meaning, apart from the Minutes, we’re very clear she was not getting the Minutes nor merely of this Case Conference but many others?

A: It’s difficult to be specific but in terms of cases that she had been concerned about, I think she has often spoken to the Social Work Department and felt that the level of response ... you’d need to clarify that with her rather than take it second-hand from me.

Q: Just finish the sentence, she felt the level of response was?

A: Less than appropriate or less than adequate or less than what she was expecting. Again we get the perception that the Social Work Department has stretched the point of responding to crises. I think that’s the perception we get.”

## 6.9 The role of the Criminal Justice Social Worker in Child Protection

### 6.9.1 Man1

Q: “... I would be interested in a little bit of your thoughts on that, how frequently you would expect Criminal Justice Workers to come across Child Protection issues and what expectation you would have of ongoing supervision and training of those workers to address those competently. Is that too complicated all in one?

A: No. I am very surprised to hear that a Criminal Justice Worker would say that it’s the responsibility of Children and Families when you consider the linkage between domestic abuse and child abuse. I’m shocked.

Q: (... I think there was a suggestion) by the Criminal Justice Worker, there was almost a bit about – “My job is to sort out housing ...” and very practical

things associated with the order that he was there to supervise and that because there was a Children and Families worker there that meant all this necessary work around the protection of the child would get done because the Children and Families worker would do that ...

A: Okay, the question I would put to the Social Worker is, the Criminal Worker is, what are you actually doing with your client, because we can have a Social Care Worker do that.

Q: We equally did hear from, we have spoken to a number of workers, not just one individual, that it would be quite possible to be a Criminal Justice Worker for a considerable period of time and not come across Child Protection issues, would that be your expectation?

A: No. Can you put surprise in my voice there?"

### 6.9.2 Man1

A: "... The skills that a Criminal Justice Worker brings to bear on their job has to include an understanding of what Child Protection is. I wouldn't expect each and every Criminal Justice Worker to have undergone the Child Protection training and equally I would expect them to know what issues are around Child Protection because of the basic training that they get as a qualified Social Worker and the induction that they get when they come to the Department. The guidelines are available to all of our staff, the research work that we undertake, the information and the knowledge that is growing around domestic abuse, around drug abuse and how that relates to child abuse, Criminal Justice Workers should know about that.

Q: How would they get to know about that? I mean how do you assure yourself as a Senior Manager within the system that they are abreast of that sort of knowledge and that they recognise the impact of that in their day-to-day work?

A: I think that you are asking a very good question there because there is a wealth of information which goes out to people, it's circulated from the Department, ... I can only tell you that the stuff is going out, I can't tell you because I don't monitor it, that they have incorporated it ...".

### 6.9.3 Man3

Q: "Now just while we've touched on the fact that you do in-house training, have you ever done in-house training for your Criminal Justice Social Workers relating to Child Protection?

A: No.

Q: Would that be something you might do?

A: Not something that I've ever seen.

Q: No, well I don't mean you personally necessarily.

A: No, but within the ...

Q: Within the division?

A: Within the division.

Q: Do you think that might be something that would be useful, perhaps just a short course every couple of years on Child Protection?

A: Yes. Yes, I think one is always concerned, and it works many ways across the branches, that staff have the opportunity to ensure that they are not disadvantaged.

- Q: So have you not done it because you've not thought about it, or have you not done it because of funding problems or what?
- A: It's not been a priority in the training agenda for Criminal Justice Social Workers."

#### 6.9.4 Man3

- A: (Speaking of non-parole licence prisoners being released, such as Mr Ness):

"In short, the Criminal Justice Social Worker would have been involved. The expectation would have been set clearly by national objectives and standards that we work to. It's not something that we make up. That is the minimal standard or the practice standards that are required. So the purpose of that pre-release meeting is to plan the release of the prisoner and to manage it in the community.

- Q: Alright, so the general purpose of supervision at that point, the non-parole supervision, is to do what? To plan for what – housing?
- A: To plan for the prisoner's release, and that would take account of housing: it would take account of financial matters. We might actually call them the welfare needs or practical needs of the prisoner, but also to ensure that any support programmes that might be required to assist this person's reintegration into the community would be put in place.
- Q: Just hypothetically, if Mr Ness had been brain injured before he left prison and needed special consideration because he had a brain injury, some physical damage or something, would it have been up to the Criminal Justice Social Worker to make special arrangements to deal with whatever arose because of that brain injury?
- A: It would have been the responsibility – it is the responsibility – of the supervising Social Worker to oversee the person's return to the community and, when they are in the community, to respond as best we can to the needs to the situation and if that's "I haven't got a house", then you try and get that. If it's to arrange some specific medical assistance, I would expect that very clearly to ... these issues to be addressed."

#### 6.9.5 Man3

- Q: "..... plainly a serious brain injury is going to change life for the victim. The Criminal Justice Social Worker knows there is a brain injury and knows he is released out into the community. What is expected of the Criminal Justice Social Worker then? Firstly, should he inform himself of the extent of the brain injury?
- A: Well I think it would be reasonable to if ... it would be reasonable to reappraise the situation that one found and to carry out, if you like ... reassess the position and, therefore, to do that you need to know the extent of what has happened, and how would I know that? I would have contact with the person's G.P. or the hospital or the consultant or whatever, but I would certainly be determining the extent of the brain injury and how his, Mr Ness', cognitive functions, by way of example, might be affected, if at all. Why would I do that? It's because I may have to report that back to the Parole Board, because

another requirement of a supervisor is to report progress of the person whilst on supervision.

Q: The real interest that I have in asking this question is to determine just how proactive he should be in a situation like this. Does he wait for the hospital to contact him or does he pick up the phone and say to the hospital “Look, I’m in this position. I have a legal responsibility to track down what’s happening here. Please give me the information?”

A: I don’t know if ... well I suppose you would, yes. I mean, I would. I would want to know as much information as I can and, within the bounds of data protection and all the rest of it, what information would be forthcoming. The purpose of doing that would be to assist me in determining whether this person was at greater risk of offending again or, given that one of our principles and one of our objectives is to contribute, promote community safety, protecting the public – that’s what we’re in business to do, as well as dealing with the welfare issues, ... I think it would be good practice, in short.”

#### 6.9.6 Man3

Q: “... What is your expectation of your Criminal Justice Worker in those complex family situations where, on a daily basis, new issues may pop up all the time which raise concern, ... where the Criminal Justice Worker is working in a family dynamic where they are often picking up information about things that are happening in the family? What is your expectation of the Criminal Justice Worker in that scenario?”

A: It would depend whether there was another Social Worker involved within the family, but clearly the Criminal Justice Social Worker’s task is not in Child Protection.

Q: Right.

A: They are not remitted to do that. They don’t get ... that’s not what they do. However, they are Social Workers and they are empowered as such. On the assumption that there were two Social Workers working here, as I know there were, ... but I am assuming that Ms Malcolm was allocated a Children and Families Social Worker and, therefore, was working within that realm, within these parameters. We then have the Criminal Justice Social Worker supervising the male partner, or possibly the partner here, on a non-parole licence. The expectation that I have is that, as I have answered before, that (1) he carries out his duties in respect of the supervision and (2) that the interface with Children and Families is to carry out a role which is information sharing, which is ... which is designed to feed into the whole management of the case.

Q: So that would be about a Criminal Justice Worker ensuring that the information they pick up from their client through their normal contact, where the level of concern is passed on to the Children and Families Worker to ensure that the bigger picture is always clear by those key workers involved in the process?

A: Yes. I mean, you’re highlighting, if I may so – and this is my own opinion – is that you’re highlighting what some have argued as a flaw in going into specialism in Social Work, is that whereas Kilbrandon et al and others argue for a one-door approach, and some of us might be old enough to remember all of that, but the one-door approach and a jack of all trades Social Worker. We don’t operate that way now. In many parts of Scotland we don’t operate that

because of the requirements of the government – the Scottish Executive now – to deliver services to offenders ring fenced. In other words, if I may say, and I'm sorry if I'm teaching you how to suck eggs, is that we don't get paid for doing childcare work.”

#### 6.9.7 Man3

- Q: “I suppose in this scenario one of the things that maybe surprised me a little bit when we spoke to SW7 was his impression of his tasks, which was very much about ensuring national standards, ensuring this man didn't re-offend, ensuring he got him housing and, you know, got all these things sorted out. In terms of his understanding of his role in relation to Child Protection and what he could bring to the process of monitoring, he seemed less clear about that.
- A: I'm surprised to hear that.
- Q: And his focus was very much about the implementation of the order and securing this man his own accommodation and making sure that ...
- A: I'm not surprised about that.
- Q: Well, I suppose that what may be happened or alleged to was that this man actually was in a position to gather a lot of important information because he was seeing Alec regularly, he was communicating with him, he was aware of situations that were going on. If a worker didn't see what they were gathering as important and then, therefore, thought “I need to pass this on because this is important information”, there is the potential that important information that the Criminal Justice Worker is gathering is not being forwarded to the key people because they don't see it as their role as such. “That's a Children and Families role to gather this type of information”. Does that make sense?
- A: Oh it makes sense, what you've said, and I'm surprised if that's the case, and you have the advantage on me because I can only say, well, I'm very clear ... I'm not surprised that the Criminal Justice Worker would be very clear what their responsibilities were under the Criminal Justice, as it were, Social Work element. As a professional Social Worker, the issue of information sharing and joint working, if I can put it in these words, is something which I would expect Officers to do.”

#### 6.9.8 Man3

- Q: “Is there a regular interface, do you believe, between Criminal Justice and Children and Families Workers? Do they work jointly on cases regularly? Is it something that in Edinburgh is common practice to have a Criminal Justice Worker working alongside a Children and Families Worker doing risk assessment, monitoring, or is it something that's case by case?
- A: Not to the extent that I think you're inferring or suggesting. Where it's required, it will happen. The numbers I can't answer you – I don't know – but equally we have joint working of Criminal Justice Social Workers in cases where there is very high risk, dangerous men, so there's an element of obviously staff's safety and personal safety comes into that. What this raises, this very unfortunate circumstance that's happened, is the questions about how ... the way that we deliver, and I could ask this generically across Scotland. Does this raise issues about the consequences of Criminal Justice Social Work

or specialism within Social Work or does it not? I don't know, is the answer to that. Discuss in 3,000 words."

Q: "You've already said you don't have specific Child Protection training. How do the (new entrants into the Criminal Justice team) get their first general awareness about the potential that even though they're a Criminal Justice Worker, they may come across a Child Protection issue that they may have to do something about and have to pass this on to their colleagues? How do they get training in that?"

A: They don't."

#### 6.9.10 **Man3**

A: "Now, one of the things I've been conscious of is that you come into the department and you might never ever see a Child Care case or you might never see a Community Care situation or whatever, so it's been important to I think redress that balance. We give them the tools. We give them the induction to the department. My expectation, reasonably I would argue, is that the Council's supervision and appraisal procedures and policy, which we have in place in Criminal Justice, very explicit, training needs analyses are carried out and, therefore, through these processes, which are recorded and up front, as it were, that's how I expect an individual's needs to be determined. There may be team needs, but you've raised an issue which is very clearly about ... I can't answer the last time we actually sat down and talked about Child Protection issues specifically."

#### 6.9.11 **Man3**

Q: "Are (your Criminal Justice Social Workers) ever involved directly in Child Protection investigations?"

A: No.

Q: Or is that something they wouldn't do?

A: No.

Q: Would there ever be a second worker in an investigation if they were active in the family?

A: In theory, they could be, yes, but examples of that I can't bring to mind at the moment.

Q: So, in a sense, their role at the moment would be one of recognition, identification and passing on to the Children and Families colleagues to fully investigate?

A: Yes."

#### 6.9.12 **Man3**

A: "The Executive issued a statement some weeks ago, which said "It is our intention to consult on a proposal to create a National Correction Agency."

Q: Right, and you understand that to mean?

A: I understand that to mean that the Scottish Prison Service and Local Authority Criminal Justice Social Work would be combined into a national agency. Now if there's one recommendation that might come out of this, one could see that such a position might be exacerbated because in the end, I'm a Social Worker

and I have received children into care at 2 in the morning and have done all of these things, and I might not have done it very recently, but I can go to my guidelines and procedures and know what to do. I would expect reasonably all Social Workers who are qualified to do that – no exception. Now the question would be is if you have Child Protection ... we've said that to do that you need to have a Child Protection certificate. So be it. I can't do that. I can be the Second Officer, though. Speculating, if Criminal Justice Social Workers disengage by primary legislation from the Social Work (Scotland) Act, because that's what would have to happen, and amendments to the Criminal Procedure (Scotland) Act 1995, then we would reach a position arguably where Criminal Correctional workers, call it what they will turn out to be if this was what happens, would have no responsibility for Social Work as we know it, the Social Workers amongst us. You could have a position ... where a correctional officer was supervising somebody on parole on a non-parole licence and the Social Worker from Children or whatever, Children and Families, were dealing with the case. Now you might argue have we then distanced it even further, or would that actually create a better situation because the delineation of responsibilities would be absolute.

Q: You might triple the manpower in the present case because you might have a man who is on parole who gets such a bad brain injury that he needs Community Care?

A: Yes.

Q: And has an involvement in the child, which means there's Children and Families input?

A: Yes.

Q: Is that right?

A: Yes.

Q: So you might end up having three people all involved with this man?

A: Yes, and perhaps support agencies too, support programme people, so, yes."

#### 6.9.13 Man3

Q: "I'm asking you whether you would expect (Alec Ness') Criminal Justice Worker to be looking at this new situation not from the point of only potential risk to the baby or the woman here, but also the potential risk to him of being placed in this situation, which seems to have potential hazards for him. Do you understand?

A: Yes, I understand what you are saying, but the assumption is the potential hazards."

#### 6.9.14 Man3

Q: "I may not have picked you up right, but I thought that you said that Criminal Justice Workers could go through their work experience, their life's work, without coming into contact with a Child Protection issue. Did you mean that? I think when you were in discussion with Moira ...

A: I suppose technically you could.

Q: Is that likely, given your client group?



- A: Well, the Child Protection is ... well it is ... it could be. Yes it could be. The more specialised we become, as it were, and what I referred to earlier is it's probable now that if ...
- Q: It's probable?
- A: It's probable if we go ... if there's ... okay. The responsibility for children and for Child Protection in the City of Edinburgh Council is Children and Families workers.
- Q: I'm not asking you about that. I'm just asking you a very specific question about Criminal Justice Workers.
- A: Hold on! Hold on! It is possible, therefore, that a Criminal Justice Social Worker will never deal as the lead officer in a Child Protection ...(after a page)... but I suppose the answer is that most people have families, so, therefore, children will be ... you know, see the children, but whether they would actually be dealing with Child Protection issues, many of them, I don't know.
- Q: But the issue is one probably of their ability to identify it, because they may not be, as you say ...
- A: I've answered your question. They are trained Social Workers, therefore I expect all Social Workers to be able to deal in these areas.
- Q: But if a new worker coming into Criminal Justice hasn't had any training in Child Protection, then would they understand their role as one of identification and passing on and doing that part of the process as you're suggesting?
- A: Yes."

#### 6.9.15 Man4

- Q: "Do you know, is there any multi-agency training that takes place across Children and Families, Criminal Justice? Is there any joint training about awareness raising of Child Protection issues?"
- A: There is, yes. Well, the Guidelines are the main training we've had of late. The new Guidelines have been published recently and all the staff would have been asked to participate. I'm sorry, I can't tell you if they all did, but I did some of the training and there were certainly people from all the agencies there." (Referring to 2003.)

#### 6.9.16 Man4

- Q: "Here we have a situation where we plainly have a Social Worker from the Children and Families Team involved once Caleb is born, but there's another Social Worker from Criminal Justice who is involved with Alec Ness, the father who killed the baby. Now, the Social Worker from Criminal Justice, how would you see him in this arrangement?"
- A: I think in that arrangement their view of the father, who I assume is on probation or something ...?
- Q: Yes.
- A: ... would be, you know, the concern that he should play a part in the Case Conference and in managing of the Case afterwards and be clear that obviously he is there to keep this man out of jail or whatever, but if the baby is having contact with this man, then he's certainly got a role to monitor this man's ability.

- Q: Alright, so the Criminal Justice Worker you would see as having a role to monitor, but you wouldn't see him as a second Worker?
- A: No.
- Q: No?
- A: Not in relation to the protection of the child. I think he's got a role certainly ...
- Q: ... the mother was living in a flat with the baby but the father was visiting every day and spending several hours every day there?
- A: I see.
- Q: Now, would the father's Criminal Justice Social Worker then have a role to play in the Child Protection arrangement in your view, or not?
- A: I think he does because if the baby is having as much contact with him, then I suppose it depends on the reasons for probation. They're obviously more suspicious than burglary or something like that ..."

#### 6.9.17 SW5

- Q: "So would it be fair to summarise that as saying the Criminal Justice Social Workers on the ground could do with a bit of training in Child Protection?
- A: I think yes.
- Q: Some of them would be getting it new presumably, and some of them would be reminded?
- A: Yes, well, for most of us since 1992 when we did, well, when we first became involved in 1992 we did generic duties and we also had a bit of experience of working in a generic capacity. But since specialisation it would be new for all of us and in that, and it is about eight years ago now, so I would say I don't even know that these students come to courses, how much they will get in Child Protection, and certainly for those of us who have been out of that arena for a long time there isn't, it's not what you were taught, there's no reminder and it's all new.
- Q: Alright, so some training would be useful, and was the other thing you were suggesting a kind of liaison person?
- A: Yes ... most of the service users that we have in Criminal Justice come with children. This case is not, would not have been classified as one of our high risk cases. So how do you, you don't want to be always knocking on somebody's door who has got the whole of Lothian to be responsible for. I think if that was delegated down a bit into the team where you could maybe have first of all not exactly an informal chat but could go along with perhaps all the cases in the Team, say these were the ones where there is an element of child care – which ones do we need to focus on.
- Q: Yes, and can we have guidance on what to look for and things like that? Alright, so you're expressing a reluctance to go to the top about something which is perhaps a very low priority issue?
- A: Well yes, I think that is maybe what I am saying, yes."

#### 6.9.18 SW5

- Q: "What link do you have or did have between Criminal Justice and Children and Families, is there a working relationship or are both areas quite separate in what they do?"

A: Both areas are very, are separately run, they are separately managed, they are quite separate in what they do and any kind of joint work would be formally arranged.

Q: Do Criminal Justice in terms of management meetings, do Criminal Justice attend Children and Families, that kind of cross-over?

A: No.

Q: Cross-over in training between Children and Families and Criminal Justice?

A: Very little, and it would be in areas, non-specific areas, we wouldn't be attending any formal Child Protection training."

#### 6.9.19 SW5

Q: "Do you think your Criminal Justice Workers ... have a clear understanding of the role in relation to Child Protection when it comes to what was described about this passing on of information and ensuring that that information is gathered and forwarded to the right person?

A: I would think, I would have to answer that in two ways. I think they have a clear understanding of what they should be doing, but I think what they do lack is knowledge of what the appropriate information is."

#### 6.9.20 SW5

Q: "The last thing is, you mentioned when you were speaking to Mrs McKinnon the fact that people within the Criminal Justice Team might sometimes lack the knowledge of what was appropriate information to pass on to the Children and Families Team. I just wondered if you could give an example of what you were thinking about when you said that?

A: Well I'm trying to think ... I'm thinking in general terms of people being alerted to parents who would neglect their child. You know, say for instance for example he went to visit a person, he was doing a home visit and he went and found the person at the house where they could be perhaps collecting their child from school or you went on several, many occasions and you go and you go to see your service user and the children are there which is even more concerning, and they should be at school.

Q: Yes.

A: Now sometimes that might bypass a Criminal Justice Worker, they may just think the children, or they may accept too readily that somebody is off sick, when they have been off sick for what, several weeks, and that's not unknown."

#### 6.9.21 SW7

Q: (Referring to formal training in Child Protection)

"Okay, so have you had any training since 1990?

A: Not that I can think of, no I've specialised in Criminal Justice since I qualified. (1992)."

#### 6.9.22 SW7

Q: “And do you have any current involvement in Child Protection matters?”

A: Well in so much as the work we do sometimes overlaps with Children and Families, we’ve had ongoing discussions with Children and Families Teams, but again no lead work.

Q: Okay, now when you say no lead work, to a non-Social Worker, what are you meaning by that?

A: Well if a client who was on probation to me was also known to the Children and Families Teams, then I would be involved in discussing that child with the family, but my role would be the supervision of the person on probation rather than any family role.

Q: I see. Are you familiar with the current guidelines relating to Child Protection in Lothian and Borders?

A: We have involvement. We’ve seen the Guidelines, we are involved in them and we know that we don’t take a lead role in that situation, so anything that came up or we became aware of we would immediately pass on to the relevant Children and Families Team.”

#### 6.9.23 SW7

A: “I knew that Shirley had had previous children accommodated by the Department in (distant place). She was very unspecific about that, but I knew that had happened. When SW4 contacted me, in some ways I was quite happy because he told me that that was the basis of their involvement and that they were going to be, if you like, involved with Shirley up to and possibly following the birth of the child, so, in some ways, I felt you know that that took a role away from me that I had been aware of but, I suppose, given everything else that was around, I felt that the baby wasn’t born; I was okay with that.”

#### 6.9.24 SW7

A: “I know this sounds terrible, but Alec was one of a number of cases that I had at the time. We prioritise our cases. I didn’t see ... I didn’t see this coming. I mean, if someone had phoned me up and said Alec had murdered Shirley, I would have ... well, I suppose looking back on it, I could see that coming – not coming but I had indicators.

Q: Yes.

A: What happened, completely threw me. I had no ... I just didn’t see it coming, I really didn’t, and it shocked me. ...”

#### 6.9.25 SW7

Q: “So Criminal Justice at the moment will be the second worker?”

A: Well we will refer on, as anyone would refer on, and take whatever role was appropriate.

Q: But could be a second worker in a (Child Protection) investigation – not lead worker but second worker?

A: Yes.

Q: And you've had that role, I think. Earlier on you've been involved in a couple of investigations over the period?

A: That's I think formalising it to a greater extent than what actually happened. It was an investigation. I'd been involved. I've sat in on interviews and been present. I have been, but not in terms of a formalised ... because we would not be involved with working with families. We don't work with families. We work with individuals.

Q: Do you think your knowledge of the Child Protection system is enough?

A: No."

#### 6.9.26 SW7

Q: "Do you see there ever being a role for Criminal Justice to have a wider remit than just the individuals and in the family context?

A: Certainly not without significant training and not without a complete change in practice because we cannot do two jobs. We have a role already. In talking to you about non-parole, non-parole is like parole but it's non-consensual. It's supervising high risk individuals in relation to their offending behaviour - my role is to look at Alec and his offending behaviour and try and do all I can to minimise the risk of that happening in the future. If we're to become involved in family work and supervision and welfare issues, then there has to be a complete overhaul of the system, and I do not foresee that happening because it seems to be going the other way."

#### 6.9.27 SW7

Q: "Was (it) important for you to have more information about the implications of his head injury?

A: I think so, and I think that would have been the next stage. I think once I'd assessed his ... once I'd got him a place where he was living, I would then have been pulling people together in order to try and get a package of support, but again that's an area of Social Work that's Community Care, and we're not trained in that respect either, so I was finding that quite complicated too but that would ...

Q: In determining how independent Alec could be?

A: Yes.

Q: We've been told he couldn't even give himself his own regular medication?

A: Again, I mean, I believe that might have been the case but we're aware of people who are in that situation who have visiting support or aids to take medication and various other things. I wasn't at all clear about where he was in terms of that and yes, that makes sense."

#### 6.9.28 SW6

Q: "Now, can I just ask you, before I get on to Caleb, do you have any formal training in Child Protection procedures?

A: No, none, other than what I did on my course.

Q: Okay, originally when you qualified?

A: Yes (as CQS in 1980).

- Q: Okay, and so do you have much experience, through your professional existence, of Child Protection cases?
- A: Certainly in the prison I do, yes; a lot of experience of preparing men for release who are deemed to be a risk to children, yes. It's a considerable part of my work in prison.
- Q: Alright, so it would be fair to say that you have current involvement in Child Protection matters then?
- A: I don't know if I would quite say that. What I have experience of is assessing the risk which men may pose to children and passing that information on. I am not involved in Child Protection. Well, I am in so much as I mean ... I don't see myself in the role of someone who is actively taking part in decisions about whether children should be in supervision or remain at home in that way. I am providing information to the people who would subsequently make decisions about whether or not a child should remain ... sorry, whether or not a child should remain at home or a prisoner should be allowed back to home.
- Q: So you see yourself as gathering information about possible risk?
- A: Yes.
- Q: And any relevant circumstances?
- A: I don't see myself really in any way as making any decisions about ... I mean, if someone, if a Children and Families person said to me "Well, you've given us all this information. Thank you very much. The man can go home", I wouldn't ... I mean, I might say "Well, that surprises me", but I wouldn't see it as being my job to persuade the person otherwise.
- Q: Okay. Well that's my next question. In the example you've just given where you are surprised by the decision to send the man home, what would you do if you had a concern for the safety of a child?
- A: Well, if I had concern for the safety of a child, I would discuss that with my line ... well, if it was a Child Care Case Conference, I would say "I want it minuted that I'm very surprised that, under these circumstances, on the information you've got, that this person is going to be allowed to stay with these children."

#### 6.9.29 SW6

- Q: (After the CPCC, and Caleb goes home)
- "SW7 knows that Ness is visiting daily and involved with the baby?"
- A: Yeah.
- Q: He wasn't living with Shirley?
- A: Yeah, at that time.
- Q: At that time. In those circumstances, to what extent would you expect the Criminal Justice Social Worker to be involved in assessing risk for the baby?
- A: I would ... well, it depends, you see, because if this is a case where there is a Children and Families Worker involved.
- Q: Yes.
- A: ... then I would be expecting the Children and Families Worker to be doing that work primarily, to the point where I would be expecting really communication from them about any perceived risk which they thought that this man on non-parole licence posed to the child. I wouldn't expect a Criminal Justice Worker to have a great deal of contact. They have to ... well,

they don't actually have to do a home visit after a certain period of time, but obviously it's good practice to do home visits, although that isn't the home, is it? It was actually somewhere he was visiting."

#### 6.9.30 SW6

- Q: "Do you see SW7 as having any duty to pass on any information or to keep his eye open for Caleb or anything of that kind?"
- A: Yes, if that information comes to him, yes, I would, yes.
- Q: So if he obtained some information which he thought might involve risk to the baby possibly, you would expect him to pass that information on?
- A: Mhm hm.
- Q: And who would he pass it to?
- A: He would pass it to the Children and Families Worker initially, and his Line Manager, I would assume.
- Q: Would you expect the Criminal Justice Social Worker and the Children and Families Worker to meet at any stage in this monitoring process?
- A: Not necessarily, no.
- Q: Would you expect them to meet before a Child Protection Case Conference to share information and make sure that all the information relating to Ness is passed over?
- A: Not necessarily, no.
- Q: Would you expect that to be done by phone or whatever?
- A: Yes."

#### 6.9.31 SW6

- A: "I mean, obviously Child Protection has to be in everyone's interests, whatever type of Social Worker you are, and Criminal Justice Workers have to put that before everything else, but in a case where there is active involvement from the Children and Families Team, I would expect the Criminal Justice Worker to play a part in the global way you are describing, but it would be secondary to the ... I would see the Children and Families Worker as taking the lead role and having most involvement with the child, but certainly the Criminal Justice Worker, depending on the proximity of his client to the family, yes, they should be in regular liaison and involvement and ideally attending Child Care Case Conferences.
- Q: Yes, so it again would be their involvement in appropriate meetings, attending planning meetings or any of those things that the Children and Families Worker might be convening to review where the case is at?
- A: Yes."

#### 6.9.32 SW6

- A: "... the Teams get issued with these guidelines, and my recollection is that there was a half day training day ... I don't know ... about 4 or 5 years ago in which we talked about some of the issues that were of common concern to Children and Families and Criminal Justice Workers, but no. Sorry, I'm probably boring you with this, but I do have to keep making the point that this

isn't because we don't think we should do this. It's just time basically. I don't think Social Workers have sufficient time basically to do an awful lot of things which, in an ideal world, they should do."

**6.9.33 SW6**

A: "The ethos in Social Work and the Criminal Justice teams is that Child Care considerations are the most important matters and, therefore, if there is any case where there is any young child in a situation with a young junkie, then there would be a discussion about the care of the child, I'm sure, ...".

**6.9.34 SW6**

Q: "In thinking about SW7's role in relation to Alexander Ness ... Would he have seen his primary function as protecting the community from further offending or difficulties coping in the community in relation to Alec Ness, or would he have seen his primary responsibility to Alec as an individual, as his client?"

A: Primarily it should be towards protecting the public, but the two things ...

Q: They're obviously intertwined?

A: They're intertwined, yes, because basically Alec Ness was someone who obviously changed after his brain injury, became more needy and required, as I see it, stable accommodation, and I think once that had been achieved then some sort of, I suppose, plan to assist him to reintegrate into society, because obviously his relationship with Shirley Malcolm was at an end, although I don't think he could quite grasp that, and I don't know what his employment possibilities were or whatever, but this would all have been to assist him but, in assisting him, we would be protecting the public because if he was in gainful employment or training or whatever, someone with his level of brain injury would require that he would be less likely, statistically anyway, to re-offend if he had a meaningful, stable life."

**6.9.35 Dr3**

Q: "In terms of the link with the Criminal Justice worker, would it have been MN who made that link and had those discussions with Alec's Criminal Justice worker?"

A: He did have a discussion, I don't know who rang who, but they were the ones liaising together, mainly to do with housing I think. I got the impression that he was slightly out of the picture, he didn't even know that Alec had had this rampaging thing in July and I was surprised about that, but yes, he was the person we were liaising with."

**6.9.36 Psyc**

A: (Just before his discharge from the Astley Ainslie):

"Well the overview was that he was really at a borderline as I've mentioned, just around this tenth percentile level, he was at a borderline level for being trustworthy or capable to look after himself in the community. He was a person who would need continuing care.



- Q: I'm sorry, I missed that, you said borderline for being?
- A: For being able to be discharged from our care, he was somebody who would need continued monitoring because he had very significant mental impairment.
- Q: Do you mean to say that you mean he was borderline for being allowed to go into the community at all, or do you mean that he was ...?
- A: Well, no he wouldn't be, I don't think he would have been sectioned.
- Q: No, I was just checking what you mean?
- A: No, it's borderline in a humanitarian sense, we could have let him go and just said well, off you go, but in terms of, you know, trying to run a decent service with somebody at this sort of level we would maintain quite close contact with them.
- Q: If he hadn't had a partner or a member of family or somebody like that, what would you have done with him?
- A: Well we would have, he would have had Social Work involvement and we would have maintained quite close contact with him, probably seen him weekly and liased with the Social Work Service, and he would have had some form, - his circumstances were difficult because in a sense he was homeless and we would have arranged, you know, frequent contact for him during the week so that people could just keep an eye on him and nip any problems or help him to solve, you now, things to do with forms or keeping appointments and things like that.
- Q: So that's talking about the test results. What about your impression of him, how did he present?
- A: He presented outwardly as being much more able than that, he was quite streetwise and he would just, I think, you know, he wasn't incapable of going and buying himself food for example if he needed to eat, or finding a place to sleep, he wouldn't have slept under a bush, he was quite streetwise, but in terms of doing the things that normal people do such as you know, maintaining a clean place to stay or looking after his clothing and you know, adhering to various timetables or regulations or forms or whatever, we thought he would be absolutely hopeless, he wouldn't even be able to fill in a form to get benefit and things like that."

#### 6.9.37 MN

- Q: Can I just ask one question, what was your contact with SW7, the Criminal Justice Social Worker?
- A: Yes.
- Q: You contacted him a couple of times following on from visits just to bring him up to date with the situation, did SW7 often phone you to bring you up to date in the work that he was doing with?
- A: He did uh huh, yes, I think SW7, I think he probably phoned me a couple of times and he did say this is what happened or have you heard or have you been in contact with them.
- Q: So SW7 would know at the time of the Case Conference that you obviously had had a fair bit of contact with Alec but SW7 didn't mention to you that the Case Conference was taking place?
- A: No.
- Q: Or invite you?
- A: No.

Q: He didn't phone afterwards to bring you up to date on the outcome of the Case Conference just for your information?

A: No."

6.9.38 P2

A: "The only thing I would do differently is I would actually go to the Social Work Department if this baby was at risk and I would have presumed the baby would have been at risk and I maybe should have contacted the Social Work Department.

Q: As opposed to simply taking the number that presumably Mr Ness gave you for SW7?

A: Yes. I felt maybe I should have spoken to somebody who was connected with, more with the baby than Mr Ness because SW.7 is more connected with Mr Ness.

Q: So was SW7's response that he was more involved with Mr Ness than with the baby?

A: No, his concerns were quite blank really. He wasn't concerned with Mr Ness really or wasn't concerned with the baby. They all had separate Social Workers and nobody seemed to talk to each other."

## **7 RELEVANT CHILD PROTECTION GUIDELINES**

7.1 We refer to the 5<sup>th</sup> edition of the “Inter-Agency Child Protection Guidelines” issued in Lothian, for implementation from 1 October 1994. These Guidelines have been superseded, and at the time of writing the 6<sup>th</sup> edition Guidelines are in force. (The present Guidelines are in a grey folder: the 5<sup>th</sup> edition Guidelines were in a navy blue folder). Chapter 6 deals with Child Protection Case Conferences, which of course are often held for older children, and sometimes held in an emergency. There are no statutory provisions relating to Case Conferences. The Guidelines say: “*The Chairperson of the Case Conference acts with the delegated authority of the agencies that constitute the Child Protection Committee. The Chairperson holds overall responsibility for the organisation and the conduct of the Case Conference. However, the responsibility for the actions of the individual agencies remains with these agencies. If an agency decided to act in a manner different from that agreed at the Case Conference, it is their responsibility to inform the designated “Case Co-ordinator”, who will inform other participants and consider the need to reconvene the Case Conference.*” (6.2)

The purpose of the Child Protection Case Conference is said to be:

- “6.1.1 *To assist in the communication of factual information;*
  - 6.1.2 *To review the decisions made during the Initial Referral Discussion stage;*
  - 6.1.3 *To decide whether the child and/or any other children are believed to be at risk of being abused, if so:*
    - the child’s name must be placed on the Child Protection Register;*
    - consideration should be given as to whether or not a referral should be made to the Reporter for Compulsory Measures of Care. If this is agreed a referral will be made by the Department of Social Work;*
    - a Child Protection Plan must be agreed;*
    - a Case Co-ordinator must be appointed who must always be a Social Worker;*
    - a review date must be agreed which must take place within six months.”*
- (6.1).

7.2 Extensive instructions are given to Chairpersons (6.4), including at 6.4.9: *“The Chairperson will ensure that the Minutes of the Case Conference are accurate and that they are distributed to the appropriate Agencies and, where appropriate, the parents within fourteen days of the Case Conference.”* At 6.12.7, the Guidelines provide that: *“The Minutes of the Conference should be completed on the standard Minute form and circulated to those attending and to parents not present. The Chairperson is responsible for making any alterations to inaccuracies noted by those in attendance. The Minutes should include, as a minimum:*

- *essential facts*
- *details of the Child Protection Plan (if relevant)*
- *whether the Conference decided to place the child or any other children in the family on the Child Protection Register*
- *recommendations for further action*
- *an account of the process of the discussion and the reasons for recommendations*
- *a note of any dissent*
- *date of review Conference”*

7.3 A sample form is given. This was followed for Caleb.

7.4 At Appendix C, page 77, useful lists of signs of possible physical abuse, signs of the possibility of non-accidental injury, signs of possible physical neglect, and signs of non-organic failure to thrive, are listed. There are similar lists for emotional abuse and sexual abuse. The five categories are known as “Criteria for Registration”, and were established by the Social Work Services Group at the Scottish Office in April 1992, for use across Scotland. Since abuse is complex, and in any one case there may be many reasons for registration, the Guidelines invite practitioners to identify which reason is to be considered the primary reason, and which other reasons are to be described as secondary. An “Index of Certainty” is given at page 84, this being a 6 point scale. Point 1 is “Certain”, and applies in all proven court cases where there is a conviction relating to the child in question, or where the abuse is admitted. Point 2 is “Very suspicious”, and various factors are listed. Point 3 is “Suspicious”, and is applicable when “All cases where the injury or abuse could conceivably have been caused in the manner described but where the history and/or circumstances of the

family indicate a high level of risk.” Point 4 is “At risk”, and applies in “All cases where it is thought that child abuse may occur (other than 5 or 6). Point 5 is “At risk due to abusive sibling/other child”, and point 6 is “At risk due to abuser in the household”, where the abuser has admitted abuse of another child, or had it proved against him. Points 2 and 3 apply in cases where evidence of injury has already emerged, either because it has been described by the victim or because injuries have been medically diagnosed.

7.5 It may be helpful to add a brief footnote about the law. The main foundation for public law relating to the care and protection of children was and remains the Social Work (Scotland) Act 1968, which set up unified social work departments, the Children’s Hearing system (see Glossary), and articulated measures which give local authorities powers and duties to intervene in the family in order to protect children. The provisions changed from time to time, and then they were overhauled by the Children (Scotland) Act 1995. The 1968 Act remains in force, although much amended, and it is supplemented by new provisions in Part II of the 1995 Act. We refer to some of the relevant concepts, such as a Child Protection Order, in the Glossary. One of the objectives of the 1995 Act was to give effect to the requirements of international Conventions to which the United Kingdom is a party, including the United Nations Convention on the Rights of the Child. Section 16(1) of the 1995 Act states the overarching principle dominating the new legislative provisions, namely that the welfare of the child shall be the court or Hearing’s paramount consideration.

## **8 DISCUSSION OF SOME ASPECTS OF EVIDENCE: Brain injuries, Relationship Strains, Housing, Allocation of GPs.**

- 8.1 Brain injuries: Their implications and consequences are a dominant theme. When Alec Ness was discharged from the Astley Ainslie, he was a divorced man with a history of failed relationships. He was 51 years old, had spent most of his recent past in prison, and had no useful way to earn a legitimate living. He described himself as a “roofer” on Caleb’s birth certificate, and had in the distant past worked in a brewery. In April 2001, he had no place to live, no legitimate source of income, and was subject to the restrictions of parole. However, with the lack of insight characteristic of his injuries, he believed that he was starting a new family with Shirley. He had stayed with her on and off, but not lived with her, prior to his head injury, and they had only met in late 2000, so there was no history of a shared relationship. Shirley felt that she had some responsibility for his head injury. We can only guess at the reasons for this: a dispute between drug dealers seems likely. In any event, she took him in willingly, and there are indications that she attempted suicide in early 2001 because she had not been permitted to visit Alec when he was in intensive care in hospital. Prior to the head injury, we believe that what mattered to Shirley was the fact that Ness provided her with physical protection, as a bodyguard, and no doubt money and drugs as well. She thought that the relationship would mean she could give up her life as a prostitute on the streets of Leith. She will have expected Ness to have recovered further when he left hospital, and she knew that she was pregnant. Whether she actually believed that Ness was the father of the child we cannot know: he certainly did believe it.
- 8.2 Strains emerged in the relationship almost immediately, when Shirley discovered just how handicapped Ness was. Although he was orientated in place, person and time, his functioning was seriously impaired. This was obvious to all those who came into contact with him. Frontal disinhibition meant that he was easily distracted, agitated and excessively talkative. His memory was poor, and he was clumsy. Visual neglect on his left side meant that he would occasionally bump into things, and he was generally ill co-ordinated. His sleep was disturbed. He could not organise himself, and remember everyday things, to the extent that Shirley felt that he could not be left alone.

- 8.3 There were other factors. Despite his obsessive devotion, we believe that Shirley was probably afraid of Ness, and the possibility that he would turn violent towards her. We heard no evidence that he ever did, but there were hints that she was afraid of him. He had a reputation before his brain injury of being a violent man. Against this, it has to be said that when Shirley asked Ness to leave in July, he did so.
- 8.4 There are signs of ambivalence in Shirley's attitude, in any event. Throughout August, September, and October, when Ness visited daily, he arrived in the morning, and let himself in with a house key. There were days when she appears to have barred the door against his entry, when he would go over the street and wait with P1. Sometimes he would wait for hours, fretting about what would be happening to Caleb. He told us, and we accept, that he went in each morning and cleared away all the signs of drug taking the night before, in case HV or SW4 dropped in. He tidied, he hoovered. He did the washing. He ran errands for her, and took the baby out to give her a break. We expect that he continued to provide her with some money, though not to the extent that he had been able to do prior to his brain injury. His capacity to engage in criminal activity was severely reduced. When she had used all her own money, and the milk tokens, for drugs, it was Ness who went and bought nappies and milk powder. He was useful for her. His presence might still swing a housing application as a couple, and his residence elsewhere meant they could claim DSS benefits as separate individuals. Had she really wanted him out of her life, Shirley could have changed the lock.
- 8.5 Housing was a major preoccupation for both Shirley and Alec Ness throughout 2001. Shirley's flat was cramped and small, and there was damp in one of the bedrooms. She saw a partner and a baby as a means to obtaining housing from the District Council as a family, although we doubt that she ever intended that Ness should live in that flat once it was available. Having waited for housing as a single person after his release from prison, Ness lost priority with the Port of Leith Housing Association while he was a patient in the Western General, and thereafter insisted upon applying anew, as a family. The couple also tried to obtain a house from the Council, declaring themselves homeless (see 21 June entry). By the time that Shirley decided that she could not stand living with Alec any longer and asked him to leave in mid-July, they were no further forward. From the end of July, Ness had a bed at a hotel on the basis

that he was a single homeless person. It was a condition of residing there that he had to return to the hotel every night. This arrangement did not involve any kind of care or support for Ness. During the 11 brief weeks of Caleb's life, there was a flurry of applications to the Housing Department which were lodged, cancelled, changed, and only some of which are evident from the Chronology here. The explanation for this chaos is simple: Ness could neither remember the advice he received, nor accept the undoubted fact that Shirley did not want to live with him in the future, because of his impaired memory and perception. We have no doubt at all that most of the time Shirley wanted to end the tension of daily visits by Ness, and to live on her own with Caleb, with only occasional contact visits, perhaps at the weekends. However, she knew (as she told Dr1 on 4 October) that if she put her foot down, and insisted that he stopped visiting, there would be no-one to care for Ness.

8.6 It is thought provoking to realise that if supported accommodation had been available for Ness, Caleb's death might not have happened. Why Alexander Ness was never assessed as needing supported accommodation is not straightforward. One reason is that SW7, his Criminal Justice Social Worker, never asked for medical advice about the extent and implications of the brain injury. He thought that some obvious symptoms were transient, and would probably improve with time. He did ask CN what the prognosis was for Alec Ness, and we accept his evidence that she was vague in her reply. However, we have no criticism of an Outreach Nurse (CN) who is guarded in what she says about the prognosis for a head injury, which is properly a question for a doctor. In any event, CN knew that Ness was using illegal drugs, which complicated his presentation from July onwards. We are clear that SW7 should have asked a doctor exactly what the head injury meant for Alec Ness, if only because it had an obvious bearing on his future offending behaviour. The Criminal Justice Social Worker did not ask the question: we reject the suggestion that there was any difficulty in obtaining information from medical professionals. This was made to us by SW2, and it appears in the social work Head of Operations' Report to the City of Edinburgh Council, dated 11 February 2003 at para 7. Both Dr3 and Psyc indicated that there would have been no difficulty in providing information, if it had been requested, and we doubt if any issue of medical confidentiality would have arisen, as it is abundantly clear that Ness would have given permission for reports to have been written.



8.7 We also note that staff at the Astley Ainslie proposed to assess Ness for the purpose of establishing whether he could live independently, but they invited him to attend that assessment by way of a letter which he probably could not have received, because he had moved on. We should say that we appreciate that it was difficult for all of the professionals involved with Alexander Ness to keep track of him, as he moved from one place to another between July and August. SW7 told us that he had planned to obtain support for Ness from various agencies, but everything depended upon him having an address in a particular part of the city, before the right to support could be triggered. It was outside our remit to investigate what happened to all the housing applications by and on behalf of Alexander Ness, that we cannot avoid concluding that such a vulnerable man should have had a flat in his own name before October 2001, over a year after his release from prison. We therefore **RECOMMEND that the Housing Department of the City of Edinburgh reviews what happened here, with a view to streamlining and supporting applications by people suffering from brain injury.**

8.8 Another gap in the provision of care for this disabled, vulnerable single man was the provision of a General Practitioner in the Leith area. Again and again, the medical staff at the Astley Ainslie sent reports to a GP in west Edinburgh, who never saw Ness. He was advised to re-register with a new GP, by SW7 and CN, but it must be remembered that this man had difficulty filling in forms and remembering to do simple everyday tasks. We think SW7 and CN may have done a little more than give advice, and did not explore this thoroughly in evidence, but it is clear that there was in fact no GP under an obligation to visit Ness when a crisis arose in July, with the result that he ended up at the Royal Infirmary accident and emergency inappropriately. Later, when he felt suicidal in October, he went to a Citizens' Advice office, rather than a doctor, and we were told that this resulted in a referral to the Royal Edinburgh Hospital, a psychiatric hospital. We see it as outside our remit to investigate what happened exactly in respect of GP registration, but we do consider that a head injury victim like Alec Ness should have had some fast-track method of changing GPs within a single Primary Care Trust area. (see also 5.9 and 6.8.15). **We RECOMMEND that Lothian Primary Care Trust facilitates the registration with GPs of brain injury**

**patients, with a view to providing them with appropriate care outside the hospital.**

## **9 ANALYSIS and RECOMMENDATIONS**

The task we were set by the City's resolution was to "undertake a comprehensive review of the interagency discussions, decision making and involvement with Caleb Ness and his family". It falls into three parts. We have not dealt with the third part in isolation: "Involvement with Caleb Ness and his family", as we consider that it is adequately covered in the other two. There is a degree of overlap, which results in some repetition, but we thought it would be helpful to concentrate on the two main questions separately. They are : "Inter-agency Discussions", and "Decision Making". We have added some thoughts of our own on issues which we think require comment.

### **9.1 Inter Agency Discussions**

We discuss this following the chronology of events.

#### **a. Before Caleb Was Born**

9.1.1 When Alec Ness was in the Astley Ainslie, the liaison between SW7 and CN was reasonably good, apart from SW7's confused request for a prognosis, which we have already discussed. See 5.4.3 and 5.4.4.

9.1.2 When Shirley became pregnant, she probably had the pregnancy confirmed at the GP practice. We did not have her medical records, but when the GP gave evidence to us, he made reference to them and we know that by 17 April 2001, at least, she was receiving routine treatment there. The GP we interviewed was not the GP with whom she was registered: he apparently was not involved at any time. She moved round different doctors, when she did show up for appointments. We did not have the opportunity to interview them, or the people at the Simpson's Maternity Pavilion who saw her for antenatal appointments. Again, we do not know the details, but it is clear that she was formally booked in, and she was being chased up by community midwives in the weeks before the birth. Unfortunately we did not have time to interview them. Yet none of these health professionals alerted the social work department to the fact that she was pregnant. It should be remembered that the GP records were full of communications from the CDPS: it was clear at once that this was

a woman who had been in the grip of a very serious heroin addiction for two decades. The records of her previous pregnancies should have provoked questions about her existing children. The doctor treating Shirley at the CDPS knew of the pregnancy eventually. Yet there was no alert, even when neonatal abstinence syndrome was expected. Had it not been for the chance mistake which confused Shirley with someone who was about to be evicted, it is possible that Caleb might never have been on the CPR.

9.1.3 Pre-birth CPCCs are quite common, and in the ideal world, we would have expected one to have been arranged for Caleb in, say, early July. But this depends on Social Work involvement, preferably at an earlier stage in the pregnancy than May. The failure to communicate the fact of the pregnancy contributed to the rushed decision making in early August 2001, which was partly due to the need to decide where Caleb went when he was well enough to leave hospital.

9.1.4 From the point of view of good practice, we think that the health care professionals identified here should have communicated the fact of the pregnancy to the relevant social work department, given the critical facts that the mother had a serious and ongoing heroin addiction, and post natal abstinence syndrome was predicted for the baby. Obviously, this might have meant breaching the medical confidentiality of the mother, and we discuss this elsewhere. However, in fairness, we have to note that the Lothian Child Protection Guidelines then in force (5<sup>th</sup> edition) do not make such an expectation clear. On the contrary, the definition of “child”, which would imply a live baby after birth to a non-lawyer, and the whole approach in the section relating to “Agency Roles and Responsibilities – Health Service Staff “ (2.3), suggests that the drafters had in mind an actual child where abuse was suspected. The short reference to pre-birth case conferences at 8.11 adds nothing to amplify the guidance from the point of view of health professionals. In these circumstances, we do not criticise any of the health professionals involved prior to Caleb’s birth, and simply comment that it is unfortunate that none of them lifted a telephone to trigger some social work input. We assume that wherever possible, sharing of information takes place with the full knowledge of the parents involved. For the future, although the 6<sup>th</sup> edition of the Guidelines says more about pre-birth case conferences (8.12), the section on health care professionals has changed very little, and we therefore **RECOMMEND that the**

**section of the Child Protection Guidelines is amended to reflect the expectation that health care professionals will notify the social work department if they anticipate there may be risk after birth for a child still in utero, even if it means breaching the duty of confidentiality owed to either mother or father.**

9.1.5 Good Practice should have led to direct communication by the social worker (SW4) with the appropriate health professionals. He did speak to Dr1, but it does not appear that he was speaking to either the primary care team or the maternity services in July. This would have enabled him to identify other areas of concern, such as Shirley's failure to attend antenatal appointments.

**b. While Caleb was in hospital**

9.1.6 Shirley's behaviour on the ward, when she was suspected of using drugs, was appropriately brought to the attention of the CPCC by the Midwife. However, she had left hospital before that, and after the CPCC she came into the hospital from home, and visited Caleb over a period of about twelve days. The nursing staff noted her appearance and behaviour on several occasions suggesting that she was under the influence of drugs. These observations were clear indications that she was using drugs in addition to her script, and they were therefore an important warning that she might be drowsy and incapable when she had Caleb at home. We were told that Nurse1 communicated this to the Hospital liaison health visitor, and the Hospital social worker. There the trail ended, as we accept that the information did not reach HV or SW4. Moreover, there is no written record in Caleb's file, to show what happened. **We RECOMMEND that a file entry is made when information is shared in this way, and in particular when liaison workers pass that information out beyond the hospital.** We understand the procedure has changed since 2001, so that now Nurse1 would be free to telephone SW4 direct with similar information, and we welcome that change.

9.1.7 The hospital does not appear to have given the HV advance warning of Caleb's discharge: she phoned the ward, only to find that he had just gone home. This is unacceptable when a baby is on the CPR. Moreover, the summary sheet sent to the HV was shockingly inaccurate, even to the point of saying the baby was a girl. (This

refers to the “HV Liaison Summary”. HosMan made it clear that she was in despair about the inaccurate and duplicate record keeping, and we can only agree. We **RECOMMEND that the LUH Trust reviews the accuracy of its record keeping for at risk children.**

9.1.8 More significantly, there is no Community Paediatrics file for Caleb. No one remembered to refer Caleb to the Community Child Health Child Protection Service, which would have led to a file being opened, although this baby is exactly the patient envisaged when the LUH Trust reviewed its procedures. On one level, this is an internal failure, which seems quite extraordinary to us. Not one, but several, Trust employees actually attended a CPCC which decided to put Caleb’s name on the CPR, yet no one referred this case to its own Service. Why not? We leave it to the Trust to follow this up.

9.1.9 Yet there is an inter-agency dimension to this which is even more important. HosMan told us that she expected her office to be notified (in advance) when a CPCC was set up, such as Caleb’s, when the child was a patient in the special care baby unit. Not a single witness mentioned this to us. We asked every witness involved with Caleb’s CPCC who should have been invited to attend, in addition to those who had been invited. Not one mentioned the Child Protection Service. We went on to interview various senior managers in social work, asking them to tell us as a matter of theory and good practice who should have been invited to Caleb’s CPCC. Not one mentioned the Community Child Health (CCH) Child Protection Service in answer to that question, or in any other context. We interviewed the Child Protection Co-ordinator. He did not make a single reference to the Acute Trust’s Child Protection office. We spoke to a Consultant Neonatal Paediatrician about many issues, including recommendations for improvements in the future, particularly for babies with neonatal abstinence syndrome: again, no mention of the Child Protection Service. We could easily have finished our Inquiry without learning that the service existed. Something has gone badly wrong here, but it goes beyond our remit to discover what or why.

9.1.10 We can only conclude that inter-agency discussions between the Lothian University Hospitals NHS Trust, Lothian Primary Care Trust and the Social Work Department are woefully inadequate, and we **RECOMMEND that serious dialogue is**

**undertaken to clarify the role of the Trusts' Child Protection Services within an interagency context.** The Child Protection Co-ordinator, who must take some responsibility for this unacceptable muddle, should obviously be involved.

9.1.11 It follows from this that training will be needed, once the exact scope of the involvement of the LUH Trust's Child Protection Service is determined. The social workers who arrange CPCCs need to be clear when to invite a representative from the Child Protection Office to a CPCC. The nursing staff told us that they had received training since Caleb's death, and were much clearer about what happens at a CPCC, and their own roles there, but there will be others who need similar training. On the basis of the limited evidence we have seen, Paediatricians and other senior medical staff who are likely to attend CPCCs are among them. It was not Neo1's fault that SW4 arranged Caleb's CPCC for a time when she was running a busy clinic, but it does not seem that it occurred to her to request a re-arranged time, although she was the one person who could have explained to the CPCC that Caleb had a much bigger problem than simply "not feeding very well". Neo-natal abstinence syndrome should have been discussed carefully at Caleb's CPCC, and this needed professional expert advice on what it meant.

9.1.12 HosMan was clear in her evidence to the Inquiry that there was a crying need for child protection training throughout the Trust, and we have no hesitation in backing her call for resources. We thought it was extraordinary that the Trust had gone to the expense of arranging a few training sessions, but not freed people up to attend them during their normal working hours. If inter-agency co-operation with the objective of creating an acceptable level of child protection in the Lothians is ever going to be achieved, staff at all levels need to know what is expected of them. We therefore **RECOMMEND that Lothian Health ensures that its various Trusts fund the training requirements identified by their own senior staff with management responsibility for Child Protection.**

9.1.13 Obviously, inter-agency discussions took place at the CPCC itself, and in the preparations for Caleb's discharge from hospital, but we have said enough about that elsewhere. See Chapter 3 generally.

**c. After Caleb left hospital**

9.1.14 As we have noted, there was no Child Protection Plan. One would have thought that at some stage soon after the CPCC someone would have noticed this. SW2, for example, in supervising SW4, should have noticed and rectified the omission. She did not. There was no discharge review meeting, when SW4 and HV could have sat down and planned the frequency of home visits, and discussed the case generally. They did meet, when they visited Shirley – always by appointment-but not for re-evaluation of risk or proper discussion between themselves. The co-ordination between the two relevant agencies, social work and health, can only be described as poor. The responsibility for making the appropriate arrangements between himself and HV, as the case workers, lay with SW4, who had been nominated “Case Co-ordinator” at the CPCC. (see 6.5 of the Guidelines).

9.1.15 When HV decided that the risks were beginning to stack up, at the end of September 2001, she took the steps which were appropriate to trigger action. She notified SW4, she notified Dr1, and she knew that the GP already knew something of the situation. Having been told of Shirley’s post-natal depression, and her refusal of antidepressants, SW4 did nothing. When she went on holiday and arranged that SW4 visit Shirley while she was away, he did not visit. This is a lamentable failure in inter-agency working, and it unfortunately cannot be seen as an isolated lapse. The evidence of PCMan2, who manages all the Health Visitors in the region in connection with Child Protection matters, made it clear that that he was concerned at how often something similar happened in other cases, both where children had already been identified as being at risk, and even more where health visitors were attempting to highlight new cause for concern. (see 6.8.18). We **RECOMMEND that the best means of triggering early reviews or immediate action in response to health visitors’ concerns be investigated, and improved upon, as a matter of urgency.**

9.1.16 The CDPS did not realise what role the social workers expected them to play, even leaving aside the failure to circulate them with the Minutes. Even if the Minutes had arrived on Dr1’s desk within a fortnight, he would have thought he understood his role. He thought that his role was only to notify SW4 in the event of frank, unambiguous evidence of risk to Caleb himself.



9.1.17 What Dr1 did not appreciate was that the expectation was for a sharing of information about Shirley any time that there was an event which might have a bearing on Caleb's safety. There is a difference, and it is a difference which is important in the provision of effective protection for our children. We cannot say exactly where the professional bodies would tell Dr1 to draw the line, but the advice from the General Medical Council quoted at 10.2.1 of the current Guidelines states: "if a doctor has reason to believe that a child is being physically, sexually or emotionally abused or neglected, it will usually require the doctor to disclose information to a third party". Merely increasing the methadone prescription, or learning that Shirley was admitting to using more street drugs, might not create a duty of disclosure in the absence of some actual evidence that this might have an impact on Caleb's care. Similarly, the knowledge of the GP that Shirley had developed post-natal depression, and further that she was refusing to take the drugs to ameliorate it, might not have been information which the GP could properly have disclosed direct to SW4 without her consent. We do not claim to know exactly where the line would be drawn, but we do consider that it is imperative that the social workers actually providing a system of child protection should know precisely what they can expect from their medical colleagues. Social workers and health workers have to be aware of the need to open up a channel of communication in every case. In this way, important information which does not breach confidentiality can be shared. **We RECOMMEND that steps are taken to clarify when medical duties of confidentiality towards a patient who is caring for a child can be waived,** and this must be undertaken as a matter of urgency. We believe that this is likely to be seen as a national issue which is not unique to Lothian.

9.1.18 There was a glaring failure of communication in the episode when SW9 from distant social work department telephoned SW4 to advise him that Shirley seemed to be utterly incapable, as a result of drug taking, on or about 7 September. How SW4 could ignore such a warning from a fellow professional is beyond understanding. We can only guess that he thought that he was much more experienced in drug related cases than she was, and was somehow relaxed about such an allegation. (He denied in evidence to us that this ever happened).

9.1.19 The most serious and bewildering lack of inter-agency understanding arises when we look at the role of the criminal justice social worker in child protection. In this case, it so happened that SW7 was working with Ness before he even met Shirley, and a connection was made between him and SW4 reasonably promptly during the pregnancy. They shared information appropriately up until the time of the baby's birth. What happened after that is that SW7 thought that his role continued to centre on Alec Ness's rehabilitation, and he believed that everything to do with Caleb was the responsibility of the Children and Families' team, who were trained to deal with child protection. He did not receive the Minutes of the CPCC which he was unable to attend, of course, but even if he had done there was nothing in them to suggest that the Child Protection plan involved him, so far as it can be said that any plan existed. He was not named as a core worker within the Child Protection Plan. He did not receive any other kind of written communication to suggest that he had a continuing role with the baby, and he did not believe that he had one. Certainly, he says that if, by chance, he had come to know of anything which pointed unequivocally towards risk to Caleb, he would have communicated it to SW4. In our view, he did have that information, but he did not recognise it as amounting to risk. He did not in any way set out to monitor the situation with Caleb in mind.

9.1.20 In view of the fact that the Minutes were not circulated, the Inquiry thought it had to find out what the normal expectations would be in this situation, in case this had a bearing on what was expected of SW7. The answers give rise to serious concern. The social workers from a Children and Families background all expected their criminal justice colleagues to have an active part to play in monitoring risk for a child, if the criminal justice worker was working with any family member, such as the child's father. They knew that the criminal justice worker could not be a lead worker on a child protection case, and they sometimes stood back from going so far as to say that the criminal justice worker would be a second worker, but they definitely expected active and informed monitoring in the interests of the child. Man2, from another angle, thought that SW7 could and should have been named as one of the group of core workers assigned to monitor Caleb in the Child Protection Plan. In stark contrast, the criminal justice workers, believed that they now could play virtually no role in child protection. They knew the Guidelines existed, and could be consulted when need be. They were preoccupied by the fact that their agency is dominated by

stringent national objectives and standards, which focus on offending and its consequences. We heard evidence of understaffing in criminal justice in 2001 (now apparently improving). We were given to understand that the priority had to be the work expected by the national standards etc, not least because the funding came ring fenced and explicitly aimed at rehabilitating offenders, protecting the public etc. The criminal justice workers are expected by their own managers to participate in information sharing which relates to child protection, but not much more. As Man3 said, rather wistfully, “We don’t get paid for doing child care work.” On the other hand, joint reviews, case conferences and the like (i.e. inter-agency discussions) could be seen to fit in with work with an offender, and were undertaken in that context.

- 9.1.21 There is no training given to criminal justice workers about child protection. They are expected to know the basics from the social work training course, although even there specialisation in criminal justice areas may restrict the training to a bare minimum. There is no joint agency training of any kind involving children and families social workers. The consequence is that those social workers who were in practice before specialist teams were set up in 1992 now feel “de-skilled”, and only too aware that what they once knew is not up to scratch in the increasingly specialist area of child protection. Those who have only ever worked in the specialist area of criminal justice, like SW7, appreciate that they know virtually nothing about child protection, and hand over willingly to their Children and Families colleagues without a backward glance.
- 9.1.22 We have to bear in mind that we are only looking at one case, but we were left with deep unease. If the criminal justice workers visiting families do not know what to look out for, the level of protection we are offering our children is far lower than it has to be. SW5, an experienced and impressive witness, gave a good example. If the criminal justice worker visiting a home notices a school aged child at home during a school day once, he might think nothing of it. If the child is there every time he visits, he should know enough to suspect truancy, or some other manifestation of distress in the child. Suitably trained, he will alert the children and families team.
- 9.1.23 There may also be a need for someone with child protection training to be made available for consultation by criminal justice workers. There should be no difficulty where the service is in the same building as the Children and Families team, but

where, as here, the teams are geographically separated, there is a problem. Consultation might perhaps be arranged by visits to criminal justice offices once a month. Man2 is too senior and too busy to do this: it needs to be someone who can be approached with “It may be nothing, but I’d like to discuss this with you” kind of concerns. We think that some practical day to day specialist assistance like this might be worth consideration.

9.1.24 We will never know whether SW7’s impression that he had no role to play in child protection after the CPCC made a difference to the outcome. Consistent with criminal justice practice, Ness was nearly always seen at the social work offices, which meant the SW7 did not have the opportunity to see what was going on in the home. Yet SW4 was working under the illusion that SW7 was actively involved in the protection of Caleb. It is a startling instance of a woeful lack of inter agency co-operation where one social worker thinks another social worker is engaged in work on a case, and the other social worker believes the opposite. **We RECOMMEND that Children and Families and Criminal Justice social work services review their joint working practices in this area as a matter of urgency.**

## **9.2 Decision making**

9.2.1 It was appropriate to allocate this case for investigation, once it was discovered that Shirley was pregnant.

9.2.2 It was obviously appropriate to arrange a CPCC, although we believe that in the circumstances a pre-birth CPCC should have been held. This is a matter of judgment, and we appreciate that others might not take that approach. The criticism here is that there does not appear to have been early enough discussion about a CPCC: it was arranged in haste when the baby was born, with the consequence that invitations were last minute. Insufficient thought went into the invitations: some were missed. It might be helpful to have a checklist of possible invitees to a CPCC, and we **RECOMMEND that a checklist of invitees for CPCCs is compiled as an aid for social workers in the future.** The agencies concerned can identify exactly when there should be notification to Community Child Health, and whether the GP should always be on the

list, when drafting the Checklist. In our view, both the GP and the HV should always be invited.

9.2.3 The 8 August Case Conference Report was handed to people attending the CPCC on 9 August. No-one had time to study it, particularly the Chair. The inadequacies of the report have been highlighted elsewhere, particularly the writer's view that this couple "presented as motivated to settle down, and parent the baby", which was disgracefully at odds with the truth. The CPCC did learn, in fact, that the couple were living apart. However, the report plainly informed the only real decision making which took place relating to Caleb. It was superficial, and based on impressions of Shirley and Alec rather than hard evidence. He could and should have made it clear that he had barely had time to get to know Shirley, much less assess her current situation. People attending the CPCC thought he knew her far better than he did. SW4 did say he had very little information about Ness, but he should also have said in the Report that information about Ness's background and brain injury was crucial.

9.2.4 The CPCC was accordingly influenced from the outset by a one-sided Report which omitted to highlight the gaps in the information which the CPCC was going to need. The police could and would have contributed information about Ness, had his name been given to them. SW4 did not ask, because ultimately he was content to proceed on the basis of a casual assumption that someone who had day to day care of a child, but who was not actually living on the premises, did not have to be assessed when risk to the baby was under consideration. That approach fed through to the CPCC.

9.2.5 It was a catastrophic error. The inexperienced and inadequately trained Chair of the CPCC did not focus on the change of circumstances since the Report had been written, or identify the need for more information, as she should have done. She should in fact have reconvened the CPCC when there was information from the Criminal Justice Social Worker for Ness, a doctor who knew the extent of Ness' brain injury, a police officer who could speak to the offending behaviour of both Shirley and Alexander Ness, and the Social Worker from the (distant) Social Work Department which had taken Shirley's two previous children into care. Instead, the CPCC muddled on, never attempting to assess risk in the round, and failing entirely to specify an appropriate

Child Protection Plan. In short, there were major errors by SW3, the chairperson on 9 August.

9.2.6 We heard references in the evidence to research into a risk assessment tool as an aid to decision making. We considered that it went beyond our remit to investigate this, but we should comment that achieving safe and informed decision making is a central task in child protection generally. We think that it is interesting to notice that the factors identified at para.7.4 of the Scottish Executive Report : “It’s Everyone’s job to make sure I’m alright”, which commonly contribute to children not being protected, are all present in this case:

- lack of information sharing across and between agencies
- poor assessment processes
- ineffective decision making
- poor recording of information
- lack of information on significant males

We **RECOMMEND that all agencies make it a priority to collaborate and put in place effective risk assessment processes to underpin decision making.**

9.2.7 According to the evidence we heard, in 2001 it was routine to have Child Protection Case Conferences chaired by senior practitioners, and that seems to continue today. This appears to contravene an arrangement between the Child Protection Coordinator and the Social Work Department which expects the chairperson will be “**above** senior social worker level.” We note that the Guidelines say at 6.2 that the Chairperson of the case conference acts with the delegated authority of the agencies that constitute the Child Protection Committee, although they do not specify the level of seniority of a Chairperson. We have no hesitation in endorsing the requirement that the Chairperson must be a Senior Social worker (or above). We suggest it is not acceptable to have a Senior Practitioner acting as Chairperson, not least because he or she will not have sufficient confidence and authority. We therefore **RECOMMEND that the use of Senior Practitioners as Chairpersons of Case Conferences is discontinued.**

9.2.8 It appears that SW3 received rather casual advice about how to chair a CPCC before she started. We think it is important that any new Chairperson receives formal training about the role and function of a CPCC, and his or her responsibilities as

Chair. We therefore **RECOMMEND that formal training in how to chair a CPCC is introduced for all new Chairpersons**. Consideration should be given to extending this to existing Chairpersons. As Edinburgh operates a rota system, we appreciate that significant numbers may be involved. This in turn may precipitate a review of the whole approach to finding Chairpersons. Consideration should be given to alternative models of service delivery: it must be appreciably easier to train and inform a small number of specialist chairpersons.

9.2.9 The real issue for the CPCC should have been whether it was safe to send Caleb home at all: we believe that this issue was not examined properly because an over-optimistic view prevailed about Shirley's drug use. The information provided by the CDPS to SW.4 in June, and again at the CPCC on 9 August, was misunderstood by the conference as meaning that Shirley's drug abuse was under control, and that the prognosis was good. The facts, as known to the CDPS, were more complicated, and we **RECOMMEND that the CDPS provides information for the use of CPCCs about the inferences which can be drawn from the factual information they are providing**, such as the extent to which a urine sample can "prove" adherence to the treatment. See 4.1.5. The chronic history of improvement and relapse, fully expected by professionals in the CDPS, was not understood by the people thinking about Caleb's future.

9.2.10 Referral to the Reporter is an issue for every CPCC, and helpfully highlighted in the format of the Minutes for these conferences. We believe that the people attending the Case Conference decided against referral to the Reporter because they misunderstood the Reporter's role. Some of them seem to have believed that referral to the Reporter would inevitably have as its consequence a Child Protection Order for Caleb. This is not the case, and there are many children who are referred to the Reporter, in respect of whom no further action is taken, after appropriate investigation. As the (distant) Reporter's office had been involved with Shirley's two older children, we believe that the assumption should have been that a referral to the Reporter was appropriate, unless good cause was shown. **We RECOMMEND that Social Workers involved with CPCCs in Lothian are encouraged to refer to the Reporter, where there is a history of previous children who have been taken into care, unless the**

**circumstances are exceptional. We also RECOMMEND that CPCC Chairs, in discussion with the Reporter, agree appropriate referral criteria.**

9.2.11 We have found as a fact that no decision was made to send Caleb home on the basis that Alec Ness would never be left alone with him. There was an understanding that Shirley would be the main carer for the baby, but everyone at the CPCC expected Alec to continue to take an interest in the baby, and to be involved in his care. The records for 20 September supports this conclusion (see Chronology), but it is also based on our evaluation of the evidence of every person attending the Case Conference, except Shirley Malcolm. See Chapter 3 generally.

9.2.12 The follow-up to the Case Conference is a sorry tale of an absence of decision making. There should have been an urgent meeting of the Case Co-ordinator and the other Case worker (HV) to agree a proper Child Protection Plan, and a co-ordinated approach to monitoring Caleb. No decision was taken to arrange one.

9.2.13 Crucially, when HV tried to alert SW4 to what she saw as increased risk factors in Caleb's life at the very beginning of October 2001, he did nothing. No decision was taken to bring forward the CPCC review date, or to hold a meeting of core workers, or to do anything at all. Had a review of any kind taken place, the deterioration in Alec Ness's condition might have been identified as an additional risk factor. Everything carried on as before. It is the absence of any decision at all at this stage which causes us most concern.

### **9.3 Comments on other matters**

9.3.1 Having fully reviewed all the evidence it is our view that neither parent should have had unsupervised care of Caleb. Had the extent of Alexander Ness incapacity been understood it would have been appreciated that placing a baby in his care was putting him at risk as well as the baby. He should never have been placed in the position where he might have harmed Caleb inadvertently. Similarly there was no evidence that Shirley's lifestyle or addiction had changed to suggest that she would be a safe carer for the baby.



- 9.3.1 The Minutes to the Case Conference are not merely a formal record for filing away. They should record the risk factors, and issues surrounding the child's future. They have to be accurate. These Minutes were inaccurate, but once again we have to blame this on the inexperience and lack of training given to the person who took the Minutes. Various witnesses complained that plucking a fully qualified Social Worker away from a busy case load, requiring him or her to sit through a meeting which will always last at least an hour, and then requiring dictation of the Minutes (or typing of the Minutes onto a computer) is an inappropriate use of professional time. We agree with these criticisms. While we accept that the taking of Minutes involves some skills, particularly in the précis of discussion, we consider that administrative staff could be trained to take Minutes well, and we therefore **RECOMMEND that resources are allocated for the employment and training of administrative staff to take and type up Minutes relating to CPCCs.**
- 9.3.2 In breach of the Guidelines, the Minutes in Caleb's case were not checked by the Chair, and they should have been. In order to reduce the risk of this happening again, we **RECOMMEND that the pro forma Minutes are changed slightly, to include a section for signature by the Chair of the relevant CPCC.**
- 9.3.3 The Minutes for Caleb's Case Conference ended up back on his file, without having been circulated to anybody. Again, this was a clear breach of the guidelines, and again it is the Chair who should have ensured that circulation took place.
- 9.3.4 We should mention that we heard evidence of a number of changes to the arrangements for inviting people to a CPCC, circulating Minutes and other matters from SW1, who explained that these changes had been put in place recently, we think in 2003. They may only relate to the Leith team, and we have no opportunity to check this. We therefore proceed on the basis that our recommendations are still necessary, although some may be superseded in some respects.
- 9.3.5 The supervision of SW4, who assessed risk in advance of the Case Conference, and then co-ordinated the monitoring of Caleb thereafter, was wholly inadequate. The supervisor, SW2, plainly left everything in the hands of SW4, and assumed that he

was doing a good job. She should have asked the questions: What do we know of Alec Ness' brain injury? What do we know about his background from Criminal Justice? Is he going to pose any risk to Caleb's safety, for any reason? Do we know enough about Shirley's past drug history? What arrangements are there with CDPS for communication, if Shirley's dependence on drugs increases? How often is SW4 to visit? How often is the HV to visit? Are the visits to be by appointment, or will there be unannounced visits? Where are the Minutes for the Case Conference? We list some of the questions, and they are only the most obvious ones, to highlight the fact that she was obviously asking nothing. While we accept that Caleb was mentioned at the regular supervision meetings, we are quite clear that no full discussion of this case took place.

9.3.6 This leads us to question the way that Child Protection cases are dealt with, even in theory. If, as here, the Social Worker who prepares the report, speaks at the Case Conference, and does most of the monitoring thereafter, has got hold of the wrong end of the stick, the only check against that mistake is the intervention of his or her supervisor. While we criticise SW2 for failing to intervene and ask the right questions, we can also see that it is difficult for a supervisor to think about a case in the round, when he has only received information about the case from the person being supervised i.e. SW4 in this case. There must be a risk that the supervisor will fail to understand the views, roles and responsibilities of the other key agencies because his own understanding is slanted from the outset. In Edinburgh we understand that it is unusual for seniors to attend case conferences. In other parts of Scotland, the supervisor would routinely attend the Case Conference along with the Case Worker, and thus be forced to think about the child, and the advice of other professionals, in a more vivid and rounded way. The objection to this, of course, is that it involves two Social Workers from the same team attending the same Case Conference, and they may take some time to travel to reach it. The total expenditure in manpower will be several hours. However, if the supervisor never hears anything about the child except as it is channelled to him or her by the supervised person, there is a real danger that his perspective (or lack of it) will cloud the Supervisor's judgement. We therefore **RECOMMEND that the supervising Senior Social Worker should attend Child Protection Case Conferences, along with the case worker from the Children and Families Team.** We see this as the only safeguard

against honest mistakes, or judgements based on inexperience, and we see this recommendation as particularly necessary in a system where more and more Social Workers with very little experience can find themselves as key workers in anxious Child Protection cases. We heard evidence that the Case Co-ordinator in Child Protection cases like this could have as little as three years of post-qualifying experience, having gained the Certificate in Child Protection Studies from Dundee University (a part-time post-graduate qualification) while working during those three years. The sharing of responsibility is a protection for the Social Workers involved, as well as for the children.

9.3.7 Monitoring after Caleb's discharge from hospital was haphazard and unco-ordinated. SW4 did visit the house four times, but the visits were all expected by Shirley, who had time to tidy up. Good practice would suggest that he should have made some unscheduled visits, and certainly that he should have been checking the family at least once a week. This baby was not subject to a high level of monitoring, as had been understood (in a vague way) at the CPCC. Similarly, the HV should have made occasional unscheduled visits.

9.3.8 If you read the Chronology, it is apparent that the signs of increasing stress on this family were noted, but not evaluated cumulatively for their significance. There were several major warning signs of acute stress. Firstly, there was SW9's report of Shirley being incapable of caring for Caleb, which was simply ignored. Shirley's prescription was increased, so that she reverted to a daily collection of high doses of Methadone. She was diagnosed as suffering from post-natal depression, and refused to accept the antidepressant medication which might have treated it. She told people of the strain she was under in trying to cope with Alec Ness, whose symptoms and behaviour probably deteriorated in the last month. Under stress himself, consistently denying that his relationship with Shirley was over, he was taking illegal drugs which depressed his poor brain function even further. (See Chronology entries 17 July, 3 October and 18 October 2001) He was so low in spirits that he was talking about suicide.

9.3.9 Although Caleb was gaining weight and developing normally, we believe that any competent risk assessment in early October would have identified these factors as

present, and posing significant risks for Caleb's safety. He was at risk of physical neglect by his mother, and physical injury from the unco-ordinated and deeply stressed Alexander Ness. We should say that we are quite clear that neither would ever have deliberately harmed Caleb: each loved Caleb deeply, as we heard in evidence from many different sources. They could not have coped with an ordinary baby: Caleb with his neonatal abstinence syndrome was probably particularly demanding.

9.3.10 We believe that HV appreciated the risks, as is evidenced by her contemporaneous records dated 28 September, 2 October and 3 October. Appropriately, she alerted SW4, and also the CDPS. There is no sign that SW4 ever pulled together the threads in his own mind, and recognised the signs of mounting pressure. Equally, SW2 in her role of supervising SW4 failed to make any connection. We accept that SW4 and SW2 could not have known of parties of drug addicts congregating in Shirley's house, to use drugs. They could not have known of Alec Ness making up bottles for the baby using cold water from the tap. The clues were there, however, and the questions were never asked. Even when Shirley spoke of her "involvement in the sex industry" on 16 October, SW4 did not ask if she was then working as a prostitute.

9.3.11 SW4 thought that SW7 was monitoring Alec Ness, and that he would report any issues which might have a bearing on Caleb's safety. SW7 thought that he had no role in monitoring Caleb's safety, and did not pass on information which might have had a bearing on risk, such as the report from the Citizen's Advice Bureau that Ness felt suicidal.

9.3.12 When SW7 sent a letter to Shirley saying that he would visit on 11 October, he arrived at 9.30 a.m. and found that she was asleep. She claimed not to have received this letter. This pattern of arrangements made, and not kept to, is a constant thread, and we acknowledge that it made it far more difficult for the Social Workers involved (and the HV) to monitor what was happening.

9.3.13 However, we cannot escape the conclusion that everything was allowed to drift along, because no single person ultimately took responsibility for blowing the whistle, and saying "enough is enough". We believe one reason for this is the fact that the current

system in Edinburgh requires a basic grade social worker to take the initiative. It also may require maturity on the part of the social worker in SW4's position to recognise that he has made a mistake. It takes confidence, and perhaps seniority, to question the decision of the CPCC and request an early review.

9.3.14 In several Scottish authorities, the notion of a core group of the key people concerned with the protection of a particular child has been introduced, in order to ensure the development and implementation of a Child Protection plan. The core group meets, and takes responsibility for deciding:

- identification of key workers;
- time frames for visits, tasks and reviews;
- implementation of the protection plan;
- monitoring arrangements;
- a requirement for ongoing risk assessment;

9.3.15 We **RECOMMEND that consideration should be given to this model of a “core group”, as a means of developing and implementing the Child Protection plan.**

9.3.16 Any analysis of what was happening in Edinburgh in 2001, at least as revealed in the evidence taken by this Inquiry, should take cognisance of the vast distance between the managers' understanding of what should be happening, and knowledge of what was actually happening on the ground in their own areas of responsibility. It was frankly astonishing to find that the Child Protection Co-ordinator did not know that the local Child Protection Guidelines - both in 2001 and today - require the CPCC to agree and outline the Child Protection Plan. (see 6.12.5 of both editions). He thought it came afterwards. It was appalling to find that the person apparently in charge of child protection in Lothian Primary Care Trust only appreciated that her remit extended beyond nurses when we pushed her to think about it. No wonder the doctors in the Astley Ainslie and the CPDS were unclear about what their roles were, when they had child protection concerns. She has no relevant experience in the field: how can she recognise what needs to be done? Conversely, it was depressing to find that the competent and trained person in charge of child protection in Lothian University Hospitals Trust knew exactly what she should do, but could not obtain the backing, resources or commitment from her employers to discharge her responsibilities. The

managers in the Children and Families and Criminal Justice social work departments were surprised when we told them what we had discovered was happening in practice: they seem to have no hard knowledge about what their own workers were doing when liaison was required between the two branches of the service. The police, again headed by an officer who himself has no child protection training, believe that they have re-organised themselves appropriately to deal with child protection matters, but they are not in fact doing what the social workers expect them to do when it comes to information sharing. There is some communication between the concerned agencies, but there is not effective communication. **We RECOMMEND that senior managers with responsibility for child protection practice have appropriate training to discharge that responsibility, in every agency.**

9.3.17 We were struck by the practical difficulties which we experienced when we asked Lothian Health and its constituent trusts to identify the appropriate senior managers with responsibility for child protection to give evidence to the Inquiry. **We RECOMMEND that the Chief Executives and Medical Directors give urgent consideration to lines of accountability.**

9.3.18 We believe that we have identified many deficiencies in the analysis of Caleb's need for protection, and his subsequent monitoring at home. It is sobering to realise that if he had not died, and a murder trial had not taken place, none of this would have come to light. In line with previous reviews, we **RECOMMEND that an independent audit of Child Protection cases is carried out**, on a random basis, in order to identify strengths and weaknesses in the system. For example, we heard from several sources that the Minutes of Child Protection Case Conferences were held up for weeks in the Leith Social Work office, as a matter of routine. We were told that there had been some improvement since 2001, but this was in response to an internal investigation of this case. This should have been identified as a cause for concern without a baby dying.

**d. Review after Caleb's death**

9.3.19 We understand, of course, that an internal review took place immediately after Caleb's death, but we did not hear evidence about this specifically. The differences between what we have found and what was outlined in the Director's statements to the Council on 11 and 17 February 2003 are somewhat surprising. However, beyond commenting that it was quite wrong to interview a key witness after this Inquiry started (see SW10), we should observe that our remit does not extend to events after Caleb's death.

## 10 SUMMARY OF RECOMMENDATIONS

- | <u>Section</u> | <u>Recommendation</u>   |
|----------------|---|
| 1) 3.4.1       | <b>RECOMMEND that the CPCC minute format is changed, so that the Chairperson has an opportunity and obligation to sign the Minutes.</b>   |
| 2) 3.6.2       | <b>RECOMMEND that an explicit discussion and decision as to whether or not the child should be discharged to the care of the parent should always be part of a CPCC for a newborn baby</b>  |
| 3) 4.2.9       | <b>RECOMMEND that a Joint Working Party prepares a Joint Protocol to inform the treatment and care of babies born with neonatal abstinence syndrome</b>   |
| 4) 4.2.9       | <b>RECOMMEND automatic referral to the Social Work Department of any baby born with neonatal abstinence syndrome, who has not been identified pre-birth</b>   |
| 5) 4.3.3       | <b>RECOMMENDATION that the Trust organises and funds mandatory child protection training, as identified by their own specialist</b>   |
| 6) 4.4.6       | <b>RECOMMEND that the Trust carefully reviews its record keeping systems to facilitate effective sharing of information</b>   |
| 7) 4.4.8       | <b>RECOMMEND that Lothian Primary Care Trust urgently allocates resources and skilled staff to institute mandatory child protection training for staff at all levels, which must include advice on the extent to which a patient's right to medical confidentiality can be breached when a child is at risk</b> |
| 8) 4.5.2       | <b>RECOMMEND that the pro forma invitation issued by Social Work Departments throughout the City should be reviewed, in consultation with the Police, and a new pro forma drawn up, which offers the Police far more information</b>  |
| 9) 4.5.20      | <b>RECOMMEND that the Police review the detail of their approach to physical and sexual abuse in collaboration with Child Protection specialists from outside the Police. Thereafter, we recommend that they re-examine their internal procedures for allocating cases</b>                                      |
| 10) 4.5.21     | <b>RECOMMEND that a clear understanding is reached between the Police and the Social Workers on information sharing prior to the CPCC</b>   |
| 11) 5.7.6      | <b>RECOMMEND that the Social Work Department refrains from interviewing witnesses where an inquiry has been set up</b>  |
| 12) 8.7        | <b>RECOMMEND that the Housing Department of the City of Edinburgh reviews what happened here, with a view to streamlining and supporting applications by people suffering from brain injury</b>   |



- 13) 8.8 **RECOMMEND that Lothian Primary Care Trust facilitates the registration with GPs of brain injury patients, with a view to providing them with appropriate care outside the hospital**
- 14) 9.1.4 **RECOMMEND that the section of the Child Protection Guidelines is amended to reflect the expectation that health care professionals will notify the social work department if they anticipate there may be risk after birth for a child still in utero, even if it means breaching the duty of confidentiality owed to either mother or father**
- 15) 9.1.6 **RECOMMEND that a file entry is made when information is shared in this way, and in particular when liaison workers pass that information out beyond the hospital**
- 16) 9.1.7 **RECOMMEND that the LUH Trust reviews the accuracy of its record keeping for at risk children**
- 17) 9.1.10 **RECOMMEND that serious dialogue is undertaken to clarify the role of the Trusts' Child Protection Services within an interagency context**
- 18) 9.1.12 **RECOMMEND that Lothian Health ensures that its various Trusts fund the training requirements identified by their own senior staff with management responsibility for Child Protection**
- 19) 9.1.15 **RECOMMEND that the best means of triggering early reviews or immediate action in response to health visitors' concerns be investigated, and improved upon, as a matter of urgency**
- 20) 9.1.17 **RECOMMEND that steps are taken to clarify when medical duties of confidentiality towards a patient who is caring for a child can be waived**
- 21) 9.1.24 **RECOMMEND that Children and Families and Criminal Justice social work services review their joint working practices in this area as a matter of urgency**
- 22) 9.2.2 **RECOMMEND that a checklist of invitees for CPCCs is compiled as an aid for social workers in the future**
- 23) 9.2.6 **RECOMMEND that all agencies make it a priority to collaborate and put in place effective risk assessment processes to underpin decision making**
- 24) 9.2.7 **RECOMMEND that the use of Senior Practitioners as Chairpersons of Case Conferences is discontinued**
- 25) 9.2.8 **RECOMMEND that formal training in how to chair a CPCC is introduced for all new Chairpersons**

- 26) 9.2.9 **RECOMMEND that the CDPS provides information for the use of CPCCs about the inferences which can be drawn from the factual information they are providing**
- 27) 9.2.10 **RECOMMEND that Social Workers involved with CPCCs in Lothian are encouraged to refer to the Reporter, where there is a history of previous children who have been taken into care, unless the circumstances are exceptional.**
- 28) 9.2.10 **RECOMMEND that CPCC Chairs, in discussion with the Reporter, agree appropriate referral criteria**
- 29) 9.3.1 **RECOMMEND that resources are allocated for the employment and training of administrative staff to take and type up Minutes relating to CPCCs**
- 30) 9.3.2 **RECOMMEND that the pro forma Minutes are changed slightly, to include a section for signature by the Chair of the relevant CPCC**
- 31) 9.3.6 **RECOMMEND that the supervising Senior Social Worker should attend Child Protection Case Conferences, along with the case worker from the Children and Families Team**
- 32) 9.3.15 **RECOMMEND that consideration should be given to this model of a “core group”, as a means of developing and implementing the Child Protection plan**
- 33) 9.3.16 **RECOMMEND that senior managers with responsibility for child protection practice have appropriate training to discharge that responsibility, in every agency**
- 34) 9.3.17 **RECOMMEND that the Chief Executives and Medical Directors give urgent consideration to lines of accountability**
- 35) 9.3.18 **RECOMMEND that an independent audit of Child Protection cases is carried out**

## **Recommendations grouped by agency**

Some recommendations appear more than once.

More than one agency: 1, 2, 3, 4, 8, 10, 14, 17, 18, 19, 20, 23, 30, 32, 33, 35.

Mostly Social Work: 21, 22, 24, 25, 27, 28, 29, 31.

Mostly Lothian Primary Care NHS Trust: 7, 13, 18, 26, 34.

Mostly Lothian University Hospitals NHS Trust: 5, 6, 15, 16, 18, 34.

Mostly Police: 8, 9, 10.

Housing: 12.

## **11 GLOSSARY**

<b>Case Worker</b>	<b>A social worker who takes responsibility for most of the work in connection with a case.</b>
<b>CDPS</b>	<b>Community Drug Problem Service See 4.1 of this Report.</b>
<b>CPCC</b>	<b>Child Protection Case Conference, not required by statute, but subject to extensive remarks in the Child Protection Guidelines.</b>
<b>CPN</b>	<b>Community Psychiatric Nurse</b>
<b>Child Protection Order</b>	<b>Where a Sheriff is satisfied there are reasonable grounds to believe a child is suffering or will suffer harm, he may grant an order authorising the removal of the child to a place of safety. See s 57(1) of the Children (Scotland) Act 1995.</b>
<b>Child Protection Guidelines</b>	<b>Not part of the statutory framework, they are now maintained and amended from time to time by the Edinburgh and Lothians Child Protection Committee. See sections 1 and 4 of this report.</b>
<b>Child Protection Register</b>	<b>Not part of the statutory framework, this computerised record is compiled and maintained by the Social Work Dept in Edinburgh in order to facilitate the sharing of relevant information between agencies etc. See current Child Protection Guidelines s 7.</b>
<b>Children's Hearing</b>	<b>A formal sitting of 3 members of the Children's Panel, comprising lay people who have been selected and trained to make decisions about children. See s39(3) of the Act.</b>
<b>Grounds of Referral</b>	<b>The Reporter must refer to a Hearing for consideration and determination of the merits, the case of any child where he is satisfied compulsory measures of care are necessary. At least one of the grounds specified in s52(2) must be established, for example, that the child is out of control, or is likely to be</b>

**impaired seriously in his health and development. See also s 65.**

**Lead Worker**

**A term usually used to denote the social worker who leads a child protection investigation, and sometimes used to refer to the social worker with case management responsibility.**

**No Order principle**

**In various defined circumstances, the Children's Hearing or the Sheriff should make no order unless "it would be better for the child that the requirement or order be made than that none should be made at all." See s 16(3). In practice this means that a court will start off with the presumption that it should make no order, but if an order needs to be made, it must constitute the minimum intervention necessary.**

**Parental Responsibilities Order**

**On application by a local authority, and only where necessary, a Sheriff can make an order depriving a person of some or all of his parental responsibilities or rights in relation to a child, for a specified period of time. See s 86(1).**

**Proof before the Sheriff**

**If a parent or child does not accept the Grounds of Referral, for example because he denies the facts stated by the Reporter, the Case is put before a Sheriff, and evidence is led from witnesses. The Sheriff then decides whether the Reporter has proved his case.**

**Protocol**

**An official or formal record, in this context laying down guidelines or rules for dealing with a problem.**

**Reporter**

**An independent official (not always a social worker) who investigates all children referred to him from any source, to see if they are in need of protection. If so, he has statutory powers (currently under the Children (Scotland) Act 1995) to draft Grounds of Referral, and to refer the child to the local Children's Hearing. There are rules for his qualifications, appointment and training. Typically, a Principal Reporter for a region of Scotland will be assisted by a number of qualified staff, many of whom will appear in court on his behalf. The Scottish Children's Reporter's Administration runs this system. See s 40.**

**"Script"**

**The prescription of substitute drugs legally offered to an addict, such as methadone instead of heroin.**

<b>Second Worker</b>	<b>A social worker who liaises with the lead worker, in connection with an allocated case.</b>
<b>Sheriff</b>	<b>Independent, legally trained judge appointed to hear a wide variety of cases, including crime, in a given area of Scotland.</b>
<b>Supervision Requirement</b>	<b>Where the Children’s Hearing is satisfied that a child needs compulsory measures of supervision, the order is made to require residence at a particular place, and/or to impose appropriate conditions. See s 70.</b>

## APPENDIX A

### a) List of witnesses

#### Social Work

Senior Management:

- Man1: .....Head of Operations
- Man2: .....Child Protection Co-ordinator
- Man3: .....Criminal Justice Services Manager
- Man4: .....Operations Manager, Children and Families (from 2003)

Social Workers:

- SW1: .....Practice Team Manager
- SW2: .....Senior Social Worker
- SW3: .....Part-time Senior Practitioner/Part-time Social Worker
- SW4: .....Main Grade Social Worker
- SW5: .....Criminal Justice Senior Social Worker
- SW6: .....Criminal Justice Senior Social Worker
- SW7: .....Criminal Justice Social Worker
- SW8: .....Team Leader of Children and Families Team (outside Edinburgh)
- SW9: .....Main Grade Social Worker (outside Edinburgh)
- SW10: .....Newly qualified Social Worker

#### Lothian Primary Care NHS Trust

- PC Man1:.....Manager
- PC Man2:.....Child Protection Adviser
- HV: .....Health Visitor employed directly by the Trust
- GP: .....General Practitioner
- Dr1: .....Consultant Psychiatrist CDPS
- Dr2: .....Specialist General Practitioner CDPS
- Dr3: .....Consultant in Rehabilitation Medicine, Astley Ainslie
- Psyc: .....Head of Neuropsychology, Astley Ainslie
- CN: .....Outreach Nurse, Astley Ainslie

#### The Lothian University Hospitals NHS Trust

- HosMan.....Consultant Paediatrician, with management responsibility for Child Protection
- Neo1: .....Consultant Paediatrician
- Neo2: .....Consultant Paediatrician (not interviewed)
- Obst: .....Consultant Obstetrician (not interviewed)
- Nurse 1:.....Neonatal Sister, Simpson's Maternity Hospital
- Midwife:.....Simpsons Hospital

Police

DI: .....Detective Inspector, Family Protection Unit (from 2003)  
DCI: .....Detective Chief Inspector overseeing Child Protection in D Division in  
2001  
DC: .....Detective Constable, Family Protection Unit, Leith  
JLO: .....Juvenile Liaison Officer, Leith (not interviewed)

Public

P1: .....Charity Director  
P2: .....Citizens Advice Bureau Volunteer  
P3: .....Friend of Alexander Ness  
P4: .....Voluntary Worker with Charity  
P5: .....Volunteer with the Charity

Others

Rep: .....Reporter Manager, Scottish Children's Reporters Administration

Alexander Ness.

**b) Letter to Inquiry witnesses**

ADVOCATES' LIBRARY  
PARLIAMENT HOUSE  
EDINBURGH EH1 1RF  
Tel: 0131-2265071

(name and address)

(date)

Dear (name),

**CALEB NESS INQUIRY**

On 20th February 2003, the City of Edinburgh Council passed a resolution to instruct an independent Inquiry into the circumstances surrounding the death of baby Caleb Ness on 18th October 2001. This followed the conclusion of the prosecution in the High Court of Alexander Ness, who ultimately tendered a guilty plea to culpable homicide. The case gave rise to questions and concerns relating to the care of Caleb.

The Council agreed that the remit of the review should be:-

"To review all the circumstances of the management of the case including:

- The decision-making in relation to the assessment and management of risk to Caleb;
- The nature and extent of inter-agency collaboration and practice;
- The identification of areas of professional practice that require to be improved as a result."

The Inquiry will be carried out by three people: Dr Helen Hammond, Consultant Paediatrician at St John's Hospital, Livingston; Mrs Moira, McKinnon, Child Protection Co-ordinator for City of Glasgow Social Work Department; and Ms Susan O'Brien QC, an Advocate with relevant legal experience.

It appears from the information available to us that you had an involvement at some stage in Caleb's life. Any information which you can give us may contribute significantly to our understanding of what happened. We are therefore writing to ask you to give evidence to the Inquiry team. We have assigned various dates for the hearings, and we hope that it will be possible for witnesses to arrange a convenient time to attend by contacting the person named in the accompanying note, Mrs Pat Younger. We shall be sitting in Edinburgh, as detailed there. If you have any queries, please do not hesitate to mention them to Mrs Younger, who will pass them on to the Inquiry team if necessary.



-2-

We should be very grateful if you would agree to assist us, and look forward to you making contact as soon as possible.

Yours faithfully,

MS SUSAN O'BRIEN QC

## c) Notes for witnesses

### **NOTES FOR WITNESSES : CALEB NESS INQUIRY**

The Inquiry has secretarial assistance from Mrs Pat Younger, who can be contacted on 0131-339 2336, or by e-mail at: davidandpat@younger.flyer.co.uk

The following dates have been assigned for hearing evidence. If it is absolutely impossible for you to attend on any of the dates selected please let Mrs Younger know what your difficulty is, and we will do our best to accommodate you. You will be booked into a slot of one or two hours, the time varying according to the anticipated scope of your evidence.

Dates available:

(dates given)

Please contact Mrs Younger and arrange a suitable time as soon as possible.

The hearing of evidence will be between 10 a.m. and 5 p.m. at the Lord Reid Building, New Assembly Close, 142 High Street, Edinburgh, which is next to the White Dove Craft shop and almost opposite the City Chambers. Full details of how to find it will be sent to you, along with written confirmation of your appointment.

This is an internal Inquiry, and accordingly members of the public will not be allowed to attend. The Inquiry team members will ask you questions, but there will be no lawyer (such as a procurator fiscal in a trial) putting any particular "case" to you. The proceedings will **NOT** be adversarial. We would therefore prefer you not to attend with a lawyer, but any witness may bring one friend, trade union representative, or lawyer if he or she chooses. That person will not have any right to participate actively in the proceedings, and must not himself be giving evidence to the Inquiry. Witness interviews will be tape recorded. The Inquiry will be more concerned with information which was known while Caleb was alive, rather than with facts which came to light at the trial. If the Inquiry team concludes that there were errors by any of the professionals involved, the implications of those findings would be for consideration by relevant professional line managers within the appropriate agency. The Inquiry team will report initially to the Lothian and Borders Child Protection Committee, which consists of representatives from various agencies, including some NHS Trusts. The final report will be placed in the public domain, but it will not name individuals, who will be identified by reference to their professional roles.

**d) Stem questions**

STEM QUESTIONS

Your full name, age and address?

What is your present position/job? What generally are your responsibilities within that role?

How long have you held this post?

Do you have any formal training in Child Protection procedures?

How much experience do you have of Child Protection cases? Do you have any current involvement in Child Protection matters? Do you know the current guidelines relating to Child Protection in Lothian and Borders (as appropriate)?

What would you normally do if you were faced with a concern about Child Protection, which needed to be referred on?

With regard to Caleb Ness: Did you have any part to play in the life of Shirley Malcolm prior to Caleb's birth?

Did you have any role to play in Alexander Ness' life prior to Caleb's birth?

Did you have any part to play while Caleb was in hospital?

Did you have any role to play in the lives of any of these people, after Caleb's discharge from hospital?

Were you involved in the Case Conference relating to Caleb held at the Simpson Memorial Maternity Pavilion on 9th August 2001?

What did you understand that the Case Conference would deal with, before you arrived at the Conference?

Before the Conference started, what did you think the possible outcomes of the Conference could be (in theory)?

What information did you bring to the meeting?

What information did you impart to the meeting?

What part did you play in the decision making at that meeting?

Does the Minute accurately reflect the discussion at the Case Conference?

Did you receive a copy of the Minute thereafter?

Did you notice that you failed to receive a copy of the Minute thereafter?

What did you understand that you personally had to do in connection with Caleb after the Case Conference?

What did you understand that other people had to do after the Case Conference?

After baby Caleb was discharged from hospital, were you ever in any way concerned for his health or safety?

If so, what did you do?

Did you personally ever assess risk, looking at risk from Caleb's point of view, after his discharge from hospital?

If you raised any concerns about Caleb with other people, what response did you receive?

What did you do thereafter?

With the benefit of hindsight, would you personally do anything differently?

If the Inquiry Team makes recommendations for the future, do you have any suggestions for recommendations which might be made?

Do you have anything else that you wish to add or to say?

Have you had any support yourself, if you have been distressed by Caleb's death?

e) **Statement by Director of Operations to the City of Edinburgh Council**



Item no  
Report no

**Report on the death of a child on the Child Protection Register –  
Caleb Ness – Date of Birth 30 July 2001**

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**Executive**

11 February 2003

- 1 Caleb Ness was born on 30 July 2001 at Simpson's Memorial Maternity Unit in the Royal Infirmary of Edinburgh. He died on 18 October 2001.
- 2 His father, Alex Ness and mother, Shirley Malcolm, had both been known to the Social Work Department prior to Caleb's birth.
- 3 Alex Ness was being seen by a Criminal Justice Social Worker, having been placed on parole supervision following a penal sentence relating to drugs. That supervision order was active at the time of Caleb's birth. Shirley Malcolm was known previously through the Social Work Department's involvement in:
  - the preparation of a Social Enquiry Report for the Sheriff Court in 1998 resulting in a Community Service Order, which was successfully completed and supervised by a Social Worker.
  - supporting her financially on behalf of [REDACTED] to visit her two children, who were in the care of [REDACTED] on four occasions between 26 November 1999 and 16 August 2000;
  - a Housing referral due to threatened eviction on 8 May 2001.
- 4 Leith Social Work Centre received a referral from the Housing Department on 8 May 2001 about a pending eviction for Shirley Malcolm. Further enquiries were made. [REDACTED] were contacted and provided background information about Shirley Malcolm and her other children and her pregnancy. A home visit was made to Shirley Malcolm by the duty social worker and contact made with the health visitor. As a result of the information obtained and this initial assessment, the case was allocated to a social worker from Leith Social Work Centre.
- 5 Shirley Malcolm and Alex Ness had met in Edinburgh. Previously, Shirley Malcolm had lived in [REDACTED] her lifestyle was chaotic due to drug misuse. Her two children from that period were taken into care by [REDACTED]. The records show the degree of chaotic parenting linked primarily to drug misuse at that time. Assessments at the time of Caleb's birth show a significant improvement. The Social Worker for Alex Ness had a long-term knowledge of him and had no reason to believe the child would be at risk of any deliberate attempt to harm him on Alex Ness' part. Alex Ness had children from a previous marriage.

- 13 Caleb went home to live with Shirley Malcolm on 16 August. Over the next 7½ weeks, between 20 August and 10 October, the Social Worker visited 4 times with the Health Visitor present. On 2 further occasions the Health Visitor phoned the Social Worker with updates. The records show that no concerns were noted as to Caleb's wellbeing.
- 14 Sadly Caleb died on 18 October and it is now known that he was killed by Alex Ness.
- 15 The Director of Social Work has requested that the Edinburgh and Lothians Child Protection Committee undertake a review of all the circumstances of this case to include the nature and extent of Interagency involvement. This method has been agreed to by the Chief Social Work Inspector for Scotland. A report on the outcomes will be submitted by the committee to the Council's Chief Executive, who in turn will report to the Scottish Executive.



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**Appendices**

**Contact/tel**

**Wards affected**

**Background  
Papers**

### **C N Statement 17.2.03**

I regret that it is necessary for me to make a further statement following my verbal report to the Executive of the Council on 11<sup>th</sup> February.

Since the statement, further information regarding the case conference minute from the meeting of 9<sup>th</sup> August 2001 has been passed to me. I reported that it was normal practice for notes of a case conference to be sent out to all attendees to afford an opportunity to verify what was recorded. This is laid down in the Child Protection Guidelines under instructions to Chairpersons: 'The Chairperson will ensure that the minutes of the Case Conference are accurate and that they are distributed to the appropriate agencies and, where appropriate, the parents within 14 days of the Case Conference'.

It is now apparent that the minutes were not distributed in this case. This information was made known to me personally on Wednesday 12<sup>th</sup> February, after I had reported to the Executive. Rather than making any further comment on this serious omission, I suggest that this too should be a matter for the review into the circumstances of this case, which as I reported, has been requested of the Child Protection Committee with additional external input subject to approval of the Council.

**f) Pro Forma Invitation to Police**

(Name and address)

Ref: (ref)

Date : Friday, 03 August 2001

Dear (Name)

**NOTIFICATION OF CHILD PROTECTION CASE CONFERENCE**

Child/Children's Name : KALIB MALCOLM

DOB: 30 July 2001

As a professional colleague who may have had contact with, or knowledge of the above named Children you are invited to attend an Initial Case Conference convened under City of Edinburgh Child Protection Guidelines, as indicated below:

**Venue :** Seminar Room - Neo Natal Unit, Simpson Maternity Unit,  
Edinburgh Royal Infirmary, Lauriston Place, Edinburgh, EH3

**Time :** Thursday, 09 August 2001 at 11:00am

If you are unable to attend it would greatly assist the work of the conference if you could communicate relevant information, preferably in writing to myself.

Please note that the City of Edinburgh operates a policy of open access of inform; please indicate, therefore, whether or not any or all of the information given may be shared with the family.

Please reply using the tear-off slip below.

Yours sincerely

(Name omitted)

Social Worker

**Children and Families Team**

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I shall/shall not\* be able to attend the Case Conference in respect of KALIB MALCOLM (DOB 30/07/01)

Name :.....

Designation: .....

Please return to Leith Social Work Centre, St John's House. 71 Constitution Street. Edinburgh EH6 7AF