

Learning From **Significant Case Reviews in Scotland**

A retrospective review of relevant reports completed in the period between 1 April 2012 and 31 March 2015

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Foreword

Most children and young people in Scotland grow up safe, healthy and enjoy the best start in life in loving, nurturing environments. Some 15,000 children in Scotland who are currently looked after by local authorities, and 2,800 children who are on the child protection register, rely on social work and other professionals to enable them to enjoy good outcomes and the best start in life. A great many more children and families receive valuable shorter-term support from social work services and a range of other agencies. This is why it is crucial that social workers, police, teachers, health staff and a range of third-sector partners all work together to protect children and young people.

On a daily basis, staff seek to build relationships with children, young people and their families to support them and improve their lives. They need to make careful and complex judgements, weighing up risks and strengths, always trying to act in the best interests of each child. Sometimes this involves very difficult decisions about removing children from their families where it is in the best interests of the child to do so.

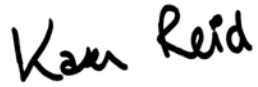
Even when staff work tirelessly, often in very challenging circumstances and above and beyond the call of duty, they cannot always prevent terrible things happening. Sadly, in a very small number of situations, adults cause harm to children and in other cases, failings have led to tragedy. It is everybody's responsibility to keep children safe, and the responsibility of all of us to learn lessons when things go badly wrong.

This report reviews the cases of 23 children in Scotland where something has gone badly wrong. Tragically, 11 of these children and young people died. Collectively, we owe it to those children to understand what happened and to find out what, if anything, must be done differently to prevent harm in the future. We need to do all we can to ensure that any necessary practice changes are made, not just in the area where the harm occurred, but right across the country so that we get it right for every child.

In this report, we have examined 20 significant case reviews, involving 23 children and young people, commissioned by child protection committees across Scotland and carried out over a three-year period. We share key findings from the reviews and make some comment on their quality and effectiveness. This is not directed at apportioning blame, but aims to support learning for the future. Some of the information in this report may be distressing to read, but learning from tragedy and mistakes requires candour and frankness. They are essential ingredients in seeking to prevent the same things happening again.

The Care Inspectorate's new role in collating and reviewing significant case reviews will help child protection committees, and colleagues in local authorities, police, health, criminal justice and education across Scotland, to reflect on practice and take prompt action where there are things that can be changed now to prevent future harm. Strong local leadership and clear focus on working together to improve outcomes for every child in Scotland are essential if we are to prevent harm, keep children safe and reduce health and social inequalities.

This work sits alongside the programme of joint inspections of services for children led by the Care Inspectorate and carried out in partnership with colleagues from Education Scotland, Healthcare Improvement Scotland, and Her Majesty's Inspectorate of Constabulary in Scotland. These inspections allow us to identify, in a structured way, how well staff across services are working together to improve outcomes for children and young people, including children who may be in need of protection, and what needs to improve.

A handwritten signature in black ink that reads "Karen Reid". The letters are cursive and fluid.

Karen Reid

Chief Executive

Note to readers

In this report, we use the term 'review' in a variety of contexts. For the sake of clarity, in most instances, we refer to significant case reviews as SCRs.

Executive summary

This report presents the findings of a review by the Care Inspectorate of 20 SCRs, conducted in Scotland over the three years from April 2012 to March 2015. The 20 SCRs involved a total of 23 children and young people, of whom 11 had died.

This report follows on from Audit and Analysis of Significant Case Reviews, published in October 2012 by Vincent and Petch. We find similar themes to those identified by Vincent and Petch, in that two thirds of children who were the subject of an SCR were living with domestic abuse, two thirds with parental mental health issues and over half with substance misuse issues. **In common with Vincent and Petch, we identified the need for improvement in the quality and consistency of SCRs.**

For almost all the children featuring in our review, there was extensive involvement by a number of services, sometimes over many years, but this was not sufficient to protect them. Child protection work presents huge challenges and the many complexities of child protection work can have a significant impact on staff. **All staff involved in child protection should have regular, reflective supervision to support them in their practice and provide sufficient advice and challenge to minimise errors and help them make sound decisions.**

High quality assessment and planning are fundamental to creating safety for children and young people. Some of the key processes that underpin safe and robust operational practice require continued improvement. These include: the extent to which information is shared and used to enhance the understanding of risks and needs; the need for better use of chronologies to inform assessment and decision making; the arrangements for children who are in transition within and between services; and better consideration of the vulnerability of older young people with risk-taking behaviour. **All child protection committees should oversee improvement action in relation to these areas of practice.**

In Scotland, we have achieved widespread understanding and acceptance that it is everyone's responsibility to keep children safe. Despite this, in many of the cases considered within this report, it was predominantly left to the lead professional to make decisions about increasing intervention where there were accumulating or raised concerns about a child's circumstances. **Chief officers and child protection committees should take all necessary action to reinforce the need for collective responsibility in keeping children safe.**

Over the three-year period of our review, SCRs were completed in only 14 of the 30 child protection committee areas and the thresholds for proceeding to an SCR varied considerably. This suggests some

committees are more likely than others to seek the insights that can be gained through an SCR of how well services are protecting children. **Child protection committees should maximise opportunities for learning and practice improvement and continue to provide the Care Inspectorate with clear information about decisions made following initial case reviews.**

Notwithstanding the resources deployed to undertake an SCR, the quality of the final reports was variable with some lacking in detail and rigour. Moreover, most SCRs presented their findings as directive recommendations that were predominantly about improving processes. Those using the Social Care Institute for Excellence's (SCIE) approach were generally more reflective and thorough. **The Scottish Government and Child Protection Committees Scotland should work together to support better quality in SCRs and greater consistency in approach. This should include building capacity for undertaking SCRs using the SCIE method and other accredited approaches.**

Child protection committees have a critical role in the governance of child protection. It was not always clear within SCRs what needed to improve and how these improvements would be measured and monitored. **Chief officers and child protection committees should focus attention on implementing and embedding demonstrable practice change as a result of learning from SCRs.**

Background to this report

In line with its commitment to ensuring that approaches to protecting children and young people are as robust as possible, the Scottish Government asked the Care Inspectorate to carry out a review of relevant reports from SCRs completed between 1 April 2012 and 31 March 2015. Our review follows on from the work of Vincent and Petch published in October 2012, which contains an audit and analysis of the SCRs conducted in Scotland from 2007, when interim national guidance for child protection committees conducting an SCR was first introduced, up to the end of March 2012.

An SCR takes place after a child dies or is significantly harmed and abuse or neglect is known or suspected. The purpose is to help services reach an understanding of what took place and learn how to better protect children and young people from serious abuse. Chief officers and child protection committees may make arrangements for the SCR to be conducted by services themselves or, more commonly, commission an independent person to carry out the SCR. The sharing of learning from SCRs is an important element of keeping services abreast of national as well as local emerging themes or patterns in relation to what increases risks for vulnerable children and young people. This report seeks to provide commentary that can help inform practitioners and agencies in their work to keep vulnerable children and young people safe.

The Care Inspectorate wrote to all chairs of child protection committees in April and June 2015 to confirm the arrangements in place for the Care Inspectorate to be a central collation point for receiving SCR reports. A code of practice for reviewing SCRs of children and young people was also circulated to the child protection committee chairs¹. In order to carry out our retrospective review work, child protection committees were asked to give the Care Inspectorate a copy of all SCRs that had been completed between 1 April 2012 and 31 March 2015. All 30 child protection committees responded to this request, some to confirm they had none, and 20 reports were submitted for the three-year period of our review.

In keeping with the approach adopted by Vincent and Petch in their review of SCRs up to 2012, our retrospective review includes some multi-agency reviews of practice, which were not specifically titled as significant case reviews, but were deemed by the relevant child protection committees to be relevant for the purposes of our review.

¹ The Code of Practice for the review of Significant Case Reviews of children and young people in Scotland, Care Inspectorate, March 2015

Method

We conducted our review in a carefully structured way. We studied individual case reports to extract key sets of information, which we used to populate a bespoke database. This enabled us to analyse our findings on a cross-case basis. We designed a template with fields to collate information in relation to the individual child and type of case, the parental/family characteristics, agency/service involvements and information specifically about each SCR's methodology and process.

The guidance we refer to in this report is the national interim guidance,² which was introduced in 2007 and which should have guided practice during this period.

² Protecting Children and Young People: Interim Guidance for Child Protection Committees for Conducting a Significant Case Review, Scottish Executive 2007

The significant case review process and reporting

Over the three-year period of our review, completed SCRs were submitted by 14 out of the 30 child protection committees in Scotland. This tells us that the majority of child protection committees did not complete an SCR during this period. Those that did submit one or more SCR did so in a variety of formats and the lack of a consistent core data set in some cases has limited the extraction of information across some fields. The varied rationales for deciding to undertake an SCR perhaps implies that a case of similar presenting characteristics may be more or less likely to result in an SCR, dependent on which child protection committee is involved. Not all SCRs had been subject to an initial case review before progressing to a full SCR. Our retrospective review does not include initial case reviews. The requirement to notify the Care Inspectorate of the decision of an initial case review was introduced from April 2015.

The centralised collection of the outcome of initial case reviews by the Care Inspectorate, implemented as of April 2015, should provide greater insight into the rationale employed by child protection committees when deciding whether or not to undertake an SCR. Similarly, the revised national guidance for child protection committees³ issued in 2015 aims to support a more consistent approach being applied across Scotland. It should enhance the collection of key information and improve the scope for sharing essential learning in the future.

In the previous audit of SCRs completed up to March 2012, Vincent and Petch highlighted a number of aspects requiring more standardisation. This is in addition to the point raised above in relation to initial case reviews, which is being addressed through the central collation arrangements. The following aspects extracted from the Vincent and Petch report continue to be relevant in the findings of our review

“There should be closer adherence to the guidance in terms of what constitutes an 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 SCR team should be listed, information about timescales should be provided and there should be some discussion of the methodology that was used including whether or not the SCR included interviews with staff.”

The significant cases reviewed

The 20 cases submitted by child protection committees for inclusion in our retrospective review concerned 23 children and young people. Three of the reports concerned more than one subject child or young person. Twelve involved significant harm or risk of harm, including one being a ‘near miss’ situation and one where a young person was responsible for causing the death of another individual. The remaining 11 cases resulted in the death of the child or young person. This is consistent with the findings of the previous, Vincent and Petch audit of SCRs in Scotland.

³ National Guidance for Child Protection Committees Conducting a Significant Case Review, Scottish Government March 2015

Non-fatal cases

Type of harm	Number of children/ young people
Neglect	2
Eating disorder	1
Mental health and risks to self and others	1
Physical abuse	4
Sexual abuse	3
Causing death of another person	1
Total	12

Fatalities

Cause of death	Number of children/ young people
Sudden unexpected death in infancy (SUDI)	3
Drowning	1
Physical injuries	1
Fall from height whilst intoxicated	1
Drug overdose	2
Suicide	3
Total	11

Fatalities

Five deaths were infants and pre-school aged children. Sudden unexpected death in infancy was recorded in three cases. Two of these involved infants dying while sleeping with their parents. The deaths of infants and young, pre-school aged children were from causes occurring whilst in their parents' care. These included sudden and accidental deaths where infants were found unresponsive after being asleep in a sleep in bed or bouncy chair and a baby who drowned when left unattended in the bath. One pre-school aged child died as a result of a physical assault. The SCRs of these accidental deaths concluded in all cases that there were previous or current social/parenting concerns and substance misuse by parent(s) was a common factor.

Six fatalities were of young people aged 15 - 17 years, five of whom were female. The deaths of teenagers were as a result of their own risk-taking or self-harming behaviour, coupled with alcohol and drug misuse, when accidents were more likely to happen, or suicide.

There were no children of primary school age among the fatalities.

Criminal proceedings

In 12 of the 20 cases (which involved 23 children), there were no criminal proceedings. In three cases, it was not apparent whether there had been a criminal investigation or what the outcome had been. In two cases, charges were brought against parents and kinship carers but subsequently dropped.

One SCR, where there was a criminal investigation regarding child sexual abuse, did not record what subsequently happened. Two cases led to convictions for culpable homicide and one for child sexual abuse. The perpetrators in these cases were imprisoned.

Some caution in interpreting the data provided

The number of SCRs in Scotland is relatively small. This, and the fact that some SCRs were missing information critical to a full understanding of the individual child and family or the context of their service or agency involvement, means there are limitations in the application of a full analysis and the extent of comparisons that may be made. It is now generally accepted that a more standardised approach to initial and SCRs in Scotland is needed. Practice in some areas has already been changing. Most, but not all, of the SCRs collated for this report provided sufficient information from which to learn and identify potential improvements.

Chapter 1: Characteristics of the children and young people and their families

Of the 23 children and young people, just over half (12) were female, 10 were male and the gender was not recorded for one child. Their ages ranged from a few weeks old to 17 years, with most being either infants or teenagers.

Age range	Number of children/young people
<1 year	7
1-2 years	2
3-4 years	2
5-10 years	2
11-17 years	10
Total	23

Ethnicity

There was no attention to recording the ethnicity of the child or parents in most cases. Only three of the children and young people had their ethnicity entered; two of these were recorded on core data sheets accompanying the SCR. These children were white Scottish (2) and mixed race (1).

Child health and disability

None of the children and young people were recorded as having any physical disability. Two infants were recorded as suffering from neonatal abstinence syndrome (NAS) (a group of problems that occur in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb). In one SCR, the review team had questioned whether the potential of foetal alcohol spectrum disorder (FASD) (a range of mental and physical challenges that occur in a person only because of prenatal exposure to alcohol) had been suitably explored in relation to the infant involved.

The majority (13) had no identified mental health or emotional wellbeing issues. One child had a diagnosis of ADHD and another had a diagnosis of autistic spectrum disorder and learning disabilities. One young person's eating disorder had been deemed life-threatening and required hospitalisation over several years.

Five young people aged 13 – 17 years were recorded as having mental health issues ranging from concerns about sustained emotional distress, anger management, depression, anxiety, obsessive-compulsive disorder, sleeping issues, self-harm and a history of medication overdose.

The SCRs indicated that there was not always a collective understanding among the staff and agencies involved regarding the extent or impact of mental health concerns. Two SCRs concerned practice and service provision in particularly unique and complex mental health circumstances. These highlighted critical differences in approach, legislation and jurisdiction when cases involving older young people move back and forth between community and acute mental health services and where young people are subject to looked-after and mental health legislation. Another two reports highlighted cross-

boundary issues in provision of mental health services. Two SCRs evidenced particular challenges in relation to health consent and confidentiality issues.

Self-harm, substance misuse and suicide ideation were a feature in almost all of the SCRs of older young people.

Family size and circumstances

Six out of the 20 cases involved families with four or more children, including the subject child. Three families had five children and one had six. This is a slightly higher proportion to the quarter of cases found in the 2012 audit of SCRs in Scotland. The significance of family size was noted in studies of cases in England by Brandon et al in 2008⁴ and 2009⁵ who pointed out that only one in ten children were in such larger families in the general population. The large families in that review tended to present multiple and complex difficulties. The increased stress of parenting four or more children meant that risk of harm was greater. Some parental behaviours such as domestic abuse, substance misuse and poor supervision of the children added to the family's difficulties. Multiple births bring additional demands, which place considerable strain on even a highly functioning family.

Living circumstances of child or young person at time of harm or death

Just over half of the children and young people were living at home when they suffered harm or died. One young person had just returned home from secure accommodation and another was on a home visit from private boarding school. With the exception of two of the children living at home who were harmed by a carer at their pre-school setting, most risks for children living at home or with relatives arose as a result of the adversities they faced within their home circumstances and family relationships. Two children were harmed while living with kinship carers.

Managing risks to children and young people in supervised or supported living circumstances presented challenges for services and some children experienced harm whilst in such settings. These cases were among the most complex and on occasions required highly individualised case planning. One child was with the mother in a hospital mother and baby unit and another young person was detained in hospital under mental health legislation at the time of death. The remaining children and young people suffered harm as a result of accident, drugs or alcohol or self harm while living in residential or supported accommodation. The children and young people living away from home (or in the case of the baby, the family) in almost all instances had been known to services and had substantial interventions in the years before entering these living arrangements. The SCRs highlighted that risks for some children and young people may be increased or become more difficult to manage at times of key transition and change. We explore this later in this report when considering key risk factors.

4 Analysing Child Deaths and Serious Injury through Abuse and Neglect – what can we learn?, M Brandon, P Belderson, C Warren et al, 2008, London, Department for Children, Schools and Families

5 Understanding Serious Case Reviews and their Impact, M Brandon, S Bailey, P Belderson et al, 2009, London, Department for Children, Schools and Families

Living circumstances at the point of harm	Number of children/young people
Living at home	12
Living with relatives or friends	2
Living with foster carers	2
Residential unit or hospital	3
Supported accommodation unit	3
Other – private school	1
Total	23

Chapter 2: Characteristics of child or young person's parents or guardians

Age

Most SCRs did not record the age of parents. The six that contained the age of the mother showed it to range from 19 to 41 years with an average of 33 years. Only three cases recorded the age of fathers.

Role and involvement of fathers

Of the 21 children and young people whose families were known to social work services, there were seven whose fathers had no involvement in their lives and two who had only occasional contact. Three children lived separately from their fathers but saw them regularly.

Five children had fathers or stepfathers who were involved with them but the extent and influence of this involvement, including any risk of harm, was not fully understood by services at the time. The reasons for this were varied and included issues regarding the family's engagement with services. In one case, other family members concealed the fact the father was living in the house although the SCR questioned whether his presence might have been reasonably deduced by the staff involved, given other presenting information. In two cases where services knew about them, the mother's new partner had not been assessed. Here, the SCRs concluded that overly positive assumptions had been formed by staff about these men's influence and contributions to a vulnerable family, without sufficient enquiries.

In the remaining four cases, the fathers had established working relationships with the professionals trying to support the family, but these were characterised by a lack of trust and either avoidance or hostility in communications. These difficulties compromised the reliability of information that professionals were able to glean about the family and, in turn, the robustness of the assessments that were made. In two of the four cases, the SCRs acknowledged the sterling efforts made by staff to engage more effectively with these families. However, in the remaining two, the SCRs concluded that the hostile behaviour of the fathers was instrumental in causing services to retreat. In one case, key professionals removed the child's name from the child protection register and reduced their involvement because they judged that their presence was antagonising the father and potentially increasing the risk of his being violent towards the mother. This left the child with very limited support.

Ethnicity

The ethnicity of parents was not recorded in most cases.

Parental difficulties

The following table provides an overview of particular aspects in relation to parents, that were identified in the audit of SCRs carried out in 2012, with a comparison of these key themes from this more recent review. In our review, there were no parents identified as affected by learning disability. Some children lived with parents who had more than one of these issues presenting simultaneously.

Theme	Number of SCRs with % in brackets	
	2007 – 2012 from 56 SCRs	2012 – 2015 from 20 SCRs
Mental health problems	24 (43%)	13 (65%)
Domestic abuse	30 (54%)	13 (65%)
Parental substance misuse	36 (64%)	11 (55%)
Criminality	31 (55%)	7 (35%)
Parents' own childhood issues	22 (39%)	4 (20%)
Learning disability	4 (7%)	0

Parental mental health

In 13 of the 20 cases, parental mental health problems were described as a factor. Eleven mothers and a grandmother caring for children were recorded as suffering from mental health difficulties. Mostly, these were described as low mood and depression. One mother's longstanding mental health difficulties required her to be hospitalised a few months after the birth of the child. Two fathers were recorded as having mental health problems. A lack of information meant much remained unknown about the mental health of fathers in general.

Parental mental health concerns in the SCRs had the potential to create significantly adverse and neglectful home environments and relationships for some children where appropriate treatment, support and intervention were not provided. Mental health difficulties frequently occurred in tandem with other issues such as parental substance misuse, domestic abuse, poverty and involvement in criminality.

In two cases, communication between the professionals involved in managing the parent's mental health and those directly involved in work with the child had been poor. The SCRs highlighted that some practitioners working with adults in the field of mental health did not consider sufficiently (or at all on occasions) the potential impact of the individual's difficulties on their role as a parent.

There seemed to be particular difficulties when parents presented as being articulate and assertive in their communications with professionals. Staff in adult services tended to expect that parents who they believed were being open about their difficulties would be equally candid with colleagues responsible for children. SCRs highlighted the need for all staff working with adults who are parents to consider the child's circumstances and proactively share information across services so that any potential risks can be fully appreciated and analysed by all of the involved staff.⁶

Domestic abuse

Domestic abuse was a feature in 13 of the 20 cases reviewed. The 65% incidence we have noted compares to a rate of 54% in the 2012 audit, but it is not possible to say if this represents an actual rise in domestic abuse, or a greater recognition by services of the harmful impact on children from exposure to domestic violence and better reporting nationally of domestic abuse. Having said this,

⁶ Findings from joint inspections of services for children and young people provide confidence that the implementation the Information Commissioner's guidance issued in March 2013 has been helpful in strengthening the confidence of staff around early intervention and sharing information across services at an early stage where there are concerns about a child's wellbeing.

in three SCRs, the review team highlighted that staff were not always recognising the importance or impact of domestic abuse on the whole family. One review team described it thus:

“A failure to adequately grasp the complex dynamics of domestic abuse relationships means professionals can have unrealistic expectations of parents experiencing such abuse and may give inadequate thought to its impact on the care of the children”.

In the other two cases where domestic abuse had not been sufficiently recognised, the SCRs focused on a lack of understanding of the importance of violence between adults in a household as a child protection risk factor and consequent failure to share information about it.

Parental substance misuse

In over half (11) of the 20 SCRs there was drug or alcohol misuse by one or both parents. This was broken down as follows:

- in three cases, both parents misused drugs and alcohol
- in two cases, both parents misused drugs
- in one case, both parents misused alcohol
- in three cases, the mother misused drugs and alcohol
- in two cases, the mother misused drugs.

The prevalence of parental substance misuse in the 2012 audit of SCRs in Scotland was 64%. In our review, the figure was 55%. The Scottish Government guidance on working with substance misusing parents, *Getting Our Priorities Right*⁷ estimated 10,000 – 20,000 children in Scotland live with parental problematic drug use. The estimated number living with parents or guardians whose alcohol use was problematic was between 36,000 and 51,000 children.

Parental substance misuse was a feature of all five cases involving the death of an infant or pre-school child. While the deaths were not directly attributable to the drug or alcohol use, this aspect, as well as others in the parents’ lifestyles, were regarded in four out of the five SCRs as potentially playing a part in enabling particular conditions or combinations of circumstances within which a child was more likely to suffer harm or accident. Two of the infants who died were born suffering from neonatal abstinence syndrome (NAS) and another was born prematurely (thought to be related to parental alcohol use). One child whose half-siblings were born with foetal alcohol spectrum disorder (FASD) had not been identified as affected by this, but the mother was noted to have had a high level of alcohol consumption during this pregnancy too and was “living chaotically”. This last child was found dead in a bouncy chair by the mother after she had engaged in a bout of heavy drinking the previous evening.

The two other cases of sudden unexplained death in infancy involved babies who were discovered unresponsive when they were in sleeping arrangements with a parent. One of these babies had been taken to the father’s house overnight because the mother had been in a drunken fight with other relatives. The drug-dependent parents of a child who drowned in a bath were described as being “distracted” from their responsibility to supervise him.

⁷ *Getting Our Priorities Right*, 2013, Scottish Government

The SCRs of these cases identified a tendency by the staff involved to rely heavily on what they could see in the present and what the parent was telling them. They did not consider a rounded weighting of risks of past behaviours, the likelihood of relapse and the ongoing impact of parental substance misuse on parenting capacity. The Getting Our Priorities Right guidance states that it “is vitally important services note that recovery timescales set for adults can often differ considerably from those that might otherwise be set to improve the wellbeing of – or to protect – any dependent children they may have”.

In the 2012 audit of SCRs, a learning point and recommendation was made in relation to all staff in health and social services involved in working with substance misusing parents from pregnancy into the early years. This stated that 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”. Further, it recommended that “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”. This should now apply to staff across all services who may have contact with families where substance misuse is an issue, so that they can support best practice and contribute to children’s safety.

Parental substance misuse was a feature in three SCRs involving teenagers who died. In addition, a young person’s older sibling had died from a drug overdose in the previous year. One teenager who committed suicide had been raised by a grandparent but continued to have extensive exposure over the years to the chaotic and drug-using lifestyle of her mother. Another young person who was adopted subsequently sought out her birth mother who was heavily involved in drug use. Subsequently, this young person was drawn into her mother’s circle of other drug-using associates. The SCRs identified the tensions inherent for professional decision-making in striving to maintain children within their families when this might bring challenges for carers in exercising suitable controls over the growing child’s desire to know, understand and identify with absent birth parents.

Involvement in criminal behaviour

Parents’ involvement in criminal behaviour was a feature in seven of the 20 SCRs. Criminal behaviour was occasionally referred to, but not detailed. Those criminal behaviours that were specifically mentioned included drug offences, serious assault, possessing weapons, domestic violence, anti-social and racist behaviour, sexual offences, child abandonment/leaving children unattended, drink-driving and other road traffic offences and a number of offences involving endangering the child or exposing them to serious risk.

In addition to the impact and potential influences of parental behaviours, children were sometimes at risk from the criminal behaviour of others in the household, such as older siblings, aunts and uncles or grandparents. One SCR highlighted a child who went on to commit a very serious act of violence who had been exposed to such aggression and violence over years that in all probability he had normalised it as a response to conflict. This child had older siblings who were said to carry knives and were involved in local gang culture.

The impact of parents' own childhood issues

There was either no or very limited information about the childhoods of parents in the majority of SCRs (14 out of the 20). This made it difficult to gain a sense of what factors, if any, from parents' own early experiences might have had an influence on their role as parents to the children and young people in the SCRs. Two SCRs noted that there were no issues of significance in parents' backgrounds. The remaining four SCRs did record parents as having experienced very significant trauma or difficulties in childhood. This included prolonged exposure to domestic abuse, sexual abuse, bereavement and early behavioural difficulties. Recognising the impact of childhood loss and trauma on adults' capacity to make strong attachment relationships and parent safely must underpin the assessment of risks and needs to children.

Poverty

We felt it would have been useful to consider the influence of factors such as poverty and housing difficulties, which are commonly present in vulnerable families. However, the SCRs in our review did not contain sufficient detail to develop or explore these as themes.

Chapter 3: Agency factors impacting on service quality

Extent of services' involvement

Of the 23 children and young people who feature in the 20 SCRs, 20 children were known to a range of services, including social work. Two children were harmed in a pre-school nursery, which came to light as a result of child exploitation and online protection monitoring by police (Child Exploitation and Online Protection Centre (CEOP)). They and their families had no involvement with social work services. A third child was known only to universal services (health and/or education).

The legal or 'case' status at the time of the harm or identification of significant risk is shown below.

Status (child or young person)	Number of children/ young people
At home – name on child protection register	3
At home – name recently removed from child protection register	2
Detained in hospital under mental health legislation	1
Detained in secure accommodation	1
With mother in psychiatric hospital mother and baby unit	1
Looked after away from home in foster care	2
Looked after at home	3
Cared for by grandmother under residence order	2
Looked after in supported accommodation, previously in kinship care	1
Throughcare supported accommodation	2
Receiving social work services as a child in need under Section 22 of the Children (Scotland) Act 1995	2
Total	20

Leadership

Difficulties were referred to in 15 of the SCRs, in how agencies functioned, or how services and agencies functioned together, which had had an impact on the management of the case and the eventual outcome. These difficulties are described below.

- Challenges caused by significant restructuring of services and teams. These included confusion about lines of accountability, management gaps, managers with responsibility for child protection who were not equipped with the necessary practice or management experience with vulnerable children and families, and managers being distracted from providing operational support to staff by tasks connected with restructuring.
- Poor implementation of a Getting It Right For Every Child approach, which failed to provide sufficient guidance for staff about their responsibilities for convening inter-agency meetings.
- Silo working and lack of inter-agency communication.
- Poor implementation of a corporate parenting approach. This was particularly evident where risks

had not been managed well for older young people.

- Failure to implement agreed policies, for example on attendance at child protection case conferences or frequency of SCRs. Lack of protocols to guide staff when working with hostile or uncooperative families or when families fail to attend key appointments.
- Lack of management support for frontline staff. This included ensuring that staff received regular, high-quality supervision and had the training and guidance they needed to do their jobs well.

Staffing and deployment

Seven of the 20 SCRs identified staffing difficulties as a factor affecting the practice and potentially, the eventual outcome in each case. These included shortages in key posts caused by unfilled vacancies and staff sickness, recruitment practices that allowed extended gaps in staffing and high staff turnover. Decisions about the need for services' continued involvement with families made in this context were overly influenced by staff availability, rather than children's needs.

Staffing shortages also increased workload pressures, increasing the likelihood of low staff morale and creating, in turn, a cycle of high staff sickness and rapid staff turnover. There were examples of cases being unallocated for lengthy periods and of inexperienced staff assuming responsibility for complex child protection cases because more experienced staff were not available.

High staff turnover also led to a situation where there were frequent changes of social worker and care arrangements for children. In some cases, this persisted over a number of years and led to a fragmented understanding of the needs of the child and their families and only a partial appreciation of their difficulties and associated risks.

Also in the context of staffing shortages and/or high absence rates, managers covered operational tasks, reducing their capacity to exercise their management functions. Risks increase significantly when managers cannot retain their objectivity about cases because of their direct involvement in day-to-day practice. This also happens when operational pressures reduce their availability for discussion with their staff, especially newly qualified or less experienced staff.

In a few cases, long standing staff performance issues had not been addressed.

Training

The majority of the SCRs identified training issues of some kind.

For the most part, training needs related to core aspects of the staff member's job in relation to protecting children and working with vulnerable families, rather than training that could be regarded as specialist in nature. Examples included understanding the purpose of a chronology or undertaking a basic parenting assessment.

SCRs also highlighted the following needs.

- Better recognition of the complexities of domestic abuse within families and the potential impact on victims and children.

- Child protection training for paediatricians and generalist consultants as required by the Royal College of Paediatrics and Child Health.
- In-depth child protection training for education staff in promoted posts and for staff working in educational nurseries.
- All professionals involved with young people to be aware of NICE⁸ guidelines on self-harm.
- Staff awareness and understanding of the significance of physical injuries in infants who are not yet mobile.
- Increased awareness of child sexual abuse and grooming behaviour.
- Improved understanding of: the impulsivity of behaviour in young people; of the need for increased vigilance to prevent suicide; and of the role of the chief social work officer in leading a safety plan for a young person in an emergency.

Information sharing and communication

Strengths were documented in relation to information sharing and communication in a significant minority of cases, but weaknesses in these were identified as a factor influencing a poor outcome or increased risks in 11 of the 20 SCRs. Weaknesses related to both the extent to which information had been shared and how known information had been used to enhance understanding of risks and needs across a multi-agency team. Information-sharing weaknesses could be broken down into four categories.

1. Failure to share information or check if there was relevant information that should inform decisions and actions.

As there are no or very few shared recording systems, recording made by agencies is not available routinely across all staff involved in a case. Special effort must be made by staff to identify a piece of information as significant and pass it on. This increases the likelihood of basic human and processing errors.

This lack of standard recording systems and processes increases the chances of assessments being made without the context of relevant information. In one case, a GP assessing an injury to a baby was unaware of a separate bruising injury occurring in the days before this, or of the history of domestic abuse in the family.

Key information was sometimes known only to one or two people in the professional network. Risks were further exacerbated if those individuals did not attend or, at least, provide information to key decision-making meetings. One SCR found that important information about a parent's mental health was known only to the family GP, who was not present at key multi-agency meetings regarding the family. The GP did not share information with the health visitor who was working with the family and who did participate in meetings at which risk and needs were considered.

⁸ Self-harm in over 8s: short-term management and prevention of recurrence July 2004 / Self-harm in over 8s: long-term management, November 2011, National Institute for Health and Care Excellence

While small in number, there were a few examples of police failing to carry out checks of the child protection register following attendance at domestic incidents and/or removing children to the homes of friends or family members. There were also cases of failure to alert emergency social work services about actions taken.

2. Poor practice at times of transition.

Services were not always completely clear about when their involvement with a child or family was ending. Where professionals assumed, rather than knew, what each other was responsible for and was actually doing, this led to significantly increased risks for the child.

There were several cases that showed weaknesses in pre-birth planning where the transient lifestyles of the pregnant women greatly increased the vulnerability of their unborn babies. In these cases, the SCRs found that, while information was shared about risks, these were not acted on timeously due to confusion about where the woman was going to be living, and therefore, which local authority and /or health board had responsibility for planning and support. The resultant late realisation of risks impacted on case assessment and planning when there was not a proactive pre-birth period of working by children's services staff. One SCR described the lack of ownership of transient vulnerable women who are pregnant and move around to avoid services as "creating accident opportunities designed in the system and waiting to happen".

3. Failure to appreciate the significance of information.

The relevance and weight of the information, and its potential impact on risks to the child, was less likely to be understood when the information given was partial or when it was not provided directly by the person at the information's source, but was instead relayed by a third party. The emphasis of children's own words (and sometimes the words of parents themselves) could be subtly but fundamentally changed in the retelling by adults and lose their impact.

Information of a legal or technical nature in particular needs to be communicated by someone from the appropriate professional background, preferably in person, so that they can answer questions and check it has been understood. There were cases where the professional network did not have the benefit of medical staff or police to help them appreciate the significance of information shared. There were two cases where medical information that should be communicated only by medical staff had been relayed to parents by police or a social worker.

In some cases, information was received and recorded without reflection of its wider implications. This happened more frequently outside multi-agency meetings, which emphasises the importance of the child protection case conference and core group as a forum that provides the necessary checks and balances, strengthening child protection practice. It also reinforces the importance of high-quality supervision for staff working with children and families, discussed further below.

4. Making assumptions.

In a number of cases, staff made assumptions that proved, with hindsight, to be incorrect. These influenced decisions and contributed directly to a poor outcome or to increased risks. These include

assumptions that parents would themselves have disclosed fully to other professionals when a service had raised concerns about children, and that parents or other family members were engaging well with adult services, whose staff were monitoring risks.

Assessment and planning

High-quality assessment and planning are fundamental to creating safety for children and young people. It is perhaps not surprising then that SCRs identified recommendations for improvement in 14 out of the 20 cases. Having examined all of the cases, we consider there were issues in relation to assessment in almost all.

High-quality assessment is dependent on effective information sharing and high levels of staff competence. It is bound to be weakened when other parts of a child protection and welfare system are not robust.

1. Decisions should be informed by assessments that consider all relevant information, from all relevant parties.

In some cases, assessments were compromised by a lack of knowledge of key elements, which were taking place in the parent's life and known only to one service, but relevant when considering their capability to parent. This included parental mental ill-health, relationship breakdown and bereavement.

Where parents' problem alcohol or drug use was managed by GPs, intervention was at a lower level than that provided by substance misuse services. Specialist knowledge on addictions and addictive behaviour and full assessment of the parents' progress in tackling their addiction was not available to inform decisions made at discussion with other staff and multi-agency meetings, including the child protection case conference.

In some cases, assessment lacked key areas. This included specific assessment of children's health needs, assessment of attachment to inform rehabilitation plans and assessment of the capacity and capability of kinship carers to provide care for children, either in the short term or long term.

In two cases, an initial referral discussion involving all relevant staff was not held when child protection concerns were raised.

2. Pre-birth assessments should be started in good time.

The cases highlighted some instances of delay in instigating pre-birth assessments despite extensive histories regarding previous children and current concerns about parents' lifestyles. In one case, a child protection plan for an older child was discharged despite longstanding concerns about domestic abuse, substance misuse and lack of care. No consideration was given to the impact of another baby on already fragile family circumstances. Social work involvement with the family was minimal thereafter.

SCRs highlighted the need for pre-birth assessments to be undertaken as specialist, multi-agency assessments, with information to be gathered over a period of time, ensuring rigour in checking out

parents' motivation and ability to prioritise the needs of the baby. Within the SCRs reviewed, this work was sometimes very rushed – in one case, undertaken over only one week.

3. Good assessment requires robust, well-informed challenge and a sense of collective responsibility.

In a number of cases, there had been a lack of multi-agency meetings which brought staff together to share information, explore its meaning, review plans and agree action. The disbanding or dwindling of core group activity following a child or young person being taken off the child protection register was particularly risky.

Some staff saw their role as being solely to provide information to the social worker (the lead professional) rather than contributing their own professional view to the combined multi-agency assessment. In one case, the case-holding social worker was not sufficiently experienced to reach a balanced conclusion about the weight of the information provided and reach an assessment alone about its implications in terms of risk for the child.

Some health and social work staff were carrying caseloads that included a number of families presenting multiple and complex issues. In such circumstances, there is a danger of professionals becoming inured to the risks. Staff in one case told the SCR team that the family concerned "was not the worst". This led the SCR to conclude that there were perhaps other families for whom there was "an even more compelling argument for service intervention". The strength of a professional network should be in providing a forum for checks and balances, which challenges any complacency on the part of any individual, provided each person in the network understands their own responsibility to contribute.

4. Practitioners and managers should be particularly alert to the danger of over-optimism.

The rule of optimism, whereby professionals unconsciously focus on the positives about families and overlook the negatives, has been written about extensively and is a well-known risk⁹. It undermines professional responses and can lead professionals to deviate from the usual procedural guidance. The SCRs showed that in some cases, assessments were slanted to an overly positive view of the case, with less favourable information omitted. Most concerningly, this could be the case even when there were strong and persistent attempts by others in the professional network to challenge.

5. Assessments must have sufficient focus on the experience of the child.

A number of SCRs noted insufficient focus on the child or a lack of attention to the child's voice. In some instances, this was because the focus was on the parents – in one case, the review team commented that, "the mother's recovery agenda took precedence over the protection and wellbeing needs of the child". In others, the family was large and the needs of each individual child were overlooked. In a few cases, there was no proper engagement with the child or young person, even when this would have been relatively easy to achieve. Here, staff failed to find ways of overcoming adults' intransigence or their inability to change. They failed to escalate action to ensure that the child or young person was safe and well.

⁹ The Protection of Children: State Intervention and Family Life, Robert Dingwall, John Eekelaar and Topsy Murray; Blackwell 1983

Some long-term involvements with substance-misusing parents were ineffective in changing the child's reality. Practice was not sufficiently informed by the Getting Our Priorities Right guidance that provides caution that, "a parent's encouraging signs of progress in substance use recovery may be too late or too slow for a child whose early experience is one of deprivation".

Care plans for high-risk young people who needed high-level support could become ineffective when key involvements were shared by too many people. There was too much attention on managing present behaviour, rather than exploration of the young person's needs and understanding of behaviour.

In many of these cases, assessment was undertaken in the context of considerable pressure in the workplace, not least the challenge to identify suitable resources for children and young people whose needs were not being met well within the arrangements they had. This was especially true when staff and services were tasked to assess young people who might be facing homelessness, mental health difficulties, drug and alcohol related problems, poverty and a lack of any stable family relationships. In a few cases, staff failed to escalate their decision making when a young person was presenting high risks. They were preoccupied with planning for exit from services when faced with difficult behaviours and associated resourcing difficulties. These SCRs highlight the need for stronger multi-agency responses to meet the needs of older children and young people.

6. Written assessments should be provided in a format that enhances, rather than obscures, understanding and insight.

Staff did not always use an appropriate risk assessment format to construct their assessments despite there being a range of useful frameworks available.

SCRs found that chronologies were not always prepared, and identified that the lack of these potentially contributed to a lack of overview within a case, or lack of shared understanding of risk in the context of the history.

7. Robust assessment requires competent practitioners.

Staff need to be confident in their understanding of the impact of domestic abuse, non-engaging families, cumulative harm and how such aspects impact on assessments, decision making and thresholds for intervention.

SCRs identified practice issues regarding risk assessment and decision making about injuries in very young, pre-mobile babies going home when there was no credible explanation of how or with whom the injury occurred.

Engagement with children, young people and families

Most SCRs identified issues in relation to how staff engaged with children, young people and families, and to the provision of services. Some SCRs highlighted considerable strengths in the dedication of staff working closely and well together to keep the child at the centre and deliver interventions in what could be highly unique and taxing cases. The goal of delivering practice that is truly child-

centred could lead to tensions in balancing individual, parental and societal factors and it was evident that most staff tried very hard to get things right for the children involved.

Nonetheless, there were a number of areas where weaknesses were identified.

There was sometimes insufficient engagement by key staff with the child or parents, leading to a lack of working relationships and a lack of regular and reliable case knowledge and information. The superficial working and lack of contact with some children meant that their home circumstances were not sufficiently monitored or understood and they remained living in situations that compromised their safety and wellbeing. A number of cases also identified a lack of direct follow-up with children when concerns had been raised by them or others regarding their wellbeing or safety. Too often, children were not seen outside the supervision of their parents.

Another theme was a lack of congruence in assessing parental co-operation. For example, several times, parents' co-operation was described as good, when in reality there were many missed appointments and failure to follow through on agreed actions. If parents were not overtly hostile they could be perceived as more engaged, a form of disguised compliance.

Fathers were sometimes invisible, in one case living secretly in the home despite a child protection plan based on him not having contact with the children. In another case, the SCR highlighted that the protection plan was overly reliant on the father as a protective adult, even though there had not been sufficient assessment of him or his role in the family.

There was over reliance by staff on what parents and young people told them. There was sometimes insufficient professional curiosity and assumptions leading to 'false optimism' regarding children's circumstances.

A few SCRs also noted that collusive and manipulative parents and carers were able to control professional involvements, sometimes without challenge, because they were plausible or used aggression, causing services to retreat.

Neglect

The risk or likelihood of neglect is implicit within the other parental behaviours that have been discussed above. Long-term and serious neglect was identified as the primary cause of harm to two children in one of the 20 SCRs, but the SCRs indicated neglect was an underlying feature in the majority (12) of cases and was a feature in the history of another. Most worryingly, neglect of children persisted in some cases over years despite what were sometimes extensive service involvements and resources. Some children were not recognised in their service involvements as having been neglected and two SCRs failed to identify neglect that was clearly indicated in the available SCR information. The long-term consequences of chronic neglect, often coupled with abuse, left some children and young people in fractured living circumstances and relationships, without the resilience they needed to take their place in the world. Effective engagement with families, robust assessment and meaningful intervention are critical to changing this picture for children in the future.

SCRs and reviewing processes, including the use of legal measures

Six SCRs made specific recommendations in relation to improving the reviewing process as well as the quality of individual children's plans. The complexities and challenges of designing bespoke care plans in a few cases confounded the professionals involved. A number of SCRs highlighted the need for staff to adhere to existing guidelines and policies, which were in place but not being followed. The following issues were identified.

In a number of longstanding cases, SCRs were not held or did not trigger a change in response when the situation deteriorated. Sometimes professionals in the child's support network did not share concerns or could not agree on a course of action, and nothing was changed as a result. This highlighted the need for work to increase staff confidence in contributing to multi-agency child protection meetings and to effectively support and challenge each other.

Concerns often needed to be higher in order to trigger a different approach where a case was already in the system, than if it was a new concern. In a number of cases, incidents were each treated in isolation rather than as part of a bigger story. In a quarter of cases, the SCR found that a multi-agency chronology might have helped clarify case history information and identify patterns or accumulations of concern.

In eight of the 20 cases, there was lack of consideration, or use, of appropriate legal measures to protect children in the face of a lack of parental co-operation or progress in implementing change. In two cases, services had sought to remove supervision requirements just before the events leading to the SCR when this was contrary to documented levels of concern. In a further case, there was a proposal to abandon a referral to the Children's Reporter due to there being no criminal charges against a parent, rather than recognising the role of the children's hearing to potentially secure protection through the civil process. In this latter case, no risk assessment was presented to support the proposal.

In a further case, the children's longer-term care was secured legally in a custody case and the supervision order discharged, even while concerns were being raised elsewhere in the multi-agency involvement about the prospective long-term carers. The concerns were not communicated to the court dealing with the residence issue and no input was sought from the school, who would have known (and presumably raised) the many issues.

We were surprised that no SCRs referred to the role of the chief social work officer in authorising an immediate detention when a child or young person was presenting as unstable, out of control and highly motivated to engage in harmful or high risk behaviour. Instead, services who thought this was required waited for the decision to be taken by a children's hearing, referring to the child as being "at risk of a secure decision being made by the hearing" rather than perhaps simply as being a child "at risk" who needed to be kept safe in an emergency situation.

There was a clear need for improved accountability through ensuring accurate records of child protection meetings and updating of outcome-focused plans. There should be no delay in drawing up child protection plans following the initial child protection case conference. A clear plan should

be in place to ensure continued safety where children's names are removed from the child protection register, which lays out everyone's roles and responsibilities. There should be clear arrangements to monitor progress against this plan. We support the recommendation of one SCR, that the minutes of core-group meetings should be made available to child protection case conference chairs to improve continuity in decision making.

SCRs identified reviews for looked-after children happening late, or being cancelled and then never rescheduled in some cases. In one, children were discharged home after many months in foster care with no review of whether this was still the right plan and no check on whether agreed actions, specified at an earlier review meeting, had been taken.

Seven SCR's noted a lack of continuity of staff in the running of child protection investigations and related strategy and child protection case conference meetings. Some SCR's highlighted 'start-again syndrome', when staff failed to take into account the past history or had a simplistic view of the case. This is more likely to happen without continuity of staff.

Staff supervision and management oversight

Thirteen out of the 20 SCR's identified the importance of staff supervision. Seven highlighted issues in relation to the robustness of supervision processes, particularly in complex cases.

In some cases, there was a lack of critical reflection and constructive challenge, leading to overly optimistic views that crystallised early judgements.

Sometimes, when supervision did take place, it was not effective in picking up common errors of human reasoning, for example failure to revise judgements and plans in the face of new evidence that undermined the validity of a current involvement.

One SCR noted that staff needed to reflect and step back from work to see that there was no real change for the child despite all efforts. Supervisors did not always have the necessary expertise themselves to guide inexperienced staff and challenge flawed thinking, such as accepting explanations for injuries that could not have been caused accidentally to babies who were not mobile.

A number of SCR's were frustrated by the lack of rigour in recording key decisions made as a result of supervision discussions and consultation with more senior managers. As a result, it was impossible to track decisions retrospectively, particularly if there were differences in staff's recollections.

Supervision did not always ensure that staff got the support they needed. Several SCR's noted the impact on inexperienced staff in carrying cases of significant complexity. Even where staff seemed to have been given regular supervision, they were not always sufficiently aware of, and using, policies on reporting violent incidents and guidance on dealing and working with hostile or uncooperative families.

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Chapter 4: Understanding of risk

Almost all of the children and young people involved in the 20 cases reviewed were known to services and receiving a range of statutory and child protection service interventions at the time harm occurred. Two of the infants who died were subject to child protection registration under the category of neglect at the time they died and another three cases had been subject to child protection registration for neglect in the past. Some children were subject to legal orders that conferred duties of care and some were involved in throughcare and aftercare support services that aimed to support them as they moved to take their place in the world.

Vincent and Petch noted when they analysed 56 SCRs in their review in 2012 that it was possible to identify particular risk factors in relation to groupings of children and young people. Further, they noted findings from studies in England by Brandon et al, which identified that a significant number of the children who become subject of an SCR were affected by a number of themes, most commonly parental substance misuse, parental mental health and domestic abuse. Brandon et al referred to the combination of these main themes as producing “a toxic caregiving environment for the child”. Our review found similar themes, in that two thirds of children were living with domestic abuse, two thirds with parental mental health issues and over half with substance misuse issues.

Interaction of child, family and agency risks

In considering the interaction of child, family and agency risks, these are shown, in the three tables overleaf, in relation to infants, primary school-aged children and teenagers respectively, in keeping with the mapping carried out by Vincent and Petch in their audit.

Summary of risk factors identified for infants

Child factors
<ul style="list-style-type: none">• Neonatal abstinence syndrome and foetal alcohol syndrome• Siblings born with foetal alcohol syndrome• Prematurity• Non-organic failure to thrive• Attendance at accident and emergency departments for injuries• Co-sleeping with parents• Previous or current child protection registration for neglect (subject child or older siblings)
Family/environmental factors
<ul style="list-style-type: none">• Substance misuse• Domestic abuse• Mental health problems• Troubled childhoods: poor attachment, lack of parent role models• Family conflict• Late booking-in pregnancy• Previous children cared for by others• Poor attendance and quality of contact with subject child or siblings• Criminality, especially for violence or drugs.• Social isolation, lack of family or community support• Housing issues such as frequent moves, anti-social behaviour, problems with neighbours• Non engagement, lack of co-operation, changing patterns of engagement• Missed health appointments, failure to obtain medical care• Previous repeat attendance at accident and emergency departments
Agency factors
<ul style="list-style-type: none">• Risks not assessed and no multi-agency pre-birth assessment• Focus on parents as opposed to the child• Pace of change not conducive to child's wellbeing• Accumulating information not analysed to allow assessment of increasing risk, or case not considered to be 'child protection'• Child not seen

Summary of risk factors identified for primary school-aged children

Child factors
<ul style="list-style-type: none">• Attendance and punctuality at school or nursery• Behaviour problems at school• Presenting as dirty at school or nursery• Health problems including weight problems• History of neglect• Episodes of being looked after away from home or with kinship carers• Singled out as a 'scapegoat' in the family
Family/environmental factors
<ul style="list-style-type: none">• Large families of four or more children• Substance misuse• Domestic abuse• Mental health problems• Troubled childhoods, poor attachment and lack of positive parental role models• Sexual abuse as a child• Criminality: violence; drugs• Social isolation, lack of family or community support• Housing issues, frequent moves, anti-social behaviour, problems with neighbours, overcrowding• Non engagement, lack of co-operation, changing patterns of engagement• Missed health appointments, failure to obtain medical care, frequent appearances at accident and emergency departments
Agency factors
<ul style="list-style-type: none">• Failure to speak to child 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• Signs indicating possible sexual abuse not identified

Summary of risk factors identified for teenagers

Teenager factors
<ul style="list-style-type: none">• Mental health problems• Risk-taking behaviour – self harm, substance misuse, offending• Long-term involvement with social work services and the children’s hearing system• Looked after with multiple placement moves• Non engagement or lack of co-operation with services.• Absconding• Previous abuse or neglect• Loss of (contact with) siblings through living apart, separate care arrangements or sibling’s death
Family/environmental factors
<ul style="list-style-type: none">• Social isolation, lack of family or community support• Known to associate with peers or family involved in risk-taking behaviour• Older siblings involved in crime or substance misuse• Parents in conflict with one another, undermining efforts to exert control and exposing young person to divided loyalties or mixed messages
Agency factors
<ul style="list-style-type: none">• Lack of resources to meet young people’s needs• Risks presented by transition to adult services• Professional powerlessness• Mental health needs not met• Housing needs not met: regarded as homeless adult rather than as vulnerable young person and exposed to homeless hostel associates• Numerous staff involved, meaning it is difficult to run tight care plan with strong working relationship(s)

Chapter 5: The significant case review process

Type of review

Seventeen of the 20 SCRs were titled as significant case reviews. The remaining three were identified as reflective learning reviews for the child protection committee.

Four SCRs were undertaken using the Social Care Institute for Excellence (SCIE) Learning Together model.¹⁰ A further two SCRs used elements of the SCIE model. The rest did not follow any specific method.

Time taken to complete an SCR

In most cases, it was not possible to know how much time was taken from the point of a child protection committee's decision to commission an SCR to completion of the report. If using the timescale of the length of time taken from the point of harm being caused to the child or recognised by professionals as significant and requiring particular action, to completion of the SCR, it was possible to measure it in 15 cases. In these, the timescale varied from five to 37 months. For our future reviews of SCRs, it will be possible to track this more accurately from the information submitted to us at the conclusion of initial case reviews.

Quality of the SCR reports

The reports varied considerably in terms of their format and length, the approach used, the degree of independence achieved, the people involved in reviewing or contributing, the thoroughness of the analysis and how the findings, strengths or recommendations were presented.

The majority (12) had a single external lead reviewer, one case had three lead reviewers and two cases had two lead reviewers. The length of reports ranged between 12 and 67 pages.

It was clear that in some cases that did not use the SCIE model, child protection committees set out predetermined parameters for the SCR at an early stage. While this approach may have been helpful in setting boundaries and allowing the SCR to be conducted in a shorter time, it could be problematic in that it did not allow the SCR to explore all aspects of the case and identify the interlinked factors that may have contributed to weakening the protective infrastructures around a child. Two of these SCRs did not highlight that services had failed to identify early neglect as relevant. Three SCRs had concluded that services had been proportionate to the needs of the case when it was evident from the material provided that this might not be correct. Indeed, there had been significant issues at key points in these case histories, in terms of consensus between professionals involved in assessment of the child or family's needs and timely provision of suitable services to meet those needs. In contrast, the SCIE method is more free-flowing in following the evidence to identify relevant issues.

The size of the review team varied from 10 members to three, the average size being seven members. In three cases, the SCR was undertaken by a single reviewer. A review team was referred to but not specified in two cases.

¹⁰ Learning together to safeguard children: developing a multi-agency systems approach for case reviews: Fish, Munro, Barstow 2009

In our view, it would be difficult for any internal lead to demonstrate the degree of independence and objectivity required to undertake a high quality SCR, in the absence of an externally validated method.

In some instances the external lead was commissioned from an authority where the child protection committee already had established links. In a few cases, there were also shared services. In one instance, the SCR had been commissioned following dissatisfaction by some professionals with the findings of an internal critical incident review of the same case. The earlier review had omitted to interview a number of highly relevant key staff. One SCR was undertaken based on information and views contained in reports provided to the lead reviewer, without accessing the relevant case records.

In comparing the different methodologies, it was evident that the thoroughness of the SCIE approach significantly enhanced the quality of the SCR information and provided valuable insights into the individual and collective thinking that was around at critical points in the case. SCR teams could gain a clearer appreciation of the rationale of staff when considering their decisions or interventions with the child and family at these key points and could reflect also on wider systems issues within and across organisations.

Executive summaries and sharing learning widely

There was variation in the approach to executive summaries. These were provided in only nine of the 20 SCRs. Some incorporated the executive summary in the body of the report while others had prepared this as a stand-alone document. It was not always clear whether there might have been an executive summary prepared but not submitted to us for our review. This may link to whether or not there was an intention to make learning from the SCR available beyond the local area. In other parts of the UK, the presumption to publish all serious case reviews is designed to support a more consistent approach to wider dissemination of information and learning.

Chronologies

Most SCRs contained a chronology or timeline with sufficient detail to understand the key events for the period under review. Four that did not have a chronology contained focused narrative of critical events occurring over a short period. One SCR referred to using a case chronology but did not replicate it in the report. The case reviewers identified the need to improve multi-agency chronologies in five cases, with recommendations related to the need for staff to better understand how chronologies should be used to identify patterns of concern and inform risk and needs assessment.

Involvement of family members

Best practice in conducting SCRs indicates that parents and other relevant family members should be involved and given the opportunity to contribute their views, where possible.¹¹ The exception to this may be when there are particular welfare or legal issues related to a prosecution. Of the 20 SCRs we have reviewed, 11 (55%) evidenced that the family was asked to be involved. In the remaining cases, three were not asked because of legal or mental health issues.

¹¹ Morris,K. Brandon,M. and Tudor,P, (2012) A Study of Family Involvement in Case Reviews: Messages for Policy and Practice, British Association for the Study of the Prevention of Child Abuse and Neglect (BASPCAN)

Aligning the SCR process with other reviews

In addition to now being the central collection point for initial case reviews and significant case reviews, the Care Inspectorate receives notifications of the deaths of looked-after children and young people, and leads on conducting multi-agency reviews of these cases. Where there is to be an SCR for a looked after child who has died, a death of a looked-after child review will be considered along with the SCR. Where a sudden unexpected death of an infant (SUDI) review has taken place, it will be assumed that the learning and conclusions from the SUDI review were known to the SCR team.

Recommendations contained in SCRs

The terminology and approaches used to describe the next steps of completed SCRs varied. For example, 'findings' (as a result of SCIE SCRs), 'recommendations', 'areas for future learning' and 'learning points'. Some SCRs also presented a list of strengths and others threaded references to strengths throughout the SCR as appropriate. In total, 26 potential strengths were put forward in the SCRs although we did not agree that they were all, in fact, strengths.

Most of the 177 recommendations arising from the 20 SCRs related to processes. Three SCRs made national recommendations in relation to:

- national case transfer protocol for non-child protection cases across local authority areas
- lack of appropriate accommodation within adolescent medium secure health settings
- reviewing and updating safer recruitment guidance.

Chapter 6: Conclusions

In almost all of the cases featured in our retrospective review, there was significant involvement by a number of services, sometimes over many years. These extensive involvements were not in themselves sufficient to protect the children and young people concerned and some SCRs had concluded that the harm or death could not reasonably have been predicted. In others, however, there were clearly weaknesses or breakdowns in the protective structures around the child. Professor Eileen Munro writing about efforts to protect children makes the point that this “inevitably involves uncertainty, ambiguity and fallibility”.¹² She points out the qualities of a trained and experienced professional and is clear that “the best predictor of future behaviour is past behaviour”.

All staff working in the field of child protection should have high quality supervision on a regular basis.

In wishing to acknowledge that parents were trying to provide suitable care, staff in the cases reviewed often lost some of the focus on their past behaviours. In order to promote the best reasoning skills in child protection, Professor Munro states that there are three sets of factors: “Having staff with the appropriate knowledge and skills, providing sufficient resources to leave time for critical thinking, and offering skilled supervision”. Seven of the SCRs identified issues in relation to the supervision of staff and our review recognised that there were questions that could be raised about the quality of supervision in a further six cases. Given the complexity and challenging nature of child protection work and its potential impact on staff, it is critical that the importance of regular, reflective supervision is recognised in seeking to minimise errors and provide clarity about professional reasoning.

All child protection committees should oversee any necessary improvement actions in relation to the areas listed below.

This report has identified a number of national practice and operational issues that echo the findings of previous child protection scrutiny in Scotland and findings from the current round of joint inspections of children’s services.

- The need for better use of chronologies to inform assessment and decision-making.
- The extent of information shared and how it is used to enhance the understanding of risks and needs within multi-agency working.
- Improved transitions to ensure roles and responsibilities are clear and that support for children continues, particularly following removal of children’s names from the child protection register.
- Continued improvement in the quality of assessments of risk and need.
- More consistent use of national risk-assessment tools.
- More rigorous management of risks and more responsiveness to changes in risk once the child is “in the system”.
- Better consideration of the vulnerability of older young people, particularly around times of transition and where there is concern about risk-taking behaviour and self-harm.

¹² Effective Child Protection, Eileen Munro, 2006 SAGE

Chief officers and child protection committees should take all necessary action to reinforce the need for collective responsibility in keeping children safe.

The idea that responsibility for keeping children safe belongs not to any one profession but is everyone's responsibility has been accepted in Scotland for more than 15 years. Shared responsibility has been reinforced through more than a decade of joint inspection activity and is embedded in the Getting It Right For Every Child approach. Nonetheless, in many of the cases that formed part of our review, it was left predominantly to the lead professional to make decisions about increasing intervention where there were accumulating or raised concerns in a child's circumstances. In a few cases, where there was a lack of consensus amongst the staff group about the level of concern being presented, the dissenting professional did not go on to escalate matters in accordance with agreed protocols. In effect, this meant that recognised risks to the child went unchallenged.

Child protection committees should continue to provide clear information to the Care Inspectorate on decisions made following initial case reviews and should take seriously the opportunities for learning and practice improvement provided by SCRs.

Child protection committees varied in their thresholds for proceeding (or not) to an SCR and then in determining the terms of reference and parameters for it. Their decisions impacted on the resulting quality of information gleaned and opportunities for identifying learning. Over the three-year period of our review, SCRs were completed in only 14 of the 30 child protection committee areas. This suggests that some committees were more likely than others to seek the insights to be gained through an SCR about how well services were protecting children. The revised national guidance on conducting SCRs, which was published on 31 March 2015, now requires child protection committees to submit to the Care Inspectorate decisions of the initial case reviews as well as the SCRs in order to understand more about the rationales being applied across the country in determining whether or not SCRs are carried out. This should mean a developing bank of information and learning that will be available to all staff in Scotland's services, and to policy and decision-makers. All concerned may benefit from the learning available in their efforts to keep children and young people safe.

The Scottish Government and Scotland's child protection committees should work together to support better quality in SCRs and greater consistency in approach. This should include building capacity for undertaking SCRs using the Social Care Institute for Excellence's (SCIE) method and other nationally recognised approaches.

The SCRs themselves were variable in quality, with some lacking in detail or rigour. Those with independent chairs were generally (though not universally) of a higher quality. Those using the SCIE method were more reflective and thorough, leading to improved evidence by including the perspectives of the staff at the time to give 'a window into their thinking' and help clarify why they saw things the way they did. It was recognised that there were additional resource implications in terms of staff and review team time when using this methodology. In relation to the terms of reference set out by child protection committees, the SCRs that used the SCIE method tended to set out with a more open mandate and considered wider systems aspects to gain a more rounded understanding of what happened in the case. Most SCRs presented their conclusions as a series of specific, directive recommendations for particular services to take action or ensure compliance and

these were predominantly about processes. The conclusions of SCRs that used the SCIE method were presented as 'findings'. These came with associated questions for the child protection committee to consider and the responsibility for taking forward identified learning or improvements was clearly vested in the child protection committee.

Chief officers and child protection committees should focus attention on implementing and embedding demonstrable practice change as a result of learning from SCRs.

SCRs were not always clear how the child protection committees' critical role in the governance of child protection and in ensuring that lessons are identified and necessary improvements implemented was going to be delivered. SCRs should be clear about what needs to improve; that is, whether it is the systems and processes themselves that need to improve, or that the issue lies with the implementation of, or compliance with, them.

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अनुरोधसापेक्षे এই प्रकाशनाटि अन्य कर्म्याटि एवं अन्यान्य भाषाय पाठ्या यय ।

یہ اشاعت گزارش پر دیگر شکلوں اور دیگر زبانوں میں دستیاب ہے۔

ਬੇਲੜੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

هذا المنشور متوافر عند الطلب بتسميات وبلغات أخرى.

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