The Scottish Government
Riaghaltas na h-Alba

National Guidance
for Child Protection Committees
Conducting a Significant Case Review

Contents Page

Annexes

Ministerial Foreword

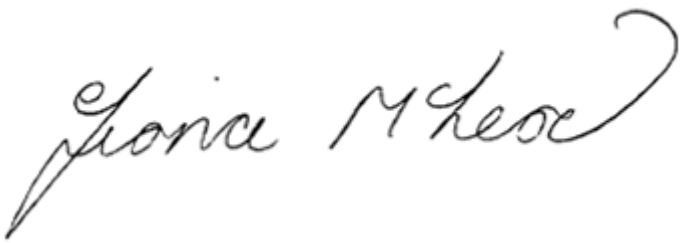
As Acting Minister for Children and Young People, I am committed to improving the life chances of children and young people in Scotland. Keeping our children and young people safe is a priority for this Government and, along with my colleagues, I will do all I can to ensure they are protected from harm.

We are very fortunate in Scotland in terms of our workforce. We have many dedicated, motivated and highly skilled people across a range of services who are committed to protecting vulnerable children and young people from harm and neglect. Each of us, whether at national or local level, across different sectors and specialties, has a role to play in preventing, identifying and acting on child protection concerns.

Although there have been significant improvements made over recent years, we must continue to ensure that, where necessary, any lessons are learnt and improvements are made. For this Government, the improvement journey never stops. We are committed to ensuring that the Scottish approach to protecting children and young people is as robust as possible.

That is why we have revised the Significant Case Review guidance. It seeks to support a consistent approach nationally and improve the dissemination and application of learning both at a local and national level.

I would like to offer my sincere thanks to all those who contributed to the development of this revised guidance. Their expertise and insight was crucial to this revision, and is a good example of partnership working in practice. By continuing working together in this way we can make Scotland the best place for children and young people to grow up.



FIONA MCLEOD
Acting Minister for Children and Young People

Who is this guidance for?

This guidance is primarily for people who sit on Child Protection Committees (CPCs). Protecting children and young people is an inter-agency and inter-disciplinary responsibility carried out by CPCs. The CPC, on behalf of the Chief Officers Group, is responsible for deciding whether a significant case review (SCR) is warranted, and for agreeing how the review is conducted. Ownership of the process and any SCR reports generated by the process ultimately belong to the CPC. CPCs and Lead Officers will want to consider the governance arrangements which are outlined on page 13.

Context

The national Audit and Review of Child Protection *It's Everyone's Job to Make Sure I'm Alright* (2002) recommended that the Scottish Executive 'consult on how child fatality reviews should be introduced in Scotland'. This was taken forward under the Child Protection Reform Programme, and national interim guidance for carrying out significant case reviews was introduced in 2007 (Scottish Executive 2007). This interim guidance aimed to provide a systematic approach to – 'help provide more clarity and consistency on what should be done and how best to act on the lessons learnt from a significant case review, both locally and across Scotland.'

In November 2009 the Scottish Government commissioned an independent short-life working group to consider how to improve the SCR process. The group made 10 recommendations to the Scottish Government. In terms of child protection, these were a priority for the Scottish Government and were signed off by the then Minister for Children and Early Years, Adam Ingram. In January 2012 the Scottish Government commissioned an Audit and Analysis of SCRs (Vincent and Petch 2012). A key finding of this research was that there was still inconsistency in how reviews were being undertaken across Scotland.

The Scottish Government responded to the recommendations of the working group and the Audit and Analysis by setting up a SCR Working Group in 2013 tasked with revising the interim national guidance. This guidance is the product of that work.

Introduction

In the context of child protection, a Significant Case Review is a multi-agency process for establishing the facts of, and learning lessons from, a situation where a child has died or been significantly harmed. Significant Case Reviews should be seen in the context of a culture of continuous improvement and should focus on learning and reflection on day-to-day practices, and the systems within which those practices operate. Wherever possible, staff should be involved in reviews and should get feedback when the review is finished. It is also important to work to clear timescales (see Figure 1).

Objectives

The overarching objectives of Significant Case Reviews are to:

- Establish whether there are lessons to be learned about how better to protect children and young people, and help ensure they get the help they need when they need it in the future;
- Learn and improve services as well as recognise good practice;
- If and when appropriate, make recommendations for action (albeit that immediate action to improve service or professional shortcomings need not await the outcome of a formal review);
- Consider how any findings, recommended actions and learning will be implemented;
- Address the requirement to be accountable, both at the level of the agency/agencies and the occupational groups involved;
- Increase public confidence in public services, providing a level of assurance about how those services acted in relation to a significant case about a child; and
- Identify national implications (where appropriate) including good practice.

This national guidance supports the achievement of these objectives by helping those responsible for reviews to:

- Undertake them at a level which is necessary, reasonable and proportionate;
- Adopt a consistent, transparent and structured approach;
- Identify the skills, experience and knowledge that are needed for the review process and consider how these might be obtained;
- Address the needs of the many different people and agencies who may have a legitimate interest in the process and its outcome; and
- Take account of the evidence base.

It sets out:

- The criteria for identifying whether a case is significant;
- The procedure for undertaking an initial case review (ICR);
- The process for conducting a significant case review including reporting mechanisms and dissemination of learning; and

- Tools to support the process of conducting an ICR and an SCR.

This guidance builds on the recommendations of the short life working group of June 2010, supports the refreshed National Child Protection Guidance Scotland 2014 and is informed by research evidence.[1] It seeks to support consistency of approach nationally and improve the dissemination and application of learning both locally and nationally.

The assumption throughout this guidance is that the Child Protection Committee (CPC) should proceed as speedily as feasible at all stages of an ICR and SCR, and that agencies should do the same. This is important in reducing stress on the child (if they are still living); their family or carers; and on the staff involved. However, the complexity or circumstances of certain cases may result in preferred timescales not being met.

Definition of a child

For the purpose of this document a child is generally a person under the age of 18 but a comprehensive definition is provided in the National Guidance for Child Protection in Scotland (Part One)

The significant case review process in Scotland

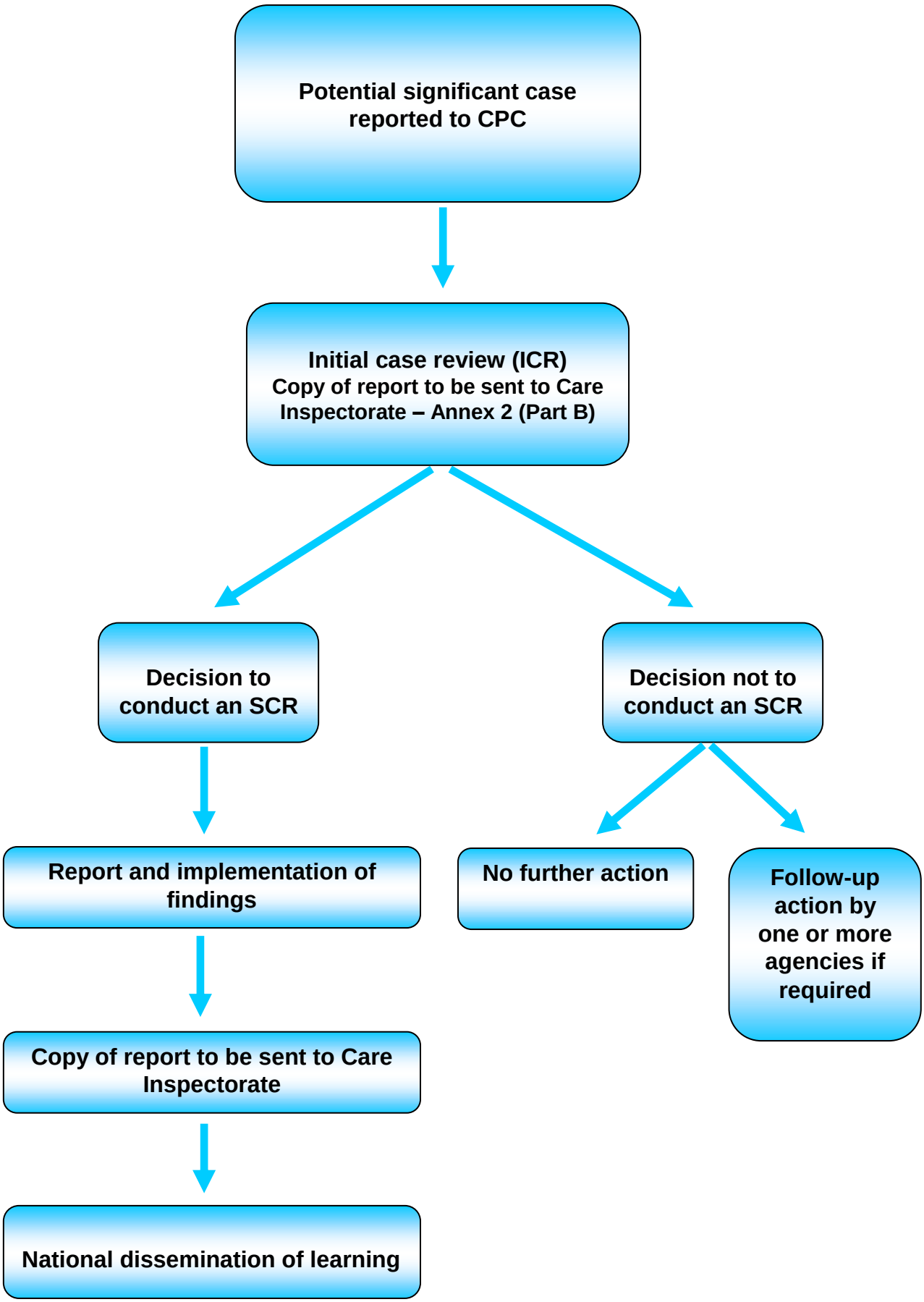
Any agency can ask for a case to be considered for review by a CPC but a family cannot ask for a review. Concerns raised by families should be addressed through relevant agencies' normal complaints procedures. CPCs are responsible for establishing the local arrangements needed to consider a potential significant case for review. This may include devolving some areas of responsibility to specific groups to take forward. Further information on family involvement in SCRs is available at http://www.baspcan.org.uk/report.php.

The review process in Scotland is summarised in Figure 1 below and explained throughout this guidance.

[1] Vincent and Petch 2012; Vincent 2010) and other parts of the UK (Brandon et al 2010; Brandon et al 2008; Brandon et al 2002; Sidebotham et al 2010; Devaney et al 2013; Care and Social Services Inspectorate Wales 2009

Figure 1

Overview of the case review process



Criteria for establishing whether a case is significant

A significant case need not be about just one significant incident. In some cases, for example, neglect, concerns may be cumulative.

Criteria

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[2];
- The death is by alleged murder, culpable homicide, reckless conduct, or act of violence[3];
- At the time of their death the child was looked after by, or was receiving aftercare or continuing care from, the local authority[4],

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 Scotland[5], ***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.

---

[2] SUDI toolkit - http://www.sudiscotland.org.uk/index.aspx

[3] The Children (Scotland) Act 1995: 'A local authority shall – (a) safeguard and promote the welfare of children in their area who are in need'

[4] 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 of the Children (Scotland) Act 1995 will be 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 comes into force. Notifying the death of a person being provided with continuing care will be a statutory of the local authority under section 26A(10) of the 1995 Act when section 67 of the 2014 Act comes into force. This guidance on significant case reviews does not replace each of these statutory notification duties. Every effort should be made to avoid duplication of the two processes (i.e. the notification of the death and the review of it) in each of these cases, only one of which (the notification of the death) has a legal basis.

[5] National Guidance for Child Protection in Scotland – Scottish Government – May 2014

Initial case review (ICR)

The CPC may not immediately appreciate that a case is significant. An Initial Case Review (ICR) is, therefore, an opportunity for the CPC to consider relevant information, determine the course of action and recommend whether an SCR or other response is required. The ICR process is summarised in the box below. An ICR should not be escalated beyond what is proportionate, taking account of the severity and complexity of the case and the process and its timescales, should not detract from agencies taking whatever urgent action is required to protect any other children and young people who may be at risk. Findings from the Audit and Analysis of Significant Case Reviews indicate that an ICR should always be undertaken.[6]

CPCs should develop their own local operating protocol for handling ICRs. This should identify who has delegated authority to accept the initial notification, instruct any further information-gathering and make a decision on whether to proceed to an SCR. Each local ICR operating protocol should be agreed with the Chief Officers Group. It should firmly reflect this guidance but retain sufficient flexibility to suit local structures.

Where time limits are referred to it is important that they are adhered to. If there is good reason for delay, the report should record the reason for that delay.

Summary of the ICR process

Step 1: Potential significant case notified to CPC as soon as practicable after the event or when a series of events suggests an SCR may be appropriate.

The initial case review notification form should be used (**Annex 1**): This includes:

- A statement about the current position of the child, and, if they are alive, what actions have been or will be taken on their behalf;
- A brief description of the case and the basis for referral;
- Any other formal proceedings underway;
- A summary of agency/professional involvement; and
- Lead contacts for each agency;

When complete, the initial case review notification form should be passed to the CPC coordinator or nominated person who notifies all agencies or individuals involved with the child using the ICR report template (**Annex 2**).

[6] Vincent S; Petch A.(2012) Audit and Analysis of Significant Case Reviews, Edinburgh: Scottish Government

Step 2: Agencies gather information and submit a report(s) to the CPC or mandated sub group as soon as possible but no longer than 14 calendar days using the ICR Report template (Annex 2, Part A). The information gathering process should include:

- A summary of involvement including background;
- An outline of known key issues;
- Any identified elements of emerging practice;
- Any identified areas for improvement;
- Any particular sensitivities (for example, from the Crown Office and Procurator Fiscal Service (COPFS), Police, Scottish Children's Reporter Administration (SCRA) or any other agency, about cases where there are ongoing, or likely to be, criminal proceedings, Fatal Accident Inquiry (FAI), Sudden Unexpected Death in Infancy Review (SUDI), Scottish Children's Reporter Administration (SCRA) or disciplinary proceedings).

If agencies cannot reasonably complete the ICR Report for the CPC within the suggested times, the reasons for this should be recorded.

Step 3: The CPC or mandated sub group meets to consider the information as soon as possible. Within 28 days of the ICR being agreed, the CPC or mandated sub group, convenes to consider agency/service information. Having a considered chronology and a timeline for this stage can help with decision making and identifying information gaps. The output of the meeting will be either:

- Further information required to enable a recommendation – set timescale for completion and supplementary meeting; or
- Sufficient information available to enable recommendation to progress to SCR or not (recording rationale).

Step 4: CPC or mandated sub group decide whether or not to proceed to a significant case review (SCR):

- An SCR should only be undertaken when the 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 and young people and their family. If there is no clear consensus within the CPC as to whether or not to progress to an SCR, the final decision rests with the CPC Chair.
- The CPC may decide that no SCR is needed but follow-up action by one or more agencies is required. This may be the case if, for example, there has been a misunderstanding of guidance, or if local protocols need to be reinforced. The CPC may want to draw appropriate guidance to staff's attention or review training or protocols on a particular theme. They may also decide to initiate local action to rectify an immediate issue or to undertake single agency action. Follow-up action should be agreed and scheduled into the CPC's future work programme.
- Where the CPC is satisfied there are no concerns and there is no scope for significant corporate/multi-agency learning or it is clear that appropriate action has already been taken they may decide to take no further action.

Step 5: Ratification of decision
The CPC should report the outcome of an ICR to the Chief Officers Group for full ratification.

Step 6: Notification and recording of decisions
All decisions (including no further action) and the reasons for these decisions should be recorded by the CPC in a report, using the headings in Annex 2 and a record of decision making.

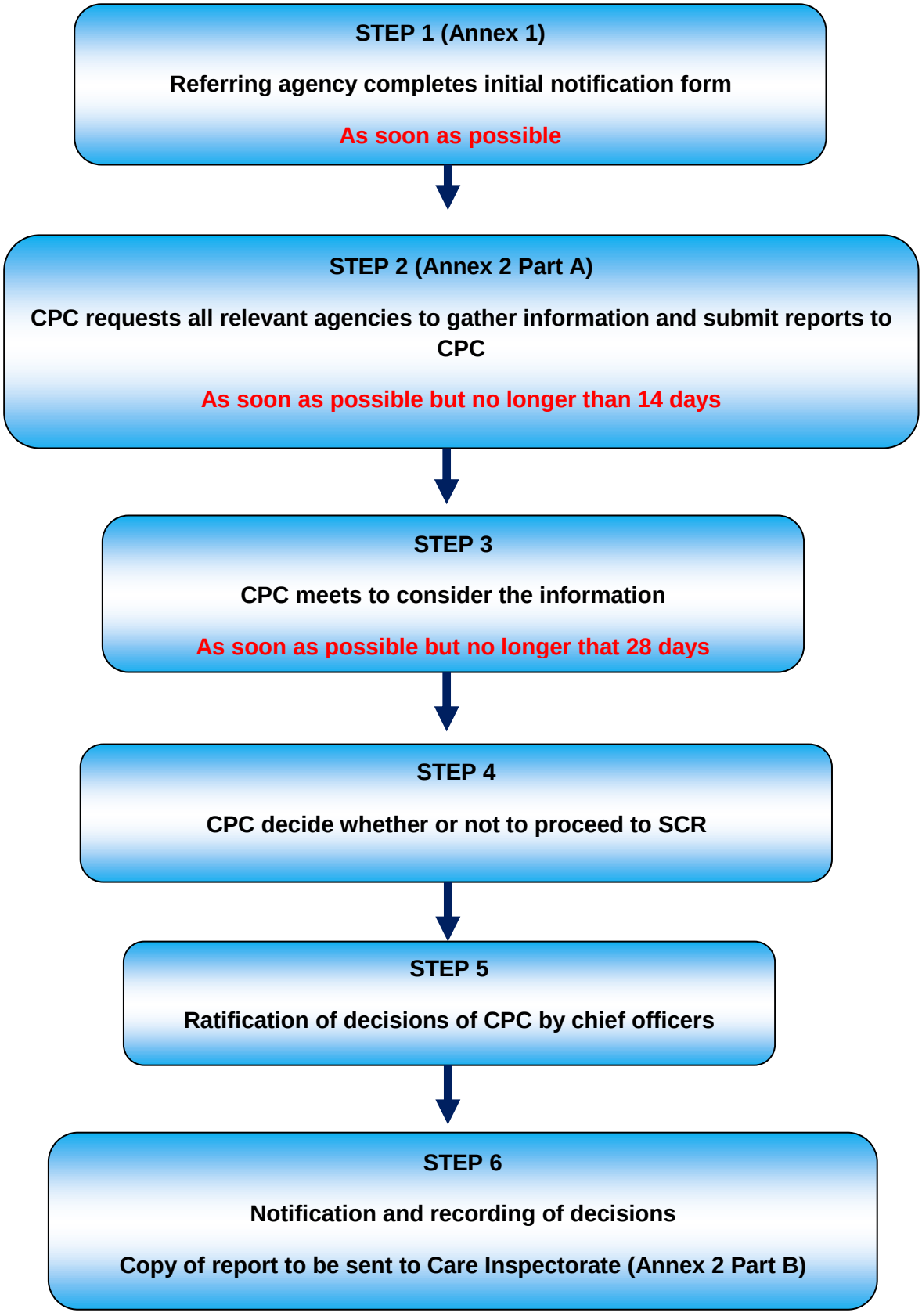
Each CPC should maintain a register of all potentially significant cases referred to it. This allows for evidencing the decisions made; monitoring the progress of the reviews; monitoring and reviewing the implementation of recommendations; and identifying contextual trends (such as prevalence of substance misuse).

A written record of the decision (Annex 2, part B) should be sent to all agencies directly involved with the child and recorded in the child's case files and the case files of relevant adults. If a decision is made to proceed to an SCR, the CPC should advise the child/young person and/or family/carers of the CPC's intentions. See section on Family/Carers page 19 and Annex 7.

Notification should be sent to the Care Inspectorate, using part B of the initial case review report (Annex 2) and, if appropriate, for parallel processes to other relevant parties (for example, Crown Office and Procurator Fiscal Service (COPFS). The Care Inspectorate's role is to collate information about the relationship between initial case reviews and significant case reviews, in order to understand more about the rationales being applied across the country in determining whether SCRs are carried out.

Figure 2

Initial case review process flowchart



Purpose of the significant case review (SCR)

A significant case review should seek to:

- Establish the full circumstances of the death/serious harm of the child (where parallel processes like a criminal investigation are in place, it may not be possible to gather and report full information);
- Examine and assess the role of all relevant services, relating both to the child and also, as appropriate, to parents/carers or others who may be connected to the incident or events which led to the need for the review;
- Explore any key practice issues and why they might have arisen;
- Establish whether there are lessons to be learned from the case, or good practice to be shared, about the way in which agencies work individually and collectively to protect children and young people;
- Identify areas for development, how they are to be acted on and what is expected to change as a result;
- Consider whether there are gaps in the system and whether services should be reviewed or developed to address those gaps; and
- establish findings which will allow the CPC to consider what recommendations need to be made to improve the quality of services.

Good practice principles

SCRs should:

- Be objective and transparent
- Have a clear remit
- Be completed to set timescales
- Be sensitive to parallel processes
- Be sensitive to the needs and circumstances of children and young people and families
- Be sensitive to the needs of staff
- Deliver clear recommendations/findings to support the CPC to improve outcomes
- Not be escalated beyond what is proportionate taking account of the severity and complexity of the case
- Evidence accountability and assist the CPC/Chief Officers to promote public confidence in the rigour of the process and services to children and young people in their local area.

Governance of significant case reviews

Governance

Chief Officers must ensure that their Child Protection Committees are properly constituted and resourced so that arrangements are clearly focused and relevant to all members of the committee itself. This also applies to any sub-committees and partner agencies, and to the wider public. Child Protection Committees must work within the wider planning framework so that their work is fully integrated with other planning forums and is as effective as possible.

Chief Officers ensure that the chair and vice chair fully understand their specific role, responsibilities and remit, and that they have an in-depth knowledge of child protection. Chief Officers will have agreed their working arrangements, terms of office and reporting and accountability arrangements.

Each Child Protection Committee will have approved procedures for managing referrals to the Chair and/or committee in terms of a possible SCR, taking decisions about the appropriateness of the referral and how it should then proceed, and also for commissioning an SCR.

Some CPCs may have an established group whose role is to oversee on behalf of the CPC matters relating to SCRs. Where there is an established group, local arrangements should outline the key roles and responsibilities of the group. Key agency representatives should be identified to attend the group meetings. In this guidance a reference to CPC could be a reference to such a group where local delegation allows.

The CPC should seek to inform all those who will input and who have a legitimate interest in the SCR at each stage of the process. As each significant case will be different, the names and roles of those with an interest might vary. Throughout the process, the CPC should consider whether there is anyone else who should be informed, or how much information should be offered to different parties on the SCR. It is important to be clear who needs to be aware of the review, what information they need, and when and how this will be provided. Each CPC should agree with local agencies who their contact points should be and their role in the process. Everyone should be clear about whether they have been contacted ‘for information’ or for decision making.

CPCs will wish to consider carefully who should lead the review in light of the particular case. This is explained more fully on page 15.

During the course of an SCR any evidence of criminal acts or civil negligence relating to the case which comes to the attention of the lead reviewer or review team should be reported to the CPC Chair.

Considerations to be made by CPC following a decision that an SCR is appropriate

Methodology

CPCs should always consider and agree the methodology to be used in undertaking the SCR. Evidence-based methodologies to consider are:

Systems approaches

A systems approach focuses on learning about how local professionals and organisations work together, in order to improve inter-agency working and better safeguard and promote the welfare of children and young people. The model has been adapted from the systems approach used in other high-risk areas of work and supports analysis that goes beyond identifying what happened to explain why it did so. The central idea of the systems approach is that any worker's performance is a result of their own skill and knowledge and the organisational setting in which they are working.

The SCIE Learning Together model

The Social Care Institute for Excellence (SCIE) Learning Together[7] approach has been designed specifically to be relevant to cases involving multi-agency working by

- using systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture
- building internal capacity by having staff trained and accredited in the Learning Together approach to reviewing
- undertaking rigorous case reviews and audits using a core set of principles and analytical tools
- accessing a pool of accredited independent reviewers as required
- building on the experience and findings of previous reviews as part of the Learning Together community.

For those conducting an SCR using this methodology, there will be no specific recommendations. Instead, the CPC will have findings and issues to consider.

The Learning Together[8] model was developed by SCIE, based on evidence from research literature and investigation methods used in engineering, health and social care.

---

[7] Learning together to safeguard children: developing a multi-agency systems approach for case reviews: Fish, Munro, Bairstow; 2009

A SCIE training programme familiarises reviewers with the Learning Together process and analytic tools. An accreditation process for lead reviewers assures basic competence. Thereafter, lead reviewer expertise is supported through supervision and regular participation in the Learning Together community of practice.

The model has three key principles:

1. Avoid hindsight bias by understanding how the case unfolded from the viewpoint of those involved. This is done by reviewers being open-minded and empathetic and having no preconceived assessment of the case beforehand. The source of information, or data, comes primarily from conversations with the practitioners and family involved and details are supported from documented evidence. The information is collated into a narrative reconstruction of events as they took place using the perceptions and understanding of people who were there at the time. Although the events taken together run chronologically this is very different from a dated chronology taken from case records alone. It forms the local 'rationality'.

2. Provide adequate explanations by appraising practice and explaining decisions and actions taken. This is done by using a specific analytical tool, called 'key practice episodes' (KPE) that helps us understand and explain why the case unfolded as it did. It gives an explicit appraisal of practice, from the perspective of what was known or knowable at the time and identifies the various factors that may have contributed to that. It is a process that holds people to account for their professional responsibilities but which can also point to the kind of things that make those responsibilities very difficult to carry out at times.

3. Move from individual instance to general significance. This allows the case to provide a 'window on the system' (Vincent 2004)[9] and tease out issues that replicate more widely rather than just being relevant to a single case. This includes the opportunity to expose those hard-to-articulate practices such as cultures and values within organisations that impact on effective working. These are written as evidenced 'findings', which then give rise to issues for the CPC to consider.

The review process aims to include the views of the case group (practitioners directly involved in the case) and the review team (members include managers from the relevant agencies), as well as family members. The model also includes the role of a champion who ensures open communication lines between the CPC and the review process. This role is commonly taken by the lead officer if they are not part of the review team.
(See SCIE website for more information on the detail of the review process and illustrations of how practitioners at different levels are included)[10].

---

[8] http://www.scie.org.uk/myscie/login

[9] Vincent, C. (2004) "Analysis of clinical incidents: a window on the system not a search for root causes." Quality and Safety in Health Care 13: 242-243.

[10] http://www.scie.org.uk/myscie/login

Root Cause Analysis

Root Cause Analysis (RCA) techniques are used to understand the underlying causes of incidents rather than identifying individual failure. Based on human error theory[11], the RCA model has been adapted for use in health and social care settings. It takes into account the active failures of frontline staff to follow a prescribed course of action and also considers latent failures, well-intentioned but in hindsight faulty management decisions by senior management, and contributory factors such as staff shortages, poor communication, busy work environment, emotional state of staff member, education and training. As such, this is a system-based approach which seeks not only to clarify the direct actions leading to the accident or incident but the contribution made by the wider organisational context.

Identify who undertakes the review

The CPC will need to consider whether an SCR should be led internally or externally or with some external overview. CPCs need to ensure that the lead reviewer and the review team, between them, have the necessary skills and competencies to undertake an SCR. These skills will differ according to the circumstances of each case and the agreed role of the review team. **Annex 3** provides a 'person specification' list for a lead reviewer.

The CPC may decide to appoint an **internal lead reviewer** if the circumstances of the case, based on the evidence of the ICR, suggest that any recommendations are likely to have mainly local impact. In the case of an internal review the team would probably be drawn mainly from within the CPC's members but CPCs should always consider using external expertise for part of the process in the form of a consultant, professional advisor or critical friend[12] – a trusted, impartial person whose functions can include reviewing data, providing guidance or challenge and critiquing an individual's work.

The CPC may decide to commission an **external lead reviewer** if:

- There are likely to be national as well as local recommendations;
- Local recommendations are likely to be multi-agency rather than single agency;
- The case is high profile, or is likely to attract media attention;
- Elected members, NHS Board members and MSPs have voiced their concerns;
- The child's family/carers or significant adults have expressed concerns about the actions of the agencies.

[11] Human Error: James Reason: Cambridge University Press: 1990

[12] Critical friends can be accessed through WithScotland – http://withscotland.org/

Where an external review is commissioned, the SCR continues to be owned by the CPC. The Chief Officers Group/CPC should agree any formal contractual arrangements that may be required, along with appropriate legal advice. They should consider which agencies will enter into the contract and ensure that individuals have professional indemnity cover. Consideration should be given to involving legal services in drawing up formal contracts covering areas like timescales, fees and confidentiality.

Any contract should also include explicit instructions on the access to, storage of, transport of, transmission of, and disposal of sensitive personal information as required by the Data Protection Act. For the purpose of the SCR, the lead reviewer is a data processor, not a data controller and will not need to be registered with the Information Commissioner's Office (ICO). This is because they are acting on the instructions of the CPC, representing the Chief Officer Group. There is further information on the role and responsibilities of a Data Processor in ICO guidance[13]. The ICO Data Sharing Code of Practice[14] details the circumstances where a data sharing agreement or contract may be required. This will be of particular relevance where there are a number of agencies inputting to the SCR.

Regardless of whether the lead reviewer is internal or external, the CPC will wish to set out clear expectations in respect of timescales, milestones in the process and deadlines for completion of reports.

The CPC should notify the Chief Officers Group and all agencies involved in the case that there will be an SCR and that fact should be recorded on the case record and the cases of relevant adults.

Chronology

The CPC will wish to ensure that a multi-agency chronology of significant events and contacts is prepared (this may already have been prepared as part of the ICR process). The chronology should be circulated to agencies and professionals to check for accuracy. GIRFEC practice briefing 8[15] contains a useful example of a chronology template.

Remit

Depending on the comprehensiveness of the information gathered at the ICR stage it may be possible for the CPC to agree the remit of the full SCR at the initial meeting or immediately afterward. If there are areas that need further clarification the CPC may ask agencies to undertake particular tasks and report back within an agreed timeframe.

---

[13] Data controllers and data processors: what the difference is and what the governance implications are – Information Commissioners Office

[14] Data Sharing Code of Practice – Information Commissioners Office

[15] GIRFEC Briefings for practitioners – Scottish Government – August 2012

In the case of an externally-led review the remit and the key question(s) should be agreed in writing by the chair of the CPC and the external lead reviewer. Regardless of who leads the review, the remit should be agreed by the chief officers.

The clearer the remit the easier it will be to manage people's expectations about the outcomes of the SCR. This applies both to those involved in contributing to the SCR, and to the wider audience. The degree of complexity and the question of who to involve might not become clear until some initial work has been undertaken, especially in the case of an external SCR. Consequently, the remit may need to be reviewed at a later stage. If changes are made, they should be agreed and appropriately documented by the CPC.

The remit should include a deadline for production of reports, taking account of the circumstances and context of the case. Where deadlines have to be extended, for example in circumstances where other proceedings intervene, this should be recorded and a new deadline agreed by the CPC.

The lead reviewer (internal or external) must be briefed by the Chair of the CPC (or person with designated responsibility). The lead reviewer must be given access to the initial reports prepared by agencies for the ICR, to help them identify which agencies need to come to the initial SCR meetings.

The written remit of the review should:

- Be agreed by the CPC. This can be reviewed throughout the SCR process but any changes should be agreed by the CPC and documented;
- Clarify roles and responsibilities across agencies;
- Set the time frame the review will cover; and
- Be clear and deliverable.

Annex 4 gives an example of a remit document which CPCs. It can be adapted to fit with local arrangements and the specific case being considered.

The review team

It is important to establish a team to support the lead reviewer so that agencies feel confident their specialist issues are understood. The CPC should ensure there is sufficient multi-agency representation on the review team in order to reflect the particular case. A review team's different perspectives can add to the depth of enquiry. Training or information requirements for the team should be considered.

The team should be agreed at the outset and agreement reached as to roles and responsibilities, who should undertake tasks such as file reading and interviews, and how disputes will be resolved. No one should be involved in a review team if they were directly involved in the case in a professional capacity.

For any review team, it is important to establish whom the key contacts are in all the agencies involved. These could be designated SCR contacts who can also advise on, and broker access to, relevant practitioners and information. Additionally, they

should be able to provide any relevant agency information (such as protocols/guidance) and generally act as a liaison point. In addition, consideration should be given to who will make links with relevant interests outside the main statutory agencies. The team will also need to gather relevant evidence from a wide variety of sources and be prepared to negotiate if information is not forthcoming.

Consideration should be given to the skills required in the review team. This will vary according to the case and agreed responsibilities of the team but CPCs, or mandated sub groups, will wish to consider ensuring that the review team has the following skills:

- A broad knowledge of children's services;
- Investigation skills;
- Analytical and evaluation skills;
- Ability to make sound judgements on information collected;
- Ability to critically analyse all factors that contributed to the significant case and the wider impacts for practice and service delivery where appropriate;
- Ability to liaise with others and establish a good working relationship;
- Ability to demonstrate sensitivity to national and local level issues; and
- Appreciation of the need to be clear about the difference between an SCR's remit and task as opposed to other ongoing proceedings relating to the case (for example, a criminal investigation).

A review may reveal staff actions or inactions which are of sufficient seriousness that they need to be brought to the attention of the employer. The review team has a duty to do this, irrespective of the SCR process.

Resources

The National Child Protection Guidance for Scotland (2014) says that Chief Officers have a collective responsibility to ensure their CPC has the resources, including staff time and finances, to fulfil its roles and responsibilities. Conducting an SCR falls within this area of responsibility. Chief officers should, therefore, agree how the review team will be financed and how its expenditure will be managed.

Administrative support should also be agreed, as should practicalities such as accommodation, secure storage of any records shared, and secure access to electronic records.

The report

It is important that there is a degree of consistency in the structure and content of SCR reports to make it easier for people to identify and use the findings, and for read-across to other reports to be made. The report should, therefore, include the areas outlined in **Annex 5**.

CPCs will wish to consider arrangements for correcting factual errors or misunderstandings in drafts of the report.

The lead reviewer will present the final report (and executive summary) to the SCR review team before it is sent to the CPC chair for consideration by the CPC. This includes both internally- and externally-commissioned reports. The CPC should deliver the report to the Chief Officers Group. The CPC may ask the lead reviewer to present the report at the Chief Officers/CPC meetings.

Freedom of information and data protection

The CPC should ensure that the review team and lead reviewer take account of the requirements of the Freedom of Information (Scotland) Act 2002 and the Data Protection Act 1998 in both the conduct and reporting of the review. The Scottish Information Commissioner's decisions[16][17] in relation to the release of SCRs also highlight issues for consideration. **Annex 6** contains an extract from an SCR which may be helpful in considering the report structure and content in respect of the Data Protection Act 1998. However, the circumstances of each case will be different and particular consideration should be given to the requirements of the Data Protection Act 1998 on each occasion. Arrangements should be put in place for secure storage and filing of confidential information and files. These arrangements should also include retention schedules and processes for destruction of the information when it is no longer necessary to hold. These details can be included in data sharing agreements. NHS will wish to seek Caldicott approval in respect of access to any patient files where this is required by the lead reviewer as part of the review process.

Involvement of the child/young person/family/carers

The family/carers of the child or young person should be kept informed of the various stages of the review as well as the outcomes where appropriate. There will be occasions where the child/young person/family/carers could be subject to investigation or have otherwise triggered the SCR. In these cases, information may need to be restricted. Close collaboration with Police Scotland, the Procurator Fiscal, and possibly SCRA will be vital.

[16] Significant Case Review Decision 241/2014 – Scottish Information Commissioner – November 2014

[17] Significant Case Review Decision 237/2014 – Scottish Information Commissioner – November 2014

There may also be cases where families are considering taking legal action against an agency or agencies that are the subject of the SCR. Individual agencies' complaints procedures should be made available to the family at the outset of their involvement with the family, and throughout any SCR investigation, as deemed necessary and appropriate. This is *not* the responsibility of the CPC or of the review team.

Every effort should be made to involve children/young people/families/carers. SCR reports should say whether or not the child or young person and families/carers were informed and involved. If not, they should record a reason. If they were involved, reports should record the nature of the involvement and document how their views have been represented. Diversity issues should be considered and adequate support should be provided to ensure that a child or young person, family/carers are able to participate.

Care should be taken about where and when a child/young person, or their family/carers are interviewed, and if any special measures are needed to support this (for example, the use of advocacy or interpreter services, with particular care given to those with impaired communication). In particular if there are, or are likely to be, criminal proceedings or if there is, or likely to be a fatal accident inquiry, the review team must consult with the local COPFS, police and/or SCRA prior to any interviews. Reviewers should be experienced in communicating with children and young people. It may also be useful to assign a member of staff as a single point of contact for the child/young person/family/carer throughout the review. CPCs will wish to consider whether it is preferable for this person not to be involved in the SCR process. The person carrying out this liaison role should be fully aware of the sensitivities and background of the case. This person's role could include advising the family of the intention to carry out an SCR and making arrangements to interview the child, family/carers or significant adults involved. Any briefing would normally be an oral discussion.

Depending on the particular case and sensitivities, consideration should be given to arrangements for feedback to the family. This may also include what how they can input to check the accuracy of what is recorded in the interim and/or final report.

Support for staff involved in a review

During the review process staff who have been involved in the case should feel informed and supported by their managers. There may be parallel processes running (such as disciplinary proceedings) as well as the SCR so sensitive handling is important.

Each organisation should have its own procedures in place for supporting staff, but the following should always be considered:

- The health and wellbeing of staff involved;
- Provision of welfare or counselling support;
- Communications with staff and keeping people informed of the process in an open and transparent way;

- Access to legal/professional guidance and support; and
- Time to prepare for interviews and for follow up.

Staff involved in a review should be given this guidance, together with a copy of the local operational protocols in their CPC area. CPCs should consider what mechanism will be used to enable contributors to check the accuracy of what is recorded as it is drafted for the interim and/or final report. When the review is complete, staff involved in the case should be debriefed before the report and findings are published.

Dissemination and publication

For each individual SCR, the CPC – in conjunction with the Chief Officers – should have a dissemination strategy that best serves the public interest and the purpose of improving service delivery. The following points should be considered, depending on the content of the SCR:

Dissemination

- CPCs should agree timing of a local dissemination which involves all agencies and which ensures the spread of any identified good practice as well as learning, particularly to front-line practitioners.
- In order to promote national learning, the findings and recommendations from all SCRs should be shared among CPCs. This should include any good practice identified and should be facilitated through the meeting of the Scottish Child Protection Committee Chairs Forum (SCPCCF) or by specially convened meetings or seminars. SCPCCF should consider what and how recommendations are taken forward at a national level.
- SCRs which include a specific recommendation with national implications should be shared with the relevant organisation and with the Scottish Government
- The Care Inspectorate, on behalf of the Scottish Government, acts as a central collation point for all SCRs carried out by CPCs in Scotland from 1 April 2012. The purpose will be to report regularly on key themes to help all CPCs improve local practices and to support their continuous improvement agenda. This work will include reporting on aspects of good practice and areas for improvement worthy of dissemination nationally.

Publication

- It is for the CPC (with chief officers' approval) to decide whether to publish the full report or just the executive summary. Influencing this decision will be considerations about the need to restore public confidence, protections within the Data Protection Act 1998, sensitivities and balancing interests in terms of the right to respect private and family life detailed in Article 8 of the European Convention on Human Rights. If, for example, the report contains identifiable personal information this should be anonymised before publication. Where the full report is not being published the summary should explain any redactions that have been made. See **Annex 4** for an example, and also the section on Freedom of Information and Data Protection.

- The CPC's first responsibility is to report to the chief officers group. But the CPC must also consider the wider reporting requirements and distribution of the report/executive summary. A list of potential organisations and people to whom the report/executive summary can also be sent to is at **Annex 7** but it is always for the CPC, in consultation with the chief officers group, to decide this in each individual case.
- It is imperative that the child's right to privacy and the child's right to be protected are at the forefront of all decisions and communication relating to publication of a SCR report.
- Family/carers and/or other significant adults in the child's life should get a copy of any report in advance of publication except if they are subject to any criminal proceedings in respect of the case.
- Publication of the report may need to be delayed until the conclusion of criminal or FAI proceedings. Where criminal, FAI or children's hearings proceedings are ongoing the publication of any report should always be discussed with COPFS and/or SCRA.

  Other considerations include:

- Whether an oral briefing for relevant parties in advance of publication is required. This is particularly the case where there is likely to be interest in the case amongst the wider public and may avoid misrepresentation.
- How publishing the SCR report will provide evidence of learning.
- How the findings of the SCR report sit within the wider context of children's services.
- Whether all parties have been informed and their views taken into account (child, family and staff).
- Liaison with COPFS/police/SCRA where criminal proceedings have taken, or are taking, place.
- Whether staff integrity has been respected and duty of care considered.

Media handling

The media can help promote more effective prevention and intervention to protect children and young people by raising public awareness about what can cause harm, and what members of the community can do to mitigate risks.

Any agreed communications strategy should include a media-handling plan. Most agencies will have communications officers for the agency and any protocols/handling issues should be developed in conjunction with them. Before the report is made public, the review team should:

- agree who will link with the media on behalf of chief officers/CPC;
- brief the relevant communications officer(s); and
- approve the wording of any quotes.

No information about an SCR should be released to the media unless it has been approved by chief officers/CPC.

Communication with the media should focus on learning, and point out that the majority of children and young people are protected. It is important not to add to any sense of alarm or confusion and CPCs should proactively offer interviews to the media where this supports their strategic objectives (for example, raising awareness of the process of SCRs or about the role of CPCs).

Once an SCR report is published and in the public domain where possible a high-level spokesperson should respond to media requests.

The significant case review and the learning cycle

The Care Inspectorate will carry out a retrospective review of relevant reports from significant case reviews completed between 1 April 2012 and 31 March 2015. The Care Inspectorate will publish guidance about this.

The CPC should consider how the analysis and recommendations from an SCR can best inform learning and practice. Types of learning that can be shared, exchanged or disseminated from significant case reviews include:

1. Learning about undertaking a review – What are the key challenges? How have CPCs overcome these? What changes or provisions could be made to support this process?

2. Learning from the analysis and recommendations produced during the course of the review – What issues are evident in the documentation of the case? What challenges for practice are evident? What recommendations were made and why?

3. Learning relating to the follow-through and implementation of the recommendations from a review – How are single and multi-agency recommendations implemented? How is this measured and monitored – have they been fulfilled and have they made an impact on practice (outcomes for children)? What are the enablers and barriers to facilitating this process?

Capturing learning in relation to the process, output and follow-through of conducting significant case reviews could be achieved in different ways:

Aspect	*Approaches to capturing the learning*
Process	Internal/external quality assurance to appraise the process Practice exchange/communities of expertise to share experiences, perspectives and skills Research to critically appraise/analyse the strengths and limitations of arrangements used by CPCs
Output	Research role – critical appraisal/analysis of the narrative (analyses) contained in the report and the recommendations made to draw out messages for practice, policy and research
Follow through	Internal/external quality assurance to appraise the process Practice exchange/communities of expertise to share experiences, perspectives and skills

The CPC should produce a summary of cases they have considered over the course of the year and introduce these into the learning cycle, whether the decision was to undertake an SCR or not. CPCs will determine the urgency for action planning and implementation within the learning cycle according to the significance of the issues raised.

In light of the findings and recommendations from some SCRs CPCs may need to review their own guidance and procedures. This could be done through the quarterly CPC chairs forum meetings or, if more urgent, by specially convened meetings.

Some recommendations may be for consideration at national level and will need to be led by the Scottish Government. Some may have implications for a range of bodies, for example, universities and colleges, or scrutiny and regulatory bodies such as the Scottish Social Services Council.

SCRs are one source of information that can contribute to a multi-agency agenda for learning as well as for practice and policy development. Other sources include the information generated through research and evaluation, joint self-evaluation[18] using, if appropriate, quality indicator frameworks, inspection and audit and organisational knowledge (in other words, the understanding and awareness that exists among the staff in different organisations). Together, these can point to critical issues for practice. Each also represents an opportunity to identify good practice that can be shared.

Learning from effective practice rather than learning from mistakes is another approach. However, learning from what works, for whom and in what circumstances may require a shift in emphasis on learning lessons from what has gone wrong. Hammond (1996) sums up the reasoning behind this approach: 'The traditional approach is to look for a problem, do a diagnosis and find a solution. Since we look for problems we find them. By paying attention to problems we emphasise and amplify them.' (Hammond 1996, pp 6-7.)

Evidence suggests that one method of learning from success is through 'appreciative inquiry'. This is a way of learning and building on existing good practice and is undertaken in a positive environment of collaboration. It is a facilitated approach undertaken with a range of staff. It identifies the essential elements of best practice and explores ways of using this knowledge to make improvements. This is achieved by exploring essential features of participants' experience of existing best practice, collectively developing a shared vision of the most desirable practice for the future and working together to develop, design and create this practice.

[18] How well do we protect children and meet their needs?; HMIe, 2009, and;
How well are we improving the lives of children and young people? – Care Inspectorate – September 2014

Significant case review and the wider context

There are a number of other processes, including SCRs under multi-agency public protection arrangements (MAPPA) and adult support and protection, that could be running in parallel with an SCR. This raises a number of issues, including:

- The relationship of the SCR with other processes, such as criminal proceedings or SCRA proceedings;
- Securing co-operation from all agencies, including relevant voluntary sector interests in relation to the release and sharing of information;
- Minimising duplication; and
- Ensuring a sufficient degree of rigour, transparency and objectivity.

Depending on the case, a number of processes could be driven by considerations wider than service failure or learning lessons across agencies. These can include a criminal investigation, report of death to PF, an FAI, and a review into the death of a looked after child. Further details of these processes are at **Annex 8.** These processes may impact on whether a review can be easily progressed or concluded – criminal investigations always have primacy. To help establish what status an SCR (including the ICR) should have relative to other formal investigations there should be ongoing dialogue with Police Scotland, COPFS, SCRA or others to determine how far and fast the SCR process can proceed in certain cases. Good local liaison arrangements are important. Issues to be considered include how to:

- Link processes;
- Avoid witness contamination;
- Avoid duplicate information being collected; and
- Decide whether to postpone an SCR if a parallel process is running, and wait for the determination of the parallel proceedings. **Annex 9** contains the national protocol for the Police Service of Scotland, COPFS, and CPCs to help with liaison and the exchange of information when there are simultaneous SCRs and criminal proceedings, an FAI or investigations that may result in further proceedings

Regardless of whether, or when, an SCR takes place, it is important that any obvious areas for improvement of practice are addressed as soon as possible. Following the death of a child or the identification of serious concerns about to a child, agencies should assess the circumstances of the case to identify if any immediate actions need to be taken. If action is required, it should be proportionate and taken at local level as far as possible.

Sometimes, if there are complex, interconnected events, a joined up SCR should be considered. For example, in the case of 16/17 year olds who are being considered under adult support and protection, CPCs will want to liaise closely with Adult Protection Committees (APCs) to determine if the criteria for an SCR have been met under this guidance, and whether a joint SCR is required.

Interdependencies

A potentially complex set of activities may be triggered by a significant case – most likely, the death of a child. It is important that local services do not interfere with, or contaminate that activity. This is vital in relation to evidence gathering where there is, or there is the potential for, a criminal investigation, whether of staff or a third party. The key requirement is to maintain good local ongoing dialogue with the COPFS and/or Police Scotland to ascertain where they are in their considerations and agree what can be progressed in the SCR. Efforts should be made to minimise duplication and ensure, as far as is practicable, that the various processes are complementary even if their purpose is somewhat different. These inter-related processes are less likely to take place if a significant case does not involve a death.

In *Protecting Children and Young People: Child Protection Committees* [19], COPFS recognised the importance of child protection and encouraged the involvement of COPFS with CPCs – especially in relation to investigations and proceedings on the death of a child. If not already the case, CPCs should seek to ensure they have a named contact in the PF's office who can pursue any ongoing dialogue needed.

There will also be agency-specific work that is routinely undertaken, particularly on the death of a child (for example, when this occurs in hospital or is unexpected such as in the case of sudden unexpected deaths in infancy). Any SCR will need to be co-ordinated to dovetail with such work to avoid duplication of effort and unnecessary further review.

Cross-authority SCRs

In the case of a potential cross-authority SCR the relevant CPCs should agree a way of joint working and, if required, joint commissioning of a lead reviewer. It may be worth considering a lead reviewer who is independent of the CPC areas involved.

Cross border (UK) SCRs

To date, cross border SCRs have been rare. Children, young people and their families/carers do become involved with services across borders. Depending on individual circumstances such cases could be considered for an SCR involving two or more countries.

[19] Protecting Children and Young people: Child Protection Committees, page 16 paragraph 4.8; Scottish Executive February 2005

It is not possible to provide definitive guidance, as each case will be unique. However, building on the experience and learning of those CPCs who have done cross border SCRs the following points are suggested for consideration:

- Early contact with the Local Safeguarding Children Board (LSCB), England and Wales, or Area Child Protection Committee (ACPC), Northern Ireland to identify a link person there and provide that body with a link person within the Child Protection Committee.

- Make available the remit of the SCR and request the LSCB/ACPC remit.

- Enter into a memorandum of understanding or data sharing agreement[20] which should be explicit in its terms about access to records, staff, family members etc.

- Consider having a member of the LSCB/ACPC as a member of the review team for specific meetings and tasks.

- Agree a communication strategy, which should be clear about media handling and what information may be made available in any report. It must be borne in mind that in England and Wales there is a duty to make public every SCR and in Northern Ireland, case management review (CMR) executive summaries are published. As there is no requirement to publish SCRs in Scotland any references to data from Scotland may have to be redacted.

- Consider joint contact with the family (or other significant persons) to make them aware of the cross border nature of the SCR and establish what arrangements will be carried out for feedback.

- In some cases, consideration should be given to the need for specialist information (for example, forced marriage, honour based violence and female genital mutilation).

[20] Data Sharing Code of Practice – Information commissioners Office

Exemplar: Initial case review notification **Annex 1**

<u>OFFICIAL-SENSITIVE-PERSONAL</u> (once completed)

The designated person within any agency should complete this initial case review notification and send it electronically by e-mail to the local CPC lead **as soon as possible and in any case within 7** calendar days of first informing the agreed lead.

The CPC lead, on receipt of the written notification should alert other services/agencies/practitioners who are involved with the child that the case has been reported as a potential SCR. This alert to other services/agencies/ practitioners can be by telephone, e-mail or fax etc. These other services/agencies will then be asked to submit an initial case review report by the CPC lead. The CPC lead will acknowledge all initial case review notification reports.

Child's name/identifier:

Child's date of birth:

Child's gender:

Name of child's parents/carers:

Parent/Carer address if different to child:

Sibling names/DOB/Gender/Address if different:

Child's home address:

Child's current residence:

Child's current legal status:

Is the child's name currently on the child protection register? Are any siblings currently on the child protection register? YES/NO

Has the child's name previously been on the child protection register? Have any siblings previously been on the child protection register? YES/NO

Education establishment details:

Grounds on which the criteria for an SCR may have been met (refer to page 9):

Are there any immediate concerns? If so, what are these and have these been passed to the relevant agency for consideration/action?

What action has been taken?

Are there any general concerns? If so what are these and have they been passed to the relevant agency/service for consideration?

Summary of the case: **Name of service/agency/professionals involved with the child:** **Any other proceedings underway:**

Annex 2

Exemplar: Initial case review report

OFFICIAL-SENSITIVE-PERSONAL (once completed)

PART A

When asked to do so, agencies/services should complete this initial case review report and send it electronically by e-mail to the CPC lead **as soon as possible and in any case within 14 calendar days**.

This report should contain information relevant to the agency/service contact/interaction with the subject or person. Each agency/service will submit details of their own involvement with the subject or person.

All initial case review reports received by the CPC lead will be acknowledged.

Date circulated:
Date to be completed:
Date returned to designated officer:
Author:
Service/agency:

Child's name/identifier:

Child's date of birth:

Child's gender:

Name of child's parents/carers:

Parent/carer address if different to child:

Sibling names/DOB/ Gender/Address if different:

Child's home address:

Child's current residence:

Child's current legal status:

Is the child's name currently on the child protection register? YES/NO

Has the child's name previously been on the child protection register? YES/NO

Have any of the child's siblings names been on the child protection register? YES/NO

Education establishment details:

1. Summary of involvement:
2. Background (include relevant issues such as health, disability, cultural, religious, sexual orientation, LAC status & history, CP registration and history, education history):
3. Outline of key issues including: • Were there strategies and actions to minimise harm? • Was there evidence of Information sharing? • Was there recognition and assessment of risk? • Was timely and effective action taken? • Was there evidence of planning and review? • How good was the record keeping? • Were legal measures used appropriately?
4. Practice issues Please identify known good practice as well as any known areas for improvement.
Any particular sensitivities (for example, from the PF or police about cases where there are likely to be disciplinary proceedings):
5. Recommendation Please highlight any areas which may require further consideration:

PART B – For completion by CPC or mandated sub-group

6. Decisions made and reasons Case Review No: Date of review report:
7. Case review group Options to be considered:

Decisions made: Reasons: Date:
8. Child Protection Committee Date notified of above decision: Note of discussion by Child Protection Committee: Decisions made: Reasons: Date:
9. Chief officers Date notified of above decision: Note of any comments/discussion by chief officers: Decisions made: Date:

Annex 3

Person specification for lead reviewer

The skills and qualities required for the lead reviewer, both internal and external, include:

Leading and directing

- Consider practice experience required for person chairing review – this may differ depending on the particular circumstances of the case
- Responsible for ensuring the required skills and experiences of the Review Team are made available
- Role of body/person setting terms of reference and providing progress reports
- Should have no preconceived views of the case/outcome
- Quality – ability to set out ground rules

Knowledge

- Should have a broad knowledge of protecting children, particularly in a Scottish context.

Analytical skills

- Those chairing/leading reviews must have the ability to interpret and analyse complex multi-agency processes and information.
- Know where, and from whom, to get specific information or expertise
- Logical thinking and ability to map out review process
- Need to understand the context in which services are delivered
- Ability to identify and manage competing interests in an SCR (for example, professional; political, organisation; public, media)

Person qualities

- Those conducting reviews need to be open minded, fair, a good listener and a logical thinker.
- Experience of practice at various levels across an organisation
- A blend of confidence and humility (to be prepared to learn)
- Need to understand professional backgrounds of those involved and be a multi-agency team player

Skills for undertaking the review

- Approachable
- Knowledge of child development and skills in communicating with children and young people
- Risk assessment/management
- Ability to challenge constructively
- Open mindedness/fairness
- Good listener
- Fair person
- Logical thinking
- Emotional intelligence
- The interviewing of significant witnesses takes time and must be undertaken with perseverance and with sensitivity
- Consider practice experience for those undertaking review – this may differ depending on circumstances of the case being reviewed

Annex 4

Examplar: remit

The following example provides a framework for CPCs in the development of a remit for use during an SCR. It includes suggested references to the key areas covered in the section ***Purpose Of The Significant Case Review*** *and can be adapted to fit with local arrangements and the specific case being considered.*

N.B. The SCIE Learning Together[21] *approach does not use terms of reference and instead sets out specific questions for the review team to consider. These questions help focus beyond the specific case and are dependent on what aspect of the multi-agency system the Child Protection Committee wants to understand.*

Remit for significant case review following [insert brief details of event e.g death of child A]

Introduction

In accordance with the 2014 Scottish Government 'National guidance for Child Protection Committees for conducting a significant case review', the [CPC name] has decided to conduct a significant case review following [details of incident].

For the purposes of significant case reviews, the Scottish Government identifies a child generally as 'a person under the age of 18'.

[Insert basic details about the case including statutory measures in place at time for example, LAC/ Child protection registration]

[Insert basic information about ICR process and where this reported to and when]

Decision to hold a significant case review

[Insert full information regarding the reasoning behind decision to hold SCR including both first and second test/criteria for SCR. Also consider inserting text related to commitment to learning and interest from for example media, Scottish Government, Care Inspectorate, local communities]

Purpose of the review

This is an example of suggested wording and should be adapted to reflect your CPC position and purpose

The purpose of the review is to establish whether there are corporate lessons to be learned about how better to protect children. To that end, the review is a process for learning and improving services and is a means of recognising good practice.

The review will assess the agency and inter-agency decision making and involvement with the family and others relevant to the case.

[21] http://www.scie.org.uk/myscie/login

Time period to be covered

The period to be covered by the review will be from [Insert timeframes]

Methodology

This section should cover the practices being used, for example SCIE methodology. The suggested wording below refers to traditional methods. This may need to be discussed and agreed with COPFS depending on the circumstances of your case.

Established practices for conducting an SCR should be used, including reviewing case files and records, development of a multi-agency chronology and timeline of what information was known to whom and when, and considering policies and guidance available to staff during the timescales the review will cover.

In accordance with the requirements of the COPFS, there will be no interviews with relevant professionals or family members until the criminal proceedings have concluded.

Following advice from COPFS, the review will take place in two phases, the first being consideration of information from files, records and policies/procedures that were in place before the incident [this will be done according to the timeframe set for the review]. Any learning from this could be reported and acted on. The second phase will commence at the end of the criminal proceedings [dependent on the nature of any ongoing criminal proceedings] and will take account of any new information. Interviews with relevant staff will be part of this second phase and files and records may also need to be revisited in this phase.

Any significant risks/needs identified by the lead reviewer during the review process will be reported immediately to the relevant chief officer [The reporting lines may differ and should be agreed on following internal discussions] from the agency concerned.

The lead reviewer will have unrestricted access to policies, protocols, procedures, case records and, at a date to be set, relevant staff. All necessary arrangements will be put in place to facilitate this.

General practitioners and practice staff are independent contractors. Their co-operation will be facilitated by [this should be discussed and agreed internally], as required. This is an example and inclusion will depend on situation.

Administrative support for the lead reviewer will be provided by [This crucial area requires internal discussion and agreement]

Specific issues to be considered in the review

[Insert specifics regarding the key areas to be considered by Lead Reviewer - bullet points may be helpful]

Involvement of family members

The following wording should be discussed with COPFS where there are ongoing criminal proceedings.

Subject to advice from COPFS, the family will be notified that an SCR will be undertaken and that contact will be made by the lead reviewer at an early opportunity in advance of criminal proceedings commencing. For this matter the family will include [Insert specific info related to your case]

Staff welfare

Wording below is an example for two-phase SCR - insert positions as agreed depending on your case

Full consideration must be given to staff welfare and support throughout the review, particularly for those who had direct involvement in the case and may be interviewed as part of the review process (Phase 2 following conclusion of criminal case). This will be the responsibility of each service/agency. Consideration should be given to a single point of support for staff. Regular updates to staff should be agreed by the Review Team.

Ethnicity, religion, diversity, gender, disability, language and equalities

The review will take account of any learning in respect of ethnicity, religion, diversity, gender, disability, language and equalities. [This is broad so may need specifics]

Organisations involved in the review
Example wording - the case and local arrangements will inform wording

The following representation should make up the review team as single points of contact from each of the relevant agencies to support the lead reviewer. The lead reviewer will chair this group as appropriate and report to the case review group.

- The list will depend on your specific case

Administrative support will be provided to the review team through the [requires internal discussion and agreement]

The review team will act as single points of contact for any information required and will assist in setting up any interviews related to their particular service/agency. The chair of the review team will be the lead reviewer who will report to the case review group.

If any other agencies are known to have had involvement with the family during the period under review, the review team will ask them to provide relevant information as required.

Chief officers from all partner agencies expect all relevant services to assist in the review process. Any difficulties will be addressed by the lead reviewer through the case review group and if necessary with the relevant chief officer of the agency concerned.

Support to lead reviewer
Example wording- you may have a critical friend(s) arrangement which differs to this

The partners will arrange to provide a critical friend(s) if needed to assist the lead reviewer in their role, as required.

Reporting arrangements
Example wording the case and local arrangements will inform wording

The lead reviewer should complete the agreed template for the review report as shown in Appendix 1. Along with the main review, the reviewer will be expected to provide an executive summary. The lead reviewer should ensure that the summary is fully anonymised and written so as to avoid the need for future redactions.

The draft report should be submitted to the case review group for consideration and thereafter to the chair of the CPC.

Expert opinion
Wording may differ depending on local arrangements

Although not considered necessary from the outset, the use of expert opinion in a consultative capacity will be kept under review.

Criminal investigations
May or may not apply to your case

Police Scotland is investigating the circumstances of the case and will report to the Procurator Fiscal.

COPFS
May or may not apply to your case

There will be ongoing liaison with COPFS through [named contact who is part of Review Group/Team useful but this will require internal discussion and agreement]

Other parallel reviews
Include whether any notifications have been or need to be made- e.g. death of LAC, SIR

Media coverage/enquiries
The case and local arrangements will inform wording here

There is high level media interest in the case, locally and nationally. CPC have agreed a broad media statement, if this is required. There will be key points as the criminal case proceeds where the media may become involved and ask for information/statements.

There should be no proactive engagement with the media; rather due process should be followed, however, the Review Team and CPC should be prepared at key milestones for media requests, in particular any subsequent trial, sentence and the publication of any review.

A single point of contact for media enquiries is to be agreed. [insert person responsible following internal discussion and agreement] will be responsible for the media strategy on behalf of all partners in respect of any queries regarding the SCR and dissemination/publication, following the conclusion of the SCR.

Family members will be informed of the findings of the significant case review in advance of publication of the executive summary.

Process and timescales
The case and local arrangements will inform wording here

- Appointment of lead reviewer and review team by [insert agreed date]

- The first meeting of the review team to take place once the lead reviewer is confirmed. The first meeting with the lead reviewer will scope and agree the process of the review and agree an outline of the work plan and timeline. This will take into account the two distinct phases of the review as outlined earlier.

- The review team will submit a written progress report on the SCR regularly to the [insert local reporting arrangements as discussed and agreed]

- Any anticipated delays in the review process must be highlighted by the lead reviewer and agreed by the chair of case review group [insert local arrangement as discussed and agreed]

- The final draft report and will be submitted to the chair of the case review group [insert timescale as discussed and agreed] for consideration and the development of an agreed action plan in response to identified areas of learning and recommendations. The lead reviewer will also prepare an executive summary, which will be fully anonymised for publication. In the first instance, the Review Team will correct factual errors or misunderstandings in drafts of the report. Any unresolved matters should be referred to the case review group and ultimately to the CPC if required. Local reporting arrangement may differ.

- The final report, executive summary and action plan will be submitted to the Case Review Group and thereafter to the [insert local reporting arrangements as discussed and agreed]

- The final report will be owned by the CPC . The decision regarding what should be published will rest with them. [insert local arrangements as discussed and agreed internally]

Dissemination and publication

Dissemination

The case and local arrangements will inform wording

- The CPC will agree a local dissemination approach which ensures the spread of any identified good practice as well as learning, particularly to front line staff.
- In order to promote national learning, the findings and recommendations from the SCR will be shared nationally with the Care Inspectorate, and through the Scottish Child Protection Committee Chairs Forum (SCPCCF) or by specially convened meetings or seminars. This will be taken forward by the Chair of the CPC.

Publication

The case and local arrangements will inform wording

- The CPC has decided that an anonymised executive summary will be published. The CPC will arrange to give the identified family members a copy of the executive summary, and will discuss the findings of the review with them before publication.
- The CPC will decide who should get a copy of the full report or the executive summary based on recommendations by the case review group.
- The CPC will give full consideration to the child's right to privacy and the child's right to be protected.
- Publication of the report/executive summary will be discussed with COPFS.
- The CPC will consider whether an oral briefing for relevant parties in advance of publication is required.
- The CPC will ensure that they have considered the integrity of staff and the duty of care.

Annex 5

Exemplar SCR Report
OFFICIAL – SENSITIVE-PERSONAL (once completed)

Core data – child	
Child's identifier	
Age of child	
Gender	
Sexual orientation	
Disability	
Health needs (including mental health and/or learning difficulties	
Education	
Living circumstances prior to incident	
Position in family/number of siblings	
Ethnicity	
Religion	
Nature of injury/cause of death	
Legal status of child	
CP registration	
Agencies/Services involved	
Parent/carer factors	
Age	
Mental health issues	
Disability	
Health needs (including mental health and/or learning difficulties)	
Substance use (if applicable)	
Convictions (if applicable)	
Relevant information about childhood (if applicable)	

Domestic abuse (if applicable)	
Antisocial behaviour (if applicable)	
Ethnicity	
Religion	
Marital/relationship status e.g. co-habitation	
Living circumstances	
Agencies/Services involved	
Environmental factors	
Financial problems	
Housing	
Support from extended family/ community	
Other relevant factors	

Introduction This should include the circumstances that led to the review, the purpose and focus of the review, the periods considered and agencies involved, the extent of the family's/carers' involvement. Note how long the report has taken and reasons for any delays.
The facts This should include the family background and circumstances, including agency involvement. A chronology of significant events, (which should also include when the child was seen and by whom and whether the child's views were sought) should also be included. Where appropriate, the chronology may be presented in a number of distinct phases and should be supplemented by a written account of what happened during each phase. A genogram may be a useful format to map out key relevant person, and families. In the reviewing of the case, a full chronology will be required but for the purpose of the report, the primary aim at this stage is to highlight areas of practice or events that are considered by the review to be particularly relevant, not to provide an overly detailed account of events. As such the full chronology should not be included within the body of the report. Details of all significant adults in the child's life should also be included.

Analysis This section should critically assess the key circumstances of the case, the interventions offered, decisions made etc. For example, were the responses appropriate, were key decisions justifiable, was the relevant information sought or considered, were there early, effective and appropriate interventions? Were any concerns about safety and/or wellbeing recognised? Was there a timely and appropriate response? Were the family and child's circumstances sufficiently assessed? Were compulsory/legal measures properly considered and was the child referred to the Children's Reporter? If so, when? It should always be remembered that the review is taking place with the benefit of hindsight and the analysis should consider the actions of services within the context of the circumstances of the time.
Key issues Following on from the analysis and depending on the circumstances of the case, the review should clearly identify the key areas that impacted on the child and agency responses and then explore these further to understand how they came about. This section should assist readers to understand the 'why' of what happened and a level of root cause analysis should be applied. It would be helpful to explore key areas within a framework of cause and effect factors – for example, resourcing, organisational culture, training, policies etc.
Learning points This section should highlight the key learning points from the review – again the focus here should not be on 'what happened', but the reasons why it happened as it will be these areas that services and organisations can actively take forward and address. This section should also actively address strengths and good practice identified as well as the learning that has taken place since the case, any changes in practice and policy that have been implemented and the outcome of changes.
Recommendations or if using SCIE model Findings and Issues These should be SMART: **S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**imed

Executive summary

This report should provide a brief, anonymised account of the circumstances of the case and agency involvement. Chronologies should not be included. Analysis of the key events has to be sufficient to allow a context for the identification of the key issues and learning points but a balance has to be struck to ensure confidentiality issues are respected. The Learning Points, recommendations and action points should be replicated in full.

Appendices

These should include, if not already within the body of the report:

- Review Team membership
- Remit
- Chronology[22]
- Files accessed
- People interviewed

SCIE Learning Together Model*

An SCIE Learning Together[23] report is structured to a standard format to include an overview of the case, an appraisal of professional practice. It identifies findings rather than listing conclusions and recommended actions. The findings articulate succinctly what the issues have been found and record how this is evidenced through answering five key questions:

- How did the issue manifest in this case?
- What makes this an underlying issue rather than an issue particular to the individuals involved?
- How prevalent is the issue?
- How widespread is the pattern?
- What are the implications for the reliability of the system?

Findings are themed together under the following patterns using a systems typology and listed in priority as defined by the review team:

- Management systems
- Family-professional interaction
- Tools (human interaction with)
- Responses to incidents
- Longer term work
- Cognitive/emotional bias

Rather than make recommendations, each finding asks questions of the CPC to help the members come to a decision as to how to resolve the issue and ensure the CPC

[22] GIRFEC Briefings for practitioners – Scottish Government – August 2012

[23] Learning together to safeguard children: developing a multi-agency systems approach for case reviews – Fish, S., E. Munro, and S. Bairstow, 2008

has measures in place to know when the issue has resolved. The responsibility for implementing change rests within the CPC and its partner agencies.

*Learning Together reviews must be undertaken by accredited Lead Reviewers.

Annex 6

Data protection and reports

The following is an extract from an SCR completed in September 2013 and may be useful in considering the report structure and content.

'This document contains the conclusions and recommendations of the Significant Case Review relating to D. In the interests of transparency, every effort has been made to disclose as much of the SCR as is lawfully possible. The only editing prior to disclosure is the redaction of personal data, disclosure of which cannot be justified under the Data Protection Act 1998 ('the DPA'). Although there has been a criminal trial and extensive media coverage of this case, and a significant amount of both personal data and sensitive personal data is, as a result of this, publicly available, disclosure of the personal data contained in this report must still comply with the DPA. This means that even though some of the redacted information may already be publicly available, or it may be considered to be in the public interest to disclose, it cannot automatically be disclosed, as the DPA contains certain conditions which must first be met. The process of redacting the SCR has involved careful consideration of:

- The need for transparency and the overall purpose of the SCR in the identification of any lessons learned.
- The public interest in disclosure.

Considering whether information is sensitive personal data, (for example, because it is information about a person's physical or mental health or condition, his/her sexual life, or the commission or alleged commission of an offence) and whether its inclusion in the SCR complies with the Data Protection Act 1998.

Balancing interests in terms of the right to respect for private and family life in terms of Article 8 of the European Convention on Human Rights, meaning that any information contained in the report relating to D himself and other people whose history was closely linked to D can only be released if it is lawful, necessary and proportionate to do so.

Following this, and on taking specialist legal advice, the review panel concluded that in the unique circumstances of this case, it would not be appropriate to release the main body of the report. The narrative of the report could not be redacted so as to remove all information carrying an identification risk or the possibility of causing harm to third parties, and it was felt that removing all such information would lead to the report being at best meaningless and at worst misleading.

The conclusions and recommendations have been included but with certain text (generally containing biographical details) redacted for the reasons set out above. Any redactions are clearly marked with the word '[Redacted]'. Some minor grammatical changes have been made (unflagged) to maintain consistency of language following some redactions.

Annex 7

Dissemination/publication: interested parties

CPCs are referred to the Freedom of Information and Data Protection section of this guidance.

Those with responsibility for local service delivery and review will include:

- The local Child Protection Committee;
- Chief officers: chief executive of local authority/chief executive of health board/Police Scotland representative;
- Director of social work/chief social work officer/senior managers in the police, education and health service;
- Staff involved in the review;
- Crown Office and Procurator Fiscal Service;
- Children's Reporter/Scottish Children's Reporter Administration (SCRA);
- Inspectorates – Care Inspectorate, HM Inspectorate of Constabulary, Health Improvement Scotland; and
- Voluntary organisations and independent providers, where they are involved in the case.

Those with wider interests in the SCR report could include:

- Child/young person/family/carers and/or significant adults of child involved;
- Local councillors/health board chairs/representatives of Police Scotland;
- Local authority, health board and police press officers;
- Scottish Government;
- Other child protection committees;
- Professional representative bodies;
- Legal representatives; and
- Unions.

Other key interests are likely to be:

- The general public;
- Elected members, for example, MSPs, MPs and Councillors

Annex 8

Inter-related processes

Criminal investigations

The core functions and jurisdiction of the police in Scotland are specified by the Police and Fire Reform (Scotland) Act 2012. This includes a duty to protect life and property. The police are an independent investigative and reporting agency to both the Crown Office and Procurator Fiscal Service and to the Children's Reporter (SCRA). The police have a duty to investigate both crimes/offences and also any sudden and unexplained deaths.

Crimes and offences

If the police get information, by whatever means, that a crime or offence has been committed, they are duty-bound to investigate. Principally the role of the police is to establish:

a) Whether or not a crime or offence has been committed;
b) Whether there is sufficient evidence to support a criminal charge;
c) Whether grounds exist for referral to the Principal Reporter, under the terms of the Children's Hearings (Scotland) Act 2011 section 67;
d) Whether there is sufficient evidence to justify the detention and/or arrest of the alleged offender; and thereafter to
e) Submit a report to the Procurator Fiscal and/or the Principal Reporter.

Where allegations of physical, sexual and emotional abuse are made involving children or young people, the police consider the following – in collaboration with other agencies – before initiating the investigation:

- The immediate safety and wellbeing of the child or other children;
- The need for medical attention, immediate or otherwise;
- The opportunity of access to the victim and to other children or young people by the alleged perpetrator;
- The relationship of the alleged offender to the victim;
- The time over which the alleged abuse has occurred;
- The need to remove the child or other children from the home, although this will only take place after discussion between the supervisor on duty in both the police and the relevant social work departments; and
- The need to obtain and preserve evidence.

After consideration of the above, which should establish the risks and needs of the child, the investigation will begin. In many such cases a senior investigating officer (SIO) will be appointed to oversee the investigation.

In matters where a serious crime or offence has been committed, the investigation will usually be conducted by specially trained officers from the Criminal Investigation Department. If the crime involves the abuse of a child, these officers will be supported by specially-trained officers from the Public Protection Unit.

The evidence of the crime or offence will be gathered in a variety of ways. These would include obtaining statements from key witnesses, gathering forensic evidence such as DNA, fingerprints, hairs and fibres and interviewing suspects.

Following the investigation, the police will prepare a report and this will be submitted to the Procurator Fiscal and/or the Children's Reporter. Decisions will also be made as to whether the accused should remain in police custody pending their appearance in court, whether they should be released on undertaking which may specify certain restrictions/provisions, or whether they should be released pending report and summons.

Sudden and unexplained deaths

All sudden and unexplained deaths must be reported to the Procurator Fiscal. The death is usually reported by a doctor (either a general practitioner (GP) or a hospital doctor), by the police or a local registrar of births, deaths and marriages.

Whether or not the cause of death is known, if a doctor is of the view that a death was clinically unexpected, it is described as a 'sudden death'. When the cause of death is not known or is not clear to a doctor, this is described as an 'unexplained death'.

Once a person's death is reported to the Procurator Fiscal, it is for the Procurator Fiscal to decide what further action, if any, will be taken.

The Procurator Fiscal may decide that further investigation is required which may include, but is not limited to, the instruction of a post mortem examination to determine the cause of death and/or instructing the police to carry out further enquiries and provide a report.

While some investigations may conclude once a cause of death is known, others may require further detailed and sometimes lengthy investigation, for example, those involving complex technical and medical issues which may require the instruction of independent experts to provide an opinion. At the conclusion of the Procurator Fiscal's investigation, it may be necessary for a fatal accident inquiry (FAI) to be held.

Once a death has been reported to the Procurator Fiscal, they have legal responsibility for the body, usually until a death certificate is issued by a doctor and given to the nearest relative. The Procurator Fiscal will usually surrender legal responsibility for the body once the nearest relative has the death certificate.

In a small number of cases, the Procurator Fiscal may need to retain responsibility for the body for longer to allow for further investigations to be carried out. This happens with only a very small number of deaths, most likely where the death is thought to be suspicious. If this is necessary, nearest relatives will be advised by the police or the Procurator Fiscal.

Post mortem examination

The Procurator Fiscal will instruct a post mortem examination for all suspicious deaths; all deaths which remain unexplained after initial investigation; and in a number of other situations where there are concerns about the circumstances or cause of the death.

Suspicious deaths

Where circumstances suggest that criminal conduct may have caused or contributed towards the death, this is described as a ‘suspicious death’. The Procurator Fiscal will instruct the police to investigate the circumstances and consider whether criminal charges should be brought which may lead to a prosecution. All deaths where the circumstances are thought to be suspicious must be reported to the Procurator Fiscal.

In circumstances where the death is considered to be potentially suspicious, the Procurator Fiscal may direct a two-doctor post mortem examination to corroborate the finding. This would be an essential element in the chain of evidence, particularly where criminal investigations and/or proceedings were to be instigated later.

Normally, a senior investigating officer (SIO) will be appointed to investigate suspicious deaths and specially trained officers would carry out these investigations. These investigations may well identify criminality and also those who may be responsible, and in these circumstances the police would follow their established investigative procedures.

Good practice would always suggest that a family liaison officer acts as the single point of contact between them and the police.

In child death cases, the procedures applied and followed are in fact the same, albeit, the services of a paediatrician and/or paediatric pathologist would be sought, often along with a forensic pathologist.

Fatal accident inquiry (FAI)

An FAI is a public court hearing which inquires into the circumstances of a death. It will be presided over by a sheriff and will usually be held in the Sheriff Court. If the death occurred as a result of an accident while the deceased was in the course of employment or where the person who died was at the time of death in legal custody (for example in prison or police custody) an FAI is mandatory. The Lord Advocate has discretion to instruct an FAI in other cases where it appears to be in the public interest that an inquiry should be held into the circumstances of the death. An FAI

would not automatically be held in respect of a child death.

The purpose of an FAI is to ascertain the circumstances surrounding the death and to identify any issues of public concern or safety and to prevent future deaths or injuries. The Procurator Fiscal has responsibility for calling witnesses and leading evidence at an FAI, although other interested parties may also be represented and question witnesses.

At the end of an FAI, a sheriff will make a determination. The determination will set out:

- where and when the death and any accident resulting in the death took place
- the cause of death, or any accident resulting in the death
- any reasonable precautions that might have meant the death and any accident resulting in the death could have been avoided
- any defect in working practice which caused or contributed to the death or any accident resulting in the death
- any other facts relevant to the circumstances of the death

The court has no power to make any findings as to fault or to apportion blame between individuals. A sheriff has the power to recommend steps which ought to be taken to prevent a death occurring in similar circumstances in future. While there is no compulsion on any person or organisation to take such steps it would be unusual for such a recommendation to be disregarded.

Death of a looked after child (LAC) review

This review is triggered by the death of a child who is, or has previously been, looked after by a Scottish local authority. The purpose is for the local authority to assure itself and others, including Ministers, that it acted promptly and competently in the particular case and to identify any necessary improvements. Public interest may needs to be taken into account.

This inquiry is internal to local authorities and is based on this guidance. The expectation is that Scottish Ministers and the Care Inspectorate would get a report as soon as possible (and not more than 28 days) after the death.

Ministers may:

- Examine the arrangements made for the child's wellbeing during the time they were looked after;
- Assess whether action taken by the local authority may have contributed to the child's death;
- Identify lessons which need to be drawn to the attention of the authority immediately concerned and/or other authorities or other statutory agencies;

- Review legislation, policy and guidance in the light of a particular case or any trends emerging from deaths of children or young people being looked after, or previously looked after.

MAPPA significant case review

The fundamental purpose of MAPPA is public protection and managing the risk of serious harm posed by certain groups of offenders. It is understood that the responsible authorities and any partners involved in the management of offenders cannot eliminate risk – they can only do their best to minimise that risk.

It is recognised that, on occasions, offenders managed under the MAPPA will commit, or attempt to commit, further serious crimes and, when this happens, the MAPPA processes must be examined. This is firstly to ensure that the actions or processes employed by the responsible authorities are not flawed and, secondly, where it has been identified that practice could have been strengthened, plans are put in place promptly to do so.

There are five stages to a MAPPA SCR;

1. Identification and notification of relevant cases
2. Information gathering
3. Decision to proceed, or not, to an SCR
4. Significant case review process
5. Report and publication

The criteria for undertaking an SCR in MAPPA is:

- When an offender managed under MAPPA is charged with murder, attempted murder or a crime of serious sexual harm;
- Significant concern has been raised in respect of the management of a MAPPA offender which gives rise to serious concerns about professional and/or service involvement;
- Where it appears that an offender managed under MAPPA is killed or seriously injured as a direct result of their status as a sex offender becoming known.

Annex 9

National Protocol for the Police Service of Scotland, Crown Office and Procurator Fiscal Service, and Child Protection Committees to assist with Liaison and the Exchange of Information when there are simultaneous Significant Case Reviews and criminal proceedings, a Fatal Accident Inquiry or investigations with a view to such proceedings

Parties

The parties to this protocol document are Child Protection Committees (CPCs), the Crown Office and Procurator Fiscal Service (COPFS) and the Police Service of Scotland (PS).

This protocol was completed following recommendations arising out of the short life Working Group's report on 'Significant Case Reviews – Developing Best Practice'. Subsequent to this a small working group was convened to develop this protocol.

The working group comprised of representatives from COPFS, PS, Chair of Renfrewshire Child Protection Committee Dundee University and Scottish Government.

Aim

The aim of this protocol is to provide a suggested framework between the parties for conducting SCRs when criminal prosecutions, FAIs or investigations with a view to such proceedings are running in parallel and for the sharing and exchange of relevant information generated by each process.

Principles

The parties to this protocol recognise that criminal proceedings, FAIs and SCRs are important processes which should each be carried out as expeditiously as possible, and should not adversely affect the progress of the other unless it is necessary in the interests of justice.

All processes are crucial to ensuring the safety and wellbeing of children and young people. The parties recognise that a significant consideration in any decision should be the welfare of children and young people.

Significant case reviews

An SCR examines the circumstances and context of a child being harmed or killed, to evaluate the nature and quality of professional contact, if any, with the child, to identify any system failures which may impact on other children, and to learn from the incident, any specific lessons which will strengthen child protection systems, locally and nationally.

A SCR is not an enquiry into why any child or young person died, was harmed or to establish who may be culpable. These are matters for criminal investigation and for employer disciplinary procedures as appropriate. It is further acknowledged that agencies may additionally have their own internal/statutory review procedures to investigate serious incidents and mechanisms for reflective practice reviews, which take place independently of any SCR or criminal investigation.

SCRs are commissioned by local CPCs. Protecting children and young people is an inter-agency and inter-disciplinary responsibility. While social work children's services usually lead on the discharge of local authorities' legal responsibilities in respect of safeguarding children, any agency (including voluntary sector organisations) or profession may be the initiator of the SCR process.

SCRs will sometimes be undertaken in circumstances where there is no concurrent criminal investigation or FAI. Similarly, some cases of criminal investigation involving harm to children or young people will not be subject to a SCR. Good local relationships and liaison arrangements between CPCs and COPFS will ensure that parallel processes are pre-planned and that changes in the status of a case (e.g. where early in an SCR the need arises to refer matters for a criminal investigation) are readily shared.

Where there are criminal proceedings contemplated contact should be made with the Procurator Fiscal, High Court in the local Federation of COPFS. Where an FAI is contemplated contact should be made with the Head of SFIU (Scottish Fatalities Investigation Unit). Contact can be made with the appropriate person by contacting 0844 561 3000. Further information relating to the structure of COPFS can be found at their website http://www.copfs.gov.uk.

The status of a significant case review (SCR) relative to other linked investigations

The paramount consideration in any decision or arrangement in respect of SCRs taking place alongside other investigations, is the need to protect children and young people from harm. In many instances this will be achieved by the successful prosecution of those who pose a threat to children in conjunction with securing improvements in systems which exist to prevent children being exposed to harm.

In the event of a child fatality or a case of serious harm which may be subject to an SCR, it is essential for the Chair of the local CPC and a representative from COPFS to confirm the likely processes of review and investigation to which the case is likely to be subjected (e.g. SCR, criminal investigation, FAI, LAC Review by Care Inspectorate, Health and Safety investigation, Fire Brigade investigation). Consideration will be given in this discussion to arrangements which allow review of systems critical to the welfare of children and young people to get underway in the context of the need to secure and preserve the integrity of best evidence within criminal and other investigations.

Timescales for a significant case review

It is desirable that the SCR should be undertaken as speedily as feasible in order to identify and redress any individual or systemic factors which may put children or young people at risk. CPC's are required to agree timescales for when reports should be produced in light of the circumstances and context of that particular case.

The timing of different processes will be determined by the particular circumstances of individual cases. It should not be necessary to postpone the initiation of an SCR until the conclusion of criminal proceedings or FAI but care must be taken that the SCR does not prejudice or put in jeopardy either of these proceedings. Therefore in some instances, an SCR process may have to be adjourned after an initial review of critical systems until the conclusion of aspects of the criminal or other investigations.

Disclosure

A SCR will usually involve the reviewer interviewing members of staff of the relevant authorities who have had engagement with the child or young person, as well as people who may be considered as having a significant part in the life of the child or young person. The material generated from this activity, including interview notes may contain information which is of relevance or importance to any criminal proceedings.

PS has a duty to reveal the existence of relevant material to COPFS. PS make a decision as to whether that material is non-sensitive, sensitive or highly sensitive. Revelation to the prosecutor does not mean automatic disclosure to the defence. COPFS will decide on whether the material should be disclosed and how it should be disclosed to the defence.

Interview of parent, carer or significant family members

It is good practice that parents, carers and significant family members are interviewed or otherwise engaged during the SCR process to seek any learning from them. The CPC, its designated reviewer the local COPFS and police officer leading the investigation, or their representative, must discuss the timing and scope of such interviews. While there may be no need to delay SCR interviews pending the outcome of a trial or FAI, a balance must be achieved between the need to capture relevant data and learning in order to protect children and the prosecution of a case in the public interest. The best timing of such interviews will differ depending on the circumstances and features of the case and as such arrangements should be made locally on a case-by-case basis.

Persons conducting SCR interviews must be conversant with rules of evidence and competent in the management of investigative processes running in tandem with criminal investigations.

Where a person is on bail for a crime or remanded, COPFS **must** give permission before any contact is made. If permission is given by COPFS the individuals legal representative must also be informed that the individual is to be interviewed. It should at all times be stressed to legal representatives that their client's participation in the SCR process is voluntary, that no adverse inference will be drawn from a refusal to participate and that any information provided for the purpose of the SCR may be disclosed in criminal or related proceedings.

Criminal cases and FAIs can take a long time to resolve and there may be some circumstances where the CPC, in carrying out its statutory duty to conduct the SCR, considers it would not be appropriate to wait to gather all possible learning about how best to safeguard children and young people. If, prior to charge or conclusion of a trial or FAI, interviews *are* undertaken by those engaged in the SCR with people who are either witnesses, suspects or have been charged with a criminal offence or potential witnesses in a FAI, this should be agreed beforehand with the local COPFS contact.

It should further be noted that the law is not settled in relation to the disclosure for Freedom of Information purposes of SCR reports and the material from which they are compiled. A presumption of exemption currently exists, but this has not been tested.

Conclusion

It may in some circumstances be possible to manage SCRs, criminal proceedings or FAI's simultaneously, without one jeopardising the other. In their own way, all processes are important to protect and promote the safety and wellbeing of children and young people, which should always remain the primary consideration.

The learning obtained from an SCR is largely dependent on the willingness of individual professionals and family members to engage in the process. They need to have confidence that any information they give will be treated with respect, and they should be made aware if it could be used for any purpose other than that for which it was intended.

Glossary

ACPC	Area Child Protection Committee
CPC	Child Protection Committee
CPR	Child Protection Register
CPCR	Child Protection Committee Review
FAI	Fatal Accident Inquiry
ICR	Initial Case Review
LAC	Looked After Child
LSCB	Local Safeguarding Children Board
COPFS	Crown Office and Procurator Fiscal Service
MAPPA	Multi Agency Public Protection Arrangements
PF	Procurator Fiscal
PIRC	Police Investigations & Review Commissioner
PS	Police Scotland
SCIE	Social Care Institute for Excellence
SCR	Significant Case Review
SCRA	Scottish Children's Reporter's Administration
SFIU	Scottish Fatalities Investigation Unit
SIO	Senior Investigating Officer
SUDI	Sudden and unexplained death in infancy

Membership of the Working Group

Emma McWilliam	Care Inspectorate
Lawrie Davidson	Care Inspectorate
Sarah Blackmore	Care Inspectorate
Jacqui Pepper	Care Inspectorate
Jane Benson	Crown Office and Procurator Fiscal
Anne Marie Hicks	Crown Office and Procurator Fiscal
Denis Bruce	Crown Office and Procurator Fiscal
Donald Mackenzie	Dundee Child Protection Committee
Adrian Lawrie	ELBEG
Viv Boyle	Fife Child Protection Committee
Gillian Buchanan	Glasgow City Council
Claire Evans	NHS
Anne Neilson	NHS Lothian
Sharon Vincent	Northumbria University
Lesley Boal	Police Scotland
Alastair Hogg	SCRA
Alyson Leslie	University of Dundee
Beth Smith	WithScotland

Bibliography

Brandon, M; Howe, D; Black, J et al (2002) Learning how to make children safer: an analysis for the Welsh Office of Serious case reviews in Wales, Norwich: University of East Anglia/Welsh Assembly Government

Brandon, M; Belderson, P; Warren, C. et al (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn? London: DCSF

Brandon, M; Bailey, S; Belderson, P. (2010) Building on the learning from serious case reviews, London: Department for Education

Care and Social Services Inspectorate Wales (2009) Improving practice to protect children in Wales: an examination of the role of serious case reviews, Cardiff: CSSIW

Devaney, J; Bunting, L; Hayes, D. et al (2013) Translating learning into action, Belfast: Queens university/NSPCC/DHSSPS

Scottish Executive (2002) 'It's everyone's job to make sure I'm alright', Report of the Child Protection Audit and Review, Edinburgh: Scottish Executive

Scottish Executive (2007) Protecting Children and Young People: Interim Guidance for Child protection Committees for Conducting a Significant Case Review, Edinburgh: Scottish Executive

Sidebotham, P; Brandon, M; Powell, c. et al (2010) Learning from serious case reviews, London: Department for Education

Vincent, S. (2010) Learning from Child Deaths and Serious Abuse, Edinburgh: Dunedin

Vincent, S; Petch, A. (2012) Audit and Analysis of Significant Case Reviews, Edinburgh: Scottish Government

Fish, S; Munro, E; and Bairstow, S (2008) Learning together to safeguard children: developing a multi-agency systems approach for case reviews, London: Social Care Institute for Excellence.

MARS (2010) Significant Case Review (SCR): Developing Best Practice, Report of a Short Life Working Group, Stirling: MARS

Morris K, Brandon M, Tudor P. 2012. Family Involvement in Case Reviews: Messages for Policy and Practice. BASPCAN: York.

The Scottish Government
Riaghaltas na h-Alba

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House, Edinburgh EH1 3DG

First published by The Scottish Government, March 2015
ISBN: 978-1-78544-208-7 (web only)

E-book in EPUB format first published by The Scottish Government, March 2015
ISBN: 978-1-78544-209-4 (EPUB)

E-book in MOBI format first published by The Scottish Government, March 2015
ISBN: 978-1-78544-210-0 (MOBI)

Published by The Scottish Government, March 2015

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS47525 (03/15)