Audit and Analysis of Significant Case Reviews

The Scottish Government
Riaghaltas na h-Alba

Audit and Analysis of Significant Case Reviews

Sharon Vincent, University of Wolverhampton

Alison Petch, Institute for Research and Innovation in Social Services (IRISS)

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GLOSSARY

ADHD	Attention Deficit Hyperactivity Disorder
CAMHS	Child and Adolescent Mental Health Services
CAPSM	Children Affected by Parental Substance Misuse
CPC	Child Protection Committee
CPCC	Child Protection Case Conference
CPO	Child Protection Order
CPR	Child Protection Register
GIRFEC	Getting It Right For Every Child
GOPR	Getting Our Priorities Right
HMIe	Her Majesty's Inspectorate of Education
ICR	Initial Case Review
IRD	Initial Referral Discussion
LAAC	Looked After and Accommodated Child
LAC	Looked After Child
MARAC	Multi Agency Risk Assessment Conference
MARS	Multi Agency Resource Service
NAI	Non Accidental Injury
NAS	Neo-natal Alcohol Syndrome
NFA	No Further Action
PF	Procurator Fiscal
SCR	Significant Case Review
SCRA	Scottish Children's Reporter Administration
SID	Sudden Infant Death
SNIP	Special Needs in Pregnancy
SUDI	Sudden Unexpected Death in Infancy

EXECUTIVE SUMMARY

This report presents the findings from an audit and analysis of 56 Significant Case Reviews (SCRs) and 43 Initial Case Reviews (ICRs) conducted in Scotland since 2007.

Background

National guidance for undertaking SCRs was introduced in Scotland in 2007 - 'Protecting Children and Young People: Interim Guidance for Child Protection Committees for Conducting a Significant case Review'. There was a commitment within the national guidance to promote national, as well as local, learning. However, in contrast to England and Wales where national analyses of case reviews are commissioned bi-annually, until now the findings from SCRs have not been collated at national level in Scotland and accessible data on the number of SCRs that have been undertaken has not been readily available. As a result, the value of learning in SCRs to date has been limited, with lessons insufficiently shared beyond local boundaries. The Scottish Government commissioned an independent short life working group of key multi-agency professionals in 2009 to consider the SCR process in the light of recent research and practice. The group made 10 specific recommendations to the Scottish Government to improve the SCR process in Scotland. This included a recommendation that they should commission an audit and analysis of all SCRs undertaken since 2007 to provide a baseline and an understanding of the relevant issues for practice. This report presents the findings of this audit and analysis.

Methods

A content analysis approach was used to undertake the review which involved elements of a case study approach so analysis could be undertaken on a case by case and cross case basis. This enabled the findings to be pulled together across the reports but also allowed the complexities of individual cases to be examined in greater depth. Such an approach permitted in-depth analysis of the interaction of child, family, environmental and agency factors and exploration of the different causal pathways to death or harm.

The study was carried out in a number of phases. The number of SCRs that had been undertaken in the 30 CPCs in Scotland since 2007 was not known prior to this study. Phase 1 was, therefore, a mapping and collation exercise to identify how many ICRs and SCRs had been undertaken since the national guidance was issued. Phase 2 of the research involved the reading/rereading of the reports, and coding and analysis of data. A template was devised to capture anonymised information about the SCR process, as well as more detailed, qualitative information about the type of case, factors relating to the children, the characteristics of the family and their

involvement with agencies, as well as factors relating to professional practice. Final analysis occurred on a case by case and cross case basis and considered:

- Recurrent themes and features
- What common features could be identified to inform practitioners and agencies about risk and serious harm
- How findings in Scotland compare with findings elsewhere in the UK, and whether there are any Scotland specific findings which have not been found in other parts of the UK
- What national policy and practice issues arose from the reports.

Findings: the SCR process

The findings of this study suggest that CPCs are following the general principles of the SCR process as specified in the national guidance but there is a lack of consistency in the way in which ICRs and SCRs are being undertaken across Scotland. There is a need for more standardisation across CPCs and for closer adherence to some parts of the national guidance:

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

Findings: type of case and child and family characteristics

Children died in half of the SCRs included in this study. A small proportion died at the hands of their parents; some died as a direct result of their own risk taking behaviour. Others died from accidents or natural causes, not as a result of abuse or neglect. In some accidental deaths, however, parents' lifestyles probably played some part in the child's death.

The other half of SCRs related to non-fatal physical injury, ingestion of substances, neglect and sexual abuse. These cases were more likely to involve abuse or neglect on the part of parents or carers, but did not necessarily involve intent.

Criminal proceedings had been instigated in half of all SCRs.

In terms of child characteristics the main findings were as follows:

- There was a slightly higher proportion of boys than girls
- A third of children were under a year old; a third were eleven or over
- Ethnicity could not be established in the large majority of cases
- Almost a quarter of SCRs involved families with four or more children
- None of the children had disabilities but a small number had health problems and almost a fifth had been born with neonatal abstinence syndrome.

The main findings in relation to parents were:

- Parents' ages were not always recorded but where age was recorded parents did not appear to be particularly young; a significant proportion were in their thirties or forties
- More than a third of parents were noted to have had troubled childhoods
- There was a high prevalence of parental substance misuse (almost two thirds of SCRs)
- Domestic abuse featured in over half of cases
- Children were affected by parental mental health in 43% of SCRs
- Well over half of families had criminal records for serious offences relating to violence or drugs
- Families were only noted to have financial problems in a small number of SCRs but this is likely to be an under estimate; there was a high prevalence of housing problems including frequent moves, overcrowding, poor conditions and intimidation from neighbours
- A high proportion of families had support from their wider extended family. In some cases this was a protective influence for the child but family members sometimes contributed to the levels of stress families experienced. A small number of families, particularly those who had moved to Scotland from another country, were socially isolated.

A very high proportion of families (93%) whose circumstances formed the subject of SCRs were known to social work services, with just 7% of families known only to universal services. This suggests that concerns had been identified in these families and had been correctly passed on to statutory services as specified in national child protection guidance. 14% of children were on the child protection register and a fifth were looked after.

Findings: agency factors

While this study identified some excellent practice, in common with previous studies it also identified that intervention is not always as child centred as it might be. All agencies, including adult services, must maintain a focus on the potential risks to the child as a consequence of their parent's lifestyle. A reflective, questioning practice culture should be adopted in which practitioners feel confident to challenge parents as well as each other. Managers must listen to frontline staff, acknowledge the difficulties they face in working with troubled families and provide appropriate supervision, training and support.

Despite considerable efforts in recent years, through the implementation of GIRFEC, and the child protection guidance and other national policies, to ensure that children and families get the help they need when they need it, the findings of this study suggest that thresholds have not necessarily been broken down and remain a concern. All professionals in child and adult services must heed Lord Laming's comment that child protection does not come labelled as such. There should be no distinction between those children who are considered to be at risk of harm and those that are not. All children may be at risk at any time and decision making for all children, including those outside the child protection system, must always be based on an assessment of cumulative risk and harm as well as need. A significant amount of progress has been made in recent years to ensure that all agencies acknowledge they have a responsibility for child protection and this is evidenced in the numerous examples of good safeguarding practice in universal and adult services identified in these SCRs. However, the reports demonstrated that there was some confusion in relation to responsibilities in individual cases and there needs to be a shared understanding of roles across agencies.

Findings: understanding risk

Children and young people die or experience harm for a range of different reasons. While there are a number of common risk factors, the way in which the various child, family and agency factors interact and result in the different types of death or harm will be unique in each case. Risks change as children get older and it is, therefore, important for professionals working with children and families to have a good understanding of child development. Parental risk factors will be important for younger children, but teenagers usually die or are injured as a result of their own risk taking behaviours.

The following risk factors were identified for cases involving infants:

Child factors	Parent factors	Agency factors
Neonatal abstinence Syndrome (NAS) Prematurity Failure to thrive	Substance misuse Domestic abuse Mental health problems Troubled childhoods	Focus on the parents as opposed to the children Child not seen Risks not assessed,

Attendance at Accident and Emergency for injuries	characterised by lack of attachment and lack of positive parental role models Criminal record especially for violence or drugs Social isolation/lack of family/ community support Housing issues – frequent moves, anti social behaviour, problems with neighbours Non engagement, lack of cooperation, changing patterns of engagement Missed health appointments, failure to obtain medical care Frequent appearances at Accident and Emergency	accumulating information not analysed to allow assessment of increasing risk, or case not considered to be 'child protection'

The following risk factors were identified for children in the middle years or in families with several children including one or more of school age:

Child factors	**Family/environmental factors**	**Agency factors**
Low attendance/lateness at school/nursery Behavioural problems at school Presenting as dirty at school/nursery Health problems including weight problems	Large families Substance misuse Domestic abuse Mental health problems Troubled childhoods characterised by lack of attachment and lack of positive parental role models Criminal record especially for violence or drugs Social isolation/ lack of family/ community support Housing issues – frequent moves, anti social behaviour, problems with neighbours, overcrowding/poor conditions Non engagement, lack of cooperation, changing patterns of engagement Missed health	Failure to speak to the child and/or to analyse their behaviour Risks not assessed, accumulating information not analysed to allow assessment of increasing risk, or case not considered to be 'child protection' Long involvement with universal and statutory services with few signs of improvement Sexual abuse not identified

	appointments, failure to obtain medical care Frequent appearances at Accident and Emergency	

Risk factors for teenagers included the following:

Child factors	**Family/environmental factors**	**Agency factors**
Mental health problems Risk taking behaviour – self harm; substance misuse; offending etc Long term involvement with social work and SCRA Looked after with multiple placement moves Non engagement/lack of cooperation with services Absconding Previous abuse/neglect	Social isolation/lack of family/ community support Known to associate with peers/family involved in risk taking behaviour	Lack of resources to meet young person's needs Risks presented by transition to adult services Professional powerlessness Mental health needs not met Housing needs not met

National policy implications and recommendations

The findings of this study raise a number of important national policy issues. A particularly significant finding is the high number of SCRs which relate to the care and protection of children living in families whose lives are dominated by drug use and the associated issues this brings, including criminality and neighbourhood problems. In most cases the child's needs had been identified and an extensive support package had been put in place, but this did not prevent these children from dying or experiencing harm. This inevitably raises issues about leaving children, particularly infants, in the care of parents involved in substance misuse, particularly when both parents and sometimes the wider extended family, have a long history of substance misuse and no one is able to provide a protective influence. It also raises issues around the threshold for intervention in respect of levels of drug dealing and intimidation known to police and other agencies such as housing.

Another challenging finding is the lack of suitable resources for the placement and support of troubled and troublesome teenagers and the impact this has on staff in a number of agencies, particularly social work, housing and mental health agencies. As these SCRs demonstrated this can lead to situations of professional powerlessness, where professionals do not know how to support these young people, resulting in them being left in dangerous situations where they are placed at significant risk of engaging in risk taking behaviour which can sadly lead to death through suicide or misadventure.

Lastly the findings demonstrate that we should not lose sight of school age children. Policies often prioritise pre-school children or adolescents but there were a number of concerning SCRs involving long term neglect and sexual abuse of school age children who had been known to statutory services for many years. These families had been correctly identified as being in need and intensive packages of support had been put in place to meet their needs but the 'rule of optimism' resulted in cases being allowed to drift. Cumulative risk had not been identified because children had not been spoken to and the reasons for their challenging behaviour had not been considered. These particular children had finally come to the attention of agencies because a particularly serious incident had resulted in them being the subject of a SCR or the accumulation of concerns had finally been picked up. In the majority of these cases children did not die but they had experienced serious abuse or neglect. They were normally removed from their parents' care as a result of the incident or catalogue of incidents that led to the SCR but retrospective analysis suggests that some of these children should have been removed much sooner.

Recommendations

1 The SCR process and separate process for review of the deaths of LAC should be better aligned
2 There needs to be more standardisation in the way in which ICRs are undertaken and reported across Scotland. CPCs should follow the national guidance, use the template and keep a register of cases. The template should be revised to include a section where CPCs can record the reason for their decision
3 The 2010 National Child Protection Guidance replaced 'Protecting Children – A Shared Responsibility: Guidance for Inter-Agency Co-operation' and the categories of abuse and neglect have changed. The national guidance should be revised to take account of this.
4 All reviews that are multi-agency and meet the criteria for a SCR as set out in the national guidance should be termed SCRs to avoid confusion
5 The national guidance should be updated to include information about the process of undertaking cross border SCRs
6 As specified in the national guidance SCRs should be undertaken by a mixed team not by a single reviewer and reports should include a list of contributors to the review
7 SCR reports should include a separate chronology or take a chronological approach
8 SCR reports should include a separate executive summary as specified in the national guidance
9 It may be appropriate for CPCs to produce separate action plans rather than including them in the SCR report but reports should provide some discussion of how the findings will be disseminated and how the recommendations will be taken forward

10 In line with the national guidance SCR reports should include information about whether or not children and families were informed and involved. If they were not involved reports should record why they were not involved. If they were involved reports should record the nature of this involvement and document how their views have been represented. Diversity issues should be considered and adequate support should be provided to ensure that family members are able to participate.

11 The national guidance states that 'A review should not be escalated beyond what is proportionate taking account of the severity and complexity of the case.' The SG should look at new review arrangements in Wales which include a continuum of review (multi agency professional forums; concise reviews; extended reviews) (see Appendix 2) and consider the appropriateness of updating the national guidance to include different levels of review

12 The decision not to interview staff may be appropriate but where staff views have not been sought SCR reports should include information about whether there was any consideration about involving them and why the decision was made not to involve them. All SCR reports should document how the findings of the review will be fed back to frontline staff

13 All SCR reports should reflect upon good practice as well as on what needs to change

14 SCR reports should record the length of time it took to undertake the review and set out any reasons for delay

15 Authorities are subject to the public sector equality duty. They should consider the relevance of protected characteristics such as age, disability, race, religion, sex and sexual orientation and ensure appropriate monitoring. Any associated cultural issues should also be considered and documented.

16 Some of the deaths of babies are accidental but preventable. Mothers and fathers of vulnerable children should be given ongoing information about safe sleep as well as at the time of their baby's birth. The Scottish Government is currently updating its Getting our Priorities Right (GOPR) Guidance and should consider including advice for professionals to warn mothers with a substance misuse problem who breastfeed to make sure they return their baby straight to his or her cot after feeding as they may be more inclined to fall asleep

17 SCRs should include information about the family's economic situation

18 SCR should record the level of involvement with SCRA

19 All staff and students in social work, social care, education, health and the police should receive training on issues that have arisen from this and other studies of SCRs

20 All staff working with children and families and students training to work with children and families in Scotland should have regular training in working with difficult to engage and hostile parents and young people

Background to the research

Introduction

This report presents the findings from an audit and analysis of Significant Case Reviews (SCRs) conducted in Scotland since 2007. The views expressed in this report are the authors and do not necessarily reflect those of the Scottish Government.

The policy context

The Scottish Government ministers have set out a vision that they want Scotland to be the best place in the world to grow up, and to bring up children. In 2010, the fully revised National Guidance on Child Protection in Scotland (Scottish Government 2010) was published. This, together with Getting it Right for Every Child (GIRFEC), has become the foundation of the work all agencies undertake in order to protect vulnerable children and young people. The evolution of the child protection guidance and also the GIRFEC national change programme has led to a change in language and philosophy. As a result, children should now be at the centre of decision making processes and their needs should be central to all decisions taken by local services. The introduction of the GIRFEC approach means that interventions should be put in place earlier by services when the likelihood of risk to the child – including their general well-being – is first identified.

National guidance for undertaking significant case reviews was introduced in Scotland in 2007 - 'Protecting Children and Young People: Interim Guidance for Child Protection Committees for Conducting a Significant Case Review[1]'. The national 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 (SCR), both locally and across Scotland' (Scottish Executive 2007).

There was, therefore, a commitment within the national guidance to promote national, as well as local learning. However, in contrast to England and Wales where national analyses of case reviews are commissioned bi-annually, the findings from SCRs have not yet been collated at national level in Scotland and accessible data on the number of SCRs that have been undertaken is not readily available. As a result, the value of learning in SCRs to date has been limited, with lessons insufficiently shared beyond local boundaries.

The Scottish Government commissioned an independent short-life working group of key multi-agency professionals in November 2009 to consider the SCR process in the light of recent research and practice. The key aims were to make recommendations to help improve consistency and practice, and to help Child Protection Committees (CPCs) build confidence and capacity in undertaking SCRs.

[1] This guidance will be referred to as 'the national guidance' throughout the report

The group, headed up by Beth Smith, Director of WithScotland, formerly MARS (the Multi-Agency Resource Service, Scotland's centre of child protection expertise housed at Stirling University), made 10 specific recommendations to the Scottish Government to improve the SCR process in Scotland.

This included a recommendation that they should commission an audit and analysis of all SCRs undertaken since 2007 to provide a baseline and an understanding of the relevant issues for practice. The full report and the Scottish Government's response were discussed at a national SCR conference for professionals in child protection on 11 November 2010. The recommendations were signed off by the then Minister for Children and Early Years, Adam Ingram, as part of the Scottish Government's key priorities on child protection. In January 2012 the Scottish Government commissioned Alison Petch (IRISS) in partnership with Sharon Vincent (University of Wolverhampton) to undertake the audit and analysis of SCRs. This work was supported by a Research Advisory Group made up of key officials from CPCs and chaired by the Scottish Government.

Aims and Objectives

The purpose of the research was to provide key baseline data on the profile, numbers and emerging themes from SCRs conducted in Scotland since 2007, and make conclusions and recommendations about the nature and characteristics of factors which can lead to a SCR, lessons that can be learned both locally and nationally and implications for both policy and practice. The analysis of SCRs in the study was to be considered against the national guidance and any additional SCR support material.

The Scottish Government and partners want to ensure that they have a system of learning and reviewing that is fit for purpose and leads to improvements in inter-agency child protection practice to protect children in Scotland. The findings of this study were expected to feed into the overall body of knowledge in this field as well as into long-term development and training plans for those involved in the SCR process both locally and nationally and into the work of the Care Inspectorate. SCRs already feature as part of the scrutiny process of child protection services across Scotland and future studies of SCRs will build on the information gained from this study and the findings will inform future policy, guidance and practice.

A key part of the research study was to help develop a national database that could be used to populate information for the future collection and analysis of SCRs. This will be an extremely useful national resource for Scotland.

The objectives for the analysis of SCRs from 2007 onwards were as follows:

1. To collate and describe data on Initial Case Reviews (ICRs).

2. To compare those ICRs which do and do not become SCRs and explore the potential contributory factors for these different outcomes.

3. To analyse the data to produce descriptive statistics and findings in relation to initial themes and trends emerging and to reflect on the potential learning from these themes and trends.

4. To consider the cases from the perspective of family-level harm or community level harm.

5. To provide an analysis and preliminary categorisation of cases of death and serious injury.

6. To provide a discussion of the implications of this audit and analysis for future local and national policy and practice in Scotland including the future of SCRs. This should incorporate comparisons from themes emerging from existing biennial reviews undertaken in England and Wales.

Methodology

To ensure that a full understanding of SCRs was obtained, a methodology of qualitative and quantitative analysis was applied to identify the main emerging themes as specified by the Scottish Government. We adopted a content analysis approach, which drew on methods used effectively in analyses of case reviews in England and Scotland (Vincent et al, 2007; Vincent, 2009). We wanted to make some comparison with information from analyses of serious case reviews in other parts of the UK and the development of the research instruments was, therefore, informed by those used in previous studies. However, we wanted to remain open to the possibility that new themes might emerge from the Scottish data and our method ensured that themes emerged from the data and that the data was not forced into preconceived categories. Our method involved elements of a case study approach so we could undertake analysis on a case by case basis as well as a cross case basis. This enabled us to pull together findings across the reports but also allowed us to examine the complexities of individual cases in greater depth. Such an approach permitted in-depth analysis of the interaction of child, family, environmental and agency factors and exploration of the different causal pathways to death or harm. This enabled us to examine in depth the role that different agencies played in supporting the case children and their families.

The study was carried out in a number of phases.

- Phase 1: Initial mapping and collation
- Phase 2: Reading, coding and analysis
- Phase 3: Final analysis.

The number of SCRs that had been undertaken in the 30 CPCs in Scotland since 2007 was not known prior to this study. Phase 1 was, therefore, a mapping and collation exercise to identify how many ICRs and SCRs had been undertaken since the national guidance was issued. All CPCs in Scotland were asked to send the

Scottish Government all the SCRs they had completed since the national guidance was issued. All 30 CPCs responded to the request and 56 password protected reviews were sent to the Scottish Government and forwarded to the researchers to ensure confidentiality. We are confident that the 56 reviews we analysed comprise all SCRs completed in Scotland since the national guidance was issued in 2007 up to March 2012, the date by which CPCs were asked to submit completed reports.

Phase 2 of the research involved the reading/rereading of the reports, and coding and analysis of data. A template was devised to capture anonymised information about the SCR process, as well as more detailed, qualitative information about the type of case, factors relating to the children, the characteristics of the family and their involvement with agencies, as well as factors relating to professional practice. This template will now be passed to the Care Inspectorate.

Final analysis occurred on a case by case and cross case basis. The analysis considered:

- Recurrent themes and features
- What common features could be identified to inform practitioners and agencies about risk and serious harm
- How findings in Scotland compare with findings elsewhere in the UK and whether there are any Scotland specific findings, which have not been found in other parts of the UK
- What national policy and practice issues arose from the reports.

Limitations of the study

In drawing together common themes, it is important to remember that the number of SCRs in Scotland is relatively small and caution needs to be exercised when considering the findings. We have attempted to compare the findings of this study with findings from studies undertaken in other parts of the UK but the findings may not be directly comparable, not least because of the smaller numbers in Scotland compared to England. We are, however, confident that we have been able to collate all the SCRs undertaken in Scotland since the national guidance was issued in 2007, so while the numbers are small in comparison with some of the English studies, the findings of this study nevertheless provide important baseline data for Scotland on which future analyses can build.

We were reliant on the data available in the reports and significant gaps in the data affected the accuracy of some of the findings. Some SCR reports provided very little information about the family. We encountered many of the same problems as Brandon et al (2009):

- There was often very little detail about parents' pasts.
- There was limited information about men in families; (one report refers to the lack of information about men stating that 'there is a real danger that, because some families seem to be subject to continuous 'reforming', it becomes so commonplace that its significance is overlooked').
- Information about the child was sometimes limited because review teams investigated processes rather than considering the child's circumstances. In some cases we were unable to establish the child's age or gender and ethnicity and disability were rarely recorded.
- There was limited information about the family's environment, for example, whether they were working and what their financial circumstances were. Poverty can cause considerable stress to families and impact on parenting capacity and it is important to be able to understand these issues.
- In some cases there was limited information about organisational culture, for example, a lack of analysis of the emotional impact for staff of working with non-cooperative, sometimes hostile families, in a context of staff shortages. Some SCRs involved file audit only and in some of these cases the impact on staff was not fully understood.

Missing information meant that we were not always able to gain a full understanding of the case and the incident which led to the child being harmed or killed. Better information is needed about the children and their families and organisational culture needs to be more fully understood.

> 'Unless more information is provided about the child and his or her family, and their
> relationships and behaviour within and beyond the family, it will not be possible to
> understand why the child was seriously harmed or killed. Service provision and inter-agency working cannot be fully understood in isolation from a proper ecological analysis of the case.' (Brandon et al 2009 p. 75)

It is probable that missing data has resulted in an under estimation of the incidence of many of the child and family characteristics reported in this study and, as in studies undertaken in other parts of the UK, such limitations mean that caution must be exercised in interpreting the findings. We have made a number of recommendations to improve the SCR process in Scotland and to ensure that CPCs record important data to enable more accurate comparability of the data in the future. We have also designed and populated a spreadsheet of anonymised information about SCRs, which will now be passed to the Care Inspectorate to support the development of their national SCR database. This will enable Scotland to improve

the quality of its national evidence base around SCRs and allow useful comparison of SCR data over time.

Finally, as Brandon et al (2009) have pointed out, it is important to remember that SCRs are not a reflection of typical child protection practice. Death and significant injury is relatively rare, the large majority of children are well protected and we need to ensure that we put as much emphasis on learning from cases where things work well as we do on learning from cases where things have gone wrong.

Structure of the report

Chapter 1 describes the SCR Process. It considers the extent to which CPCs are following the national guidance in relation to ICRs and SCRs and makes recommendations for standardising processes across Scotland.

Chapter 2 considers the types of cases the SCRs related to, describes the characteristics of the children and families who were the subjects of SCRs, provides information about the environments in which they lived and describes the contact they had with different agencies.

Chapter 3 considers the main practice themes that were identified in the SCRs.

Chapter 4 attempts to provide an understanding of risk by considering the various child, family and agency factors involved in SCRs. It considers the ways in which various risks interact in individual cases to result in the death of, or harm to, a child.

The final conclusions and recommendations section highlights some of the national policy issues and lists all of the recommendations made in chapters 1 to 4.

In addition to recommendations, learning points for practice are identified throughout the report and a number of practice examples have been taken from the SCR reports to illustrate some of the main points. Anonymised quotes and case studies from the SCR reports have also been used to illustrate the main findings. All of the names that are used in chapter 4 are fictitious. Case studies and quotes have been included in the report because they significantly strengthen the learning potential of the study but we must bear in mind, as noted above, that the children and families whose circumstances form the subject of an SCR are a very small proportion of the total population of children and families known to statutory services. By their very nature SCRs focus on cases where things have gone wrong and the practice which is described in this report is not, therefore, representative of all practice undertaken by children and adult services in Scotland.

Chapter 1: The Significant Case Review process

1.1 Introduction

This chapter describes the SCR Process. It considers the extent to which CPCs are following the national guidance in relation to ICRs and SCRs and makes recommendations for standardising processes across Scotland.

1.2 Initial Case Reviews (ICRs)

An ICR is a process carried out by CPCs after receiving a report of a possible significant case. The purpose of an ICR, as explained in the national guidance, is to determine whether or not a SCR is merited (see Box 1 below).

Initial case reviews

Where a case arises which appears to meet the criteria for a SCR set out in the national guidance, the Reporting Officer must notify the CPC using the ICR Report template which is included in the national guidance.

The national guidance stipulates that the Reporting Officer should notify the CPC within one working day of identifying the case, where this is feasible. The Reporting Officer should, at the same time, notify all other agencies or persons known to be involved with the child of their report to the CPC using the template. All these agencies or persons should submit their own report(s) to the CPC within 10 working days, also using the ICR Report template. If the Reporting Officer or agencies cannot reasonably complete the ICR Report for the CPC within the suggested times, that should not detract from agencies taking whatever urgent action is required to protect any other children who may be at risk.

The CPC will then consider whether the information is sufficient to reach a decision on the need for an SCR or whether further information is required before a measured decision can be taken. The national guidance states that in order to decide whether more information is necessary, the CPC may find that preparing a co-ordinated chronology brings out the need for such information. If the CPC decides that more information is necessary, it will stipulate what this is, and will decide which agencies must provide it. This information should be provided within 20 working days, where this is feasible.

The national guidance states that the ICR should deal with the following matters:

- A brief description of the case and the basis for referral;
- A co-ordinated chronology of events;
- A note of agency/professional involvement;
- 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;
- Any other formal proceedings underway;
- Any elements of poor practice;
- Any elements of good practice;

- Any particular sensitivities (e.g. from the Procurator Fiscal (PF) or Police about cases where there are likely to be disciplinary proceedings);
- Lead contacts for each agency; and
- The CPC's decision as to whether or not to proceed to an SCR, with reasons.

The ICR may lead to a number of outcomes:

- No further review;
- No further review needed but follow-up action desirable;
- Initiation of local action to rectify an immediate issue; or
- An SCR, and the CPC to decide on which kind of SCR to commission.

The national guidance also stipulates that each CPC should maintain a register of all potentially significant cases referred to it in order to:

- Evidence the decisions made;
- Monitor the progress of the reviews undertaken;
- Monitor and review the implementation of recommendations; and
- Identify contextual trends (e.g. prevalence of substance misuse).

1.3 The ICRs: type of case and child characteristics

We received and analysed 43 ICRs:

- 20 related to deaths of children and young people
- 22 were non-fatal cases
- One did not specify whether the case involved a death or not (though the national guidance states that the ICR should include a brief description of the case)
- 12 involved teenagers; two concerned 11 year olds; 11 concerned children aged two to five; two were age 6 to 12 months; nine were five months or under; the child's age was not specified in the remaining seven cases (although the recommended template in the national guidance includes the child's date of birth)
- Nine concerned looked after children (LAC); and in 12 cases children were recorded as being on the Child Protection Register (CPR).

1.4 Findings from the analysis of ICRs

Some CPCs submitted a lot of ICRs and no SCRs; others sent us SCRs but no ICRs. We expected to receive more ICRs than SCRs since ICRs are undertaken to determine whether or not to have a SCR but some CPCs only seem to have sent us ICRs which did not proceed to SCR. We are not, therefore, confident we received all ICRs which have been undertaken in Scotland since the national guidance was issued in 2007, although it is possible that contrary to the national guidance some

CPCs proceed straight to an SCR. The national guidance stipulates that CPCs should maintain a register of all potentially significant cases referred to them. One CPC sent us their full register of ICRs which was extremely useful because we could be sure we had received all ICRs from that particular CPC.

There appears to be a lack of consistency across Scotland concerning the ICR process. Despite the fact that the national guidance includes a reporting template, reporting structures vary considerably across CPCs. The process set out in the national guidance appears to be being followed in that agencies seem to undertake their own reviews and produce a single agency report, then come together for some sort of multi-agency discussion at which a decision is made as to whether or not to proceed to a SCR. There may be more than one meeting; for example, in one case the ICR report stated that there were three panel meetings to consider the information from various agencies, identify practice issues and make a decision.

Although the national guidance stipulates that the ICR should consider the reasons for a decision, in many cases reasons were not recorded. Some of the cases which did not proceed to SCR seemed very similar to those that did and it would have been useful to have had more information about why these cases did not proceed. For example, a number of sleep related deaths where there were no suspicious circumstances but the child was on the CPR did not proceed; there were also a number of suicides of LAC which did not proceed. These types of cases also featured in our sample of SCRs. One ICR concerned a baby on the CPR who died after being assaulted by his father in hospital. His parents were living in a family unit and the decision not to proceed seemed surprising given that the criteria for a SCR appeared to have been met. In another case, a child was found alone with her dead mother who had overdosed. There had been a previous incident where the child had been found alone with her mother but on this occasion she had recovered. The outcome of this ICR was that health and social work should undertake internal reviews. This case also seemed to meet the criteria for an SCR, indeed there were cases like this in our sample of SCRs, and it is surprising that internal reviews were recommended when more than one agency was involved.

A number of ICRs that did not proceed to SCR involved LAC and it is possible that these cases may not have proceeded because there is a separate review process for the deaths of LAC undertaken by the Care Inspectorate. However, none of the ICR reports recorded this as the reason for not proceeding and our sample of SCRs included deaths of LAC so in some CPCs such cases clearly do proceed to SCR. Indeed one SCR report stated that the CPC had decided to undertake an SCR because it considered an earlier Social Work Inspection Agency (SWIA) review had not provided enough information to guide the service in making improvements.

Where reasons for not proceeding to SCR were offered this was sometimes because the CPC considered that the issues had been fully explored by the ICR. Certainly,

the more detailed ICRs thoroughly explored the issues. Other reasons cited were that there would be no expected learning from the case, or that the criteria for undertaking a SCR were not met. In one case where a young person on the CPR had died in a car accident and was a passenger in a stolen car, it was concluded that a full SCR was not required because the circumstances leading to the young person being on the CPR were not related to the death.

Recommendation 1: The SCR process and separate process for review of the deaths of LAC should be better aligned.

Some ICRs concluded that a single agency review or case file audit would be more appropriate than a SCR. As will be seen below, however, some SCRs only involve case file audit and do not interview staff which suggests that some cases that do and do not proceed to SCR may in fact be reviewed in exactly the same way. This may be related to differing definitions of what constitutes a SCR across CPCs which is further explored below. In one case where the outcome of the ICR was that a SCR was not required but there should be a case file review it was noted that the Scottish Children's Reporter's Administration (SCRA) would not share documents for case file reviews and this may have some impact on decisions.

In a small number of cases ICRs stated that the decision not to have a SCR might be reviewed following the results of a criminal examination or toxicology report.

Very few CPCs appeared to be using the reporting template but some had developed their own forms. For example, one had an initial notification form with a tracking section with key dates to be inserted but the dates were not always filled in. The national guidance includes suggested timescales for completion of ICRs but in most cases it was not possible to determine whether these timescales had been met from the information provided in the report.

Some ICR reports were long and included detailed background information about the child and family but others were much shorter with very little information about the case or the family. Some reports identified good practice as well as poor practice in line with the guidance and also included chronologies, made recommendations for improved practice, and outlined action points; others did not.

Case example
One CPC's ICR reports included excellent discussion around whether or not to proceed to SCR and whether or not the criteria for a SCR were met; the views of different agencies were also reflected. When cases did not proceed, case reviews were sometimes recommended so that professionals could still get together to discuss the case. Where cases did proceed, decisions around who should be on the SCR review team, for example whether SCRA needed to be included, were well documented.

Recommendation 2: There needs to be more standardisation in the way in which ICRs are undertaken and reported across Scotland. CPCs should follow the national guidance, use the recording template and keep a register of cases. The template should be revised to include a section where CPCs can record the reason for their decision.

1.5 The Significant Case Review (SCR) process

The national guidance sets out the criteria for determining whether a case is significant (see box below).

Criteria for Significant Case Reviews (SCRs)
'A significant case need not comprise just one significant incident. Any of the circumstances below could suggest that a SCR may be required. An ICR should first determine whether an SCR is merited. The detail and level of review will depend on the individual case and circumstances. A review should not be escalated beyond what is proportionate taking account of the severity and complexity of the case. What is provided in this section is a guide for helping CPCs, professionals, and all agencies make judgements about the way forward. The list should not be seen to exclude cases that may not precisely fit the criteria but which have nevertheless clearly triggered significant professional concern. These cases should be left to professional judgement and a CPC decision on how to proceed.

When a child dies and:
• 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 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 CPC that the child having been on the CPR has no bearing on the case;
• The death is by suicide or accidental death;
• The death is by alleged murder, culpable homicide, reckless conduct, or act of violence;
• The child was looked after by the local authority;
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.

When a child has not died but has sustained significant harm or risk of significant harm, under one or more of the categories of abuse and neglect set out in 'Protecting Children – A Shared Responsibility: Guidance for Inter-Agency Co-operation'. Bear in mind that cumulative inaction or wrong action may be more difficult to evidence but nevertheless should be considered to the best extent possible, ***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. It is expected that CPCs would consider any request made to them for a review, even if the case had been considered at the Initial Case Review to require no further action. It would also be expected that any concerns raised by families and similar interested parties would be addressed through the normal complaints procedures for each agency involved'.

Recommendation 3: The 2010 National Child Protection Guidance replaced 'Protecting Children – A Shared Responsibility: Guidance for Inter-Agency Co-operation' and the categories of abuse and neglect have changed. The national guidance should be revised to take account of this.

1.6 Terminology

The findings of this study suggest that there is some confusion around terminology and what constitutes a SCR across CPCs. In response to our request for copies of all SCRs undertaken since national guidance was issued in 2007, CPCs sent us all their SCRs but some also sent us 'Significant Incident Reviews', 'Critical Incident Reviews', 'Reflective Learning Reviews' and 'Learning Reviews'. We included all these reports in the analysis for a number of reasons:

- while they were not termed SCRs, CPCs sent them in response to our request for SCRs so must have perceived them to be SCRs;
- they were all multi-agency reviews;
- they all appeared to meet the criteria for a SCR as specified in the box above.

It is possible that some CPCs are reluctant to call a review a 'Significant Case Review' because of the negative connotations associated with such reviews. One CPC informed us that they only called a review an SCR if it was externally commissioned but the guidance specifies that SCRs can be internal or externally commissioned and offers advice on which type of review might be more appropriate:

> 'The CPC may be more likely to decide in favour of undertaking an SCR themselves where the circumstances of the case, based on the evidence of the Initial Case Review, suggests that any recommendations are likely to have mainly local impact. In this case, the staffing resources for the SCR would

probably be drawn mainly from within the CPC's members. An external specialist or consultant may also be used for some part of the process … The criteria which may persuade a CPC to commission an external SCR include:

- There are likely to be national as well as local recommendations;
- Local recommendations are likely to be multi-agency rather than for a single agency;
- The case is already high profile, or is potentially likely to attract a lot of media attention;
- Councillors or MSPs or other elected members have voiced their concerns about services locally;
- The CPC is facing multiple reviews; and/or
- The child's family/carers or significant adults may have already expressed concerns about the actions of the agencies'.

One SCR report provided a very useful discussion about whether or not the case met the criteria for an external review as set out in the guidance. It was decided that only one of the criteria was met and this alone was not sufficient to warrant an external SCR.

Recommendation 4: **All reviews that are multi-agency and meet the criteria for a SCR as set out in the national guidance should be termed SCRs to avoid confusion.**

1.7 Cross border SCRs

Two SCRs were cross border cases. One involved a case where a young person had lived in both Scotland and England and the SCR related only to the Scottish element. The other case similarly stated that it would not comment on practice outwith the area in which the incident, and subsequent accommodation of the children, took place. In a further case, the report states that information sought from an English authority was not received promptly and held up the SCR. England's Serious Case Review (SCR) processes are different to review processes in Scotland and there may be issues for CPCs undertaking cross border SCRs.

Recommendation 5: The national guidance should be updated to include information about the process of undertaking cross border SCRs.

1.8 The review team

The national guidance states that:

> 'The best person to lead a review may be a recognised professional or external consultant who can bring a team together. It is important to assemble a mixed team so that the key agencies feel confident that their specialist issues are understood. The different perspectives of a mixed review team can add to the depth of enquiry.'

It also states that the SCR report should include a list of contributors to the review but some reports had no information about the review team. 34 reports included information about the size of the team. Six reviews were undertaken by a single independent consultant but most were undertaken by multi-disciplinary review teams.

Table 1: Size of the review team

Size of review team	**Number of reports**
1	6
2	2
3	4
4	6
5	6
6	1
7	4
8	3
9	1
10	1
No information	22
Total	**56**

20 reports mentioned that the review team included some sort of independent representation:

- Five were conducted by an independent chair.
- Nine were undertaken by independent consultants.
- One review team sought professional advice from another local authority.
- One team commissioned an independent analyst to produce a timeline.
- One review had a large team comprising two lead reviewers (a nurse consultant from the health board and a lead officer of the CPC) plus representatives from the health board, education, police, social work, a third sector agency, and a critical friend identified through MARS.

In two cases both internal and external reviews appear to have been undertaken: one report stated that an internal SCR was followed by an external review of the process by a lead officer of a CPC from a different local authority, plus a nurse consultant for vulnerable children; in another case an independent review was commissioned by the Chief Officers Group at the same time as an internal review was undertaken to ensure validation of the SCR and to address wider issues which might emerge.

Recommendation 6: As specified in the national guidance SCRs should be undertaken by a mixed team not by a single reviewer and reports should include a list of contributors to the review.

1.9 The report

The average number of pages was 25. The shortest report was just two pages long; the longest was 87 pages.

Table 2: Length of reports

Number of pages	Number of reports
Under 10	14
10-19	13
20-29	11
30-39	9
40-49	2
50 plus	7
Total	**56**

The national guidance states that SCRs should include a chronology of agencies' and professionals' involvement with the child:

- More than half (32) the reports included a standalone chronology.
- An additional four reports did not have a separate chronology but took a chronological approach to reporting which is a useful way of presenting information about the case.
- A further eight reports referred to a chronology, sometimes in an appendix, but these were not sent to us.
- Another three reports mentioned that a chronology was being prepared.
- Nine reports did not include a chronology or make any reference to one.

The national guidance also specifies that there should be a separate executive summary but surprisingly few reports included one. Two of the reports we were sent were executive summaries only but one of these was longer than many of the full reports.

Recommendation 7: SCR reports should include a separate chronology or take a chronological approach.

Recommendation 8: SCR reports should include a separate executive summary as specified in the national guidance.

1.10 Recommendations and action plans

The national guidance states that recommendations should be few in number. The average number of recommendations was 11. The least number was zero, the most was 48. Some individual recommendations were, however, fairly long and detailed and comprised a number of sub sections. It was difficult in such cases to establish the total number of recommendations because one recommendation might comprise up to five separate sub recommendations.

Table 3: Number of recommendations

Number of recommendations	Number of reports
0 to 5	16
6 to 9	12
10 to 14	14
15 to 19	8
20 to 24	3
25 and over	3
Total	**56**

Twelve reports included an action plan and one further report referred to an action plan in an appendix but we were not sent this information. 43 reports did not include an action plan but some of these reports stated that agencies would be required to develop action plans; a couple of reports stated that recommendations would be progressed through the Continuous Improvement Plan; another stated that the CPC would consider the recommendations and support agencies to take them forward; and one included a form for completion by the CPC.

The recommendations have been categorised according to the Quality Indicators (See Appendix 1).

Recommendation 9: It may be appropriate for CPCs to produce separate action plans rather than including them in the SCR report but reports should provide some discussion of how the findings will be disseminated and how the recommendations will be taken forward.

1.11 Family involvement

The national guidance provides information about the involvement of families in the review process (see box below).

Family involvement
'The family/carers of the child involved should be kept informed of the various stages of the review and the outcomes of these where this is appropriate. Clearly, there will be occasions where the family could be subject to investigation or part of the problem relating to the significant case which triggered the SCR. In these cases information may require to be limited. Close collaboration with the Police and the Procurator Fiscal will be vital. There may also be cases where families are looking to take 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 should not be the responsibility of the CPCs or specifically of the review team. Care should be taken about where and when a child or their family/carers are interviewed. Reviewers should be experienced in communicating with children. It may also be useful to assign a member of staff to be a liaison point throughout the review. 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 … Family/carers and/or other significant adults in the child's life should receive a copy of any report in advance of publication. Consideration should be given as to whether an oral briefing 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'.

The national guidance states that the SCR report should document the extent of family/carer involvement but in over half (30) of cases the report contained no information about family involvement and we were unable to deduce whether families were informed or whether they participated in any of these cases. In four cases the report stated that families did not participate but there is no information about whether they were invited to participate or not, with the exception of a statement in one case that the family were unaware of the SCR. In six cases, the report stated that a decision was made not to contact the family. In one of these cases the decision was made at the request of the police. In the other five cases the review team made this decision. The decision not to invite families to participate was usually made because criminal proceedings were being conducted and/or because of intense media publicity surrounding the case. For example:

> 'The solicitor representing M had already stated that she was not willing to meet the Review before she had received the decision as to the criminal inquiry.

> The review team subsequently concluded that it would not be necessary to interview her.'

In one case, however, the report stated that there was a conscious decision not to interview the family given that the SCR was 'concentrating on practice, policies and procedures of the agencies who were involved with the family'. This seems surprising since families may have views about practice, policy and procedures that would be different from professionals and worthy of consideration.

Sixteen reports included evidence of some communication with families. In three cases families were informed but declined to participate. In one of these cases, the review team contacted a Children's Rights Officer to ask the children if they wished to participate. They responded that they might wish to be consulted in the future but not at that stage. The CPC was, however, asked to consider the effects on the children when considering the report for publication as they would be adversely affected by any media coverage relating to the case. In another case the family were informed about the review, and about the outcome of the review, but there is no information about whether they were actually asked to participate. The report states only that:

> 'The relevant social worker discussed the purpose and process of the review with the parents and hand delivered a letter from the CPC which advised them of the decision'.

There is evidence that families participated in twelve SCRs. One report states that the team met with the family but there is no further information about the nature of this involvement. In two cases adoptive parents were interviewed and in one case the child's grandparents participated and the review report states that

> 'They have shown enormous integrity and dignity throughout this process, and have been very measured in their responses.'

Practice example
In one case both birth parents had learning disabilities but contributed to the SCR process through an advocacy worker.

Mothers participated in a further four cases. In one of these cases, the report noted that the team met with the mother on two occasions and had further communication with her by email and letter. In two of the cases where mothers were interviewed fathers were also invited to participate but declined to do so. In one of these cases the father initially agreed to meet the team but further contact could not be achieved. The review team also considered whether to involve the two older children in this case but decided this would be inappropriate considering what they had been through. The report also noted that the team attempted to obtain the trial transcript of

evidence from the oldest child but were unsuccessful. In one case the child's ex foster carer and adult sibling were interviewed as well as the mother and in another case the referring relative was also interviewed. In this case there was a detailed discussion with the mother and an appendix to the report drew on her perspective on domestic abuse.

In one case the child's father and his current wife requested a meeting with the review team and questions posed by him were listed in an Appendix. This report also noted that the child's mother was aware of the review but declined to be involved.

One report stated that four family members (the parents and the two eldest children) all accepted an invitation to participate in the review 'and their compelling views are included in the relevant sections of this report.'

A young person contributed in one further case. This was an unusual case where an SCR had been undertaken following the young person's complaints about the standard of care he received in a young person's unit. The report stated that

> 'The first Chair of the Review considered whether or not C, as a young person, should be involved in the Review. He concluded that given his age and his contact with the CPC office enquiring as to the progress of the Review, it would be appropriate to see him to explain the remit of the Review. As a result the Chair and the Lead Officer saw him on two occasions. It was apparent from these meetings that his only concerns were that as his complaints had been upheld and they represented a sustained course of negligence by Social Work and that other children in his situation should be protected from experiencing similar treatment. The Significant Case Review Panel subsequently determined he should not be involved in the Review. At the point where the second Chair of the Review assumed responsibility for completion of the SCR report, C had been informed of this and two telephone conversations took place between the second Chair and C focussed on the process and timescales for completion of the Review report. C has asked that the final report is shared with him.'

Recommendation 10: In line with the national guidance SCR reports should include information about whether or not children and families were informed and involved. If they were not involved reports should record why they were not involved. If they were involved reports should record the nature of this involvement and document how their views have been represented. Diversity issues should be considered and adequate support should be provided to ensure that family members are able to participate.

1.12 Approach

Few reports included any detail about the methodological approach which was taken but one stated that root cause analysis was used and another stated that the chronology was analysed using the timeline tool from the 'Root Cause Analysis toolkit'.

Some reports indicated that staff were interviewed but others stated that the review was based on file audit only and that staff were not included. One stated that staff were not interviewed because many of them had moved on. Another stated that

> 'Having not had the opportunity to speak with staff the writer is unable to comment on what agency constraints may have impacted on this case and this requires to be borne in mind by the reader.'

In many cases there may be good reason not to interview staff but in this particular case the report writer appears to view the absence of the staff perspective as a missed opportunity. As one report noted 'the Team considered the working environment in which practitioners operate to be crucial'. Frontline staff can offer valuable insights into their working environment and we need to seek their views in order to be able to understand practice from a systems perspective. Some reviews that were based on documentary analysis identified recording as problematic and inevitably there was a somewhat 'thin' feel to some of the analysis in these reports. Staff also welcomed the chance to be involved in reviews. One SCR commented that staff needed support following a child death. In this case residential staff reported that they felt marginalised and would have welcomed the opportunity to talk about how they felt and reflect on the circumstances of the case.

One report stated that a member of the review group held separate meetings with practitioners and managers from each of the six agencies involved. The groups identified key points where opportunities were missed to protect the children earlier. This sounds like a very useful, reflective approach where individual members of staff are not made to feel as though they are under interrogation by being interviewed alone but have an opportunity to be involved in the review process. The report stated that

> 'The SCR group believes this methodology should be independently evaluated in relation to its effectiveness and possible use for future SCRs.'

Another review team set up a sub-group to 'identify points of learning in relation to individual and multi-agency practice'.

One report took an interesting approach in the way it reported its findings, identifying areas of strength and areas for improvement under 12 significant themes; another

listed recommendations as Benchmarking Questions. One report summarised the findings under the HMIe Quality Indicators (2004) – how well are children and young people protected and their needs met i.e:

- How effective is the help children get when they need it
- How effectively do services promote public awareness of child protection
- How good is the delivery of key processes
- How good is operational management in protecting children and meeting their needs
- How good is individual and collective leadership?

Practice example
One SCR report was particularly reflective. It was noted that this was the first SCR this CPC had undertaken and that they wanted it to be a 'learning process'. The aims of the review were well thought out. The focus of the review was 'to take a comprehensive look at agency and inter-agency involvement and decision-making with a view to considering

- Were there any aspects of agency action or inaction that may have contributed or failed to prevent this tragedy? If so, what were they?
- What, realistically, could be put in place to reduce the likelihood of a similar incident occurring in future and how should any recommended action be monitored or audited?'

Particular areas for exploration were also outlined: 'thresholds regarding domestic abuse and substance abuse, in particular alcohol use; response to specific incidents, in particular three police concern forms and referral from a family member; the way cumulative factors were dealt with; and appropriateness of any assessment work, including degree to which men involved in the family were included in this; sharing information within and between agencies and use of the initial referral checklist in child protection procedures'.

Key features of the approach included working in pairs; viewing family members as central to the process; using the review as a 'window into practice'; an integrated chronology; identifying areas of good practice; and using identified issues to 'guide' conversation with practitioners. This careful reflection resulted in an unusually detailed and painstaking account of the wider family context of the child being presented in the report, which paid equal attention to the father of the two older children and his role in the life of the mother as well as the father of the child who died. This SCR might be used as an exemplar but it related to a very high profile case. It was also a lengthy procedure and not all cases may require such a long, reflective review.

Recommendation 11: The national guidance states that 'A review should not be escalated beyond what is proportionate taking account of the severity and complexity of the case.' The SG should look at new review arrangements in Wales which include a continuum of review (multi agency professional forums;

concise reviews; extended reviews) (see Appendix 2) and consider the appropriateness of updating the national guidance to include different levels of review.

A number of reports stated that their remit included the identification of good practice, for example:

> 'Thus the Review looked at areas which appeared to have worked poorly but also at what was working well in order to identify where strength could be added. The Team considered this approach to be the most appropriate one to take in order to avoid negative perceptions of blame and fault finding.'

> 'The review should be understood as a process for learning and improving services to children and as a means of recognising good practice.'

Thirty three reports included some discussion of good practice.

Recommendation 12: The decision not to interview staff may be appropriate but where staff views have not been sought SCR reports should include information about whether there was any consideration about involving them and why the decision was made not to involve them. All SCR reports should document how the findings of the review will be fed back to frontline staff.

Recommendation 13: All SCR reports should reflect upon good practice as well as on what needs to change.

1.13 Timescales

In comparison with other parts of the UK the Scottish national guidance does not include specified timescales for undertaking an SCR (Vincent 2010). There was no information in the reports about how long 39 of the SCRs took to complete. 17 reports included information about completion times:

- three took less than six months to complete
- seven took between six and 12 months
- seven took over a year, with the longest taking 20 months.

Several reports mentioned that SCRs were held up as a result of ongoing criminal investigations. For example:

> 'My report was delayed and hampered by the Crown's failure to share information with me for a period of over 12 weeks, despite the fact that there was an agreement that my report would remain confidential until after the

> prosecution – in the event of a prosecution … While ultimately, my report has not disclosed any element of procedure or policy which might have put children at risk and which required to be remedied, such a delay in co-operation could have had a profound effect if my enquiries had proved otherwise'.
>
> 'The Review period was originally set at three months. However it immediately became clear that this would not be sufficient in all the circumstances. In particular as inquiries by the Crown Office and Procurator Fiscal Service (the Prosecuting Authorities) were then in hand it was not possible to progress the Review by interviewing witnesses which, in the circumstances of the case, the team considered an essential element of the Review. The Review process began in early 2009 but was effectively suspended while the criminal and prosecution processes were in hand … The progress of the Review during 2009 was inhibited by awaiting the outcome of the criminal inquiry and potential Fatal Accident Inquiry processes. Although the team members are content that the duration of the Review has been reasonable in all the circumstances it is recommend that any future Review should consider, inter alia; - staff resilience; the impact of the pressure of normal duties; and a commitment to achieving as short a period of review as the circumstances of the case allow, in order to ensure it is completed more expeditiously.'

One report stated that the

> 'Independent Chair of the CPC and Chief Officers Group wished the SCR to be commissioned quickly to implement any recommendations – to await the outcome of any criminal process would significantly delay the implementation of action in any areas that required to be strengthened'.

In this case the review team negotiated with the PF to allow an action plan to be developed while the report was still sub judice. The SCR was then initiated once the police enquiry was completed and following the decision by the PF that there would be no prosecutions (three months after the child's death). In another case a redacted SCR was produced. This provided useful context and addressed the issue of at what stage an SCR can be conducted when there is an ongoing criminal investigation.

Recommendation 14: SCR reports should record the length of time it took to undertake the review and set out any reasons for delay.

1.14 Chapter summary

The findings of this study suggest that CPCs are following the general principles of the SCR process as specified in the national guidance but there is a lack of consistency in the way in which ICRs and SCRs are being undertaken across

Scotland. There is a need for more standardisation across CPCs and for closer adherence to some parts of the national guidance:

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

Chapter 2 Type of case and characteristics and circumstances of the children and their families

2.1 Introduction

The 56 SCRs related to 71 children and young people because eight concerned more than one child in the family and one of these related to children in two separate families. This chapter considers the types of cases the SCRs related to and describes the characteristics of the children and families who were the subjects of SCRs. It also provides information about the environments in which they lived and about their level of contact with agencies.

2.2 Type of case

Just over half (29) of the 56 SCRs related to a child death; almost half (27) concerned non-fatal cases. There was a higher proportion of non-fatal cases in this study than in recent English analyses where around a third of cases have been non-fatal (Brandon et al 2008; 2009). The 29 cases involving a child death can be broken down as follows:

Table 4: Breakdown of child deaths

Type of death	Number of SCRs
Overdose/drug intoxication	5
Sudden Infant Deaths (SIDs)/Sudden Unexpected Deaths in Infancy (SUDI)	4
Suicide	3
Natural causes	3
Infant sleep related deaths	3
Non accidental injury (NAI)	2
Infant smothered after mother fell asleep while breastfeeding	1
Homicide	2
Death related to bullying	1
Unexplained injury	1
Fire death	1
Unascertained pending further investigation	1
No information in report	2
Total	**29**

All of the SCRs relating to overdose/drug intoxication concerned children and young people aged 11 or over. In some of these cases it was not possible to determine whether the death was due to misadventure or suicide.

One of the SIDs/SUDIs involved possible smothering. The child's mother was initially charged with murder but charges were dropped after she was admitted to a

psychiatric hospital. Another of the SIDs/SUDI cases referred to the fact that the mother slept on the couch with the baby next to her but did not say whether this had happened on the day the baby died.

One of the sleep related deaths involved a baby who died from overlaying after sleeping in bed with her parents. Another infant died from asphyxiation from a cot net and the SCR stated that there may have been elements of neglect in this case. The third infant was found dead in her pram.

One of the homicide cases was a child killed by her mother at some point in her second year of life. The other was a child of 23 months and the mother's partner was convicted of culpable homicide.

The two cases where there was no information in the report about why the children died both appear to have been related to suspected NAI or neglect. In one case there was no information in the SCR but we were also sent the ICR and this referred to the fact that the baby fell off a sofa while the parents were asleep after taking drugs. The other child was a two and a half year old for whom there had been previous concerns in relation to physical injury and the SCR referred to there having been a police investigation.

A post mortem for one of the children who died from natural causes at 19 months old identified mixed toxicology but there were no prosecutions in this case.

The non-fatal cases can be broken down as follows:

Table 5: Breakdown of non-fatal cases

Type of case	**Number of SCRs**
Physical injury	11
Ingestion of methadone, heroin or other opiates	6
Neglect	2
Sexual abuse	2
Concern for unborn child	2
Child cruelty and sexual abuse	1
Neglect and sexual abuse	1
LAC convicted of homicide	1
Safety in care following a complaint by the young person	1
Total	**27**

Four of the six children who ingested substances were aged between two months and three and a half; one was 12; and one was nine. It was alleged that the nine year old had injected heroin. Her urine sample revealed traces of cocaine and morphine.

One of the physical injury cases was an unusual SCR with a primary focus on the issues of social work presence around the serving of a Child Protection Order (CPO). It focused on the detail of procedures, for example, what went on in the ward, but provided only minimal consideration of the wider background of the father and the potential risk he posed to the child, although this was alluded to.

A number of other non-fatal cases involved unusual circumstances. For example, one of the sexual abuse cases involved a 12 year old girl giving birth. The SCR referred to

> '… the complexity of this case and the inherent difficulties involved in a constructive review of such a case when the press and external agencies, who are not in full possession of all facts, shine a spotlight on it.'

An SCR which involved the care received by a young person who had previously lived in a children's unit was also unusual. It centred on the young person's numerous complaints in relation to not feeling safe due to the actions of other young people in the unit.

2.3 Criminal proceedings

Half (28) of the SCR reports indicated that some sort of criminal investigation had been undertaken or was underway; in one further report it was noted that there would have been a criminal investigation but the perpetrator killed himself. The proportion of SCRs involving criminal investigation is higher than the 38% in the Brandon et al (2009) study.

The following information could be gleaned from the reports in relation to criminal proceedings:

Criminal investigation
In five SCRs the criminal investigation was reported to be ongoing
In two SCRs the police investigated and referred the case to the PF but there is no further information about what happened after this
In five SCRs the police referred the case to the PF and the PF decided not to proceed
In one SCR the child's mother was initially charged but charges were dropped when she was later detained in a psychiatric unit
In eight SCRs charges were made but there is no information about the outcome: - In one case both parents were charged with culpable and reckless conduct and neglect - In one case the child's mother was charged with attempted murder - In one case the child's mother was charged with neglect and exposing/administering a controlled drug - In one case the child's mother was charged under the Child and Young Person Act - In one case the child's mother and female partner were charged with attempted murder

- In one case the child's mother and grandmother were charged with neglect - In one case the child's father was charged with causing injury - In one case it is noted that there were charges against the child's father but these are not specified
Seven SCRs provide information in relation to conviction : - In one case the child's mother's partner was found guilty of culpable homicide and sentenced to 10 years in prison - In one case the child's mother was convicted of murder and given a life sentence with a minimum of 15 years - In one case a LAC was convicted of culpable homicide and sentenced to 11 years - 2 cases were not proven, one against the child's father and one against the mother's partner - In one case the child's mother and a neighbour were convicted (the mother for neglect; the neighbour for sexual offences) but there is no information about the sentence - In one case the foster parent's son was imprisoned for sodomy and lewd and libidinous practices (charges against the mother were dropped)

2.4 Child's gender

The gender of 13 of the 71 children was not recorded in the SCR report and a further two children were not yet born so their gender was not known. Of the 56 children whose gender was recorded:

- 59% (33) were male
- 41% (23) were female.

Analyses undertaken in other parts of the UK have similarly found higher proportions of males than females in SCRs (Brandon et al 2008; 2009; Rose and Barnes 2008).

2.5 Child's age

In nine SCR reports the age of the child or children was not specified but in eight of these cases we were able to determine the child's age group, though not their specific age, from additional information provided in the report such as the chronology. The age breakdown of 70 of the children was, therefore, as follows:

Table 6: Age of child

Age of child	**Number**
Unborn	2 (3%)
Under 1	21 (30%)
1-4	18 (26%)
5-10	5 (7%)
11-15	19 (27%)
16 and over	5 (7%)
Total	**70 (100%)**

A third of children in this study were under one compared to almost half in the two most recent studies undertaken in England (Brandon et al 2008; 2009). The proportion is more comparable with the 29% of under ones in the Rose and Barnes study (2008). In common with studies undertaken in other parts of the UK, a high proportion of children were under three months old. A fifth of children (13) in this study were very young babies under three months old.

There was a slightly lower proportion of children under five in this study compared to studies in other parts of the UK (59% compared to two thirds in the two most recent English studies (Brandon et al 2008; 2009)). A third of children were aged 11 or over compared to a quarter in the two most recent studies in England (Brandon et al 2008; 2009) and 40% of the SCRs evaluated by Ofsted (2008). Just 7% of young people were 16 or over, a slightly lower proportion than the 10% found in recent studies in England (Brandon et al 2008; 2009).

Almost three quarters of the 15 children who were under six months old were male. Brandon et al (2009) also found that there were more SCRs for infant males than females.

2.6 Child's ethnicity

The child's ethnicity was only recorded in two of the 56 SCRs. In these two cases ethnicity was recorded as White Scottish. We were, therefore, unable to establish the ethnicity of children involved in 96% of SCRs in Scotland. In a small number of cases we were able to establish the ethnicity of the child's parents from information provided in the report: in one case both parents were recorded as being Polish; in another the father was recorded as being Italian and it was noted that the child's mother spent most of her childhood in Italy. In another case there was a reference to the fact that English was not the first language of either parent but there was no further information about what impact this may have had on the case, for example, how the parents' views were sought considering English was not their first language. The child had died from head injuries at nine months old and had had two previous concerning injuries - a head injury at seven and a half months, and a shoulder injury at eight months, both unusual injuries for a child of this age. The family were perceived by the health visitor as 'a well functioning family with no risks identified' but no evidence was provided in the report to suggest that the health visitor had considered the cultural implications of the case. For example, there is no information about whether the family had any social support which may have been an issue considering they were from Poland and English was their second language.

In another case information presented in the SCR suggested that the child's parents were likely to have been Asian since the child's mother was noted to have had an arranged marriage with her cousin in Pakistan and to have remarried in Pakistan. Again there was no discussion of cultural issues in relation to this case. In a further case the SCR stated that the child's mother had married the 'putative father'

according to Islamic law but no further information was given in relation to the ethnicity of the child or the parents.

Recommendation 15: Authorities are subject to the public sector equality duty. They should consider the relevance of protected characteristics such as age, disability, race, religion, sex and sexual orientation and ensure appropriate monitoring. Any associated cultural issues should also be considered and documented.

2.7 Family size and structure

The SCRs concerned 57 families as one involved two separate families. Between a fifth and a quarter (13) of SCRs concerned only children with no siblings (this compares to a quarter of cases in the Brandon 2008 and 2009 studies); a further quarter (15) concerned children who had one sibling.

In just under a quarter (13) of cases there were four or more children in the family including the index child or children (a very similar proportion to that in the Brandon et al (2009) study). Brandon et al (2009) noted that nationally only ten per cent of children live in a family with four or more children (Bradshaw 2006) which suggests that the risk of harm may be more acute in larger families as a result of the known stresses and difficulties that large families experience, most notably poverty. In one of the families in this study the parents had eight children, all of whom had been accommodated. In another family of five children there was a history of concerns over nine years regarding domestic abuse, anti-social behaviour, poor school attendance, failure to attend health appointments, the children being left unsupervised, parental alcohol use, very poor physical conditions in the home, and the child's mother's failure to co-operate with services. Cases that involved all the children in a family tended to involve larger families and frequently centred around long standing neglect.

Brandon et al (2009) also noted the extra demands that multiple births are known to place on parents. They concluded that being a twin might present an additional risk of harm to a baby, especially when the family faced other difficulties. Multiple births only featured in one of the SCRs in this study. This case concerned a 17 month old child who was the only survivor of triplets, whose younger sibling was the only survivor of twins. The child also had an older sibling who was noted to have significant health needs. The SCR related to NAI following a period of concern around non-organic failure to thrive.

Previous research has found that children who are killed or significantly harmed are more likely to be the youngest child in the family (Reder and Duncan 1999; Wilczynski 1995) but this finding may be due to the fact that young babies are at greater risk. A large proportion of cases in this study (45%) concerned the youngest child in the family (this proportion is almost identical to that found in the Brandon et al study 2009).

2.8 Child health and disability

Some victims of child death or significant abuse have been perceived as difficult to care for by their parents and carers due to disability, health problems or behavioural problems, suggesting that children with disabilities or health risks may be at greater risk of becoming the subject of an SCR (Reder et al 1993; Wilczysnki 1995; Brandon et al 2005). None of the children in this study were recorded as being disabled but the SCRs referred to a number of health problems. The most common health issue which was mentioned in 18% (10) of cases was neonatal abstinence syndrome (NAS) or fetal alcohol syndrome. In one of these cases NAS was accepted to have been caused by the mother's back pain medication but in the remaining cases it was the result of parental substance misuse. In eight cases children were recorded as having been born premature and spent time in a special care baby unit; in a number of these cases prematurity was related to NAS.

In three cases issues around failure to thrive and/or developmental delay were recorded.

Three young people were noted to have mental health issues and another child was recorded as having ADHD. One young person had substance misuse issues.

Other recorded health problems included asthma, a nephratic condition, possible heart murmur, dermatological issues, respiratory issues, shingles and sleep problems. In two cases children were reported to have had repeated head lice infestations.

In three cases there were concerns about children's weight. In one of these cases the child had been overweight; in two cases underweight. In one of the cases where the child was underweight professionals mistakenly attributed this to an eating disorder. It was not until the child was admitted to hospital after ingesting substances that agencies realised the weight loss had been due to substance misuse.

One child was noted to have had repeated illness presentations but no abnormalities had been found. Repeated presentations for illness may be a warning signs for fabricated illness particularly in cases where mothers have mental health problems.

2.9 Age of parents

Mother's age was not recorded in 31 of the SCR reports (although in one report the mother was described as being very young). Where information on mother's age was provided her age at the time the SCR was undertaken was as follows:

Table 7: Mothers' age

Age of mother	Number of SCRs
20 – 29	9
30 - 39	13
40 and over	3
Total	**25**

All of the mothers in the age range 20-29 were between 20 and 24.

The father's age was not recorded in 40 cases (although in one case he was described as very young).

Table 8: Fathers' age

Age of father	Number of SCRs
Under 20	1
20 – 29	6
30 - 39	5
40 and over	4
Total	**16**

The father who was recorded as being under 20 was 17.

2.10 Key parental themes

Table 9: Key parental themes

Theme	Number of SCRs
Substance misuse	36
Criminal record	31
Domestic abuse	30
Mental health problems	24
Troubled childhoods	22
Learning disability	4

2.11 Substance misuse

The most frequently mentioned parent characteristic in the Brandon et al (2009) study was domestic violence. In this study parental substance misuse was the most frequently mentioned characteristic featuring in 59% (33) of SCRs. This is a slightly

higher overall prevalence of parental substance misuse than that found in recent analyses in England (Brandon et al 2008; 2009).

- In 21 SCRs (over a third of all cases), both parents were reported to misuse drugs
- In nine cases the child's mother was recorded as misusing substances
- In two cases the child's father
- In one case the report did not specify whether one or both parents misused drugs.

In all of the SCRs involving substance misuse, the evidence presented in the report suggests the level of misuse was serious and likely to have had a significant impact on the parents' capacity to care for and protect their children. One mother was described as possessing

> '… limited parenting skills which were compounded by her drug misusing behaviour'.

In another case both parents were long term drug users. The mother had a five year opiate history and was recorded as

> '… injecting so frequently jeopardising her health and causing abscesses to her legs'.

Both parents were on a methadone prescription but were also known to use non-prescribed drugs including injected heroin and oral diazepam.

In a family where both parents misused alcohol the 11 year old child's views about his mother's drinking were usefully included in the SCR report.

> '… she would drink and fall asleep on the sofa and they would find her in the morning. He said that the children would all ask her not to drink. He said that he didn't blame her as it must have been hard to be a single parent with so many children, and that she hadn't been out for years, since she had the children.'

As noted above a number of children had been born with neonatal abstinence syndrome which can present particular challenges in relation to parenting. Babies with neonatal abstinence syndrome are known to cry a lot, have problems feeding and be particularly demanding to care for (Vincent 2010).

The SCRs provide significant evidence that universal services and adult services are identifying risks during the prenatal period and correctly referring mothers to social work services during pregnancy because of concerns about their substance misuse. They also provide evidence that parents' drug use is being monitored throughout their pregnancy, as well as afterwards, and that any changes are being recorded. For example, in one case maternity services made an initial referral to social work

because of a mother's heroin use. At this time the mother's drug use was declining and she was recorded as smoking rather than injecting heroin. She was noted to be on a stable methadone programme of 26mls per day with plans to reduce to 10mls in the latter stages of pregnancy. The child's father also had a substantial history of drug use, and was known to be a drug courier. The SCR stated that the baby's premature birth

> '… could have been predicted in that it is not untypical of babies of substance misusing mothers.'

After the child's birth the report stated that the mother's 'drug use appeared to be largely stable', but information subsequently emerged that she was disengaging from methadone and using large amounts of cannabis. Around the same time the child's father tested positive for poly drug use, was on 40mls methadone and his drug use was described as 'chaotic.'

One SCR focused specifically on the management of pregnancy for a mother who misused substances. The Getting Our Priorities Right (GOPR) protocol for children affected by parental substance misuse (CAPSM) had not been followed in this case and this issue was at the heart of the SCR. This case is unusual in that the evidence suggests that protocols and procedures were correctly followed in most other cases. This SCR offered a model of how the case could have been managed, an 'alternative approach to the case'. There was, however, a lot of detail in the report and it was difficult to determine the extent to which the shortcomings in the case resulted from failures and omissions on the part of services or from non-engagement of the mother.

A number of reports usefully analysed the risks presented by parents who misuse substances. For example:

> 'There are by definition significant potential risks for the children of drug-using parents, particularly in their infancy when they are at their most vulnerable, but, equally, being a drug user does not preclude someone from being able to provide an acceptable level of parenting'.

Numerous professionals had recorded that there were 'no identified child care concerns' in this case but their focus on the mother's drug misuse rather than the risks this presented to the child meant the child slipped off the professional radar and was sadly murdered by her mother at some point between the ages of one and two.

Some of the deaths and injuries to children involving substance misusing parents were, as in the case above, clearly non-accidental. Others, for example the cases involving ingestion of substances, were accidental in that there may have been no intent on the part of the parent to harm the child, but because they involved the child accessing their parents' drugs, were, therefore, directly attributable to the parents' substance misuse. In other cases where children died accidentally it was difficult to

establish whether their deaths were directly related to their parents' substance misuse. For example, in one case where the mother was a long term and high risk drug user (using methadone and non-prescribed drugs), and the father was also a drug user, the baby died as a result of smothering after the mother fell asleep while breastfeeding. The SCR stated that Department of Health guidelines encourage breastfeeding for mothers on methadone but there are issues of timing in respect of when to take methadone and when to feed. The guidance suggests that feeding is best done immediately before medication and should be avoided for one to two hours afterwards and that medication is best taken in a single dose before the baby's longest sleep. This mother was taking her methadone in two halves which the guidance does not recommend but the SCR report stressed that her methadone use may not have had any bearing on the child's death, and that she may have just fallen asleep as a result of tiredness. Despite the tragic outcome, this case demonstrated some very good practice in relation to supporting the mother to care for her baby.

Learning point
All health and social care staff should be familiar with guidance in relation to breastfeeding for mothers taking methadone. They should be able to offer safe advice and feel confident to question mothers to ensure this advice is being taken.

Recommendation 16: Some of the deaths of babies are accidental but preventable. Mothers and fathers of vulnerable children should be given ongoing information about safe sleep as well as at the time of their baby's birth. The Scottish Government is currently updating its Getting our Priorities Right (GOPR) Guidance and should consider including advice for professionals to warn mothers with a substance misuse problem who breastfeed to make sure they return their baby straight to his or her cot after feeding as they may be more inclined to fall asleep.

Parental substance misuse cannot be considered in isolation from other factors. The SCR reports demonstrated that substance misuse is often associated with other issues including criminality and neighbourhood problems. One family experienced significant intimidation because of their drug debts. They had moved on several occasions to escape this intimidation and it was noted that this had a considerable impact on the child. In some SCRs there was evidence that drug misuse and associated issues permeated the lives of several generations of a single family. For example, one report revealed that the mother and grandmother

> 'Operated a small business at home dealing in prescribed and other drugs - without proper health and safety mechanisms and shrouded, because of the illegal nature of the enterprise – in secrecy and subterfuge'.

The children were recorded as having been aware of where the 'stash' was hidden and to play at drug dealing. The young person in this case later died from drug intoxication. The results of her post mortem suggested she had been using drugs for

six months and had had a previous overdose but neither the school or health had suspected she was involved in drugs.

In another case both parents and one set of grandparents, with whom the child lived for much of his earlier life, all misused substances. The grandparents had a number of drug related convictions and the SCR report noted that the grandfather

> '… admits to funding his drug use through his daughter's prostitution'.

The child's grandmother died when the child was 10, believed to be from a drug's overdose.

A number of SCRs related to teenagers who died as a result of drugs overdoses and in the majority of these cases the young person's parents were also known to be substance misusers. Two SCRs involved overdose/ingestion of substances by school age children. One of these cases related to an eleven year old who died from an overdose. It was unclear whether the child's death was due to suicide or accident. No one had known the young person was involved with drugs but the mother and grandmother were known to police and criminal justice for offences related to the supply of drugs. The other case involved a nine year old who was admitted to hospital after ingesting her mother's drugs. This SCR revealed that there had been no clear dispensing arrangements for the mother's medication. It also identified that there were no clinical protocols for the withdrawal of children from acute opiate withdrawal. Protocols related only to babies or adults, not to children. As in the other case outlined above, no-one had suspected this young person was taking drugs. She had been losing weight but professionals mistakenly believed this was caused by an eating disorder.

Learning points
Professionals in universal and statutory services should be open to the possibility that children and young people living with parental substance misuse may themselves be involved in drug use;
Protocols are needed for children who are withdrawing from opiates

Practice example
Some good practice was identified in relation to substance misuse. For example one SCR revealed good inter agency support in supporting the resilience of the two older children in a family where both parents misused alcohol. Another SCR identified good practice by the drug treatment service in its use of drug diaries
'… the issue of drug diaries to clients is good practice as it shares ownership and provides the service user with a clear sense of responsibility.'

2.12 Domestic abuse

Domestic abuse featured in just over half (29) of SCRs. In one case there had been at least eight incidents of domestic abuse involving the police over a four year period

and on one occasion the eldest daughter had also been involved in a fight with her step-father and had sustained a swollen jaw. In another case it was noted that the child's mother had had several violent partners and

> '… domestic violence was an everyday part of family life.'

Practice example
One mother had experienced serous abuse from two different partners and on one occasion the SCR recorded that she had had to flee naked from the house to escape the abuse. She was interviewed for the SCR and the report included a very useful analysis of her experiences of domestic abuse. It is very illuminating in terms of how she must have been feeling at that time and provides considerable insight into how difficult it would have been for services to assist her. She reported that

> '… her situation as a victim of domestic violence was such that she would have been unlikely to accept any help that might have been offered.'

This case example demonstrates that parents can provide key information about issues such as domestic abuse for the purposes of review which cannot be gleaned from written records or interviews with professionals. They may be able to offer possible reasons for their non-engagement and cooperation which may go some way to explaining why despite good intentions on the part of individual professionals, services are ultimately unable to meet all families' needs.

2.13 Mental health problems

Parental mental health problems were alluded to in 39% (22) of the SCRs:

- in 18 cases the child's mother had mental health issues;
- in one case the child's father;
- in three cases both parents.

It is important to note that there may be less identifiable risk factors in cases involving serious mental health concerns. Multiple risk factors may not need to be present in such cases (Vincent 2010). For example, in one case there appeared to be few risk factors but information in the chronology revealed that on frequent occasions before and after the baby's birth different professionals had recorded that the child's mother was feeling suicidal and/or experiencing negative feelings about her pregnancy, or about the baby:

> 'Feels like doesn't want to wake up. Has tried smothering herself with pillow most nights-knows it will not work.'

> 'Unsure how feels about pregnancy. Occasional thoughts life not worth living but not bad enough to harm self. '

> 'Report mood low, thinks the pregnancy is a big mistake.'

> ‘Attended A/N clinic, reports that she tried to hang herself’.
>
> ‘Mood remains very low, can’t face the future, wishes something will happen to her or the baby, doesn’t know if she wants this baby, "feels like ending it all’”
>
> ‘Hospital advising that M has seen baby once since birth and has indicated she may not go to the Neo-Natal Unit. M apparent low level of interest may be an early indication of some worry.’

It was also noted that this mother had had periods of disengagement from mental health services when she would not attend appointments and that she was unhappy about social work involvement in her life:

> ‘M very unhappy about this, doesn't understand why Psychiatry and Social Work "interfering"’

In addition professionals were concerned that she was unwilling to reveal where she was moving to:

> ‘Latest information is that M is leaving on 10th December, however, is avoiding passing on her address to any of the professionals involved.’

There was very little information about the child’s father in this SCR. There was no information about his relationship with the child’s mother or about whether he would be able to support her to care for the child and whether he could, therefore, be viewed as a protective factor. It is noted in the chronology that he did not know the full extent of his wife’s mental health problems but this was not considered in the review.

The impact of mental health issues on parenting was not always fully considered particularly when concerns were not framed as ‘child protection’. This issue is discussed in more depth in the next chapter. For example, one SCR described the case as

> ‘An extremely complex case where the mother was eventually diagnosed with a personality disorder. The extent of her problems and the impact of this on her ability to care safely for her children were not initially recognised.’

A number of SCRs involved teenagers with mental health issues and raised issues about vulnerable young people who are referred to Child And Adolescent Mental Health Services (CAMHS) where there is no psychiatric diagnosis. These SCRs highlight the need to clearly identify support pathways for these young people.

Practice example
One SCR noted good practice around mental health. When a young person was unable to engage directly with CAMHS staff they worked closely with residential workers so they could support the young person’s emotional and psychological well-being.

2.14 Learning disabilities

Previous research studies have found that a significant number of adults in families where children suffer significant abuse have learning difficulties (Reder et al 1993; Brandon et al 2005). Parental learning disability featured in only 7% (4) of these SCRs. In one case both parents had severe learning disabilities and the child had been placed with kinship carers. Unfortunately we were only able to obtain the executive summary for this case so we only had access to a limited amount of background information. The SCR was undertaken because the child sustained 'life threatening head injury, retinal haemorrhages, torn frenum, metaphysical fractures and over 50 bruises' at a year old. It is not clear from the summary who perpetrated the abuse but the injuries appear to have been sustained while the child was in the care of kinship carers, not in the care of the parents.

In the other three cases the child's mother was noted to have learning disabilities. One of these cases concerned neglect over a number of years. While the mother's learning disability was noted to be mild there were numerous references to the fact that she was struggling to cope:

> 'She found it increasingly difficult to cope with her children as her family grew and developed'.
>
> 'It became consistently obvious over time that the mother did not have the organisational skills, flexibility, energy or ability to manage the children's basic care and emotional needs.'
>
> 'There is evidence over the past 11 years of the mother being overwhelmed by the parenting task'.

2.15 Criminal behaviour

Child killers or perpetrators of significant abuse have frequently been found to have criminal records, with a high proportion having convictions for violent crimes (Wilczynski 1995; Brandon et al 2005). In more than half of SCRs (31) parents or carers were recorded as having a criminal record; in a further case it was noted that that there had been considerable police involvement but no charges had been brought (this figure corresponds with the half of parents with a criminal record in the Brandon et al 2008 study).

- In 9 cases both parents were recorded as having convictions;
- in 12 cases the child's father;
- in 8 cases the child's mother;
- in 2 cases the mother's partner.

In most cases criminal offences were fairly serious, often relating to drugs and/or violence. For example, in one case the mother had two convictions for assault as a young adult and had a further conviction for causing severe injury to her oldest child

when he was one and three quarters. She had also been committed for trial and detained on a charge of attempted murder after stabbing the child's father but was released after two months due to insufficient evidence, absence of complaint and no specific intent. The child's father had convictions for road traffic offences and racially aggravated conflict.

Several generations of one family were often known to police. For example, in one case where the child's father received a life sentence for murder when the child was nine, the grandparents also had a longstanding and varied criminal history. The grandmother was noted to have 20 aliases and had received police warnings in respect of soliciting. In another case the young person's father had spent time in prison, his older brother had an extensive criminal history and had been charged with murder, and he had a long criminal record himself.

Four young people whose circumstances formed the subject of the SCR had a criminal record themselves. In one of these cases the SCR raised issues around the response to the young person's escalating criminal behaviour within the children's unit and around the appropriateness of the police detaining the young person.

2.16 Parents' childhoods

Information about parents' childhoods is useful because it can give important insights into parents' states of mind and their ability to care for and protect their children (Vincent 2010). Adults who kill or abuse children, or who live in households where children die or suffer serious abuse, have sometimes been found to have been in care themselves, or to have been abused or separated from their parents (Wilczynski 1995; Reder and Duncan 1999). In over a third (22) of SCRs parents were recorded as having had troubled childhoods:

- in 6 cases this was both parents;
- in 13 cases the child's mother;
- in 3 cases the child's father.

This is likely to be a significant under estimate of the prevalence of parents' troubled childhoods since, as Brandon et al (2002) commented, SCR reports often contain very little information about parents' childhoods. In 16% (9) of cases parents were recorded as having been in care; and in two cases parents were noted to have been abused. Two parents were noted to have been young carers and one mother had been sent to Pakistan to marry her cousin at the age of 14. Other parents had experienced bereavement or witnessed domestic abuse in their childhoods. For example, in one case the father's siblings had died in a fire. He became a LAC and had a history of disruptive behaviour and mental health problems. The child's mother had also been affected by bereavement: her mother had died of an overdose and she had been brought up by her father.

Another mother had experienced a number of periods in local authority care as well as on the CPR and it was noted that

> '… her experience of parenting was inconsistent and affected by instability.'

One mother had been on a supervision requirement and services had a history of intermittent involvement with her from an early age in respect of emotional, physical and sexual abuse, poor school attendance, and alcohol intoxication. The SCR report stated that the father of the child was considered to be from a 'respectable' family but that once he was with the child's mother a pattern of drinking and domestic violence emerged.

2.17 Financial pressures/poverty

Previous studies have identified high levels of poverty amongst families involved in SCRs (Sinclair and Bullock 2002; Brandon et al 2002). Financial problems or other evidence of material hardship were mentioned in less than a fifth (11) of the SCRs in this study (this compares with much higher proportions in studies in England and Wales (Brandon et al 2002; Brandon et al 2008)). The level of financial hardship identified in this study is, however, likely to be a significant under estimate. Presumably because agencies are not primarily concerned with improving the socio-economic circumstances of families, review reports often include minimal information on families' financial positions and whether or not they are working or claiming benefits (Vincent 2010). While poverty is unlikely to be a predictor of child death or significant abuse, as Brandon et al (2002) pointed out it may form a backdrop to other factors which are known to impede parents' capacity to protect their children. It is, therefore, always useful to consider the implications of poverty and financial problems in an overall assessment of families' circumstances.

Practice example
One SCR identified good practice by a GP who had encouraged the patient presenting with depression to seek support for social issues and debt problems. It was noted that the GP had used attendance for routine issues as an opportunity for discussion of wider concerns.

Learning point
Professionals should always consider the family's financial circumstances and the impact of poverty.

Recommendation 17: SCRs should include information about the family's economic situation.

2.18 Housing

In common with previous studies in other parts of the UK (Sinclair and Bullock 2002; Brandon et al 2002; 2008) the findings of this study suggest that families involved in

SCRs in Scotland experience significant housing problems. Housing issues were recorded in over half (29) of cases. Many families had experienced multiple moves and periods of homelessness and/or suffered overcrowding or lived in poor conditions.

Housing was an issue for some young people who had been looked after. Many of these young people had experienced multiple placement moves. For example, one young person who died at 17 from possible drug intoxication had been looked after and accommodated (LAAC) since the age of four and had moved continually:

- She had multiple foster placements before being adopted at age six
- At age eleven family relationships broke down following her allegation of abuse by her adoptive brother. Her behaviour became challenging and she was placed in residential school for two years
- She then spent several months at a residential treatment centre in England
- She was then in secure accommodation for six months
- She was then placed in a foster placement back in her local community for ten months
- She then lived in various supported accommodation resources for six months
- At the time of her death she was living in bed and breakfast accommodation but the plan had been for her to return to foster care.

In common with other young people this girl died at a time when there was considerable uncertainty about where she was going to live. It is impossible to say whether this had an impact on her death but it must have caused her extreme anxiety and may have been one of several factors that contributed to her risk taking behaviour.

A case involving travelling families was particularly illuminating in relation to the issue of keeping track of families who move frequently. Frequent moves can impact on the continuity of services such as health and education. In this case because the families were travellers there were also cultural issues in relation to school attendance.

> ‘Child 1 missed a considerable part of his first school term. It is unclear if professionals felt this was a significant concern or whether this was viewed as the cultural norm of travelling families’.

This and other SCRs involved families who were ‘missing’ in the sense that no service was aware of their whereabouts. The SCR noted that there are now better arrangements for locating missing persons in education and in health and two other SCRs acknowledged good practice in tracking families who have moved or are planning to move out of the area.

Practice example
In one case agencies expressed concerns that the family were moving to England and the mother was unwilling to provide professionals with a forwarding address. There was evidence of good practice around the family's proposed move to England. Mental health services had raised concerns that the mother was planning to move and was being evasive about her new address and this led to discussion of the Missing Family Alert System. It was confirmed this could be activated should she leave the area. The health visitor also contacted the medical centre in the area the family were planning to move to and shared information with the local health visitor in that area.

Six families were known to housing and/or police as a result of anti-social behaviour and seven SCRs mentioned that families had problems with neighbours. For example, one stated that

> 'Neighbours sent a petition to [the] Council alleging anti-social behaviour, fighting stabbing, dealing, police raids'.

Two families had experienced very serious intimidation in their neighbourhood and one young person had been bullied by other residents in the residential unit where he lived.

Housing agencies may have important information about families that other agencies do not have access to. For example, in a case where social work were not fully aware of domestic abuse or anti-social behaviour the SCR reported that housing could have intervened following seven alleged reports of domestic abuse. They had failed to do so because they had only interpreted this information in relation to anti-social behaviour, not in relation to child protection. In other cases housing had passed on concerns about anti-social behaviour and/or neighbourhood problems and professionals were able to consider this useful information in their overall assessment of risk. The police are also frequently called to neighbourhood disputes and may have important information they can share with other agencies.

Learning point
Housing agencies and police hold important information in relation to anti-social behaviour and neighbourhood problems which should be shared with other agencies.

Practice example
One SCR noted good practice in housing in affording homeless families priority following domestic abuse. The report also identified that housing were

> '… persistent in offering ongoing tenancy support in relation to domestic abuse and rent arrears.'

2.19 Family/community support

Support from a member of the extended family or from the wider community can be a protective factor for children and can help promote resilience. More than half of the families involved in these SCRs were noted to have family support and in many cases there was evidence to suggest that this was a protective influence for the child.

Practice example
One SCR referred to the critical support of the grandmother who took on three grandchildren under the age of five. The kinship care placement, initially arising out of an emergency placement, was considered by the reviewers to be a caring environment in which the child and his siblings thrived and developed and were able to successfully maintain contact with their parents. Despite the tragic outcome (the child died of meningitis) this case can be considered as an example of positive kinship care.

Support from the extended family was sometimes a key part of the support plan for the child. Grandparents sometimes moved in with families to provide support. In one family, ongoing support for the children involved extensive involvement from both sets of grandparents and great grandparents and the review team identified placement with the extended family at times of crisis as good practice

> 'Professionals worked in partnership with the extended family when implementing the protection plan. This was clearly communicated and understood by the family'.

Grandparents and other family members can play an important surveillance role. In some cases it was family members who had raised concerns and alerted agencies in the weeks leading up to the incident that led to the SCR.

One SCR concluded that agencies did not fully utilise family support for a young person who was LAAC. The report stated that no attempts were made to re-establish overnight contact with his mother after this stopped and the role of his grandmother was not maximised which was surprising considering that she was initially seen as a major protective factor in the young person's life. There were also no plans in place for the young person to have contact with his brother who was in prison.

One mother had significant involvement from her father but felt that agencies stood back because they knew he was supporting her and would take her to his house when she was struggling to cope. Her father is quoted in the SCR as saying

> '… although they did not neglect their duties – they did not fulfil their duties'.

Family support is complex and may sometimes be as much a source of stress for families as a source of support. One SCR stated that there was confusion over the role of the grandmother and whether she was a source of stress or support. Another

case involved a strong matriarchal extended family headed up by the mother's mother. While it was noted that this provided a 'stable family background for the two boys to live in' the report also commented that 'strong inter-family ties and support systems may shun or avoid outside support or intervention'. Families that shun intervention may be families where the level of risk is particularly high.

Learning point
Professionals should always consider the potential protective role of members of the extended family but be open to the view that family members may be as much a source of stress as a source of support

Seven reports commented that families were socially isolated, a known risk factor for harm. Families who had moved to Scotland from other countries appeared to be particularly isolated. In a case involving a family who had moved from Italy to Scotland to escape drug use the child's mother was described as having no friends and little family contact. The care plan for her baby was crucially dependent on the grandmother coming over from Italy to provide support. A contingency plan was drawn up so that in the event of support from the grandmother not working out or being insufficient, the mother and children would move to residential provision. Although this was good practice, it was noted that a consequence of reliance on the grandmother was that there was some fall-out between the mother and father resulting in the father leaving home on two occasions after the baby was born. It was also uncertain what the longer term plans for the child would be once the grandmother returned to Italy. A Polish family was recorded as being similarly isolated. The mother was estranged from her family and had no peer support network in Scotland.

Learning point
Social isolation should always be considered as a risk factor. It may be a particular risk in families that have moved to Scotland from other countries

Social isolation played a particularly important role in a case involving a child who was murdered by her mother. The mother's social isolation meant that the child had not been seen by any agency, including universal services, for a very long time. She had effectively disappeared off the radar of all services.

2.20 Contact with agencies

The families whose lives formed the subject of the SCRs had a high level of involvement with statutory services. Just four families were known only to universal services.

Families known only to universal services

There was very little information in the SCR reports about the four families known only to universal services, presumably because services had minimal knowledge of them. All four of these SCRs involved infants aged between seven weeks and eight months who were admitted to hospital with NAI. One of the infants died. There were no previous concerns for this infant apart from minor bruising and skin blemishes observed by the childminder which had been explained. There had been some health involvement in respect of an upper respiratory tract infection and the family were awaiting a hospital appointment for a possible heart murmur. The SCR concluded that there were

> 'No actions that any agency could have taken that might have conceivably prevented the death of this child'.

There had been no previous concerns at all in relation to the three infants who did not die apart from a reference in one report to the fact that

> '… parents were very young and the mother, in particular, was felt to be vulnerable'.

While these SCRs did not identify any practice issues prior to the incident leading to the SCR, significant issues were identified in relation to practice after admission in two of the reports, around whether and when to apply for a CPO and how to effectively communicate with parents. One report stated that

> '… in reality Child A returned home to a situation of potential risk – no visit was made to the family home by any agency on the day of discharge.'

Families known to statutory services

At the time of the incident resulting in the SCR, eight (14%) of the children were on the CPR and had a child protection plan. This is a slightly lower proportion than the 17% who were subject to a child protection plan in the Brandon et al (2009) study and a slightly higher proportion than the 12% of children in the Brandon et al (2008) study. In seven of these cases the child was registered for physical neglect and in all of these seven cases the primary reason for registration was that the child was at risk of harm due to parental substance use:

- Four of these cases involved infants: one was found dead in her pram and the cause of death was undetermined; one death was due to mechanical asphyxiation; one infant died of SIDs; one was smothered after the mother fell asleep while breastfeeding. In one of these cases prebirth planning had been delayed and the Child Protection Case Conference (CPCC) was not held until six days after the infant was discharged from hospital. Another case highlighted good practice throughout including early intervention to put all three children on the CPR.

- Two cases involved three year olds who ingested substances.
- One case involved a nine year old who ingested substances. The child had originally been registered under the category of physical injury when she had been threatened by a neighbour but this had later been changed to physical neglect due to parental substance use.

The eighth case involved a child registered for emotional abuse who ingested heroin when aged eleven.

In a further two cases the index child was not registered at the time of the incident leading to the SCR but had been previously registered. One was registered from age one month to four and a half months for physical neglect due to parental alcohol misuse. The child died at 14 months and cause of death was unascertained. In another case there had been a brief period of registration but the case was closed following a long period where there were no concerns. This family had previously lived in another area and the older sibling had suffered NAI. The SCR report stated that social workers

> '… were of opinion [mother] should never have sole responsibility for children'.

In three cases a sibling was registered or looked after at the time of the incident resulting in the SCR. In one of these cases while the index child had not been registered the level of support offered to the family was considered by the review team to be equal to that of a child on the register.

In one case a children's hearing had been arranged at the time of the incident leading to the SCR and a decision had been made to hold a CPCC to register the children under the category of neglect. The child had been known to social work since birth and high levels of support were in place to assist the child's mother. The child was admitted to hospital at a year old with head injuries and the mother was charged with attempted murder.

Eleven SCRs related to children who were or had been looked after. These cases included deaths of teenagers and neglect and sexual abuse of younger children. Most of these children had been known to statutory agencies for considerable periods of time and the SCRs revealed significant practice issues. It should, however, be noted that much of this practice had taken place some years previously and many of the reports were keen to stress that practice had changed significantly since then.

One case involved abuse of four children in foster care. In the last four years of the placement there were concerns about whether the care received was 'good enough'. Concerns revolved around:

- Lack of stimulation for the children
- Poorly furnished and maintained bedrooms

- Worrying practice including use of CCTV and grounding the children in a small, windowless room
- Rigid approaches to control behaviour including prolonged periods of grounding, locked doors, controlled diet, rigid bathroom routines, removing bedroom lighting
- The foster mother appearing exhausted, inconsistent in mood and unable to manage the children's behaviour
- The children's emotional wellbeing and behaviour.

The SCR report concluded that

> 'They did not have the skills to manage these four damaged children. The level of stress on occasions within this family I believe was very high, and sadly [the foster mother] found it difficult to accept support and lacked the insight into the needs of distressed children.'

In another case which involved the neglect and sexual abuse of two children the

> 'CPC recognised retrospectively that the children had experienced significant harm while subject to compulsory measures of care, and at times the child protection system.'

In the remaining cases where children were known to social work children had never been registered or looked after and in most of these cases child protection procedures had never been instigated. Referrals had either resulted in NFA or the child had received support as a child in need. Some children had been referred on a number of occasions. For example, one child had been referred five times – once by housing, once by criminal justice, once by the health visitor, once by her grandmother, and once by an anonymous referrer. The family received home care and day care following one of the referrals but the other referrals had resulted in NFA and a comprehensive assessment had never been undertaken.

One family had moved into the area four months prior to the child's birth, at which stage there were no concerns. A referral was made following the child's admission to hospital for injury at a month old. Medical staff were satisfied with the explanation of how the injury was sustained (the father reported collapsing while holding the baby and the mother reported that he was undergoing tests for blackouts which was subsequently found to be untrue). Background information on the parents sought from the previous area of residence revealed that the father had been looked after and had a history of violence, alcohol misuse and domestic abuse; a former partner's child had been registered as a result of alleged physical abuse by the father. A decision was made to take no further action under child protection procedures and the family moved to Northern Ireland. A month later the child was admitted to hospital with five fractures. The review concluded that social work staff should have challenged the medical opinion that the child's injuries were accidental, especially

after they had received the information about the father which should have resulted in a joint social work and police child protection investigation.

The Scottish Children's Reporter Administration (SCRA)

There was no reference to the child or their siblings having any involvement with SCRA in 23 cases. Some of these families may have had SCRA involvement but there is no information about this in the SCR report. Certainly the evidence presented in some of these reports suggests that there should have been referrals to SCRA in a number of these cases, at least following the incident that led to the SCR, if not before.

There was documented involvement with SCRA in 59% (33) of cases:

- In some of these cases there was substantial involvement because the child was a LAC and there was or had been a supervision requirement
- In a small number of cases there was a referral to SCRA and a decision had been made to call a hearing but this had not taken place before the incident that resulted in the SCR
- In other cases referrals had been made to SCRA but these appear to have resulted in NFA
- In a small number of cases a referral to SCRA was made only after the incident that resulted in the SCR
- In 10 cases SCRA's involvement was noted but there is no further information about the nature of this involvement in the report.

Recommendation 18: SCRs should record the level of involvement with SCRA.

Some SCRs implied that referrals should not have resulted in NFA. For example, in one case there had been six referrals from the police to the Reporter in relation to domestic abuse and the review team felt these referrals had not been treated seriously enough. In a couple of cases referrals had not taken place within the correct timescales. In one of these cases this meant there was a gap of nearly a year between the child's birth, at which point the referral had been made, and the initial children's hearing.

Education

Schools have considerable contact with children and are, therefore, well placed to identify and monitor risks to school age children. The children involved in 32 SCRs were too young to attend school or nursery and had no contact with education agencies. Children were recorded as attending nursery in four SCRs. In one of these cases there had been issues around attendance and in another the parents had often been unfit to collect the children and had been aggressive to nursery staff.

One or more children in the family attended school in 20 SCRs and in 15 of these cases concerns were recorded at school including exclusion, attendance issues, and

behavioural issues. Three young people were, or had been, at residential school. Another young person committed suicide immediately after attending a children's panel meeting where it was decided that he should be placed in a residential school. He was reported as having been very unhappy about this decision. Three SCRs mentioned that educational psychology were involved and in two cases there was involvement from learning support. Only one SCR report stated that the young person had no problems at school and achieved eight standard grades. A further two young people were initially noted to have had positive educational experiences but had then started to disengage.

Schools were noted to have engaged in some positive work to support children.

2.21 Chapter summary

Children died in half of the SCRs included in this study. A small proportion died at the hands of their parents, some died as a direct result of their own risk taking behaviour. Others died from accidents or natural causes, not as a result of abuse or neglect. In some accidental deaths, however, parents' lifestyles probably played some part in the child's death.

The other half of SCRs related to non-fatal physical injury, ingestion of substances, neglect and sexual abuse. These cases were more likely to involve abuse or neglect on the part of parents or carers, but did not necessarily involve intent.

Criminal proceedings had been instigated in half of all SCRs.

In terms of child characteristics the main findings were as follows:

- There was a slightly higher proportion of boys than girls
- A third of children were under a year old; a third were eleven or over
- Ethnicity could not be established in the large majority of cases
- Almost a quarter of SCRs involved families with four or more children
- None of the children had disabilities but a small number had health problems and almost a fifth had been born with neonatal abstinence syndrome.

The main findings in relation to parents were:

- Parents' ages were not always recorded but where age was recorded parents did not appear to be particularly young; a significant proportion were in their thirties or forties
- More than a third of parents were noted to have had troubled childhoods
- There was a high prevalence of parental substance misuse (almost two thirds of SCRs)
- Domestic abuse featured in over half of cases
- Children were affected by parental mental health in 43% of SCRs

- Well over half of families had criminal records for serious offences relating to violence or drugs
- Families were only noted to have financial problems in a small number of SCRs but this is likely to be an under estimate; there was a high prevalence of housing problems including frequent moves, overcrowding, poor conditions and intimidation from neighbours
- A high proportion of families had support from their wider extended family. In some cases this was a protective influence for the child but family members sometimes contributed to the levels of stress families experienced. A small number of families, particularly those who had moved to Scotland from another country, were socially isolated.

A very high proportion of families (93%) whose circumstances formed the subject of SCRs were known to social work services, with just 7% of families known only to universal services. This suggests that concerns had been identified in these families and had been correctly passed on to statutory services as specified in national child protection guidance. 14% of children were on the child protection register and a fifth were looked after.

Chapter 3 Practice themes

3.1 Introduction

This chapter considers the main practice themes that were identified by the SCRs. It is important to note that while practice issues can be identified with the benefit of hindsight, their identification does not imply causation. In the large majority of cases the practice issues identified in this chapter are unlikely to have had an impact on the child's death or the harm that they experienced. Some SCR reports were keen to make this point, for example:

> '… there was no evidence of failure to care, lack of care or very poor practice.'
>
> '… more could have been done, although it may not have prevented the tragedy that ensued.'
>
> '… [the death] cannot be attributed to any action or failure on the part of the agencies involved with him and his family prior to his birth or his death.'
>
> 'While there is much to be learned, a change in practice is unlikely to have had a different outcome. However regrettably there are many children who do and will face similar circumstances in terms of their social and living environment. The comments in this report are intended to be helpful to the professionals upon whose shoulders society places the responsibility of getting it right all the time.'

It is also important to note that because of the time it takes to undertake a SCR where practice issues are identified CPCs are likely to have already made practice improvements by the time the SCR is published.

The fact that some SCR reports identify very few practice issues suggests that in many cases that result in a SCR practice is actually very good. Most children are not harmed as a result of actions taken by professionals. For example:

> 'There was nothing any agency could have done to change the family's attitude and child's Mother and Grandmother must take sole responsibility for their actions and acknowledge that by not seeking medical assistance they are responsible for child's death.'

Practice example
One report usefully included a section which provided an update for each agency on the practice changes which had taken place since the incident. For example, there was a discussion about how Getting it Right for Every Child (GIRFEC) was expected to result in improved practice.

In cases where children did not die, good practice was sometimes highlighted following the incident that resulted in the SCR. For example, one report stated that it is the

> '… opinion of the Review Group that the action of agencies immediately following this incident prevented further significant harm.'

3.2 Focus on the child

In common with previous studies in other parts of the UK, some of the SCRs in this study highlighted a lack of focus on the child. In cases involving infants the focus of practice was sometimes unduly weighted towards the needs of the parents as opposed to the safety of the child.

> 'Although all practitioners sought to deliver effective services to M and Baby C, the Review found that the child's best interests were ultimately lost sight of in the overall lack of an effective holistic assessment of M's parenting ability.'

This is particularly likely to be the case where parents are known to adult services due to substance misuse, mental health or domestic abuse and intervention inevitably focuses on their needs. The impact of these issues on the health and welfare of the child as a consequence of the actions and lifestyle of the parents was not always fully considered. In particular, a number of reports highlighted that the risks and needs of children were not identified in relation to domestic abuse. It can be useful to step back and reflect upon the child's story. The SCRs themselves made minimal reference to what the child's experience would have been, or how he or she would have been feeling at the time.

Learning point
Professionals should critically reflect upon the child's story, think about what their experience is likely to be and how they are likely to be feeling

The Victoria Climbie Inquiry report (Laming 2003) included a section entitled 'Working with deceitful people' in which Lord Laming talked about the extent to which professionals believed what Victoria's carer told them without ever questioning her. Vincent (2010) cited numerous examples of parent's deliberately deceiving professionals in previous inquiries and reviews in Scotland including the Caleb Ness and Danielle Reid reviews. There were further examples of professionals believing parents' accounts of why children sustained injuries or why they were not attending school in this study. For example, a hospital concluded that the mother's explanation of a child's injury was 'extremely plausible'. They accepted her explanation that the child's father had been undergoing tests for blackouts which was subsequently found to be untrue. In common with professionals in other cases they were

> '… reassured by the parents' apparent co-operation and openness.'

A mother who twice offered an explanation to a specialist addictions nurse for a positive toxicology result that she had 'taken co-codamol for toothache' also appeared to have been believed.

In another case a GP accepted the mother's explanation for injuries following an anonymous allegation which the review panel considered should have been grounds for referral to a paediatrician. The child's older sister also made comments at the residential unit where she lived in respect of her sibling's injuries that

> '… should have been logged and passed to the fieldwork manager for follow up … The review group believes that the response of the professional staff to the mother and [older daughter] was strongly influenced by the apparently positive presentation of [the child's] mother as a caring and concerned parent.'

Although the mother had provided inaccurate information, failed to keep appointments, and failed to seek medical treatment for the child's injury,

> 'The positive impression given by [the child's] mother and [older daughter] appear to have led health and social work staff to accept at face value their statements giving assurances with regard to the care and protection of [the child].'

One SCR commented that there was little recognition of the parents' manipulation of workers and deflection from the issues. Everything was accepted at face value without checking. When the child missed school her mother was often very specific about treatment allegedly given and was, therefore, very 'believable'. There were occasions when the child was not seen for two or three weeks and the SCR report noted that no consideration was given to seeing her in school.

Learning point
Parents' explanations for injuries and non attendance at school should always be checked out and considered in the context of other risk factors such as missed appointments

Vincent (2010) found that professionals were over optimistic about parents' capacity to change in previous inquiries and reviews in Scotland including the Caleb Ness and Eilean Siar reviews. This is also a finding of this study. One SCR report commented that

> 'An almost inevitable 'rule of optimism' prevailed due to the difficulties in verifying all aspects of information given by parents.'

The reviewers stated that this case highlighted

> '… difficulties inherent in the management of cases where workers are required to gather information from substance misusing parents who have an investment in manipulating, disguising or withholding information.'

In a case involving a mother with learning disabilities

> '… for many years the attitude to the mother from professionals was one of sympathy.'

The review concluded that professionals involved in the case were overly influenced by

> '… a culture of low expectations and a fatalistic view for some of [the] children.'

One SCR report stated that professionals should engage in reflective practice to retain a focus on the welfare of the child as opposed to the needs of the mother, in order to avoid drift and the operation of the 'rule of optimism'. Another SCR similarly warned of the dangers of the rule of optimism

> 'so much is recorded as pressures for this family one wonders if the writer is seeking for any evidence of strength to balance these. The danger of this approach is that it is strengths based and potentially underpins a rule of optimism leading to a distorted analysis of impact on or risk to the child … the welfare of this mother and baby were compromised as a result.'

Reluctance to challenge parents was a theme of a number of SCRs

> 'There was almost an ongoing tolerance of the parents' chaotic drug use without real challenge with them about the impact their behaviour had on their daughter.'

Professionals did not always see or listen to the children and, therefore, missed vital signs of abuse or neglect. For example, in one case where the children were placed with foster carers and sexually abused by the foster carer's son, there had been a number of warning signs to suggest concerns in relation to the children's emotional well being and behaviour. There was a history of challenging behaviour of the three older children at school, and they all ran away from the foster carers on more than one occasion and expressed unwillingness to return:

> 'D began raising concerns about the quality of care at home and voicing his wish to leave.'

> 'Child 3 presented with sexualised behaviour from an early point in the placement and made accusations to the foster mother regarding her son. These were interpreted as lies and rooted in her birth experiences.'

Professionals did not explore the reasons why the children had run away or consider that the challenging behaviour they were exhibiting might be due to sexual abuse. The children later stated that they did not think they would have been believed if they had disclosed abuse.

Learning point
The reasons for challenging behaviour at school and/or absconding from foster or residential care should be explored

In another case where a young person who was looked after had a history of absconding the review concluded that the young person should have had advocacy support and that there should be debriefing with children following episodes of absconding.

One young person had been placed on the CPR after being threatened with violence by neighbours but there was no evidence of attempts to undertake work with her following these threats and she had not been referred to any agency for counselling.

Another SCR related specifically to a young person's complaints that he had not been listened to when he had reported feeling unsafe in a children's unit. The SCR concluded that his complaints had not been taken seriously:

> 'Staff saw him as being inappropriately focused on his own rights without taking responsibility for his own actions. He was seen as difficult and vexatious.'
>
> 'Staff believed he contributed to his own situation i.e. he was 'the author of his own misfortune' and he was expected to moderate his own behaviour.'
>
> 'Staff dealt with his complaints in a defensive way and did not consider his complaints demonstrated his vulnerabilities or needs.'

Failure to listen to this young person had a significant impact on decisions made in relation to his care and safety

> 'The situation C faced was somewhat normalised by staff who made little attempt to identify alternative resources or placements which would better meet his needs or keep him safe. There was no effective short, medium or long term planning.'

In another SCR the children's behaviour was similarly identified as the problem. Addiction workers never visited the mother and children at home and only saw the children face to face on a couple of occasions. They regularly noted that the mother was struggling to cope but case recordings suggested they viewed the children as the problem and felt they needed to change their behaviour. They made no attempts to challenge the mother's lifestyle or provide opportunities for her to change her behaviour.

One SCR noted that the focus of work had been on the baby and the mother but there had been little consideration of the child's siblings or father. The views of the older children had not been sought and the review concluded that there should be an assessment of all family members who have an active role in a child's life.

3.3 Thresholds

The issue of thresholds, particularly what constitutes a child protection case, and lack of clarity between children deemed to be in need of protection and children considered to be in need, was identified in the Victoria Climbie inquiry (Laming 2003) and in earlier Scottish inquires and reviews including those of Carla Nicole Bone, Danielle Reid and Kennedy McFarlane (Vincent 2010). A third of SCRs in this study referred to issues around thresholds which suggests that this issue is still concerning.

There appeared to be some confusion with regard to the status of referrals between different agencies and different professionals. While some professionals believed they had made a child protection referral, the person to whom they had made the 'referral' considered this to be information sharing or a request for support. Some health professionals were frustrated that social work defined their concerns as early intervention rather than considering them to be child protection referrals.

> 'The Review found throughout the interviews that practitioner's understanding of terminology was not consistent. There was confusion as to the appropriate terminology for referrals. Despite this the Review found that these misunderstandings had no substantive impact on the outcome of this case because the Support Midwife for Vulnerable Pregnant Women, after consultation, appropriately escalated the referral to a CP1 and contacted Social Work Services.'

> 'Both the referrer and receiving agency must be clear of the status of a referral as this will determine the application of procedures and immediate response.'

In one case there was confusion about information passed to SCRA and whether this constituted a referral.

A number of SCRs concluded that on some occasions, for example, following suspicious injuries or allegations, formal child protection procedures should have been initiated. In most of these cases there was no suggestion that professionals failed to follow procedures. Across social work, the police and the Reporter 'no further action' was considered to be an appropriate response to each individual injury or allegation. The problem was that professionals did not always consider all the injuries and concerns about a child as a whole. Had they done so concerns may have been escalated to child protection or further assessment may have been undertaken which may have resulted in a different outcome.

> 'There were occasions when concerns were dealt with appropriately as child welfare, however there were examples where professional practice fell short of identifying escalating risk to the children and instigating child protection procedures.'

One SCR concluded that

> ‘Had there been stronger early statutory intervention the review team are of the opinion that the children would have been removed and placed into care at an earlier stage.’

In some cases, particularly those involving long term neglect and/or failure to thrive, a number of agencies had been involved with the family. All the agencies involved had made huge efforts to meet the families’ needs but because children were considered to be ‘in need’ as opposed to ‘at risk’ cases drifted in spite of high levels of intervention and children were sadly not protected from harm.

> ‘Over the years concerns about the state of the home living conditions were referred to on many occasions as were the children’s unkempt presentation with no significant and lasting improvements.’

> ‘… there was a clear failure of all involved services to apply the welfare principle.’

A health visitor had raised concerns with a variety of clinicians on at least eight occasions within four months but the impact of a mother’s mental health issues on her parenting was not fully considered as concerns had not yet been framed as ‘child protection’. Such examples bring to mind Lord Laming’s comment that child protection may not come labelled as such (Laming 2003).

One SCR concluded that there was a need to develop robust processes for cases which did not come under the banner of child protection but which raised significant concerns and were often very complex. In this case a hospital had not treated methadone ingestion as ‘child protection’ or even as serious. It took two days to refer on to social work and the child protection advisor had not been informed.

Learning point
Child protection concerns should always be considered and risk identified in cases that do not meet the threshold for statutory intervention

In September 2012 the Scottish Government published a risk assessment toolkit which will support professionals in identifying risk and protecting vulnerable children.

In another case, even when concerns were eventually treated as child protection, action was significantly delayed because there were differences of opinion about which agency should gather information and progress the assessment. Despite a child protection referral being made at 20 weeks gestation, nothing had been done in terms of child protection assessment by the time the child was born.

3.4 Staffing issues

Previous studies have found that frontline staff are not always qualified, appropriately trained, supervised or supported. The following staffing issues emerged in a small number of SCRs in this study:

- Lack of expertise or training in child protection amongst health and social care professionals
- The need for further training for professionals in health, social work, and social care, including at senior management level, in relation to substance misuse, including responsibilities in relation to GOPR , and ingestion of substances by children and young people
- The need for training in child development and attachment theory
- The need to ensure panel members are reminded of the basic principles of the hearing system and purposes of a supervision requirement; and a need for clarity among SCRA staff as to what a Reporter should do in a situation where he or she proposes to take a decision contrary to the recommendation of the local authority
- The need for additional training on issues that have arisen from SCRs
- Lack of supervision and support for staff in social work, the police and health visiting
- The need for improved single and multi-agency understanding of service demands and better workforce deployment
- The need for social workers to have the confidence to challenge medical opinion.

The Scottish Government will be publishing a National Framework for Child Protection Learning and Development later this year to support the children and families workforce and those that do not have direct contact with children. The National Health Scotland Education Scotland Core Competency Framework for the Protection of Children was published last year for NHS staff.

Some good practice was noted in relation to supervision and support. For example, one SCR reported that the health visiting team had made good use of support, supervisions and advice from the child protection adviser; another noted that the level of supervision was rigorous and appropriate in social work.

Heavy demands on social work, health visiting and midwifery in the context of low staffing levels and sickness were mentioned in a number of SCRs. For example, a social worker's line manager had been off sick for some months so there were 'insufficient opportunities for critical reflection and direction'. Initial response teams were most likely to be reported as being under pressure: one social worker who was passed a case already had 18 cases for rapid assessment and the senior supervised 15 cases. One review noted that

‘Front-line staff that are extraordinarily busy are being asked to:

- Make decisions within complex inter-agency systems about where the correct place is to refer their concerns;
- Receive referrals and decide whether they are appropriate and, if not, spend time getting them picked up by the correct resource.’

Three key staff – the midwife, the health visitor and the social worker - were reported as having been sick or on leave in a week that was particularly crucial in terms of the child’s welfare and protection. In another case the case manager midwife had been off sick for three months and there was no process to reallocate the case.

Recommendation 19: all staff and students in social work, social care, education, health and the police should receive training on issues that have arisen from this and other studies of SCRs.

3.5 Assessment and decision making

Previous studies have identified issues around assessment and decision making including assessments not being undertaken; failure to take account of all the information known to various agencies including past history; and failure to include significant males (Rose and Barnes 2008; Brandon et al 2002; 2008; Vincent 2010). Assessment was discussed in over half of the SCRs in this study and the following issues were identified:

- No comprehensive or multi-agency assessment of need/risk undertaken
- The impact of parental drug misuse not adequately explored
- The risks and needs of children not identified in relation to domestic abuse
- Little recognition of the accumulation of risk factors /reassessment not undertaken in relation to new concerns
- A reactive response to isolated incidents rather than looking more broadly at underlying issues and taking a holistic view
- No analysis of historical information and the impact this may have on parenting ability
- Failure to engage the police in assessment despite there being a history of drug misuse and offending behaviour.

One SCR concluded that

> ‘Decision making as to the welfare of a child rests upon what is known and shared by the agencies and by joint or multi-agency assessment or analysis, taking into account <u>all</u> the available information. The apparent absence of such an assessment or analysis appears to have been an important factor which impacted on the decision to discharge Baby C before the date previously set … Had those responsible for Baby C’s discharge from hospital more fully taken into account her mental health history, her alleged suicide attempts, her

> repeated occasional negative presentations as to becoming a mother and the concerns recognised during her time in hospital after the birth, it is possible that he would not have been discharged without a full post-birth case conference. While this would not necessarily have prevented his death it is reasonable to infer that had he been in hospital on the day of his death he would have been under observation and medical intervention would have been available.'

A number of SCRs identified issues in relation to risk assessment in families with chaotic drug use. One SCR acknowledged that this was difficult but concluded that

> 'in reviewing the chronology, the Review Group had questions regarding the repeated patterns of non-engagement, poor levels of childcare and protection, criminal activity on the part of one of the adults and the lack of any measurable or maintained change in parental behaviour over time.'

In one SCR relating to parental substance misuse there was little acknowledgement of the emotional and psychological impact of the mother's drug use on the children and addictions staff did not carry out a comprehensive addiction assessment that would have provided information about her drug dependency and the impact this may have had on her ability to provide care and protection for her children. Addiction issues were not addressed within the overall care plan, there was no consideration of undertaking a joint assessment with addictions staff and there was no joint pre-birth addiction/risk assessment.

In another case where there had been no assessment of the mother's capacity to parent her children in the context of substance misuse, staff were quoted as saying 'we had suspicions but no proof'; 'there was no corroboration'; 'there were no convictions'; 'it was hearsay'.

In one case a number of professionals were involved with each parent but the parents were not seen as a couple in relation to support for their drug use

> 'Too many drugs agencies were involved focusing on the separate needs of the parents rather than on how the drugs use of one may have impacted on the other…Co-ordination of the role of different drugs workers was required in order to view the family's needs holistically.'

In a case involving a teenager who committed suicide there had been little consideration of the reasons for his behaviour. Professionals had sought to manage his anger without exploring why he was angry.

> 'It is felt that a comprehensive assessment would have informed intervention and may have assisted in the response to the escalating need on the night [the young person] committed suicide … such an assessment would have enabled a full analysis of the information held across agencies where cognisance of the impact of domestic abuse could have been considered.'

Practice examples
Some good practice was identified in relation to assessment of risk and need and decision making and planning:

- forensic CAMHS carried out a full and through risk assessment;
- clear identification of risk, concern and need in an initial child protection report;
- assessment and re-assessment informed healthcare planning;
- a decision was made to have a child protection conference once the package of support was considered not to be working and to accommodate the young person for a period of assessment;
- rigorous monitoring of feeding and weight concerns;
- a multi-agency case management approach was adopted at an early stage
- vulnerable young persons' meetings enabled ongoing risk factors to be evaluated, intervention strategies to be reviewed and respective roles of individuals to be reaffirmed.

3.6 Communication

A considerable amount of good practice was identified in relation to multi-agency communication and information sharing in the 56 SCRs:

- Between criminal justice social work and children and families
- Within and between health services, including between primary care and hospitals
- Between housing and social work
- Between children and families and addictions (social work informed when mothers failed to attend addictions appointments; joint visits conducted)
- Between CAMHS and residential units.

Individual members of staff were frequently praised. For example,

> 'The midwife who was co-coordinating care in the labour ward showed exemplary practice in progressing the management of this case and support to the mother.'

This midwife was off work for three months but was noted to have responded immediately on her return to alert social work and other health professionals to the fact that the child's father was back living in the family home.

Other reports highlighted good practice by several members of staff across different agencies:

> 'Professionals across agencies worked well together, and there was a strong emphasis on supporting the couple to care and protect their children in the context of their continuing substance misuse and personal difficulties, which impacted on their parenting of both children. This was achieved through working closely with the extended family. The findings highlight strengths in

practice, particularly in respect of communication, information sharing and responsiveness.'

The level of good practice identified suggests that the lessons of previous inquiries and reviews in relation to information sharing have been learned and this is now being reflected in improved practice. It is interesting that in comparison with earlier Scottish inquiries and reviews (Vincent 2010) this study did not find any significant issues with regard to information not being shared because of concerns around confidentiality.

On the whole the SCRs revealed a significant amount of information sharing and very good communication across and between agencies. There were, however, some concerns regarding communication within and across agencies. Previous studies have identified weaknesses in communication and information sharing within health (Owers et al 1999; Ofsted 2008) and this study similarly identified a number of issues within health, for example, between forensic CAMHS and GPs; between hospitals and primary care; and between hospitals:

'Systems inhibited the free flow of information particularly between hospitals. This resulted in assessments and subsequent action being taken without those making the decisions being appraised of the full facts, for example the family's social history and the father's medical history.'

In one case discharge information was not communicated to the health visitor. In another the

'Health visitor did not contact Hospital to advise them of ongoing concerns regarding the arm injury and the parent's reluctance to seek immediate medical attention for this.'

The need for better information sharing across GP practices was also identified. When a patient was struck off for selling prescribed drugs new practices she registered with were not formally informed of the reason why she was struck off, allowing her to start doing the same thing again.

Inadequate sharing of information was a recurrent theme with significant decisions not always communicated to all the practitioners involved in a case or important information not being accessed or shared across agencies. In particular the SCRs identified a need for:

- better information sharing on domestic abuse between justice and child care services
- better communication between children and families and addictions staff
- better communication of Reporters' decisions (reasons to parents should set out clear expectations and explain that there will be a re-referral in the event

of lack of cooperation ; and full reasons for decisions should be communicated to social work and schools)
- more multi-agency meetings to share information.

One SCR commented that

> '… in the period leading up to the incident the chronology, from mid 2006 onwards, details a level and intensity of professional involvement which should have triggered increased concern and formal inter-agency communication.'

There were numerous examples of professionals with important information to share being missing from meetings:

- the police, the GP and criminal justice were missing from an initial case conference;
- education and the police were not invited to the post-birth case conference;
- criminal justice staff were not part of the care plan and important information they held was not shared;
- information from a drug treatment service was passed on through social work rather than by someone attending from this agency so information 'became diluted in the translation to attendees'
- information subsequently gleaned from criminal justice social work was not communicated to other agencies prior to the child's death.

Cross border communication was also identified as a challenge when parents moved from a different local authority or a different country.

3.7 Roles and responsibilities

Some SCRs highlighted confusion over roles and responsibilities. A lack of recognition of joint responsibility and shared ownership of work with complex families and over-reliance on social work were common themes. Adult services appeared to be most guilty of this. For example, in one SCR addiction workers were noted to refer to child protection case conferences as a 'social work meeting'. Other areas of confusion or uncertainty included:

- the respective responsibilities of hospital and locality based social workers, particularly when the hospital was not in the same local authority as the social work department
- responsibilities for pre-birth planning and supervision of processes and practitioners in relation to vulnerable families
- lack of understanding of the role and purpose of some meetings including the Multi Agency Risk Assessment Conference (MARAC) and joint Special Needs in Pregnancy (SNIPs)/social work meetings at hospitals

- no clear understanding who was 'in charge' of a case (the role of key worker was not always understood by professionals or families leading to confusion as to who was co-ordinating care for the family)
- the role of the Reporter and what is meant by making a referral
- cases when young people move and have a throughcare worker in the new area but children and families workers in the old area retain responsibility for supervision
- the role of educational psychology in the care planning process
- the responsibilities of housing staff in relation to the GOPR protocol
- inadequate understanding of the roles and responsibilities of others amongst health visitors including uncertainty about who was doing case management and who was undertaking a risk assessment.

One SCR noted that

> 'Ultimately it is not legislation or procedures which protect vulnerable children but professional competence and commitment, and there were a number of occasions in the history of this case where these qualities were not at the standard they should have been. Redrafting procedures cannot address this but it can be re-emphasised to staff in training, and in management and clinical supervision, that it is everyone's responsibility to look after vulnerable children and that it is absolutely critical that each individual professional takes responsibility for her or his role in ensuring that such children receive the attention and caring commitment they need and deserve.'

3.8 Procedures

Only a very small number of SCRs identified that procedures were not followed, indicating that children are not being harmed because professionals do not follow procedures. The following procedural issues were noted:

- police referrals to SCRA not submitted in the required timeframes
- child protection procedures around pre-birth assessment not followed properly
- discharge processes not followed correctly
- Vulnerable Young Person Procedures not used despite the young person self harming and frequently absconding
- GOPR not followed.

In cases where protocols or procedures had not been followed this was sometimes because the procedures themselves were confusing or inadequate. For example, interagency guidance appeared not to have been followed in health

> '… due to systems within health at that time where a number of protocols and guidance existed for health professionals to follow. There were not clear pathways and protocols in place for appropriate and timely referral of possible physical abuse cases for specialist investigation and paediatric forensic

examination. In addition there were relationship difficulties between the specialist services in the General and X hospitals which were impacting on patient care.'

Another SCR concluded that there was a need to review child protection procedures in health because current procedures did not ensure active consideration of whether injuries may have been caused non-accidentally and precluded cumulative consideration of past injuries. The review team suggested that it should be mandatory to implement child protection procedures in cases where there was an allegation that an injury was non-accidental.

One SCR highlighted concerns in relation to school policies and procedures: the school's bullying policy was not as robust or as explicit as it could be and it was unclear how well embedded it was; the review team was also concerned about the schools' monitoring of punishment levels.

3.9 Recording

Inadequate record keeping has been a theme of previous studies (Brandon et al 2002; 2008; Ofsted 2008; Vincent 2010). Some of the SCRs in this study concluded that record keeping practices were generally of a high standard. For example, one stated that the comprehensive nature of health files helped cross-referencing between files and evidenced a high standard of information sharing, which was crucial to effective management and planning. Another noted that records confirmed that there had been significant communication between relevant practitioners regarding the mother's mental health and well-being. Some SCRs noted that there had been some very good documentation and recording practice but this had not always been fully utilised to inform the planning process.

Some SCRs did identify the quality of records as problematic. The following issues were highlighted:

- Records being too descriptive and not sufficiently analytical (for example, records that related to home visits were not sufficiently detailed and did not reflect specific concerns and key actions unique to the case)
- Inaccuracies and inconsistency in dates (particularly in education files)
- Subsequent information being collected but not added to files
- Evidence of multi-agency planning not being clearly recorded
- Reasons for decisions not being recorded.

In addition the complexities of families' circumstances and their history were not always addressed in detail in the records available to review teams

'… records do not reflect their detailed analysis and reasoning. They do not provide a systematic, comprehensive account of what are considered to be the particular risks as well as the specific protective factors.'

Comments in one SCR demonstrated the fact that good record keeping may not be more time consuming. Good records are not necessarily longer, rather they are simpler and more integrated:

> 'Records in both authorities were extensive and cumbersome, not well geared to a chronological, straightforward account of a child's and family's experience over time and of their current situation. There was a large number of files, inches thick, with a variety of different forms for different situations or legal requirements.'

Interviews with staff sometimes revealed that concerns had been discussed at length by a range of agencies but these discussions did not feature in written reports. This provides further corroboration of the finding in Chapter 2 that staff may need to be interviewed for the purposes of a SCR if records are inadequate to ensure reviewers have a full understanding of the circumstances of the case. Some reviewers noted that they were unable to access older records at all, including records from health visitors and schools.

One SCR centred around complaints a young person had made in residential care. While all his complaints had been logged the reviewers found no evidence of the response to these complaints being recorded. The young person had requested access to his records and the review concluded that his request had been handled badly. He had seen a lot of information in files that should have been removed and this had had a detrimental effect on his emotional health.

3.10 Chapter summary

While this study identified some excellent practice, in common with previous studies, it also identified that intervention is not always as child centred as it might be. All agencies, including adult services, must maintain a focus on the potential risks to the child as a consequence of their parent's lifestyle. A reflective, questioning practice culture should be adopted in which practitioners feel confident to challenge parents as well as each other. Managers must listen to frontline staff, acknowledge the difficulties they face in working with troubled families and provide appropriate supervision, training and support.

Despite considerable efforts in recent years, through the implementation of GIRFEC and the child protection guidance and other national policies, to ensure that children and families get the help they need when they need it, the findings of this study suggest that thresholds have not necessarily been broken down and remain a concern. All professionals in child and adult services must heed Lord Laming's comment that child protection does not come labelled as such. There should be no distinction between those children who are considered to be at risk of harm and those that are not. All children may be at risk at any time and decision making for all children, including those outside the child protection system, must always be based on an assessment of cumulative risk and harm as well as need. A significant amount

of progress has been made in recent years to ensure that all agencies acknowledge they have a responsibility for child protection and this is evidenced in the numerous examples of good safeguarding practice in universal and adult services identified in these SCRs. However, the reports demonstrated that there was some confusion in relation to responsibilities in individual cases and there needs to be a shared understanding of roles across agencies.

Chapter 4 Understanding Risk

4.1 Introduction

This final chapter attempts to provide an understanding of risk by considering the various child, family and agency factors involved in SCRs. It considers the ways in which various risks interact in individual cases to result in the death of or harm to a child. The overall pattern of risks will be unique in each individual case, but some risk factors may assume more prominence at different stages in a child's development. For example, previous chapters demonstrated that younger children are more likely to be at risk of physical injury by a parent or caregiver whereas teenagers may be most at risk from their own risk taking behaviour. Previous chapters attempted to identify common themes by looking across cases but this chapter takes a different approach. It looks in depth at a small number of individual case studies which represent the various stages of child development with a view to trying to understand how the various risk factors interacted to lead to the incident that resulted in the SCR. It also attempts to identify points at which more might have been done to protect the children.

Learning point
It may be useful for professionals to consider some of their existing cases in this way in order to identify the level of current risks to the child and to assess whether the support the child and family are currently receiving is appropriate in terms of managing these identified risks

4.2 The interaction of child, family and agency risks

In more than a quarter (15) of the SCRs we analysed, children were living in families affected by parental substance abuse, parental mental health and domestic abuse; two of these three risk factors were present in well over half of cases; and more than three quarters of children lived in an environment where one or more of these factors was present. While the coexistence of these risk factors cannot predict serious abuse or death,

> 'The combination of these three problems can produce a toxic caregiving environment for the child.' (Brandon et al 2009)

Children living in households affected by these factors are, therefore, likely to be at increased risk of harm. One SCR report noted the need for staff in all agencies who work with children and families to be aware of the strong correlation between substance misuse, domestic abuse and mental health.

In more than a fifth of cases (12), children lived in families where at least one parent had criminal convictions in addition to being affected by parental substance abuse, parental mental health and domestic abuse. In addition, many of these families had also moved frequently and/or lived in poor standard housing, and the parents had

often had troubled childhoods themselves. The way in which individual risk factors interact is very complex but by considering the interaction of child, family and agency factors we can understand why some of the incidents might have happened. Some SCRs included very useful analysis of the interaction of the various risk factors. For example, in one SCR the underpinning theme throughout was the parents' use of alcohol and domestic abuse but the report also built on the mother's early experiences, a childhood characterised by physical, emotional and sexual abuse, and the impact this was likely to have had on her own ability to parent. Against the backcloth of child, family and environmental risk we can then consider the role that the various agencies involved in the case played. In this case the agency response had been primarily incident driven with little attention to the wider perspective and the accumulation of incidents that would have been evident if a full chronology had been prepared. It is important that professionals do not just identify all the various risks but also think about how they interact. This case demonstrated that professionals sometimes prioritise one risk over another. In this particular case, as in a number of other SCRs, domestic violence was not given the same status as substance misuse. There is a reference to professionals

> '… seeing domestic violence as a consequence of alcohol intake and mutualising it.'

Professionals had undertaken some excellent practice around parental substance which was evidenced in the SCRs but children were not always protected to the extent they might have been because all of the risks presented by the parents' lifestyle were either not identified or not considered holistically.

4.3 Engagement and cooperation

Parental non engagement is known to be a risk factor for abuse and neglect (Vincent 2010). Chapter 2 demonstrated that many of the children and families whose circumstances were the subject of SCRs were known to and received support from a range of different services. There were, however, issues around families engagement or cooperation which should be considered in the overall assessment of risk factors:

- parents frequently failed to attend appointments for themselves or their children;
- children had poor school or nursery attendance;
- professionals were often unable to contact families or were refused access to the home or to the child.

Engagement was a theme of almost half of the 56 SCRs and this is likely to be an under estimate as a number of reports had very little contextual information about families. In one of the SCRs a foster carer was reported to be a

> '… very independent lady who found it difficult to accept guidance and assistance.'

She refused all professional support and kept professionals at a distance.

> 'They did not have the skills to manage these four damaged children. The level of stress on occasions within this family I believe was very high, and sadly [the foster mother] found it difficult to accept support and lacked the insight into the needs of distressed children.'

The review concluded that the foster mother's attitude to professional support may have given the children the message that professionals cannot make things better even when they are aware of difficulties.

> 'This could have impacted on the children's ability to disclose the sexual abuse by [foster parents' son].'

In some cases non engagement was linked to social isolation. Agencies had an extraordinarily high level of failed contacts with one mother who was particularly socially isolated: there were 19 failed attempts to see the child. The SCR stated that there should have been more rigorous follow up the last time the child was seen at home when the drugs worker had passed on concerns to the health visitor in relation to the listlessness of the child and the poor state of the house. The child was murdered by her mother after not being seen by any agency for a considerable period of time.

One review focused specifically on the history of engagement with a family over the years. It recorded a huge volume of poor school attendance; failure to attend appointments; and failure to achieve contact:

- Professionals were unable to achieve contact on 17 out of 32 visits made in the year after the twins' birth;
- Health visitors made nine unsuccessful attempts to contact the family;
- The parents' failed to attend four Children's Hearings dates in one year.

Learning point
Services should have missed appointment protocols in place and professionals should periodically collate the number of missed appointments to enable risks to be highlighted

Patterns of engagement may be complex. Rather than not engaging at all, most families have periods when they do engage and periods when they do not. For example, one SCR report stated that it is

> '… not correct to say that Mother did not engage with services. Mother's history is one of ad hoc engagement. Not one of non engagement. During her

short pregnancy she actually had 19 contacts with professionals in person or on the phone.'

Changes in patterns of engagement may be particularly illuminating. For example, mothers who have previously engaged with services may begin to refuse access to professionals if they have a new violent partner. Patterns of school attendance may also be key. Some children were noted to have previously good school attendance but then started to disengage and this may be a significant predictor of increased levels of risk. In cases where children are known only to universal services and there is no monitoring of risk by statutory agencies, poor engagement or non-attendance for immunisations or other health checks, or poor school attendance or lateness may be particularly significant. The implications of patterns of non-engagement or cooperation were often not considered: in one case addictions staff did not follow up on missed appointments; in another no-one considered that the child protection plan was not working due to non-cooperation and might need to be reviewed.

Learning point
Patterns of cooperation and school attendance should be monitored and any changes should be explored as they may be indicative of increased levels of risk

While non-cooperation is a risk factor the findings of this study also suggest that cooperation should not automatically be viewed as a protective factor. The tendency to accept what parents say at face value, which was described in the previous chapter, can lead professionals to mistakenly identify cooperation as a strength. For example in one case there were

'… numerous references to the fact that the couple were cooperating with professionals and therefore no need to proceed through the child protection route.'

As Brandon et al (2009) have pointed out, what appears to be cooperation may in fact be disguised compliance. Parental cooperation should, therefore, be balanced against other risk factors and should not be the overriding factor when making decisions about how best to protect children:

'… the decision to proceed to a child protection Case Conference should not be based on whether or not the couple are cooperating and should be based on an identified risk of significant harm to the unborn child.'

Staff were sometimes praised for attempting to engage with families in situations of outright hostility. For example, one SCR stated that there was

'… evidence of staff engaging with this family however at times they found this difficult due to mother's behaviour and perceived aggression and reluctance to engage with services. '

This mother's aggression led to her being struck off the GP list and the SCR discusses the implications of this for her children. Although the SCR discussed the mother's aggression and the wariness of staff, it was unclear from the evidence presented whether this had an impact on the provision of support to the family.

Other SCRs similarly discussed the difficulties for staff in addressing complex child protection issues where there is little co-operation and sometimes outright hostility from parents. One referred to the feeling of powerlessness on the part of midwives who were trying to protect a mother and her child from an aggressive father. Three security guards had been in attendance at this child's birth and the impact on staff must have been enormous. The review team praised the hospital duty social worker who began an assessment following the birth for her work in establishing a rapport with the mother in a very short time. She had also tried to engage with the father to lay the foundations for a more thorough risk assessment.

In another case a mother and her partner had been intimidating to panel members and other professionals. The review concluded that it was possible that early assessment procedures were compromised due to professional concern and anxiety about engaging with the mother and her partner. Her hostility may have made professionals reluctant to challenge her and her failure to provide appropriate care and protection. This SCR noted that staff needed additional support in working with difficult to engage families. It is surprising that this was not a more frequent recommendation across the 56 SCRs and we must remember that professionals undertake excellent work with children in troubled families in the context of extremely difficult circumstances.

Staff faced similar problems engaging teenagers as they did engaging parents. In one SCR involving a teenager who committed suicide, the review concluded that services had made attempts to engage the young person in the context of a resistant mother and a disengaging young person. The social worker had had a positive relationship with the family and a member of CAMHS staff had forged a working relationship with the young person that resulted in some of the best service interaction he received. There were, however, a number of issues around engagement. Non engagement with staff was a feature within the residential unit where the young person lived and an addictions service had attempted to engage him but was not flexible enough to meet his needs and had withdrawn too early when he refused to engage. The reviewers concluded that this service could have considered adopting a more individually customised programme of intervention for the young person. They were particularly concerned that the young person's supervision requirement was terminated because he was not engaging with services and concluded that this constituted a failure to grasp the basic principles surrounding the approach to vulnerable young people.

Recommendation 20: All staff working with children and families and students training to work with children and families in Scotland should have regular training in working with difficult to engage and hostile parents and young people.

Learning point
Intervention for young people should not automatically be withdrawn when they refuse to engage; instead services should consider how they can be more flexible in order to meet individual needs

Practice example
One SCR noted good practice by third sector organisations in relation to engagement:

> 'It is important to highlight the family were engaging at times with non-statutory services who were providing considerable support to both the children and parents. There is a need to emphasise the potential of non-statutory services being able to keep families who have a track record of avoidance with statutory services engaged in child protection processes and the requirement for statutory agencies to ensure consultation and inclusion of these services in the overall assessment of children and their families.'

4.4 Understanding risks to infants

Previous research has found that children are at most risk when they are infants and chapter 3 revealed not surprisingly that most SCRs in Scotland, as elsewhere, relate to young children. Just over half of the children who were under six months old died. Most of these deaths were attributed to SIDs/SUDI and/or were sleep related. The majority of non-fatal cases involving children under six months were physical injury cases.

Brandon et al (2009) pointed out that the high proportion of babies under six months in SCRs reinforces the importance of the protection role for health professionals (especially midwives and health visitors) working with young babies and their families. In most of the cases in this study, however, the children were well known to services. Their needs had been identified in the antenatal period and their families were receiving a considerable amount of intensive support. Only one of the 15 babies under six months was not known to social work services. There had been no previous concerns about this eight week old infant prior to her being admitted to hospital with significant head injury and fractured ribs. Her injuries were initially thought to be accidental but she suffered seizures the following day and her father was suspected of causing NAI. Concerns in respect of the 14 infants who were known to social work services included parental substance misuse, parental mental health issues, domestic abuse, non-attendance for immunisations and health checks and poor engagement by parents. Two of these infants were on the CPR for physical

neglect at the time of the incident resulting in the SCR and another two had older siblings who had been on the CPR.

Case study: Holly

Background to the case and child and family factors

Holly ingested methadone which had been prescribed to her father when she was three years old. After spending a night in hospital she made a full recovery. There had been a long history of concerns in respect of her parents' drug use and involvement in drug dealing. There were concerns in relation to the parenting of Holly and her three siblings. There were also concerns in relation to domestic abuse, and failed appointments. All four children were subject to child protection proceedings. They were on the CPR for physical neglect and were subject to formal supervision requirements. The children's grandmother played an important role. For a period of time all four children were under her care and it was noted that '… if children are removed from her care then social work will instruct a CPO to be sought'. Holly's mother had her first child at 17. She had previously attempted suicide and taken a drugs overdose, and had been misusing drugs for at least ten years. Holly's father had a long history of drug use, drug dealing and other offences and had served two prison sentences.

Agency issues and points at which more could have been done to protect the child

Holly was a member of a very troubled family where there had been multiple incidents and involvements, a family on the boundaries of remaining within the family home, where the children had experienced a period of placement with their grandmother. Within this complex picture there is much that reflected enduring good practice. There was ongoing and major involvement from the health visitor and nurse, social work, police, and addiction services, and the two youngest children received intensive support from early education staff. The parents had been abusive to nursery staff and at times had not been in a fit state to collect the children. Overall, there was good inter-agency co-operation and information sharing as reflected in the integrated chronology extending over more than ten years. Nonetheless, a number of factors were identified that inhibited a full risk assessment being undertaken:

- not all review and core group meetings were well attended
- addiction service workers were not always invited or not given sufficient notice
- GPs were not aware of the full family circumstances when they agreed dispensing protocol arrangements for the father
- There was not always consistent information as to whether the father was living in the family home
- The health visitor did not appear from records to be fully aware of the father's methadone dependency and dispensing programme
- The full picture of childcare responsibilities, volatile personal relationships, domestic abuse, and reliance on methadone was not necessarily understood by all professionals and 'this had an impact on the effectiveness of integrated care planning'.

More could have been done to protect the children at the time they were returned to their parents' care after living with their grandmother and when the methadone protocol was agreed.

The child's mother was often assumed to be the main carer of the children but the incident triggering the review took place when the father was in sole charge and the likelihood of this should have been factored into the risk assessment. It was also unclear whether the GP was fully aware of the father's role in the family when the methadone dispensing regime was agreed. Both parents admitted to 'topping up' with other substances and it was not clear whether the child's plan fully considered the impact of this on their ability to care for the children.
It was unclear whether the health visitor knew about arrangements for the storage of methadone in the house and to what extent there had been co-operation in seeking to install cupboard locks. Neither was there any evidence that childcare social workers had been briefed on any of the issues regarding storage, nor was there any expectation that they had a role in terms of providing safety advice. As a result it was the

> 'Conclusion of the review group that it seemed likely that lack of proper supervision and care on the part of F led to the methadone being available for the 3 year old to use as part of the play activity.'

The children were returned to the care of their parents after a relatively short time with their grandmother but it was

> 'not clear there was evidence of sufficient improvement for a long enough time to inform this decision … we are of the view that social work services should examine the process that lead to this decision.'

Summary of main risk factors

- Parental drug misuse and dealing
- Criminality
- Mother's mental health
- Missed appointments; lack of parental co-operation
- Child neglect
- Lack of understanding of methadone protocol by some professionals
- Removal of the children from their grandmother's care.

Case study: Shannon

Background to the study and child and family factors

Shannon was aged 22 months; her brother Aiden was five months. The children had different fathers. Aiden was taken to his GP with physical injuries and admitted to hospital; his sister was then observed to have physical injuries as well and also admitted. There was a CPO after the incident and the children were removed. The SCR report stated that there was an ongoing criminal investigation but did not specify whether one or both parents were under investigation.
Professionals and neighbours/family members had observed and reported a number of concerns prior to the children being admitted to hospital for physical injury:

- Aiden's poor weight gain;
- allegations of domestic abuse;
- anti-social behaviour;
- poor engagement by the parents and non-attendance for immunisations and other health checks;
- Aiden had a burn on the back of his head;

- concerns about the treatment, care and cleanliness of Shannon.

The children lived with their mother and Aiden's father. The parents' ages were not recorded. Aiden's father had been looked after, was recorded as having had mental health issues since the age of four and had a history of violent offending. He asked his GP for a referral to addiction services for heroin use. In a referral to children and families criminal justice social work also alleged that the mother was a heroin user. Both parents suffered bereavement of family members when they were children.

Agency issues and points at which more could have been done to protect the child

The family were known to health services and social work. Five referrals – one from housing, one from criminal justice, one from the health visitor, one from the Grandmother, and one anonymous referral resulted in NFA or initial investigation; none had led to a case conference and a comprehensive assessment had never been undertaken. The family received home care and day care following one of the referrals.

The family had received a warning and threat of eviction from housing due to anti-social behaviour. The police were called to their house on a number of occasions following reports of domestic disturbance and anti-social behaviour by the mother, neighbours and housing but no crime was ever established.

The report mentions that referral to SCRA from the police had not taken place within the specified timescales but it is not clear when this referral was made.

The social worker did not receive supervision and did not have appropriate experience or training and it was noted that police supervision could have been better.

Lack of assessment was a major factor in this case:

- no comprehensive assessment was undertaken;
- assessments were commenced but not concluded;
- parental drug misuse was not fully explored;
- the risks and needs of the children were not identified in relation to domestic abuse.

There was a lack of recognition of joint responsibility and an over-reliance on social work who were not fully aware of the domestic abuse or anti-social behaviour. There was also a lack of communication between the hospital and primary care. The discharge process was not followed correctly with discharge information not communicated to the health visitor.

There is some good analysis in the SCR report including a section on missed opportunities to intervene.

> 'The review team has considered these matters carefully and have concluded that there were several key opportunities that, had they been responded to differently, by all of the opinions concerned would have resulted in more focussed and timely interventions for the children.'

With hindsight the SCR identified a number of points at which more could have been done to protect the children:

- Housing were informed of seven suspected incidents of domestic abuse in one month and could have intervened (the police were only made aware of one of these incidents) but they only interpreted the information in relation to anti-social behaviour. If social work had been aware of the alleged domestic

violence/anti-social behaviour they may have initiated an investigation about the welfare of Shannon and her mother.

- Just before the birth of Aiden following the referral from criminal justice the pre-birth alert could have been followed up by an assessment and there could have been a pre-birth case discussion and care plan.
- After Aiden was admitted to hospital with a burn on his head and sticky eyes there should have been a pre discharge case meeting and the care and protection of Shannon should have been considered
- Two months before Aiden was admitted to hospital the second time there was a decision to convene a multi-agency discussion as a result of accumulating concerns. This discussion should have been convened more quickly given the level of concern.

Summary of main risk factors

- Previous concerns relating to abuse and neglect (Aiden: poor weight gain, sticky eyes, burn on the back of the head; concerns re the treatment, care and cleanliness of Shannon)
- Domestic abuse
- Poor engagement by parents (the midwife, health visitor and social worker were unable to contact the family; the child was not taken to day care; non-attendance for immunisations and other health checks)
- Mental health (father)
- Substance misuse (father, possibly mother too)
- Violence/offending (father)
- Troubled childhoods (both parents)
- Financial problems (mother presented as destitute to housing and social work on a number of occasions)
- Housing issues (warning for anti-social behaviour)
- Accumulating information not analysed to allow assessment of increasing risk.

Some of the risks, for example, domestic abuse, substance misuse, and mental health and the interaction of these risk factors do not appear to have been fully explored. Risk may have increased at the point that the family became particularly hostile to agency involvement and stopped taking Shannon to day care.

4.5 Understanding risks in the middle years

There are fewer SCRs involving children in the middle years. These cases typically involve more than one child, and normally relate to non fatal cases where there is a history of concerns relating to neglect over many years. Policy initiatives often focus on the early years and it is important that we do not neglect the middle years of childhood and lose sight of these important cases. Scottish Government national policies promote early intervention and prevention and this can take place at any stage of a child's life. Services should ensure that they are working to the principles of GIRFEC when working with children of all ages. Child death review experts in New Zealand recently recommended that we should focus intervention on the middle years in order to prevent children dying from suicide, overdose and other accidents when they are teenagers. Education has a significant amount of contact with children

in these years and may have an important role to play in relation to safeguarding and protecting these children.

Case study: the Brown and McDonald families

Background to the case and child and family factors

This case unusually involved two families: three children from the Brown family and two from the McDonald family. The case involves ingestion of heroin by a one year old in the Brown family. On the face of it, this case might, therefore, be considered to be a case involving an infant, but on closer reflection, although the incident that resulted in the SCR occurred to an infant in the Brown family, many of the concerns relate to escalating concerns to school age children in the McDonald family. The case demonstrates that in some cases there may be no identified concerns for the index child but if we consider other siblings in the family, including those that do not live in the same household, or other families with whom the child associates, the level of risk may be significantly higher.

Both families were part of the travelling community. Only the Executive Summary was available in relation to this case so some of the background information on the families was unfortunately missing or unclear.

The SCR notes that with hindsight, in the last few months before the incident that led to the SCR there was an '… overall picture of escalating concerns and risks to these children held locally by each agency'. The case led to all five children being accommodated by the local authority.

Most of the concerns were in relation to the McDonald family

> 'this family came to the attention of all agencies on a regular basis and for a number of reasons including, chaotic lifestyle, antisocial behaviour, lack of attendance at school and health services, alongside continual child welfare concerns, criminal activity and substance misuse.'

Agency issues and points at which more could have been done to protect the children

There was a sequence of intermittent involvement from education, health, social work, and the Reporter but follow through was often hampered by the families moving on. There were, however, also examples of calls and referrals to agencies not being formally recorded or actioned.

Although there were increasing concerns around neglect the focus of intervention tended to be on welfare issues rather than child protection. In relation to the McDonald family

> 'There were occasions when concerns were dealt with appropriately as child welfare, however there were examples where professional practice fell short of identifying escalating risk to the children and instigating child protection procedures'.
>
> 'the case appeared to be drifting and while identifying the need to clarify the way forward no actual action was taken.'

The report writers concluded that had earlier assessment been undertaken and there been a referral to a children's hearing in relation to the McDonald children, 'then the need for a CPO could have been avoided'.

There was no discussion with the children at any stage.

There were a number of points at which more might have been done to identify risk and protect the children. In relation to the McDonald family:

- In 2003 there was a referral from the police to the Reporter but the subsequent report made no mention of substance use
- More could have been done following an urgent referral from a homelessness agency to social work in 2005 in respect of the younger child which outlined concerns around the mother's drug use and care of the children
- In 2005 the mother and older child were caught shoplifting. The police and social work visited but there was no Initial Referral Discussion (IRD)
- Further concerns were raised in 2005 including a GP referral in respect of neglect and the mother's alcohol misuse but there was no assessment and information was not shared with a third sector organisation 'who were dealing with the case'
- The father died in 2006 but no consideration was given to the impact of this on the mother and on her ability to care for the children
- In 2006 a referral from a third sector organisation to the Reporter should have led to a case discussion and social work should have taken responsibility for multi-agency assessment
- In 2008 there were two episodes when child protection concerns were identified (the state of the home, hostility from the mother, the older child was dirty and an infected head wound was covered in head lice, the mother and older child appeared at the Registrar's office and seemed to be under the influence of drugs). The second episode resulted in an IRD and consideration of a CPO but 'again these issues were de-escalated into child welfare'.

In relation to the Brown family if there had been an alert to the GP regarding the grandmother's report of the mother's drug use and information that she was being supplied by the McDonald family had been shared more widely 'it should have alerted professionals to additional child protection risks for the two families concerned'. The alert from the grandmother should have been taken much more seriously. Referrals from family members resulting in NFA is a theme that emerges across several SCRs and it is important to remember that family members hold a lot of information that should be taken seriously.

There appeared to be good practice from a third sector organisation involved with the family. There was a comment in the SCR that 'It is important to highlight the family were engaging at times with non-statutory services who were providing considerable support to both the children and parents. There is a need to emphasis(e) the potential of non-statutory services being able to keep families who have a track record of avoidance with statutory services engaged in child protection processes and the requirement for statutory agencies to ensure consultation and inclusion of these services in the overall assessment of children and their families.'

Summary of risk factors

Brown family:

- Travelling family - frequent moves around the country and the impact this has on service provision and continuity
- Antisocial behaviour
- Domestic abuse
- Lack of engagement with services
- Failure to register with a GP
- Parental problem substance misuse
- Professional failure to consider risks outside the immediate family

McDonald family:

- Travelling family - frequent moves around the country and the impact this has on service provision and continuity
- Lack of engagement with services
- Children's non-attendance at school and professionals perception that this was the cultural norm for travelling families
- Chaotic lifestyle
- Children's learning difficulties
- Antisocial behaviour
- Parental problem substance use

This case epitomises the issue of thresholds for intervention, with the added complexity of working with the travelling community, both practical in respect of people moving on, and cultural issues around school attendance

> 'Child 1 missed a considerable part of his first school term. It is unclear if professionals felt this was a significant concern or whether this was viewed as the cultural norm of travelling families.'

The challenges of inter-agency communication will be magnified when different areas and changing locations are involved, nonetheless there were a number of cross referrals which do not appear to have been actioned. The SCR notes that there are now better arrangements for locating Missing Persons in Education and in Health.

4.6 Understanding risks to teenagers

Nine SCRs related to teenagers. Cases involving teenagers are much more likely to be deaths. Seven of these teenagers died: four from drug or alcohol intoxication; and three from suicide. One teenage case involved a previously LAAC young person who committed a homicide. All the teenagers in the study were known to social work services and seven were recorded in the SCR report as having been known to SCRA. All the young people known to SCRA were, or had previously been, LAAC.

Although the SCRs involving adolescents have unique characteristics there are a number of shared features. These cases are likely to involve very troubled young people who are, or have been, looked after, who have often experienced a high number of placements, and whose lifestyles are characterised by substance misuse, mental health issues or emotional problems, and other risk taking behaviour. Such cases have previously been found to frequently involve offending and sexual exploitation although only one of the teenagers in this study was recorded as being involved in prostitution. SCRs involving teenagers are quite different from those involving younger children. The young people were often abused or neglected when they were younger and at this point in their lives the risk factors were similar to those for the younger children in this study, including parental risk factors such as substance misuse and mental health, and non-attendance or problems at school. Once these children were removed from their parents' care many of these risk factors no longer applied but new risk factors such as problems relating to their own

mental health, or risk factors as a result of their lifestyle, including substance misuse and offending behaviour, took the place of earlier risk factors. The reasons why these young people died or were injured are also different to the reasons why younger children die or are injured. They are not harmed by their parents, they usually die through suicide or as a result of their own risk taking behaviour (Vincent, forthcoming). Their deaths are, therefore, not directly related to abuse or neglect but the abuse or neglect they experienced in their childhood, and agencies response to this, undoubtedly played some part in contributing to these tragic outcomes. In many of these SCRs agency issues which were identified related to past practices. While it is useful to acknowledge that local practice may have moved on and to point out that these issues may no longer apply, it is still a useful exercise to consider these agency issues across cases in order to identify any national learning. These young people's needs clearly were not met and we need to consider whether anything can be done at a national level to protect other young people in similar situations. Many national policy initiatives have focused on the early years. This is appropriate but we also need to ensure that older children's needs are prioritised and that we do not continue to fail these young people. One of the SCRs expressed concern about the lack of priority given to adolescent services, and commented that adolescents were a missed group.

Case example: Laura

Background to the case and child and family factors

Laura died from 'possible illicit drugs intoxication' at the age of 17. She had had a very troubled life. She experienced physical and emotional abuse and neglect in her early years, and came to the attention of social work at three and a half following reports that her mother was supplying drugs. She had multiple foster placements before being adopted at age six. Her behaviour became challenging and she was placed in residential school for two years at age 11. Family relationships broke down following her allegation of abuse by her adoptive brother and she was then placed in a residential treatment centre in England for several months, followed by secure accommodation for six months, then a foster placement back in her local community for ten months. She then lived in various supported accommodation resources for six months and was living in bed and breakfast accommodation with a plan to return to foster care at the time of her death. Laura was involved in drug use and prostitution and had criminal offences. Psychiatric assessment revealed borderline personality disorder traits and there was some evidence that Laura's mental health had deteriorated prior to her death. She was said to have regressed to the level of a seven year old.

Laura had resumed contact with her mother before she died. Her mother's lifestyle was characterised by drug misuse and prostitution. Laura's care plan had indicated that contact with her mother should be supervised because 'there was a concern that [Laura] may try to over identify with her birth family'. She was found dead in a flat occupied by friends of her birth mother.

Agency issues and points at which more could have been done to protect Laura

The SCR only focused on the last 12 months of Laura's life. Within this period she had contact with accident and emergency, the police, social work, psychiatric services, her GP, the Children's Reporter and the Children's Hearings System and a third sector agency that provided supported accommodation.

This case is characterised by multiple adversity combined with professional powerlessness. Laura was subjected to an unfortunate and relentless stream of multiple adversities throughout her life. The case was extremely complex and there was a sense that agencies were at a loss as to how to help her in the months before her death. Laura's social worker's line manager had been off sick for some months prior to her death and there were 'insufficient opportunities for critical reflection and direction'.

There was significant concern in relation to accommodation

> 'She was unable to manage placements within a family care or residential setting and social work considered that all other accommodation options had been exhausted.'

There was discussion of a therapeutic resource outwith the area but

> '[Laura's] social worker reported that she had insufficient time, prior to the children's hearing, to approach social work management to discuss the option of this particular resource.'

The children's hearing agreed with the recommendation for a therapeutic resource but social work management subsequently decided to pursue neither this resource or secure accommodation as desired by Laura. They reconvened to consider local options and recommended a foster care placement but Laura was to remain in bed and breakfast accommodation until this was available. It was suggested that there should be a review hearing to consider the revised plan but this had not taken place at the time of Laura's death. The SCR also noted that Laura

> 'no longer had access to support through the agreed plan outside office hours and at weekends.'

Inability to provide accommodation for Laura when this was required may have played a considerable role in this case

> 'whilst it is accepted that it is not always possible to provide the right resource to meet identified need because of resource constraints and competing demands from within services, the need for a Level 4 Foster Placement with therapeutic support could have been anticipated and identified within plans at a much earlier stage.'

There was also no practical discussion of how to avoid Laura having unsupervised contact with her birth mother.

The SCR report notes that insufficient weight was given by GPs to Laura's Looked After Status, history and vulnerability

> 'There appeared to be inherent tensions for GPs between considering [Laura] as a young adult and respecting her rights and wishes in relation to sharing confidential information, and on the other hand considering her as a very vulnerable young looked after person who was placing herself at risk of harm.'

Health information was not routinely shared within health or with other services and the significance of health issues related to prostitution; misuse of prescription drugs to self harm; use of illicit drugs including cocaine and heroin; reported difficulties with eating, sleeping and anxiety were not fully considered in terms of increasing the levels of significant harm to Laura.

The police had 14 contacts with Laura in the year prior to her death. The police shared information with the Reporter and social work but

‘the significance of the nature of offending behaviour and pattern and the risk of sexual exploitation in relation to the prostitution activities should have been considered on an interagency basis, and a record produced of decisions and rationale behind them.’

The reviewers noted that there were no specific interagency policies and procedures in relation to assessment of risk in young people over the age of 16 where risks relate to harm from their own behaviours.

Summary of risk factors

In Laura’s early years:

- Abuse and neglect
- Breakdown of adoption and feeling of betrayal that her allegations of sexual abuse not believed.

More recently:

- Multiple placement breakdowns and agencies inability to meet her accommodation needs
- Borderline Personality Disorder and deteriorating mental health
- Substance misuse
- Prostitution
- Criminality
- Contact with mother
- Professional powerlessness.

4.7 Chapter summary

This chapter demonstrated the complexities of understanding risk in cases which result in a SCR. Children and young people die or experience harm for a range of different reasons. While there are a number of common risk factors which were identified in chapters 2 and 3, the way in which the various child, family and agency factors interact and result in the different types of death or harm will be unique in each case. Risks change as children get older and it is, therefore, important for professionals working with children and families to have a good understanding of child development. Parental risk factors will be important for younger children but teenagers usually die or are injured as a result of their own risk taking behaviours.

In summary the following risk factors were identified for cases involving infants:

Child factors	Parent factors	Agency factors
NAS Prematurity Failure to thrive Attendance at A&E for injuries	Substance misuse Domestic abuse Mental health problems Troubled childhoods characterised by lack of attachment and lack of positive parental role models Criminal record especially for violence or drugs	Focus on the parents as opposed to the children Child not seen Risks not assessed, accumulating information not analysed to allow assessment of increasing risk, or case not considered to be ‘child protection’

	Social isolation/lack of family/ community support Housing issues – frequent moves, anti social behaviour, problems with neighbours Non engagement, lack of cooperation, changing patterns of engagement Missed health appointments, failure to obtain medical care Frequent appearances at A&E	

The following risk factors were identified for children in the middle years or in families with several children including one or more of school age:

Child factors	**Family/environmental factors**	**Agency factors**
Low attendance/lateness at school/nursery Behavioural problems at school Presenting as dirty at school/nursery Health problems including weight problems	Large families Substance misuse Domestic abuse Mental health problems Troubled childhoods characterised by lack of attachment and lack of positive parental role models Criminal record especially for violence or drugs Social isolation/ lack of family/ community support Housing issues – frequent moves, anti social behaviour, problems with neighbours, overcrowding/poor conditions Non engagement, lack of cooperation, changing patterns of engagement Missed health appointments, failure to obtain medical care Frequent appearances at A+E	Failure to speak to the child and/or to analyse their behaviour Risks not assessed, accumulating information not analysed to allow assessment of increasing risk, or case not considered to be 'child protection' Long involvement with universal and statutory services with few signs of improvement Sexual abuse not identified

Risk factors for teenagers included the following:

Child factors	**Family/environmental factors**	**Agency factors**
Mental health problems Risk taking behaviour – self harm; substance misuse; offending etc Long term involvement with social work and SCRA Looked after with multiple placement moves Non engagement/lack of cooperation with services Absconding Previous abuse/neglect	Social isolation/lack of family/ community support Known to associate with peers/family involved in risk taking behaviour	Lack of resources to meet young person's needs Risks presented by transition to adult services Professional powerlessness Mental health needs not met Housing needs not met

Conclusions and recommendations

Conclusions

The fact that the large majority of children whose lives form the subject of SCRs are known to statutory services is positive in the sense that universal services have correctly identified that they are in need of support and appropriately passed their concerns onto statutory services in accordance with policy and procedure. The SCRs provided considerable evidence of excellent multi agency working with agencies effectively sharing information and coming together to meet children's needs. However, the fact that children died or were harmed despite high levels of multi agency communication and provision of intensive support is concerning.

The findings of this study raise a number of important national policy issues. A particularly significant finding is the high number of SCRs which relate to the care and protection of children living in families whose lives are dominated by drug use and the associated issues this brings including criminality and neighbourhood problems. In most cases the child's needs had been identified and an extensive support package had been put in place but this did not prevent these children from dying or experiencing harm. This inevitably raises issues about leaving children, particularly infants, in the care of parents involved in substance misuse, particularly when both parents and sometimes the wider extended family, have a long history of substance misuse and no one is able to provide a protective influence. It also raises issues around the threshold for intervention in respect of levels of drug dealing and intimidation known to police and other agencies such as housing.

Another challenging finding is the lack of suitable resources for the placement and support of troubled and troublesome teenagers and the impact this has on staff in a number of agencies, particularly social work, housing and mental health agencies. As these SCRs demonstrated this can lead to situations of professional powerlessness, where professionals do not know how to support these young people, resulting in them being left in dangerous situations where they are placed at significant risk of engaging in risk taking behaviour which can sadly lead to death through suicide or misadventure.

Lastly the findings demonstrate that we should not lose sight of school age children. Policies often prioritise pre-school children or adolescents but there were a number of concerning SCRs involving long term neglect and sexual abuse of school age children who had been known to statutory services for many years. These families had been correctly identified as being in need and intensive packages of support had been put in place to meet their needs but the 'rule of optimism' resulted in cases being allowed to drift. Cumulative risk had not been identified because children had not been spoken to and the reasons for their challenging behaviour had not been considered. These particular children had finally come to the attention of agencies because a particularly serious incident had resulted in them being the subject of a

SCR or the accumulation of concerns had finally been picked up. In the majority of these cases children did not die but they had experienced serious abuse or neglect. They were normally removed from their parents' care as a result of the incident or catalogue of incidents that led to the SCR but retrospective analysis suggests that some of these children should have been removed much sooner.

List of recommendations

1 The SCR process and separate process for review of the deaths of LAC should be better aligned.
2 There needs to be more standardisation in the way in which ICRs are undertaken and reported across Scotland. CPCs should follow the national guidance, use the template and keep a register of cases. The template should be revised to include a section where CPCs can record the reason for their decision.
3 The 2010 National Child Protection Guidance replaced 'Protecting Children – A Shared Responsibility: Guidance for Inter-Agency Co-operation' and the categories of abuse and neglect have changed. The national guidance should be revised to take account of this.
4 All reviews that are multi-agency and meet the criteria for a SCR as set out in the national guidance should be termed SCRs to avoid confusion.
5 The national guidance should be updated to include information about the process of undertaking cross border SCRs.
6 As specified in the national guidance SCRs should be undertaken by a mixed team not by a single reviewer and reports should include a list of contributors to the review.
7 SCR reports should include a separate chronology or take a chronological approach.
8 SCR reports should include a separate executive summary as specified in the national guidance.
9 It may be appropriate for CPCs to produce separate action plans rather than including them in the SCR report but reports should provide some discussion of how the findings will be disseminated and how the recommendations will be taken forward.
10 In line with the national guidance SCR reports should include information about whether or not children and families were informed and involved. If they were not involved reports should record why they were not involved. If they were involved reports should record the nature of this involvement and document how their views have been represented. Diversity issues should be considered and adequate support should be provided to ensure that family members are able to participate.
11 The national guidance states that 'A review should not be escalated beyond what is proportionate taking account of the severity and complexity of the

case.' The SG should look at new review arrangements in Wales which include a continuum of review (multi agency professional forums; concise reviews; extended reviews) (see Appendix 1) and consider the appropriateness of updating the national guidance to include different levels of review.

12 The decision not to interview staff may be appropriate but where staff views have not been sought SCR reports should include information about whether there was any consideration about involving them and why the decision was made not to involve them. All SCR reports should document how the findings of the review will be fed back to frontline staff.

13 All SCR reports should reflect upon good practice as well as on what needs to change.

14 SCR reports should record the length of time it took to undertake the review and set out any reasons for delay.

15 Authorities are subject to the public sector equality duty. They should consider the relevance of protected characteristics such as age, disability, race, religion, sex and sexual orientation and ensure appropriate monitoring. Any associated cultural issues should also be considered and documented.

16 Some of the deaths of babies are accidental but preventable. Mothers and fathers of vulnerable children should be given ongoing information about safe sleep as well as at the time of their baby's birth. The Scottish Government is currently updating its Getting our Priorities Right (GOPR) Guidance and should consider including advice for professionals to warn mothers with a substance misuse problem who breastfeed to make sure they return their baby straight to his or her cot after feeding as they may be more inclined to fall asleep.

17 SCRs should include information about the family's economic situation.

18 SCR should record the level of involvement with SCRA.

19 All staff and students in social work, social care, education, health and the police should receive training on issues that have arisen from this and other studies of SCRs.

20 All staff working with children and families and students training to work with children and families in Scotland should have regular training in working with difficult to engage and hostile parents and young people.

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APPENDIX 1

Recommendations from SCRs categorised within the Quality Indicator Framework "How well do we protect children and meet their needs?" (HMIe 2009).

There were over 500 recommendations made in total from all the significant case reviews from 2007 to 2011. A number of common areas for improvement have emerged. In order to make it easier to identify these key themes the recommendations have been mapped against the quality indicators used in the self-evaluation framework *"How well do we protect children and meet their needs?"* (HMIe 2009).

Although the recommendations were spread across many of the quality indicators almost half of them fell within the process quality indicators and a further quarter of them related to policies and procedures.

The majority of recommendations were around **Information sharing and recording (QI 5.2)** and the mains themes to emerge were:

- There was a need to clarify what information should be shared and to which relevant partners. This included relevant background information held by each agency about adults. Services needed to ensure that information was shared at an early stage.

- Services needed to have robust communication systems in place to allow all staff working with a family to be aware of any concerns raised. This also included information, for example, on pregnant substance misusing women.

- Managers needed to ensure that there was a joint understanding of when to share information including concerns about children. There also needed to be a joint understanding of the significance of the information shared. This was particularly relevant for children affected by parental substance misuse. Information shared at child protection meetings was often incomplete, not up-to-date and or relevant to help make informed decisions.

- When staff had a concern about a child this was not explicitly and clearly communicated to other services in writing. Staff should clearly record what information has been shared between professionals and with families.

- A major concern was the lack of either single or multi-agency chronologies to identify significant events in a child's life.

- Multiple records kept for each child made it difficult to retrieve and gather all relevant information on children and their families.

- The quality and completeness of case records for individual children was very variable. Poor recording was leading to poor information sharing and ineffective assessment of risk and needs. Poor record keeping was particularly seen when services were introduced, cases were opened, closed or transferred.

- Staff were not always using recording proformas and tools effectively when sharing information between and across services. There was a lack of management oversight and little recording of decision making evident in records. Additionally there was insufficient management auditing of record keeping practice.

Another significant theme to emerge was **Recognising and assessing risks and needs (QI 5.3)** and the main themes noted were:

- There were issues around the recognition of what makes children vulnerable. This included the impact of adult behaviours and health issues on children. Additionally staff did not always recognise patterns or accumulating concerns about the welfare of children, including the unborn child.

- There was still a need at an early stage of producing an assessment to gather all relevant information, both current and historical, which could have an impact on the care, welfare and protection of children. Following this stage there was poor analysis and recording of this information. This included information on children, parents, carers and other adults coming into contact with children.

- Better quality single agency, holistic assessments were required to inform comprehensive interagency assessments of risk and needs. However, these assessments were not always recorded well. They were not always completed for individual children within a family or analysed well. Comprehensive assessments were not reviewed regularly or updated.

A further significant area was the **Effectiveness of planning to meet needs (QI 5.4).** The main themes to emerge were:

- Some staff were unclear about their role and responsibilities when attending child protection meetings. Relevant staff were not always present at these meetings. This meant relevant information was not always available to help assess risks and plan to meet the needs of vulnerable children.

- Individual children's plans were not specific enough. They did not have stated outcomes which could be measured. They failed to consider actions to be taken if plans were not progressing nor did they take sufficient account of changing circumstances in a child's life.

Policies and procedures (QI 6.1) was another area of significant concern. These concerns can be categorised into three distinct areas:

- There were gaps in procedures and guidance for staff and protocols between services on specific areas of practice.

- In many areas where there were procedures and guidance there was a need for them to be reviewed and updated in line with current professional understanding and practice.

- There were examples where staff had not followed clear guidance and procedures available to them. There was a need for regular management audits to ensure staff were complying with their policies and procedures.

Finally the reviews highlighted the continuing need for **Staff training, development and support (QI 7.3)** around protecting children. The two areas highlighted were:

- All staff including those who did not directly work with children and out of hours staff needed to receive further training to increase their awareness of their individual role and responsibility to protect children. This included children affected by domestic abuse, parental substance misuse, parental mental illness and neglect. Further training was also required for staff to know how and when to share information and how to challenge decisions.

- Services needed to consider how joint risk assessment training was provided to staff. Practitioners still needed help to be able to understand the nature and impact of parental illness or psychological difficulties and from this identify both risk and protective factors. Additionally services needed to ensure that any such training provision included awareness raising regarding the need to engage with and include fathers and new partners, hostile parents and responding to new information in ongoing assessments.

Overall, the recommendations focused on improvements to processes and very few recommendations related to the impact quality indicators.

APPENDIX 2

New arrangements for undertaking Serious Case Reviews (SCRs) in Wales

In 2009 the Care and Social Services Inspectorate Wales (CSSIW) commissioned a review of the arrangements for conducting SCRs in Wales and their effectiveness in improving practice and interagency working. The review recommended a continuum of reviewing, learning and improving policy and practice. The Deputy Minister for Social Services, in a statement to the National Assembly on 20 October 2009, welcomed the report and its recommendations and asked for specific proposals for implementing the ideas in the report and a second phase of work on next steps was commissioned in January 2010 with the purpose of developing proposals and guidance for implementation. A progress report by Wendy Rose – 'Improving practice to protect children in Wales: developing a new national framework for learning and reviewing' was published in September 2010 and set out the broad direction of travel. The Progress Report was endorsed by the Welsh Safeguarding Children Forum and in February 2011 the Welsh Assembly Government announced plans to implement a new learning framework to replace SCRs. Draft practice guidance (Welsh Government 2011) has been subject to national consultation. During 2012 pilot child practice reviews have been undertaken in accordance with the guidance to inform the detail of the new arrangements. Regulations regarding the responsibilities of LSCBs are being amended and the implementation of the new framework will commence in 2013. The new framework consists of:

- **Multi-Agency Professional Forums:** an LSCB annual programme of multi-professional learning events for practitioners and managers, primarily to examine multi-agency case practice and findings from child protection audits, inspections and reviews, to improve local knowledge and practice and to inform the Board's future audit and training priorities.
- **Concise Reviews:** a multi-agency review of practice in circumstances where a child has died, or has been or was in danger of being seriously harmed as the result of abuse or neglect **and was not** on the child protection register within the last six months and was not a looked after child or a care leaver under the age of 18. The review engages with relevant children and families in so far as appropriate and seeks to include their perspectives, and it involves practitioners and their managers who have been working with the child and family. A planned and facilitated practitioner-focused learning event is held, conducted by a reviewer independent of the case management, to examine recent practice, using a systems approach. At the conclusion of the review, there is an anonymised Child Practice Review Report which is to be submitted to the Welsh Government and published by the LSCB. The process will be completed as soon as possible but no more than six months from a referral from the Board to the Review Sub-Group.
- **Extended Reviews:** a multi-agency review where a child has died, or has been or was in danger of being seriously harmed as the result of abuse or

neglect **and was** on the child protection register within the last six months or was a looked after child or a care leaver under the age of 18. It follows the same process and timescale as a Concise Review, engaging with relevant children and families, in so far as they wish and is appropriate, and involving practitioners and managers throughout. There is an additional level of scrutiny of the work of the statutory agencies and the statutory plan(s) in place for the child or young person. The review is to be undertaken by two reviewers working closely together, one of whom will bring an external perspective and who will have responsibility for the scrutiny of how the statutory duties of all relevant agencies were fulfilled. An anonymised Child Practice Review Report is to be submitted to the Welsh Government and published by the LSCB (Welsh Government 2011).

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The Scottish Government
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