care inspectorate

A report into the deaths of looked after children in Scotland 2009-2011

April 2013

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Contents

Introduction 1

Background 2
- A looked after child 2
- The legal background 2
- How the Care Inspectorate reviews the deaths of looked after children 2
- How the Care Inspectorate works with partner colleagues 3

Profiles of the children who died between 1 January 2009 and 31 December 2011 4
- Deaths of children in Scotland 4
- Death rates of looked after children and all children 5
- Ages of looked after children who died 5
- Places where looked after children who died resided 6
- Causes of death of looked after children 6

Responses by the local authorities 7

Issues raised from reviews of local authority reports 8
- Children and young people with life limiting conditions 8
- Education 9
- Children who died as a result of intentional self-harm or as the result of an event of undetermined intent 10

Conclusions 11

Important note

The work discussed in this report was begun by the Social Work Inspection Agency (SWIA) and taken over by the newly-formed Care Inspectorate on 1 April 2011.

Where this report uses the terms 'we' and 'us', please be aware it will mean either or both of these organisations, depending on chronology and context.

Introduction

Sadly, a small number of children who are in the care of local authorities die each year.

This is a deeply traumatic experience for the families, carers, friends and relatives of these children. Such a traumatic event can cause great pain and suffering to those involved.

In order to better understand the circumstances in which looked after children die, we are publishing this report to examine the deaths of the 30 looked after children who died in Scotland between 1 January 2009 and 31 December 2011.

A further eight looked after children died in 2012 and the circumstances of their deaths will be included in a future report.

When a looked after child dies, local authorities must inform Scottish Ministers within one day and then go on to provide a full report. The Care Inspectorate is also notified and reviews the reports.

The purpose of this publication is to:

- identify characteristics of those children who have died and the reasons for each of their deaths
- consider the circumstances of their deaths and comment on the reports local authorities provide
- identify any possible implications for the future care of children and young people, always with an eye to whether there are lessons to be learned.

While this report will be of little comfort to those who have been bereaved, we feel it is important for all people involved in looking after children – including carers and families – to be aware of these circumstances and reflect on the information contained here.

I am very grateful to colleagues from across Scotland who have contributed to this report. It is our intention to publish a similar report in future years.

Annette Bruton
Chief Executive

Background

A looked after child

A 'looked after child' generally means a child who is in the care of their local authority. A child is looked after because they need services and care in order to be supported, either to live with their own families, or in an alternative care setting.

Some looked after children continue to live in the family home following involvement with the children's hearing system. Other looked after children live away from their family home, such as with a foster carer, a carer that is related to them, prospective adopting parents, in a residential care home, in a residential school or in a secure unit.

There are many, often complex, reasons why a child may become a looked after child. Usually, it is to promote their care and protect them.

Some will have experienced neglect or abuse which may be of a sexual, physical or emotional nature. Some children are looked after because their parents are unable to look after them due to their own problems or poor parenting skills. Some children and young people with complex difficulties or disabilities are looked after in specialist residential schools or in respite care[1].

The legal background

The Looked After Children (Scotland) Regulations 2009 require local authorities to notify Scottish Ministers when a looked after child dies, within one working day. Before April 2011 – and for some of the time covered by this study – notifications were made to the Social Work Inspection Agency. The Care Inspectorate was formed in April 2011 and took over this part of that organisation's work.

Since March 2013, local authorities have been required to notify not just Scottish Ministers about the death of a looked after child, but the Care Inspectorate also. This position is set out in the **Looked After Children (Scotland) Amendment Regulations 2013 (SSI 2013/14)**.

The guidance to those regulations requires local authorities to submit a report and supporting documentation following notification of a death. The Care Inspectorate obtains specialist medical advice and works together with education colleagues to review this material.

How the Care Inspectorate reviews the deaths of looked after children

Once a local authority submits a report and supporting documentation about the death of a looked after child, the Care Inspectorate seeks specialist medical advice and works together with Education Scotland colleagues to review this report and documentation to:

- examine the arrangements made for the child's welfare during the time he/she was looked after
- assess whether action taken or not taken by the local authority may have contributed to the child's death

[1] It is possible that some local authorities may interpret legislation differently in terms of whether they define a child receiving respite care as being a looked after child.

- identify lessons which need to be drawn to the attention of the local authority who had responsibility for the child and/or other local authorities or statutory agencies
- draw attention to the potential need for reviewing legislation, policy, guidance, advice or practice in the light of a particular case, or trends emerging from the deaths of children being looked after.

At the Care Inspectorate, we retain the services of a specialist medical advisor to help with our reviews of the deaths of looked after children. The designated medical advisor analyses material provided by the local authority, including information from health services, and forms conclusions on the quality of medical care provided to a looked after child who has died. Sometimes the medical advisor requests further medical information.

How the Care Inspectorate works with partner colleagues

When a local authority reports the death of a looked after child to us, our specialist advisors work closely with colleagues from other scrutiny and expert agencies.

Education Scotland

On our behalf, Education Scotland reviews the educational provision for looked after children who have died. Education Scotland's expertise in examining the provision of education services and the partnership working between schools and psychological services and child and adolescent mental health services is particularly pertinent.

Local authorities

When reviewing the death of a looked after child, we work closely with the local authority to ensure we get the right information about how social work, education and health services have provided services and support and how they have worked together to meet the child's needs. Sometimes we may ask a local authority to obtain information on our behalf from another agency, such as a health board.

The Crown Office and Procurator Fiscal Service

We work closely with procurators fiscal, as they are involved following the death of a looked after child. The former practice of delaying review work until the conclusion of a fatal accident inquiry is now more flexible. At the discretion of the relevant procurator fiscal, the Care Inspectorate can complete a report or reach interim conclusions before the completion of a fatal accident inquiry process. In some circumstances, the Crown Office has used our reports to inform its decisions about whether to hold a fatal accident inquiry.

Generally, there are three reasons for us to discuss the death of a looked after child with the procurator fiscal:

- when we need a post mortem report to be released to us
- sharing our conclusions to help the procurator fiscal decide about actions they may take, such as ordering a fatal accident inquiry
- where the procurator fiscal asks us to delay our review until after a fatal accident inquiry has been held and findings made public.

Profiles of the children who died between 1 January 2009 and 31 December 2011

The following table shows how many looked after children there were in Scotland in each year of this study:

Year	Looked after children (at 31 March)	Looked after children as a percentage of the population of all children
2009	15,288	1.38%
2010	15,892	1.44%
2011	16,171	1.47%

Points to note
Source: Scottish Government Children Looked After 2009, 2010, 2011. The 2009 number of looked after children is as at 31 March. The percentages in the second column are calculated using total population figures provided from the National Records of Scotland mid-year population estimates updated May 2012.

Local authorities reported 30 deaths of looked after children in the period 2009 - 2011.

Their ages ranged from one year to 17 years. The children lived in both rural and urban areas and came from 16 local authorities. Six children came from one large local authority. Two children were from minority ethnic communities.

Sixteen local authorities did not report any deaths of looked after children between 1 January 2009 and 31 December 2011.

Deaths of children in Scotland

This table shows the number of looked after children who died in Scotland in each year, and the total number of children who died in the same year. The table shows, for example, that of the 398 children who died in 2011, six (1.5%) were looked after children. It is difficult to draw conclusions about trends from the numbers alone, because the numbers are very low .

The number of children who died and the number of looked after children in Scotland, 2009-11

Year	Number of looked after children who died	Total number of children who died	Percentage of all children who died who were looked after at the time of their death
2009	18	443	4.06%
2010	6	411	1.46%
2011	6	398	1.51%

Points to note
Source: Scottish Government Children Looked After 2009, 2010, 2011. The 2009 number of looked after children is as at 31 March. Figures on the deaths of children are from the National Records of Scotland.

Death rates of looked after children and all children

This table compares the number of looked after children who died to the total population of looked after children to establish a death rate per 1,000 children. This allows a more meaningful comparison over time, as rates will take account of changes in the size of the population as well as the number of deaths.

In 2011, for example, there were 0.37 deaths per 1,000 looked after children. This rate has decreased over the three years in question but, because the numbers of children involved are very small, this apparent trend should be treated with caution.

This rate can be compared with the death rate in the wider population of children aged 0-18, shown in the final column of the table below. In 2009, the death rate per 1,000 looked after children was considerably higher than the general population death rate. In 2010 and 2011, it was only very slightly higher than the death rate in the wider population.

In summary, although the numbers involved are very small, the data points towards a decreasing trend in deaths of looked after children, which tends to be in line with the death rate in the wider population of children aged 0-18.

The rates of death of looked after children and all children in Scotland, 2009-11

	Deaths per 1,000 looked after children	Deaths per 1,000 of all children
2009	1.18	0.40
2010	0.38	0.37
2011	0.37	0.36

Points to note
Source: Figures on death rates for children are from figures provided by the National Records of Scotland, updated August 2012.

Ages of looked after children who died

The following table shows how many of the 30 looked after children who died in Scotland between 2009 – 2011 were boys, how many were girls, and what ages they died at.

Overall, 70% of deaths were of boys, and 30% of girls. In each age group, boys accounted for a higher percentage of deaths than girls. Half of the deaths were of children aged 15, 16 and 17 years, and 23% were aged 4 years and under.

Age range	Number of children	Boys	Girls
4 years and under	7	4	3
5 to 9 years	2	2	0
10 to 14 years	6	5	1
15 to 17 years	15	10	5
Total	30	21	9

Places where looked after children who died resided

The children who died were living in a range of placements, shown below. Most - 40% - were living in residential care placements, 13% were in foster care placements and 37% were living at home or with relatives at the point at which they died. Of those recorded as living at home, many had been looked after away from home at an earlier period in their lives.

In a previous report to this one, published by the Social Work Inspection Agency (SWIA), more looked after children who died were in residential settings than in their home or with relatives.

Placement	Number of looked after children who died
Foster care/respite fostering	4
Living at home or with relatives	11
Residential care	12
Homeless/supported accommodation	2
Secure care	1
Total	30

Causes of death of looked after children

The causes of death of looked after children are given below. These are the causes given in the notifications and documentation we received from local authorities.

Cause of death	Numbers of children
Life-limiting conditions	8
Other health issues (includes sudden death, complex health conditions, illness)	7
Suicide	5
Accidental death	5
Murder	1
Drug/alcohol related	3
Unknown/unascertained	1

Over the past three years, since the last report, there has been an increase in deaths resulting from health issues other than life-limiting conditions.

Responses by the local authorities

The Looked After Children (Scotland) Regulations 2009 require local authorities to report the death of a looked after child within one working day of the child's death. Following such notification, the local authority should provide a full report in 28 days. Almost all local authorities notified us within one working day. The majority of local authorities provided reports within the 28-day timescale. Delays were mainly due to difficulties accessing information from partner agencies.

We issue guidance for the content of such reports. Reports should cover a range of issues relating to the child and his or her family, assessment, care management, reviews, medical and educational reports. We ask services to identify the aims of their work with the young person and their family, and to evaluate the impact of multi-agency working. All the reports that were submitted provided appropriate material, but the depth and quality of the analysis varied considerably. There was evidence that senior managers had authorised reports in most, but not all, cases. Some reports contained long descriptions of the child's circumstances with little or no analysis of the issues that may have affected the child or of the effectiveness of services and supports provided. We will work with the Scottish Government to look at how the guidance can support better reporting. That will support local authorities and other agencies to learn as much from their reports as possible.

The reports with the best quality of analysis gave relevant detail of the child's life, discussed assessment and care management and, where necessary, commented on the circumstances that led to his or her death. Some reports contained detailed and sensitive accounts of how the authority had supported the family and/or carers after their child had died. The introduction of **Getting it right for every child**[2] was more apparent in the work of some local authorities than others. More recently, there has been increasing evidence of good multi-agency working, particularly between social work and education services.

Where a looked after child dies, and there are concerns about professional and/or service involvement or lack of involvement, the area child protection committee should consider an initial case review and use this to decide whether it needs to carry out a significant case review[3]. If a child protection committee decides to convene a significant case review or some other form of multi-agency review, the Care Inspectorate would normally wait until this process is complete before reaching its conclusions.

Out of 30 deaths in the period covered by this report, child protection committees commissioned an initial case review in five cases, and a full significant case review was undertaken in three cases. These reviews looked in depth at the circumstances and identified risk factors and learning for future practice. They were helpful in identifying areas of practice requiring improvement and also in helping carers and staff to recognise the complexity of the factors which appeared to have contributed to the death of the young person.

In a very small number of cases, local authorities carried out some other form of review into the circumstances of the child's death. The decision about whether to convene a significant case review

[2] Getting it right for every child is a Scottish Government intitiative that sets out a fundamental approach to working with children and young people that is focused on outcomes and supports consistency across services.

[3] Protecting Children and Young People: Interim Guidance for Child Protection Committees for Conducting a Significant Case Review, Scottish Executive March 2007.

or, indeed, whether this had been considered at all was not always clear. There were a few deaths where, having reviewed the documentation provided, we considered the criteria for a significant case review had been met and would have provided a sound basis for shared learning. A recently published research report commissioned by Scottish Government into significant case reviews[4] confirmed there was a need to clarify and align the processes that relate to local authorities reviewing the deaths of a looked after child and the responsibilities for child protection committees to consider the need for multi-agency serious case review.

At the request of Scottish Ministers, the Care Inspectorate will become the central collation point for significant case reviews. The Care Inspectorate will develop a role in reviewing the quality of initial case reviews and significant case reviews, and disseminate the learning from any themes and good practice identified.

Issues raised from reviews of local authority reports

We do not reach conclusions about reports provided by local authorities until we have considered all the relevant material we can obtain and heard the outcomes of any other legal procedures.

We asked local authorities for more information in two thirds of reported deaths and a small number of authorities were slow to provide this. Sometimes the delay was caused by a difficulty in finding the required data and delays by other agencies such as the police, the procurator fiscal, or child and adolescent mental health services. If there has been a post mortem, the Care Inspectorate's medical advisor cannot complete their review until they have been able to study the post mortem report.

Looked after children who died between 2009 and 2011 represent 1.5% - 4% per year of all children who died in Scotland in this period. Numbers are very small and this limits conclusions that can be made about trends or underlying issues. Reviewing the deaths of looked after children over a three-year period has, however, led to the identification of a number of potential issues which can inform health and care policy and child protection approaches in the future.

Children and young people with life limiting conditions

We have found variable responses to planning for palliative and end of life care. Some local authorities work closely with colleagues in health, and with the Children's Hospice Association Scotland, to plan sensitively for the end of the child's life. In around half of all the reviews of the deaths of looked after children with a life limiting condition, we found high quality end of life care and planning.

The management of health in relation to palliative care of children and young people with life-limiting conditions was good but we rarely saw evidence of multi-agency care planning. This meant that the day-to-day carers as well as the child and family may not have been kept informed of changes in the child's condition. Exceptions to this were those children who were managed by hospice teams who had exemplary end of life care.

[4] Audit and Analysis of Significant Case Reviews, Sharon Vincent and Alison Petch October 2012

In children where acute deterioration was possible, there was evidence in some cases that the Children and Young People Acute Deterioration Management Form[5] had been used. This important document, promotes inter-agency communication and consensus decision-making involving the child and the family, where the child is approaching the end of life. There are guidance notes in conjunction with the full resuscitation planning policy for children and young people, to help with the completion of this document.

We recommend that all looked after children with a life-limiting condition should have a high-quality end of life care plan.

The use of anticipatory care planning at an earlier stage may increase communication about the child's and family needs and improve inter-agency working, although there may be circumstances when some children with chronic, longstanding illnesses die suddenly before clinicians have categorised them as being at the end of their life.

In December 2010, the Social Work Inspection Agency produced a practice guide, in conjunction with Children's Hospice Association Scotland, called **End of life care and planning for children and young people with life-limiting conditions**. It is available at www.careinspectorate.com

Education

Reviews of education identified the need for improved communication between schools and partner agencies responsible for the care of looked after children. The reviews also pointed to an improving trend in supporting looked after children systematically in both mainstream and special schools. They indicated the ways in which children and young people were referred for specialist services such as psychological assessment and child and adolescent mental health services.

More schools appeared to be improving their approaches to supporting children and young people who had experienced bereavement following the death of a looked after child through individual and group programmes of support. However, this was not consistently well done across schools and services.

Reviews found that, where a looked after child with social, emotional or behavioural needs had been excluded from school, they were often without educational provision for quite lengthy periods. These young people, who experienced a number of transitions within care and education settings, found greater difficulty in forming positive relationships and achieving their educational potential. This suggests, therefore, that changes and exclusions make already vulnerable young people even more vulnerable.

[5] www.cen.scot.nhs.uk/files/cypadm-guidance-notes.pdf

Children who died as a result of intentional self-harm or as the result of an event of undetermined intent

In the period of this report a small number of young people died as the result of accidents on the road or railway. Three young people had misused substances which led to their deaths but this was not considered intentional self-harm. Rather, they were living chaotic lifestyles and appeared not have fully realised the risks involved in what they taking and or drinking.

We recommend that, as part of a comprehensive assessment of needs and risks and an outcome-focused care plan, all looked after children should have access to effective resources to address issues of substance misuse.

Where a child had died as a result of intentional self-harm or as the result of an event of undetermined intent, the reports from the local authority nearly always concluded that the circumstances of the child's death could not have been foreseen. However, we saw evidence that most of the children in this circumstance had made threats of self-harm or had previously harmed themselves. Furthermore, staff or services working with the young person did not always recognise risk factors such as the suicide of a parent or close friend. Not all reports were clear that there had been a risk assessment and a management plan for the child.

We recommend that all looked after children who have threatened self-harm or have previously harmed themselves should have a risk assessment and management plan. Consultation with, or referral to, local child and adolescent mental health services should be considered. Staff working with looked after children should be trained to be alert to suicide risk factors, and be supported to recognise and manage them.

In the period of this report five young people aged 13-17 years had killed themselves. Some of these children were living at home, and others were in residential units. The majority of the young people died between late evening and early morning. Some, but not all, of the child protection committees for the local authority areas concerned convened significant case reviews.

We found evidence of effective services in some, but not all, areas of the country for young people who self-harmed. Children and young people in this group had attended accident and emergency departments in different areas of the country following overdose and self-harm. We found that in some areas accident and emergency staff had not referred the children and young people for further assessment to the child and adolescent mental health services team.

We recommend that looked after children who present to medical staff at casualty following overdose or self-harm are reviewed by the on-call psychiatrist covering that casualty department and are then referred to their local child and adolescent mental health services for early follow-up.

Working with hard-to-reach young people is a very challenging area. Some children who had been referred to child and adolescent mental health services had not been willing to take part in any assessment or treatment. In some areas of the country, the child and adolescent mental health services teams offered a consultation service to professionals with a view to consistent multi-disciplinary management with shared decision-making in the care of these children. In other incidences, when problems continued to arise for these young people, a common approach was to ask yet another agency or professional to become involved - which might not be what is needed for the child - resulting in multiple groups being involved, with lack of continuity and overall coordination.

We recommend that services involved in the delivery of care to a looked after child co-ordinate and review their activities to ensure a lack of co-ordination does not compromise care.

In June 2009, the Social Work Inspection Agency held a seminar that provided an opportunity for local authority staff to discuss the findings of the report previous to this one (for 2006-2008) and to hear a presentation from a Choose Life representative about suicide prevention. Staff asked for further guidance on suicide prevention for looked after children. A joint working group between the Social Work Insepction Agency, Choose Life, Scottish Borders Council, the (then) Care Commission, LGBT Youth and the Fostering Network was set up to consult with a wide range of staff in services which care for children and young people. The work culminated in a practice guide called **Suicide Prevention for Looked After Children and Young People** published by the Care Inspectorate in June 2011. This is available at www.careinspectorate.com

Conclusions

The death of any child is always a traumatic experience. Those responsible for the health, wellbeing and care of looked after children across Scotland work hard to provide the best possible start in life for children in the care of the local authority.

This report shows that, while there is good practice in the care of looked after children and young people, there are always lessons to be learned from tragic cases. Those lessons are pertinent for local authorities, child protection committees, health professionals and those involved in the delivery of care.

At the Care Inspectorate, we will continue to work with Scottish Government and partner agencies in order to review the regulations and guidance covering the deaths of looked after children, and contribute to updating the guidance on significant case reviews.

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