SCOTTISH GOVERNMENT
CHILD PROTECTION SYSTEMS REVIEW:

Child Protection Committees, Child Protection Registers & Case Conferences, and Significant and Initial Case Reviews

Background Paper Three:
Significant and Initial Case Reviews

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Introduction

1.1. On 25th February 2016, former Cabinet Secretary for Education and Life Long learning, Angela Constance MSP announced a National Child Protection Improvement Programme for Scotland in a statement to Parliament**.** This programme consists of a number of areas of work: a review of the formal elements of the child protection system; practice in the Children's Hearings system; steps to promote and support leadership; the role of inspection agencies; improving data and evidence; and action to address the impact of neglect on children. This complements ongoing work on addressing child sexual exploitation; child trafficking and internet safety.

The Scottish Government has established this review group to consider **formal child protection systems including Child Protection Committees, Child Protection Register and case conferences, and Significant and Initial Case Reviews**. This is the third in a series of briefing papers to inform the meeting of the Review Group. This paper explores current legislation, policy and evidence on Significant and Initial Case Reviews.

Background

2.1 The number of children who are killed by another person in Scotland continues to fall. Child homicides decreased from a five-year average of 11.3 per million in 2005/06 to 6.3 per million in 2014/15 (Bentley et al., 2016:17). However, 'studies have indicated that the number of child deaths where abuse or neglect is suspected as a factor is higher than shown in the police-recorded homicide figures' (Bentley et al., 2016; see also Brandon et al., 2012).

2.2 In 2002, seventeen recommendations were provided as part of a National Child Protection Review, "It's Everyone's Job to Make Sure I'm Alright": Report of the Child Protection Audit and Review; including, Recommendation 6: 'The Scottish Executive should consult on how child fatality reviews should be introduced in Scotland. This should include consultation on how they should be conducted,

how review teams should be constituted, to whom they would report and what legislative framework is required to ensure their effectiveness' (Scottish Executive, 2002). A working group was set up and interim guidance was developed for Child Protection Committees (Scottish Executive, 2007).

2.3 In January 2012, the Scottish Government commissioned the first Audit and Analysis of Significant Case Reviews across Scotland (Vincent & Petch, 2012). A key finding of this research was that there was still inconsistency in how reviews were being undertaken across Scotland. In response, the Scottish Government set up a Working Group in 2013 tasked with revising the interim national guidance. In 2015, the Scottish Government issued National Guidance for Child Protection Committees on Conducting a Significant Case Review to support Child Protection Committees in the process and governance of Significant and Initial Case Reviews.

2.4 In recognition of the variability and the need for wider learning, Scottish Ministers asked the Care Inspectorate to become the central collation point and undertake qualitative evaluation on all Significant Case Reviews as of 01 April 2012. The Care Inspectorate is required to report publicly on these findings to provide independent public assurance on the quality of care for children and young people; to share any learning and signpost good practice; and to support improvements to child protection practices and policy across Scotland (see Care Inspectorate, 2015; Care Inspectorate, 2016).

2.5 There can be a range of concurrent proceedings which occur when a child dies which can include criminal proceedings, formal Inquiries, professional disciplinary procedures and local reviews. Fatal Accident Inquiries (FAIs) are conducted where children die in custody or where the Procurator Fiscal decides an Inquiry is in the public interest. Neo-natal deaths are subject to a Sudden Unexpected Death in Infancy Review (SUDI), where there is an unexplained death of a child under two years old. The circumstances and agency responsibilities in respect of all children who die while looked after are reviewed

by local authorities and the Scottish Government, and are the subject of a statutory report to Ministers.

Legislation

3.1 The Children (Scotland) Act 1995 has provided the main legal framework for child welfare and protection in Scotland. Local authorities have a duty to safeguard and promote the welfare of children in their area. Notifying the death of a looked after child is a statutory duty of the local authority looking after that child under regulation 6 of the Looked After Children (Scotland) Regulations 2009. Notifying the death of a person being provided with aftercare under section 29 (10) of the Children (Scotland) Act 1995 became a statutory duty of the local authority under section 29(10) of the 1995 Act when section 66 of the Children and Young People (Scotland) Act 2014 came into force. Notifying the death of a person being provided with continuing care became a statutory of the local authority under section 26A (10) of the 1995 Act when section 67 of the 2014 Act came into force. The local authority must, as soon as reasonably practical, notify the Scottish Ministers and Social Care and Social Work Improvement Scotland (known as the Care Inspectorate).

3.2 The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 makes provision for the holding of public inquiries in Scotland respect of fatal accidents, deaths of persons in legal custody, sudden, suspicious and unexplained deaths and deaths occurring in circumstances giving rise to serious public concern. Fatal Accident Inquiries (FAIs) are conducted where children die in custody or where the Procurator Fiscal decides an Inquiry is in the public interest. In some instances full information regarding the whole circumstances may have been examined at a criminal trial or any relevant recommendations for consideration of professionals issued as a result of other official proceedings, such as a Critical Incident Review commissioned by the NHS. If Crown Counsel consider that there is nothing further which needs to be explored in the public interest or require a

specific determination to be sought by the Crown from a Sheriff then they will not instruct a FAI.

3.3 The UK Government ratified the United Nations Convention on the Rights of the Child (UNCRC) 1989 in 1991. The UNCRC contains 54 articles; of particular interest are: Article 3 where the best interests of the child should be the primary consideration; Article 12 which states that "…parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child"; Article 19 where governments must protect children from all forms of violence, abuse, neglect and mistreatment; and Article 34 protection from sexual exploitation and sexual abuse. Part One: Rights of Children in the 2014 Act requires Scottish Ministers and public authorities to report on steps taken to support the UNCRC.

Policy

4.1 The National Guidance for Child Protection Committees on Conducting a Significant Case Review which the Scottish Government published in 2015. The National Guidance provides criteria for establishing whether a case is significant:

> ***When a child dies and*** the incident or accumulation of incidents (a case) gives rise to significant/serious concerns about professional and/or service involvement or lack of involvement, and ***one or more of the following apply:***
>
> - Abuse or neglect is known or suspected to be a factor in the child's death;
> - The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear to the Child Protection Committee that the child having been on the CPR has no bearing on the case;
> - The death is by suicide or accidental death;
> - The death is by alleged murder, culpable homicide, reckless conduct, or act of violence;
> - At the time of their death the child was looked after by, or was receiving aftercare or continuing care from, the local authority,

> ***When a child has not died but*** has sustained **significant** harm or risk of significant harm as defined in the National Guidance for Child Protection in Scotland, ***and*** in addition to this, the incident or accumulation of incidents (a case) gives rise to serious concerns about professional and/or service involvement or lack of involvement, and the relevant Child Protection Committee determines that there may be learning to be gained through conducting a Significant Case Review (Scottish Government, 2015:8).

4.2 On behalf of the Chief Officers Group, a Child Protection Committee is responsible for deciding whether a Significant Case Review is warranted and how the review will be undertaken (Scottish Government, 2015). An Initial Case Review (ICR) is 'an opportunity for the Child Protection Committee to consider relevant information, determine the course of action and recommend whether a Significant Case Review or other response is required' (Scottish Government, 2015:9). Following an ICR, a decision to proceed to a Significant Case Review is taken when SCR criteria are met; where there is potential for significant corporate learning; and where an SCR is in the public interest and in the best interests of children, young person and their family.

4.3 In March 2015, the Care Inspectorate published a Code of Practice for the Review of Significant Case Reviews for children and young people in Scotland. The Code states that as part of a commitment to further improvement, the Care Inspectorate will:

> (a) seek information about all Initial Case Reviews (ICRs) carried out by Child Protection Committees (CPCs) to understand the rationale for proceeding or not proceeding to an SCR;
>
> (b) act as a central collation point for all SCRs completed across Scotland at the point at which they are concluded;
>
> (c) review the effectiveness of the processes for conducting each SCR and reporting informally to individual COGs and CPCs on good practice and areas of improvement;
>
> (d) conduct a biennial review of all SCRs completed in Scotland, and, reporting nationally on the key learning points for the benefit of relevant services across Scotland and the Scottish Government.

4.4 There have been a range of professional development and training opportunities provided by With Scotland, based at the University of Stirling (see for example,

Fotopoulou, 2016). There has been development work using a range of methodologies for Significant Case Reviews; for example, the English Social Care Institute for Excellence (SCIE): Learning Together model which uses systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture (SCIE, 2012).

Evidence Base

5.1 Whilst there is a wealth of research evidence on child abuse and neglect, there has been far less attention on child fatalities and how the examination of these tragedies may allow us to develop effective prevention initiatives (Vincent, 2013; see also, Brandon et al., 2012). In January 2005, the Scottish Executive Education Department commissioned an international overview of approaches to child deaths and significant cases; this included a survey that was conducted on approaches in 16 countries, a literature review and interviews with child protection experts (Axford & Bullock, 2005). The research informed the Child Death and Significant Case Review Group, which was established as part of the Child Protection Reform Programme. The review highlighted the importance of cultural context in reviewing practice and emphasised an appreciative understanding of why an inquiry or review was being undertaken. In the UK data, from the 1990s there has been a shift from an inquisitional perspective to a learning approach with a greater clarity around processes; although there was an international recognition of the tensions in these approaches. The authors conclude 'there is little point searching for a 'perfect' universal model', instead we need 'to avoid perceiving child death reviews as something isolated from other developments and practices and to view their function in the light of the wider child protection process and, indeed, the whole range of services for all children at risk of impairment to their health and development' (Axford & Bullock, 2005:55).

5.2 The first audit and analysis of Significant Case Reviews presented findings from 56 Significant Case Reviews (SCRs) and 43 Initial Case Reviews (ICRs) conducted in Scotland since 2007(Vincent & Petch, 2012). There had been child fatalities in

half of the SCRs included in this study (due to risk taking behaviour, accidents, natural causes, or at the hands of their parents or carers). One third of children were aged under one, and a third of children were aged over eleven; there was a slightly higher proportion of boys to girls, and none of the children had a diagnosed disability. The majority of families (93%) were involved with social work services, with just 7% of families known only to universal services (for example, health, education). 14% of children were on the Child Protection Register and a fifth of children were looked after. A quarter of the SCRs included children in families where there were four or more children. Around two thirds of parents experienced drug and/or alcohol problems; just over two fifths had a mental health problem; over half affected by domestic abuse and over half involved in serious criminal behaviour. The economic circumstances of families were often not recorded; however, frequent housing problems suggested material hardships.

5.3 The audit highlighted a lack of consistency in the SCR and ICR processes and proposed an increased standardisation across Child Protection Committees:

- There needs to be more consistency in the way in which ICRs are undertaken and recorded, and there is a particular need for better recording of the reason why ICRs do or do not proceed to SCR.
- There should be closer adherence to the guidance in terms of what constitutes a SCR and in relation to production of chronologies and Executive Summaries.
- There should be more discussion of how findings and recommendations will be taken forward including the ways in which they will be disseminated to staff and where appropriate, to families.
- There should be discussion of whether or not children and families were included and if not, why not; where families are included the SCR report should provide details of how they were involved and how their views were represented in the report.
- The members of the review team should be listed, information about timescales should be provided and there should be some discussion of the methodology which was used including whether or not the review included interviews with staff (Vincent & Petch, 2012:5).

5.4 As part of the inspection process with a focus on child protection arrangements, concerns have been identified about the decision making processes and quality of Significant Case Reviews produced (Care Inspectorate, 2014). In 2016, after

the Review Group had met for the first time, the Care Inspectorate published a triennial review of Significant Case Reviews in Scotland. Between 1 April 2012 and 31 March 2015, twenty Significant Case Reviews concerning twenty-three children and young people were submitted to the Care Inspectorate (Care Inspectorate, 2016). There are thirty Child Protection Committees in Scotland; just under half of all Child Protection Committees had commissioned a Significant Case Review and submitted it to the Care Inspectorate (n=14).

5.5 The profile of children was very similar to the earlier Vincent and Petch study (2012) in relation to gender, age, limited data on ethnicity and no recorded disability. Eleven children had died (5 infants or pre-school and 6 adolescents aged 15-17 years old) and twelve children had been significantly harmed or were at risk of harm. The fatalities included drowning, physical injury, drug overdose, suicide, accident and sudden unexpected infant death. In over half of the cases, parental mental health was a factor as was a similar rate for domestic abuse. Parental substance misuse was documented in over half of all SCRs and was a feature in all five cases involving the death of an infant or pre-school child. Similarly to Vincent and Petch (2012), the vast majority of children (87%) had social work involvement; furthermore, three children were on the Child Protection Register and a further two children had their names recently removed (Care Inspectorate, 2016).

5.6 The Care Inspectorate identified areas for wider learning on the Significant Case Review process:

- Four reviews used the Social Care Institute for Excellence (SCIE) Learning Together model and a further two used various aspects;
- Timescales in conducting SCR varied from 5 months to 37 months;
- 12 were conducted by a single external lead reviewer and there was variations of quality in terms of thoroughness of analysis and process;
- 9 SCR had an Executive summary and the majority contained a chronology;
- Just over half (55%) evidenced that the family had been asked to be involved and three stated that the family were not asked due to legal proceedings or on mental health grounds.

The Care Inspectorate concluded that there is a need to improve the consistency and quality of Significant Case Reviews; furthermore, it considered that SCRs were not always clear on what needed to improve and how this would be monitored by Child Protection Committees (Care Inspectorate, 2016).

Some Questions

1. In your experience, what are the strengths and limitations of the current Significant and Initial Case Review processes?
2. How can families be involved in Initial and Significant Case Reviews? Can we share examples of good practice?
3. What are the advantages and disadvantages of different models for conducting Significant Case Reviews? For example, root and branch analysis, SCIE model. Should the Scottish Government recommend one approach?
4. Should Scotland set up a national expert group to oversee all Significant Case Reviews? Should we use multiagency teams rather than single reviewers?
5. How can the learning from Significant and Initial Case Reviews improve outcomes for more children and their families?
6. What are your views on the publication and/or wider dissemination of Significant and Initial Case Reviews?
7. Should we conduct Significant Case Reviews for where children have been protected from harm successfully? Is it possible to develop a model for 'what works' in protecting children and learning from this, as well as seeking learning when tragedies or near misses have occurred?

Contact details:

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