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Protecting Scotland's Children and Young People: It is Still Everyone's Job

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CHILD PROTECTION SYSTEMS REVIEW:
COMMISSIONED BY THE SCOTTISH GOVERNMENT

An examination of the role and function of
Child Protection Committees, Child Protection Registers, Child Protection Case Conferences, and Significant and Initial Case Reviews as part of the Scottish Government's National Child Protection Improvement Programme

Report by Independent Chair, Catherine Dyer CBE

March 2017

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Acknowledgements

There are many people to thank for their assistance with the work of this Review.

The considerable commitment of time and expertise by the members of the Review Group cannot be underestimated and was invaluable.

They shared their own well-informed views throughout the Review frankly: identifying what is working well, what needs to be improved and how to achieve that.

Their canvassing of emerging findings and recommendations with colleagues, and contacts across their professional networks meant that the Review engaged with a rich cross section of all those currently involved with child protection work in Scotland.

We also learned much from the professionals who invited us to attend their meetings and conferences to hear of their work and gather their observations on the system.

The insight around international child protection approaches which Dr Sharon Vincent provided was particularly appreciated by the Review Group; as was the generous assistance given by Dr Vincent and a wider network of child protection experts who provided peer-review of the papers drafted for consideration at our meetings.

The high quality of these papers and overall support to the Group came from CELCIS in the form of Dr Louise Hill and her colleagues, who facilitated our deliberations and provided IT and administrative support, all of which made possible the examination of the evidence and delivery of this Report and Recommendations within such short timescales.

The Review Group hope that the recommendations are helpful to all those involved in working to keep children and young people safe in Scotland.

Catherine Dyer

Independent Chair
March 2017

Executive Summary

Background

On 25th February 2016, the then Cabinet Secretary for Education and Lifelong Learning, Angela Constance MSP, announced a National Child Protection Improvement Programme for Scotland (CPIP). This programme includes existing commitments on child sexual exploitation; child trafficking; and internet safety, along with a number of new areas of work. These include: a review of practice in the Children's Hearings System; agreeing steps to promote and support leadership; refreshing the role of inspection agencies; improving data and evidence; agreeing further action to address the impact of neglect on children and young people; and a review looking at how the child protection system currently works and what could be improved across Scotland. [1]

The Review Group

A Child Protection Systems Review Group was established with representation from a wide range of professionals with child protection expertise at a national and local level, and independently chaired by Catherine Dyer (Former Crown Agent and Chief Executive of the Crown Office and Procurator Fiscal Service). The Review Group was asked by Ministers to look at the operation of the formal child protection system - including Child Protection Committees, Child Protection Registers and case conferences, and Initial and Significant Case Reviews - and to recommend what changes or improvements might be needed to these underpinning processes and structures in order to protect children and young people more effectively.

At each stage of the process, Review Group members consulted via their organisations and networks and provided written and/or oral feedback. Over forty written consultation responses were analysed as part of the review process; alongside attendance at various strategic meetings and visits to services supporting children and families.

Findings

The Review concluded that when children or young people are identified as being at risk of or subject to significant harm then the child protection system in Scotland works well and that the components that the Group were asked to review are

[1] Child protection in its broadest sense means protecting a child from abuse and neglect. Within the formal child protection system, the term child protection applies specifically where a likelihood or risk of significant harm to a child has been identified.

capable of delivering the support needed for these vulnerable children and young people.

The issues the system deals with are complex and sensitive. With new risks emerging and legislation and practice changing, those working in the system are constantly assessing how risks can be mitigated and improvements delivered. The Review identified three overarching and cross-cutting themes as critical to continuing to improve processes and structures in order to protect children and young people more effectively: Leadership, Governance and Accountability; Developing a Learning Culture; and Shared Values.

Leadership, Governance and Accountability

Leadership is a critical factor in creating a system with effective processes and culture to ensure children are protected from abuse and neglect. Child protection work necessarily requires input and collaborative working from thousands of staff across multiple organisations. Although referred to as a child protection 'system' it consists of a number of organisations with distinct core functions and with very different boundaries, resources, governance and accountability routes. Child Protection Committees, the local inter-agency strategic partnership for child protection, are often required to address issues which are common to their counterparts in other parts of the country. There is a need for greater coordination to strengthen and support practice, reduce duplication of effort and deliver greater consistency across the country. The Review recommends the establishment of a National Child Protection Leadership Group to support this. The Leadership Group should identify work needed to support Chief Officers to strengthen delivery of their responsibilities and there should be regional leadership events for Chief Officers Groups and Chairs of Child Protection Committees.

There is no single national collation point regarding details of children and young people who have been or are currently on a Child Protection Register. This means that professionals can find it difficult to obtain information urgently on children and young people who have moved across local authority boundaries and may have been on a Register elsewhere. The Review recommends exploring the viability of a National Child Protection Register.

The Review considered how child protection processes are used with 16 and 17 year olds and concluded that there was a lack of consistency and some ambiguity. The very limited circumstances in which 16 and 17 year olds can be referred to the Children's Reporter for use of compulsory measures means that there are challenges in the interaction of the child protection system and the Children's Hearings System. The Review recommends that work should be done to clarify

these issues and to strengthen alignment for children of all ages where child protection processes interact with the Children's Hearings System.

Developing a Learning Culture

Working with children who are at risk of significant harm and their families is complex and challenging and the Review reinforced the importance of a continuous learning approach. The Review recommends that the new Leadership Group, along with Child Protection Committees Scotland, should support a continuous improvement approach and that the Scottish Government should develop a strategic programme to develop robust data sets to support this.

The Review looked in particular at current approaches to Initial (ICRs) and Significant Case Reviews (SCRs), with a focus on how learning from these reviews is shared and implemented. The Care Inspectorate currently receive copies of all SCRs and the Review recommends that their role be extended to act as a central repository for all ICRs as well, and that the Care Inspectorate should explore development of a 'Community of Practice' portal to support better sharing of learning. The Review also recommends that the Scottish Government should explore a new tiered approach to, and methodology for, Initial Case Reviews and Significant Case Reviews, based on the 'Child Practice Review' three level model used in Wales, which would help get learning into the system faster. Work should also be undertaken to develop a set of national standards setting out skills and competences for those undertaking reviews.

Shared Values

The overarching theme of shared values emerged in relation to children and young people, families and the workforce. The Review identified local examples of good practice in involving children and young people in child protection processes but that this was not consistent or widespread. The Review recommends that the Children and Young People's Commissioner Scotland should be invited to work with partners to develop a programme of work to understand children's experiences of formal child protection systems in Scotland. The Review recognised the importance of ensuring that children, parents and wider families are part of the decision-making processes and that there are a range of approaches that can be used in child protection processes to support parental and wider family participation. It is recommended that Child Protection Committees should explore a range of approaches to Child Protection Case Conferences that are underpinned by a strengths-based ethos.

List of Recommendations

Recommendations on Leadership, Governance and Accountability

Recommendation 1

A National Child Protection Leadership Group should be established in order to further support, strengthen and improve, from a national perspective, activity on child protection across Scotland. This group should report and account to Scottish Ministers.
Key tasks of the Leadership Group in Year 1 should be:

- Oversight of implementation of the recommendations of this report
- Review of the arrangements for child protection across current planning and service delivery processes, including Integration Joint Boards (IJB) and in relation to the duties set out in the Children and Young People (Scotland) Act 2014.

Recommendation 2

Chief Officers should be supported by the National Child Protection Leadership Group and Child Protection Committees Scotland to strengthen delivery of their responsibilities, as set out in the National Guidance for Child Protection in Scotland (2014), and to identify areas where further work may be required, such as:

- Clarity of reporting mechanisms between Child Protection Committees and Chief Officers' Groups
- Descriptions of the roles and responsibilities of Child Protection Committees (including that of Chairs of Child Protection Committees) and Chief Officers' Groups
- Supporting Child Protection Committees to carry out their roles and functions in line with the requirements set out in national guidance.

Chief Officers should pro-actively engage with and report to elected members and other local scrutiny bodies as the local representatives of their communities and provide opportunities to listen to community concerns and hold learning events at a local level.

The Scottish Government should resource a number of regional leadership events via the Leadership Group for all Chief Officers' Groups and Chairpersons of Child Protection Committees to network, share good practice and collectively horizon scan for new risks facing children and young people.

Recommendation 3

It is critical that the Chief Executive of each local authority, working with the Chief Officers' Group, ensures that Chief Social Work Officers have sufficient support to provide professional leadership, advice and scrutiny across all public protection

matters (including child protection), given their key statutory responsibilities within the local authority.

Recommendation 4

The Scottish Government should review both the measures available to protect 16 and 17 year olds and whether the Children's Hearings (Scotland) Act 2011 should be amended to allow any young person aged 16 and 17 years old to be referred to the Principal Reporter where there is a need for compulsory measures.

Recommendation 5

When a Child Protection Case Conference is held, whether or not a child is placed on the Child Protection Register and at any subsequent points when the child protection plan is reviewed, a referral to the Reporter should be considered and the decision on referral should be clearly recorded.

Recommendation 6

The development of a National Child Protection Register that can be securely accessed by all appropriate professionals should be explored. In the short term, it should be ascertained whether it is possible for Police Scotland to use a flagging system on the National Police Vulnerable Persons Database to identify all children placed on a local Child Protection Register.

Recommendations on Developing a Learning Culture

Recommendation 7

The Care Inspectorate should become the central repository for all Initial and Significant Case Reviews and should explore the development of a 'Community of Practice' portal on the Care Inspectorate website to enable secure access to all Reviews by child protection professionals in all relevant organisations.

Recommendation 8

The Scottish Government should explore a new tiered approach to and methodology for Initial Case Reviews and Significant Case Reviews, based on the 'Child Practice Review' model used in Wales.

Recommendation 9

A set of National Standards should be developed setting out the skills and competences required of those reviewers undertaking Initial Case Reviews and Significant Case Reviews. Appropriate involvement of the child or young person and their family should be a key component of training for reviewers and a Good Practice Guidance Note should be developed on how to engage with children, young people and families involved in child protection processes. This should ensure all Reviews are timely, proportionate and contribute to an on-going learning culture.

Recommendation 10

The National Child Protection Leadership Group and Child Protection Committees Scotland should support local areas to deliver robust continuous improvement programmes. This should include working with relevant organisations to synthesise and share learning from different sources including inspection, research, reviews and local practice.

The Data and Evidence work stream of the Scottish Government Child Protection Improvement Programme should develop a strategic programme to deliver robust data sets to support child protection improvement. The Scottish Government should develop a national resource for advice on using child protection data for local planning and service development.

Recommendations on Shared Values

Recommendation 11

The Children and Young People's Commissioner Scotland should be invited to work with partners to develop a programme of work to understand children's experiences of formal child protection systems in Scotland. This work should include the further development of accessible tools and information directly for children to support their participation in decision-making and events held to support front-line practitioners working with children. This work should include the development of a Good Practice Advocacy Guide for child protection.

Recommendation 12

Child Protection Committees should ensure children, parents and wider families are part of the decision-making processes and explore a range of strengths-based participatory approaches to Child Protection Case Conferences to achieve this.

Chief Officers, Heads of Service and senior management should support front-line professionals to participate in all stages of Case Conferences, Core Group meetings and Children's Hearings.

1. Introduction

1.1. **In Scotland we want all children and young people to be safe from abuse and neglect throughout their childhoods.** We want a society that can protect, nurture and value our children and young people. For the majority of children and young people, parents and primary carers provide the love and care that children and young people need. Being a parent can be hard and some parents can face challenges in their lives that impact on their ability to care for their children. Research indicates that the majority of abuse and neglect of children occurs within families (Gilbert et al., 2009). We know that children and young people living with parental substance misuse, domestic abuse, parental mental health and parental learning disabilities can face greater adversities and are more likely to require the wider support from families and professionals. Unemployment, poverty, discrimination, poor housing, ill-health and disability also adversely impacts on children and young people's outcomes. For some children and young people, physical, sexual and emotional abuse occurs out with the family; for example, by an adult in a position of trust known to the child or young person (such as a teacher, nursery worker, youth worker, cleric, residential worker), a person within the community and, to a lesser extent, 'stranger' abuse. There is an increasing awareness about children and young people who are being sexually exploited and abused via the internet. The Scottish Government and professionals working with children and young people are committed to understanding children's lives as a whole and have, through a growing evidence-base, recognised the importance of early intervention to tackle the root causes of risk and social disadvantage to ensure that every child and young person has the opportunity to grow and flourish.

1.2. The Children and Young People (Scotland) Act 2014 is a key part of the Scottish Government's strategy for **making Scotland the best place in the world for children to grow up**. By facilitating a shift in public services towards the early years of a child's life, and towards early intervention whenever a family needs help, this legislation encourages **preventative measures, rather than crises responses**. Underpinned by the Scottish Government's commitment to the United Nations Convention on the Rights of the Child 1989

(UNCRC), and a national approach to improving outcomes for children, known as Getting it Right for Every Child (GIRFEC), the Act also establishes a new legal framework within which services will work together to support children, young people and families. This national collaborative approach is critical in providing the right help, at the right time, from the right people. The right help, the timing of that and the people best placed to provide it will be different for every child and young person. The support that most children need will come from their families and communities and the universal services, such as mainstream health and education services. However, some children and young people will need the help of additional support and specialist services; and a minority may need compulsory interventions by the state to keep them safe, help them overcome the impacts of adversity and reduce the risk of serious harm (see Figure one, Child at the Centre).

Figure One: Getting it Right for Every Child: Child at the Centre (Scottish Government, 2014)

1.3. It is everyone's job to keep children and young people safe, and professionals in health, education, police and social work have specific responsibilities when they become aware that a child or young person is being subjected to harm, or is at risk of significant harm. The scale of the task faced by the myriad of professionals in health, education, police, social work and third sector organisations in identifying children and young people at risk and developing

plans to effectively protect each of them cannot be underestimated. It is estimated that less than a tenth of those children and young people who experience abuse or neglect are known to formal child protection agencies and many children and young people who experience abuse and neglect may not be detected, reported or recorded within formal child protection systems (Gilbert et al., 2009). A UK-wide study based on self-reporting of child maltreatment found almost six per cent of children under the age of 11 and 18.6 per cent of 11-17 year olds had experienced severe maltreatment during their childhoods (Radford et al., 2011). For those children and young people who do disclose abuse, it is most likely to be to a mother or friend, rather than a professional. Some children report disclosing abuse and neglect, but remain 'unheard' and no action is taken (Allnock & Miller, 2013). Disclosure in itself can be problematic, as experiencing neglect on a day-to-day basis can be more difficult to disclose than a specific incident (Vincent et al., 2004). In a review of children and families' access to services where neglect had occurred, children stated that what they were looking for was 'somebody to notice that they are unhappy and ask them why' (Burgess et al., 2014: 25).

1.4. In the worst-case scenarios where there is neglect or abuse, children and young people can die or suffer seriously adverse outcomes. A triennial review of Significant Case Reviews in Scotland (1 April 2012 to 31 March 2015) included eleven child fatalities: five were infants or pre-school children and six were young people aged 15-17 years old. A further twelve children had been significantly harmed or were at risk of harm. The fatalities included drowning, physical injury, drug overdose, suicide, accidental death from falling when intoxicated and Sudden Unexpected Death in Infancy (SUDI) (Care Inspectorate, 2016). In Scotland, the five-year average rate of child homicides has decreased by 44 per cent over the last decade (Bentley et al., 2016:17). Decline in fatalities is one indication of progress in child protection; however, 'studies have indicated that the number of child deaths where abuse or neglect is suspected as a factor is higher than shown in the police-recorded homicide figures' (Bentley et al., 2016; see also Brandon et al., 2012).

1.5. In Scotland, there has been significant progress in recognising that everybody has a responsibility for protecting children following the publication of 'It's everyone's job to make sure I'm alright': Report of the Child Protection Audit and Review' (Scottish Executive, 2002) and the subsequent reform programme (2003-2006). A process review found that the subsequent guidance, Protecting Children and Young People: Framework for Standards (2004) and Protecting Children and Young People: Child Protection Committees (2005) were particularly important in improving roles, effectiveness, significance and influence (Daniel, et al., 2007). These steps have supported the ethos and value-base for the national approach to improving outcomes for children, Getting it Right for Every Child (GIRFEC). There is widespread recognition that a whole system approach is needed, professionals cannot work in silos and they must have a shared aspiration to improve outcomes for all children and young people at the earliest opportunities.

1.6. Inspection reports focused on child protection across Scotland have demonstrated the excellent frontline work of professionals and strategic partners who are 'continuing to make significant strides in improving the quality of services' (Care Inspectorate, 2014a:9). Scotland has a child protection system which works; the purpose of this review is to further support the improvement of delivery of child protection work locally, regionally and nationally to ensure that Scotland's child protection system can meet the needs of our most vulnerable children and young people now and in the future.

This Review

1.7. Ministers at a national level, elected members at a local level and professionals working with children and young people need to ensure that legislation, policy and practice are working effectively to protect children. It is not processes and procedures that protect children; people protect children. However, it is important to regularly consider the structures and processes which need to be in place to support those working together to identify and protect children at risk of significant harm.

1.8. On 25th February 2016, the then Cabinet Secretary for Education and Lifelong Learning, Angela Constance MSP, announced a **National Child Protection Improvement Programme for Scotland** (CPIP). This programme includes existing commitments on child sexual exploitation, child trafficking and internet safety, along with a number of new areas of work. These include: a review of practice in the Children's Hearings System; agreeing steps to promote and support leadership; refreshing the role of inspection agencies; improving data and evidence; and agreeing further action to address the impact of neglect on children and young people; as well as this review which has been looking at how the child protection system currently works and what could be improved across Scotland, drawing on research evidence and practice experience.

1.9. As part of the CPIP, this Review was commissioned by Mark McDonald MSP, Minister for Childcare and Early Years, to examine **the role and function of Child Protection Committees; the use of Child Protection Registers and Child Protection Case Conferences; and the efficacy of Significant and Initial Case Reviews** and to recommend what changes or improvements may be needed to these underpinning processes and structures in order to protect children more effectively.

1.10. The Scottish Government established a National Review Group independently chaired by Catherine Dyer CBE (Former Crown Agent and Chief Executive of the Crown Office and Procurator Fiscal Service) which involved representation from a wide range of professionals with child protection expertise at a national and local level. This included professionals from local authorities, health boards, Police Scotland, Care Inspectorate, Scottish Children's Reporter Administration, Social Work Scotland, Child Protection Committees Scotland, Royal College of Paediatrics and Child Health Scotland, Scottish Association of Social Workers, Convention Of Scottish Local Authorities, Children and Young People's Commissioner in Scotland, Coalition of Care and Support Providers in Scotland, as well as other professional membership organisations and academia (see Appendix A for Review Group Membership and Terms of Reference). Logistical support and background information was provided by Dr

Louise Hill, based at the Centre for Excellence for Looked after Children in Scotland (CELCIS), University of Strathclyde.

1.11. The Review Group has considered how child protection systems currently work, or don't work, across Scotland with the aim of recommending what can be done to strengthen the steps that are taken by professionals working in child protection when children have experienced, or are at risk from, harm. The tight timescales and remit for this Review inevitably meant that it could not be as wide-ranging as to cover in detail the system which supports children who are not the subject of child protection measures. The Review Group acknowledged that much work is already underway - including improving the identification of, and support for, children who may require protection - and that there will always be a need for ongoing learning and improvement for how well partners across the whole system are working together.

Methodology

1.12. The Group met six times between August and December 2016. Background papers summarising legislation, policy, practice developments and research evidence on different aspects of child protection in Scotland were written for the Review Group and circulated in advance of each meeting. All papers were also peer-reviewed by experts in the field who were not members of the Review Group. Each paper concluded with a series of questions that were used to focus the Review Group's discussions and for subsequent consultation. At each stage of the process, Review Group members consulted via their organisations and networks and provided written and/or oral feedback. Over forty written consultation responses have been analysed as part of the review process; alongside information from attendance at meetings of professional bodies and visits to services supporting children and families. Analysis of all publically available Fatal Accident Inquiries (FAIs) and Significant Case Reviews (SCRs) has been undertaken. Recommendations included in this report were developed with the Review Group and this Report was submitted to the Minister for Childcare and Early Years, Mark McDonald MSP at the end of December 2016.

1.13. The Report of this Review is divided into three sections. The first section provides an **overview of the existing child protection structures in Scotland, how they originated and how they are currently used**. The second section reflects the Review Group's findings and discusses three **thematic areas that the Group considered to be critical to improving the protection of children: Leadership, Governance and Accountability; Developing a Learning Culture; and Shared Values**. Recommendations for future approaches are presented throughout this section. The final section provides a conclusion and appendices, including a glossary and list of acronyms, for those readers requiring additional information.

2. Background on Child Protection Structures in Scotland

Child Protection Committees

2.1. Child Protection Committees are not creations of statute. They were first established in Scotland across each local authority in 1991. Since then, they have been subject to reforms and review. The Scottish Executive's Child Protection Reform Programme (2003-2006) resulted in national guidance, Protecting Children and Young People: Child Protection Committees (2005). **Child Protection Committees** (CPCs) are current strategic fora for local interagency child protection partnerships. They are locally-based, inter-agency strategic partnerships responsible for the design, development, publication, distribution, dissemination, implementation and evaluation of child protection policy and practice across the public, private and wider third sectors in their local authority locality and in partnership with all those working in child protection across Scotland. Their role, through their respective local structures and memberships, is to provide individual and collective leadership and direction for the management of child protection services within their local remit and to contribute to the provision of effective child protection across Scotland. They work in partnership and are accountable to their respective Chief Officers, comprising of Local Police Commanders and Chief Executives of Health Boards and Local Authorities, and the Scottish Government to take forward

child protection policy and practice. Through this structure, they are democratically accountable to local elected members.

Child Protection Registers & Case Conferences

2.2. There is no legal requirement for the use of Child Protection Registers, Child Protection Case Conferences or Child Protection Plans in Scotland; however, these are all core components of the formal child protection processes outlined in the National Guidance for Child Protection in Scotland (Scottish Government, 2014).

2.3. When there is a concern that a child (including an unborn child) or young person is considered to be at risk of significant harm, an inter-agency Child Protection Case Conference is arranged by the relevant local authority social work department. The conference will be informed by an investigation of concern which is usually undertaken on a multi-agency basis. A **Child Protection Case Conference** involves a range of relevant professionals, family members and the child (if appropriate) and will consider whether a multi-agency Child Protection Plan and/or review of an existing Child's Plan is required to reduce the risk of significant harm to the child. A Lead Professional who is responsible for co-ordinating the work will be identified. The Case Conference will decide whether to place the child's name on a Child Protection Register or where there is a need for Compulsory Measures of Supervision in which case a referral to the Children's Reporter is required (if this has not already been done). In 2014-2015, just over 6000 Child Protection Case Conferences (excluding reviews) were held in Scotland; of these, 73% resulted in a child being placed on the Child Protection Register (Scottish Government, 2016a).

2.4. All local authorities are responsible for maintaining a central register for their authority area of all children – including unborn children – and young people who are the subject of an inter-agency Child Protection Plan. This is called a **Child Protection Register**. The register is an administrative tool designed to alert practitioners that there is sufficient professional concern about a child to have warranted an inter-agency Child Protection Plan being in place. A child

and family are supported by a Core Group of those professionals who are involved in delivering the Child Protection Plan. The **Core Group** are critical in working directly with the child and family to reduce the risk of harm to that child. The Child Protection Plan will be reviewed at a subsequent multi-agency Case Conference for the professionals to consider evidence of any progress which has reduced the risk and to decide whether there is still a risk of significant harm requiring the child to remain on the Child Protection Register.

2.5. In 2015, around 3 in every 1000 children under 16 were on a Child Protection Register in Scotland; however, there is variation across Scottish local authorities in the rates of registration on the Child Protection Register (Scottish Government, 2016a). Children can be placed on a Child Protection Register before they are born; around 5% of registrations are for unborn children. Just over half of all children on Child Protection Registers are under the age of five (Scottish Government, 2016a).

2.6. Over the last fifteen years there has been an upward trend in Child Protection Registrations; between 2000 and 2015 there was a 34% increase in the number of children on a Child Protection Register (Scottish Government, 2016a). The most common concerns (and there can be multiple concerns with an average of 2.5 concerns per child) identified at Child Protection Case Conferences for children who were subsequently placed on the Child Protection Register were: emotional abuse (39%), neglect (37%) parental substance misuse (36%), domestic abuse (35%), non-engaging family (24%), parental mental health (23%), physical abuse (22%), and sexual abuse (9%). Around one in six children who are on a Child Protection Register had previously been on a Child Protection Register (Scottish Government, 2016a).

2.7. The Children's Hearings System is the legal system in Scotland which plays a key role in the care and protection of children where it is decided that compulsory measures are needed. Around 13,688 children were referred to the Children's Reporter on care and protection grounds in 2015/16; this equates to 1.5% of children and young people in Scotland under the age of 16 (SCRA, 2016). Lack of parental care was the main reason for a care and protection

referral (41%); followed by 1874 referrals due to a child being a victim of a Schedule One offence (14%) (SCRA, 2016:9) (see Appendix E for a Glossary of terms). In an audit of Child Protection Orders between 1st October and 31st December 2013 conducted by the Scottish Children's Reporter Administration, just over a quarter of Child Protection Orders (27%) were for pre-birth children with the most common established ground being 'lack of parental care' (77%) and the majority of children were consequently looked after away from their birth parents (70%). (Henderson & Hanson, 2015).

Significant and Initial Case Reviews

2.8. A **Significant Case Review** (SCR) is instigated when a child dies, or is discovered to have been exposed to or suffered significant harm and the Child Protection Committee considers that a Review is necessary because the undernoted circumstances apply.

2.9. **When a child has died** and the incident (or accumulation of incidents) gives rise to significant/serious concerns about professional and/or service involvement or lack of involvement, and one or more of the following apply:

- Abuse or neglect is known or suspected to be a factor in the child's death;
- The child is on, or has been on, the Child Protection Register or a sibling is or was on the Child Protection Register. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear to the Child Protection Committee that the child having been on the Child Protection Register has no bearing on the case;
- The death is by suicide or accidental death;
- The death is by alleged murder, culpable homicide, reckless conduct, or act of violence;
- At the time of their death the child was looked after by, or was receiving aftercare or continuing care from, the local authority.

When a child has not died but has sustained significant harm or risk of significant harm as defined in the National Guidance for Child Protection in Scotland (Scottish Government, 2014), and in addition to this, the incident (or the accumulation of incidents) gives rise to serious concerns about professional and/or service involvement or lack of involvement, and the relevant Child Protection Committee determines that there may be learning to be gained through conducting a Significant Case Review (Scottish Government, 2015).

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

2.11. There can be a range of concurrent or sequential proceedings which occur when a child or young person dies or has experienced significant harm. These may include criminal proceedings, formal Inquiries, professional disciplinary procedures and local reviews. Neo-natal deaths are subject to a **Sudden Unexpected Death in Infancy Review** (SUDI), where there is an unexplained death of a child under two years old. The circumstances and agency responsibilities in respect of all children who die while 'looked after' are reviewed by local authorities and the Scottish Government, and are the subject of a statutory report to Ministers.

2.12. **Fatal Accident Inquiries** (FAIs) are inquiries conducted in public before a Sheriff when children die in custody or where the Crown Office and Procurator Fiscal decide an Inquiry is in the public interest. Between 2000 and 2015 there were 27 Fatal Accident Inquiries into the deaths of children and young people

under eighteen years of age. Of these, four were concerned with deaths of five children or young people known to the authorities because of concerns around their safety as a result of parental behaviour or their own risk taking behaviour. In one case where the young person had committed suicide the Sheriff had no criticism of the professionals involved in the care of the young person. In two cases there had been criminal proceedings against adults in connection with the circumstances which led to the deaths occurring; in the first case a parent and in the second case against a person known to the young person who had supplied them with drugs which caused the death. In the latter case the Sheriff stated that the levels of care that the young person had received from health and social work professionals were of the highest level. In the other case the Sheriff determined that the death might have been avoided if the agencies involved had obtained all the pre and post birth information available across a number of organisations' records and there had been better communication between them allowing better assessment of risk to the child leading to different decisions being taken. In the FAI into the suicide of two children, the Sheriff determined that there were other actions which the professionals involved could have taken by which the deaths might have avoided, including the provision of all information and better communication.

2.13. In 2016, the Care Inspectorate published a triennial review of Significant Case Reviews in Scotland. Between 1 April 2012 and 31 March 2015, twenty Significant Case Reviews concerning twenty-three children and young people were submitted to the Care Inspectorate from fourteen Child Protection Committees (Care Inspectorate, 2016). The profile of children was very similar to the earlier Vincent and Petch study (2012) in relation to gender and age, with limited data on ethnicity, socio-economic circumstances and no recorded disability. Eleven children had died (five infants or pre-school and six young people aged 15-17 years old) and twelve children had been significantly harmed or were at risk of harm. The fatalities included drowning, physical injury, drug overdose, suicide, accident and sudden unexpected infant death. In over half of the cases, parental mental health was a factor, as was a similar rate for domestic abuse. Parental substance misuse was documented in over half of all SCRs and was a feature in all five cases involving the death of an

infant or pre-school child. As with the findings of Vincent and Petch (2012), the vast majority of children (87%) had social work involvement; furthermore, three children were on the Child Protection Register and a further two children had their names recently removed from a Register (Care Inspectorate, 2016). The Care Inspectorate concluded that there is a need to improve the consistency and quality of Significant Case Reviews and confirmed that SCRs were not always clear on what needed to improve and how this would be monitored by Child Protection Committees (Care Inspectorate, 2016). There is currently no national data on the number of Initial Case Reviews conducted in Scotland or comparative audit.

3. Overarching Themes

3.1. As part of the review process, three overarching and cross-cutting themes were identified as critical to improving processes and structures in order to protect children and young people more effectively: Leadership, Governance and Accountability; Developing a Learning Culture; and Shared Values. These themes emerged through discussion and debate held by the Review Group based on four background papers which considered: Child Protection Committees, Child Protection Registers and Case Conferences, Significant and Initial Case Reviews, and the experiences of children and families of child protection processes. Review Group members also facilitated the collation of over forty written consultation responses to inform discussions and which were subsequently analysed. A matrix table has been developed for the reader to show the interaction of themes and formal processes in regards to the recommendations (see Appendix G).

4. Leadership, Governance and Accountability

Sharing a Vision for Protecting Children and Young People

4.1. **Leadership is a critical factor in creating a system with effective processes and culture to ensure children and young people are protected from abuse and neglect.** To deliver the shared aspiration for Scotland to be a safe place for children, in their families and communities, there needs to be action at a local and national level and a strong collective voice that can be heard by children, young people and adults that the abuse or neglect of a child or young person in twenty-first century Scotland is not acceptable. This responsibility is shared by the public and all authorities; so far as public bodies and relevant agencies are concerned, all have obligations under their regulatory frameworks and professional codes of practice to protect children and young people.

4.2. The Scottish Government and Scottish Ministers demonstrate their leadership role by communicating their commitment to protect children and young people and by driving forward improvements in child protection policy and practice to better meet the needs of children and young people at risk of abuse and neglect. Scottish Ministers should continue to strongly support the GIRFEC approach in ensuring children, young people and families are provided with the right help, at the right time from the right people. The importance of early intervention to tackle the root causes of the risks of harm and social disadvantage is reflected through national social policy agendas (for example, Equally Safe, Equally Well, Scottish Attainment Challenge, Early Years Collaborative). In a critical leadership role, the Scottish Government and Scottish Ministers are required to ensure that policy agendas are connected across Government to deliver synergy of vision for children and young people across the policy landscape.

4.3. Scottish Ministers and public bodies have a duty to report every three years to Parliament on the steps taken to support the UNCRC under Part One: Rights of

Children in the Children and Young People (Scotland) Act 2014 and will need to include information on the steps they have taken to protect children and young people from all forms of violence, abuse, neglect and mistreatment (Article 19) and protect children from sexual abuse and exploitation (Article 34).

4.4. There is always a balance to be struck between delivery of services to meet local needs and achieving desired national outcomes. This aspiration requires a strong national voice of those professionals involved to promote better understanding of common issues and pursue solutions collaboratively. From the inception of the Scottish Parliament there have been a number of reviews and consultations which have involved representatives from the organisations involved in child protection. As noted in the introduction, if it is to be successful, child protection work necessarily requires input and collaborative working from thousands of staff across multiple organisations at strategic and several managerial levels in order to properly support those involved in front line casework. Although referred to as 'a system' it consists of a number of organisations with distinct core functions and with very different boundaries, resources, governance and accountability routes. For example, Police Scotland and the NHS are key contributors to the system. Both are national bodies but deliver locally through 13 Police Divisions and 14 Health Boards which are not coterminous. There are 32 Local Authorities and 30 Child Protection Committees. Third sector services, which provide support for many Child Plans, vary considerably across Scotland. The complexity of this delivery and resourcing landscape adds further dimensions of challenge to front line professionals already dealing with some of the most sensitive issues while striving to achieve the best outcomes for each individual child and young person in need of protection.

4.5. Child Protection Committees at a local level are often required to address issues which are common to their counterparts in other locations. The Review Group has observed this can cause significant duplication of effort, as well as a lack of consistency, both of which, in some instances, can affect the quality of work delivered. Greater coordination to strengthen and support practice across the country, such as provision of nationally developed training materials,

access to expert reviewers who have the competencies required to deliver high quality Significant Case Reviews, common data and management information sets could better support Child Protection Committees to facilitate improved effectiveness. Agreement around common styles of reporting on the adequacy and effectiveness of arrangements to protect children and young people locally; sharing of learning and good practice across all relevant organisations and locations; providing materials to all CPCs so that they are at the forefront of understanding current and new risks to children and young people in Scotland; and coordination of national campaigns aimed at raising public awareness around how to keep children and young people safe and what to do if there is a concern are further examples of work which could benefit from a sector-led collaborative approach. In addition to achieving greater consistency this should also free up resources currently engaged in actions which are duplicated across local authorities and the other organisations to increase the resources available to them for other areas of child protection work.

4.6. **The introduction of a body, such as a National Child Protection Leadership Group with senior leadership representation from the organisations which have responsibilities for scrutiny and delivery of child protection, could assist the whole sector by providing national strategic oversight and mechanisms for improvement across Scotland.** It could own a programme of continuous improvement while at the same time ensure that the impact of any proposed policy changes was properly understood and taken into account before changes were pursued. It would provide a united and visible point of contact for policy makers and public sector organisations with other responsibilities to make sure any changes in legislation or service provision take into account the needs of, and impact on, child protection matters. For example, the Leadership Group could work with the Care Inspectorate, Child Protection Committees Scotland and the Child Death Review National Resource Centres which are currently being developed, to identify themes and develop national public awareness campaigns to prevent deaths and significant harm in the future. Scottish Ministers should define the membership and chairing arrangements of the Leadership Group and attend an

annual meeting to receive progress reports. Secretariat support from the Scottish Government could assist in the administration of the meetings. This would demonstrate a commitment to ensuring consistency, where that was appropriate, and promote a learning culture across all organisations involved in child protection, at all levels.

4.7. A strong and coherent vision at a local level is essential to ensure that children are protected now and in the future. Clear leadership from Chief Officers' Groups, comprising of Local Police Commanders and Chief Executives of Health Boards and Local Authorities, play a vital role in ensuring high standards of child protection and support in their area. Chief Operating Officers for the Integration Joint Boards (where in existence) also have a key role. In the light of the changing structures and environment in which CPCs and Chief Officers are operating, CPC Chairpersons and Chief Officers need effective governance and scrutiny mechanisms. Defined roles and relationships are critical in proactively promoting the importance of child protection in the crowded landscape. Child Protection Committees need to be supported and also held to account by Chief Officers' Groups and elected members.

4.8. The National Guidance for Child Protection in Scotland (2014) describes the core role and functions of Child Protection Committees. There needs to be an environment to enable these functions to be fulfilled by all partners and clear articulation of how Child Protection Committees and Chief Officers' Groups interact with other strategic bodies to meet their core functions in relation to Child Protection.

4.9. Strong leadership and vision requires the Chairperson and all members of Child Protection Committees to have a clear role and remit. To be effective, the CPC must have committed membership from the local representatives at a strategic level and sufficiently senior to commit the organisation to action from across health, education, social care, police, relevant service providers and the third sector. It is critical that every member understands their role on the CPC. This is particularly important due to the level of structural changes within health and

social care (Audit Scotland, 2016). The CPC should be open to learning and development opportunities. This should involve a regular review of membership and a sign up to a collectively agreed direction of travel.

4.10. The Chairperson of a Child Protection Committee has a critical role and clear responsibility for the vision and aspirations around protecting children and young people in their local area. The Review Group recognised that a crucial skill is the ability to challenge and influence partners, Chief Officers and elected members. While CPC chairs may have different backgrounds (some are recruited externally, whilst others are professional officers of the Local Authority or professional officers of another Community Planning Partner e.g. Police), the Review Group considers that the focus should be on the qualities of each individual Chairperson and CPC member, relative to a clear job description and person specification. To improve quality and consistency of these two documents, national standards could be developed. Furthermore, supporting national standards could include a requirement to participate in national meetings and learning events provided by Child Protection Committees Scotland and others.

4.11. The Chief Social Work Officer (CSWO) has a key professional leadership role in local authorities and beyond. The overall objective of the CSWO is to ensure the provision of effective, professional advice to local authorities, including elected members and officers, regarding the authorities' provision of social work services. The post should assist the authority in understanding the complexities of social work service delivery – including in relation to particular issues such as corporate parenting, child protection, adult protection and the management of high risk offenders - and also the key role social work plays in contributing to the achievement of national and local outcomes. The Audit Scotland (2016) Social Work in Scotland report highlights the CSWO role requires attention and protection at a time of significant structural change.

Legislative Framework

4.12. There is no legislative expression of the role and function of Child Protection Committees in Scotland. CPCs duties include planning services to safeguard, support and promote the wellbeing of children and young people. For example, the Children (Scotland) Act 1995 (section 19) is revised by the Children and Young People (Scotland) Act 2014 which outlines the duties and planning arrangements that should be in place for children's services and partners (from 1st April 2017). Under the Adult Support and Protection (Scotland) Act 2007 (section 42), Adult Protection Committees have been placed on a statutory footing. In a minority of areas, there has been integration of Adult Protection Committees and Child Protection Committees or appointment of a joint chair.

4.13. In England and Wales, Local Safeguarding Children's Boards were placed on a statutory footing in response to the previous non-statutory Area Child Protection Committees being deemed to have performed poorly in some areas and research suggesting their lack of statutory power had limited their effectiveness. However, the Wood Review found that 'the duty to cooperate is not a sufficient vehicle to bring about effective collaboration between the key agencies of health, the police and local government' (Wood, 2016:7). The Review Group noted that while legislation can be used to reinforce the structures, and in some instances the processes, to be used nationwide, legislation alone does not provide solutions to the issues caused by cultural and organisational barriers and that such solutions are needed to deliver improved effectiveness and consistency.

4.14. A number of recent reports have considered the strengths of and potential challenges to the child protection system in Scotland, given overall governance takes place in such a complex landscape (Brock 2014; Care Inspectorate 2014a, 2014b, 2015a). Child Protection Committees should have strong connections to other public protection fora; for example, Multi-Agency Public Protection Arrangements (MAPPA), Alcohol and Drug Partnerships, Violence against women forums. Brock highlighted issues caused by the 'current sprawling landscape of policies, guidance, funding streams and initiatives' for

planning children's services and 'how the replication 32 times at Community Planning Partnership (CPP) level will present inevitable challenges, particularly with overlay of local policy and operational and protocols' (Brock 2014:13). Brock's recommendations specific to Child Protection Committees include the need for the Scottish Government, Chief Officers and Child Protection Committees to review the impact of Health and Social Care Integration and for Child Protection Committees to set out proposals in their annual reports to raise community awareness of their work. There is recognition that legislation, policy and planning processes can be confusing, especially with health and social care integration leading to different structural and governance arrangements (Audit Scotland, 2016).

4.15. The Review Group identified the need to strengthen alignment in the child protection processes interacting with the Children's Hearings System. Some variations in when children and young people were referred to the Reporter were apparent, particularly given that the placing on the Register indicates significant concern in terms which could lead to compulsory measures being required. There were examples of children and young people having been placed on the Register more than once before being referred to the Children's Reporter. The group considered that a discussion with the Reporter about a potential referral should form part of the action prior to a decision at a Case Conference and the reasoning behind any decision not to refer the child or young person to the Reporter should be clearly recorded if that was the outcome of the Case Conference.

4.16. Children and young people placed on the Child Protection Register are considered to be at risk of significant harm and require a Child Protection Plan. Each of the 13 Divisions in Police Scotland has a 'Concern Hub' where officers report information about concerns they have identified suggesting a child, young person or adult is vulnerable and at risk of harm. The Hub places this information onto the national Vulnerable Persons Database (VPD). This is then used to ensure that officers attending incidents or receiving reports from members of the public are aware of the previous history involving the vulnerable individual which may have been dealt with by other officers and can

alert officers to relationships which may give rise to concerns for the safety and wellbeing of the vulnerable individual which require further investigation or a referral to the Children's Reporter. The majority of referrals to the Reporter originate from situations where police officers come across circumstances where they consider a child or young person is at risk.

4.17. The Review Group noted that there is no single collation point regarding details of children and young people who have been or are currently on a Child Protection Register. Each Local Authority has a 'Keeper of the Register' and makes arrangements for an 'out of hours' service to respond to enquiries from relevant professionals in other organisations as to whether or not a child or young person is on that Register. Professionals can find it difficult to obtain information urgently on children and young people who have moved across Local Authority boundaries and may have been on a Register elsewhere. Therefore, there is an opportunity to explore the viability of a National Child Protection Register that can be securely accessed by all appropriate professionals. In the short term, it should be ascertained whether it is possible for Police Scotland to use a flagging system on the National Vulnerable Persons Database to identify all children placed on local Child Protection Registers.

4.18. Children can be placed on a Child Protection Register pre-birth up to the age of eighteen. However, many contributors to the Review felt that there was a lack of clarity regarding whether 16 and 17 year olds could be placed on a Child Protection Register. The Care Inspectorate (2016) triennial review of Significant Case Reviews included six fatalities of young people aged between 15 and 17 years old. The Review Group considered it particularly concerning that there appeared to be some legal ambiguities. There were different regional practices in whether 16 and 17 year olds could be provided with adult protection plans; in addition the adult processes available were described as having higher thresholds of risk.

4.19. A young person aged between 16 and 18 years old cannot be subject to compulsory supervision measures (unless they are a looked after child and have previously been subject to Compulsory Supervision Order prior to their 16th birthday). The Review Group considered that the Scottish Government should review and address the legal inconsistencies in current systems when protecting 16 and 17 year olds.

4.20. The Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016[2] makes provision for the holding of public inquiries in Scotland with respect to fatal accidents; deaths of persons in legal custody; sudden, suspicious and unexplained deaths; and deaths occurring in circumstances that give rise to serious public concern. Fatal Accident Inquiries (FAIs) are inquiries conducted in public before a Sheriff when children die in custody or where the Crown Office and Procurator Fiscal Service decide an Inquiry is in the public interest. In some instances full information regarding the whole circumstances may have been examined at a criminal trial or any relevant recommendations for consideration of professionals issued as a result of other official proceedings, such as a Critical Incident Review commissioned by the NHS. If Crown Counsel considers that there is nothing further which needs to be explored in the public interest, or require a specific determination to be sought by the Crown from a Sheriff, then they will not instruct a FAI.

4.21. The Review Group identified a lack of clarity about whether SCRs could be conducted when fatalities investigations, Fatal Accident Inquiries or criminal proceedings were ongoing. A Crown Office, Police Scotland and Child Protection Committees protocol had been developed in 2014 to avoid any unnecessary delays to SCRs where potential court proceedings were being considered. The protocol between the Crown Office, Police Scotland and Child Protection Committees on SCRs and criminal proceedings is being reviewed and will be further publicised in order to reduce delays in SCRs being concluded.

[2] Prior to 2016 it was the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

Raising the Quality Bar

4.22. The Care Inspectorate (2014a) described a '*mixed picture*' in relation to the arrangements for leading and delivering effective services to protect children and young people. The report considered key themes including leadership and direction through Child Protection Committees, child sexual exploitation and initiatives in the sector. Chief Officers' Groups and Child Protection Committees were described as '*continuing to make significant strides in improving the quality of services'* and themes relevant to the most effective Committees were highlighted, including:

- Effective leadership, solid partnership working and active, energetic working groups progressing key priority areas.
- Independent chairs and new structures have the potential to bring new perspectives and opportunities.
- Sound quality assurance systems adopted, with performance jointly monitored across relevant services and systematic approaches to joint self-evaluation.
- Results from quality improvement used to inform priorities and reinforce a collective commitment to meeting them.
- Good quality quantitative and qualitative data used for measuring and reporting on progress against agreed priorities.
- Strong links between the work of Child Protection Committees and integrated children's services planning.

4.23. The Care Inspectorate (2014a) report outlined their role in future work with Child Protection Committees, this included:

- Help develop a set of proxy indicators of improved outcomes for children in need of protection across the wellbeing indicators.
- Support the development of sound performance management information about the quality and effectiveness of key processes.
- Promote joint reporting about public protection by Child and Adult Protection Committees and encourage committees to consider how best to report on their business plans, standards and the quality of their performance.

- Support and challenge Child Protection Committees to consider why there are very low numbers of children and young people being placed on the Child Protection Register because they are at risk of sexual abuse.
- Monitor the impact of changing structures and re-organisation on strategic partnerships for public protection.

4.24. The work of the Care Inspectorate has provided valuable national and local learning opportunities to strengthen frontline practice, alongside strategic developments. There is a strong commitment to self-improvement approaches and appreciative inquiry to support professional practice at all levels. There is a growing body of evidence from inspection reports and reviews to build on and support improvements to child protection practices and policy across Scotland (Care Inspectorate, 2014a; 2014b; 2015a; 2015b; 2016).

Recommendations on Leadership, Governance and Accountability

Recommendation 1

A National Child Protection Leadership Group should be established in order to further support, strengthen and improve, from a national perspective, activity on child protection across Scotland. This group should report and account to Scottish Ministers.

Key tasks of the Leadership Group in Year 1 should be:

- Oversight of implementation of the recommendations of this report
- Review of the arrangements for child protection across current planning and service delivery processes, including Integration Joint Boards (IJB) and in relation to the duties set out in the Children and Young People (Scotland) Act 2014.

Recommendation 2

Chief Officers should be supported by the National Child Protection Leadership Group and Child Protection Committees Scotland to strengthen delivery of their responsibilities, as set out in the National Guidance for Child Protection in Scotland (2014), and to identify areas where further work may be required, such as:

- Clarity of reporting mechanisms between Child Protection Committees and Chief Officers' Groups
- Descriptions of the roles and responsibilities of Child Protection Committees (including that of Chairs of CPC's) and Chief Officers' Groups
- Supporting Child Protection Committees to carry out their roles and functions in line with the requirements set out in National Guidance.

Chief Officers should pro-actively engage with and report to elected members and other local scrutiny bodies as the local representatives of their communities and provide opportunities to listen to community concerns and hold learning events at a local level.

The Scottish Government should resource a number of regional leadership events via the Leadership Group for all Chief Officers' Groups and Chairpersons of Child Protection Committees to network, share good practice and collectively horizon scan for new risks facing children and young people.

Recommendation 3

It is critical that the Chief Executive of each local authority, working with the Chief Officers' Group, ensures that Chief Social Work Officers have sufficient support to provide professional leadership, advice and scrutiny across all public protection

matters (including child protection) given their key statutory responsibilities within the local authority.

Recommendation 4

The Scottish Government should review both the measures available to protect 16 and 17 year olds and whether the Children's Hearings (Scotland) Act 2011 should be amended to allow any young person aged 16 and 17 years old to be referred to the Principal Reporter where there is a need for compulsory measures.

Recommendation 5

When a Child Protection Case Conference is held, whether or not a child is placed on the Child Protection Register and at any subsequent points when the child protection plan is reviewed, a referral to the Reporter should be considered and the decision on referral should be clearly recorded.

Recommendation 6

The development of a National Child Protection Register that can be securely accessed by all appropriate professionals should be explored. In the short term, it should be ascertained whether it is possible for Police Scotland to use a flagging system on the National Police Vulnerable Persons Database to identify all children placed on a local Child Protection Register.

5. Developing a Learning Culture

Learning from Significant and Initial Case Reviews

5.1. Working with children who are at risk of significant harm and their families is incredibly complex and challenging. It is imperative that all professionals in local front-line roles, operational management, strategic and national roles are committed to a continuous learning approach. Understanding professional practice in this context requires 'a common theoretical framework that helps individuals and organisations move beyond apportioning blame to learning together about what is helping and what is hindering efforts to help children, young people and families' (Munro, 2011:63).

5.2. From the 1990s, there has generally been a shift from an inquisitional perspective when a child dies or suffers significant harm, to a learning perspective with a greater focus on contextualising professional practice in an ecological system. However, there continues to be a high level of political and public scrutiny that can impact on an open, reflective, learning culture and result in defensive practice. As Axford and Bullock (2005:55) argue in their international review, 'there is little point searching for a 'perfect' universal model', instead we need 'to avoid perceiving child death reviews as something isolated from other developments and practices and to view their function in the light of the wider child protection process and, indeed, the whole range of services for all children at risk of impairment to their health and development'.

5.3. Drawing on a public health approach, there should be a greater emphasis on prevention strategies in relation to child deaths and significant harm. Whilst there is a wealth of research evidence on child abuse and neglect, there has been far less attention on child fatalities and how the examination of these tragedies may allow development of effective prevention initiatives (Vincent, 2013; see also, Brandon et al., 2012). The Review Group considers that learning from Significant Case Reviews to prevent deaths might be more successfully framed from a public health perspective and could be linked to the

National Child Death Review System that is currently under development. It aims to ensure that information is collected in relation to all child deaths and learning shared to try to prevent future child deaths or contribute to child health and wellbeing (Scottish Government, 2016b). For example, in Australia, child death reviews are conducted on themes from which public awareness campaigns are developed.

5.4. Scottish Ministers asked the Care Inspectorate to become the central collation point and undertake qualitative evaluation on all Significant Case Reviews from 1st April 2012. The Care Inspectorate is required to report publicly on these findings to provide independent public assurance on the quality of care for children and young people; to share any learning and signpost good practice; and to support improvements to child protection practices and policy across Scotland (see Care Inspectorate, 2015b; Care Inspectorate, 2016).

5.5. As part of the inspection process with a focus on child protection arrangements, issues were identified about the decision-making processes and quality of Significant Case Reviews (Care Inspectorate, 2014a). In March 2015, the Care Inspectorate published a Code of Practice for the Review of Significant Case Reviews for children and young people in Scotland. The Code states that as part of a commitment to further improvement, the Care Inspectorate will:

> (a) seek information about all Initial Case Reviews (ICRs) carried out by Child Protection Committees (CPCs) to understand the rationale for proceeding or not proceeding to an SCR;
>
> (b) act as a central collation point for all SCRs completed across Scotland at the point at which they are concluded;
>
> (c) review the effectiveness of the processes for conducting each SCR and reporting informally to individual COGs and CPCs on good practice and areas of improvement;
>
> (d) conduct a biennial review of all SCRs completed in Scotland, and, reporting nationally on the key learning points for the benefit of relevant services across Scotland and the Scottish Government (Care Inspectorate, 2015b).

5.6. The Review Group were of the view that to ensure access to learning across professionals involved in child protection, all Initial Case Reviews should be

submitted to the Care Inspectorate for analysis and review, as well as any Significant Case Reviews; the Care Inspectorate should hold an annual learning event to disseminate findings from ICRs and SCRs at a national level; and Care Inspectorate reports should provide anonymised case studies to emphasise the learning points.

5.7. The Care Inspectorate (2016) reported on different methodological approaches for conducting SCRs and ICRs and shared concerns over the quality of analysis and consistency. A range of terminology was being used for different reviews and this was considered to be unhelpful. In the review period, four SCRs had used the Social Care Institute for Excellence (SCIE) Learning Together model and a further two used various aspects (Care Inspectorate, 2016). A number of local areas have stated a commitment to using this model for Significant Case Reviews in the future. The Social Care Institute for Excellence (SCIE) Learning Together model uses systems thinking to gain a deeper understanding of current local practice and cultivate an open, learning culture (SCIE, 2012). There was caution in proposing one methodological approach; however, there was agreement that the essential elements of a SCR and ICR should be set out in the Terms of Reference. The triennial review found that SCRs were not always clear on what needed to improve and how this would be monitored by Child Protection Committees (Care Inspectorate, 2016).

5.8. There was concern about the range of timescales for SCRs that did not always correspond to the complexity of the review or the methodological approach. For example, timescales in conducting SCRs varied from 5 months to 37 months (Care Inspectorate, 2016). Twelve SCRs were conducted by a single external reviewer (out of twenty) (ibid.). There was also discussion within the Review Group about there being little evidence based information around whether or not there were varying thresholds with regard to conducting ICRs and SCRs around the country. There was a perception that some conclusions of reviews were known with 48 hours of an incident, yet the process was much longer and often found what was expected. There was a particular interest in the multi-

agency professional forum approach used in Wales that could be appropriate for these cases (for more information see, Appendix F & Welsh Government, 2012).

5.9. There was mixed evidence on the national and local learning following a SCR and ICR. At a national level, there are limited learning opportunities arising from Initial Case Reviews. The Review Group considered this to be a missed opportunity as ICRs could provide a valuable understanding of child protection practice. Given the relatively small number of SCRs in Scotland and limited review of ICRs, themes could be identified from SCR and ICRs collectively. There was a concern that front-line staff are not fully involved in the dissemination and future action plans. There were some reflections that the cultural environment played a significant role in how the learning from SCRs and ICRs was considered and taken forward. The learning from SCRs and ICRs should not be considered in isolation. Although it is understandable that they are seen as a critical lens for protecting children and young people, they should only be one part of a wider improvement agenda for protecting children and young people. Local and national improvement programmes could consider sharing with the public and media system reviews where there has been learning of how children have been successfully protected when previously identified as being at risk of significant harm.

5.10. There were a range of views and experiences about the full or partial publication of SCRs. There is not a central accessible repository for all SCRs conducted to enable the sharing of information and learning across all professionals involved in child protection work. Routine publication of all SCRs could be highly sensitive for families, front-line practitioners and local areas. There was often media interest in the publication of the findings of SCRs. Examples were given where the level of redaction required to comply with data protection principles in SCRs not only delayed any publication of a summary of findings, but could severely limit learning opportunities. The Review Group considers that there could be an anonymised central repository held by the Care Inspectorate which could be accessed for research and learning (subject to appropriate research ethics procedures).

5.11. Given the issues raised regarding local and national learning, variability and timescales, the Review Group recommends that the Scottish Government should explore a new three-tiered approach to Initial Case Reviews and Significant Case Reviews, based on the 'Multi-Agency Child Practice Reviews' used in Wales (Welsh Government, 2012; see Appendix F for more information). This would involve establishing: multi-agency professional forums, concise reviews and extended reviews. In certain circumstances, reviews should focus on the previous 12 months rather than covering an extended period. It is anticipated that this approach would provide a more streamlined, flexible and proportionate approach to reviewing and learning from what are inevitably complex cases. This should ensure reviews are timely, proportionate and part of an on-going learning culture.

Engaging Communities

5.12. The Scottish Government and public service providers are committed to delivering public service reform as recommended by the Christie Commission. The Commission proposed an asset-based approach, where services are developed *with* people, rather than *for* people.

> 'We recommend that, in developing new patterns of service provision, public service organisations should increasingly develop and adopt positive approaches which build services around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience' (Christie Commission, 2011:27).

At the heart of the Christie Commission reforms are preventative approaches and early intervention to tackle inequalities across Scotland. This commitment is pertinent to the provision of child protection services and greater recognition of the role that children, young people, families and communities can play. There is an opportunity for community initiatives which protect, support and promote the wellbeing of all children and young people.

5.13. As set out in the National Child Protection in Scotland Guidance (2014:40), the core functions of Child Protection Committees include public information and

communication, alongside continuous improvement and strategic planning. This requires raising public awareness and involving children, young people and families. Public awareness may be focused on how a member of the public can notify appropriate services if they have concerns about a child. There may be particular areas identified (for example, raising awareness about online safety of children). There are also opportunities to consider the messages for families who are in need of support. In an English study with 42 families, the importance of publicising positive outcomes in child protection work was emphasised by one parent:

> 'People think they (social workers) are there to take your kids away, but they're not. They are there to help you. I think they need to …. make people understand that' (Ghaffer et al., 2012: 900).

5.14. Community knowledge about child protection is likely to be principally known through media reporting of high-profile cases where a child or young person has died and/or experienced abuse and neglect. It was observed that the media often focussed on any comment in a SCR on past practice that could have been better; without clarifying that the practice was not directly linked to the harm occurring. National development of positive news stories about professionals protecting children and franker explanations of the complexities and challenges experienced by professionals who were seeking to prevent harm was considered by the Review Group to be likely to encourage better understanding of the issues and raise public engagement.

5.15. Elected members play a pivotal role in championing the work of Child Protection Committees and making strong links to Community Planning Partnerships and other strategic planning groups. Elected members can share concerns facing local communities in regards to protecting children in a CPC planning forum. They can provide insight and support on public awareness of child protection issues. Responsibility for local accountability in the allocation of resources also lies with elected members. Improved understanding of some of the complexity in working with children and young people at risk of significant harm and the value of early intervention for local authority decision-making would be valuable.

Improving Analytical use of Data and Evidence

5.16. The ability to analyse complex data is critical to developing services to protect children and young people at a local and a national level. Part 3 (Children's Services Planning) of the Children and Young People (Scotland) Act 2014, requires every local authority and its relevant health board to jointly prepare a Children's Services Plan for the area of the local authority, in respect of each three-year period. Part 3 aims to improve outcomes for all children and young people in Scotland by ensuring that local planning and delivery of services is integrated; focused on securing quality and value through preventative approaches; and dedicated to safeguarding, supporting and promoting child wellbeing. **This demands that systems be put in place to regularly collect and analyse information relating to service performance and child wellbeing.**

5.17. An understanding of national and international evidence on identification, referral, service provision and long-term outcomes for children and their families should be used to inform the work of Child Protection Committees. The Review Group considers that it would be valuable to examine the reasons behind apparent variations in patterns of child protection registration across the country. One area that has been identified as having a significant impact on child abuse and neglect, but where data is rarely analysed from this perspective, is the socio-economic circumstances of families (Bywaters, et al., 2016). For example, the Care Inspectorate's (2016) review of Significant Case Reviews found that economic circumstances of families were often not recorded; however, frequent housing problems suggested material hardships.

5.18. Such information should come from a range of sources, and include both quantitative and qualitative data. The views of children, young people and families, and front-line professionals will be particularly valuable in making assessments of progress (in respect of children and young people feeling safe). Moreover, useful information will already be stored in the information management systems of Children's Services Planning partners, and by service providers, offering detailed insight into how services are working for specific

groups of children. Careful consideration must be given to how such information is collected, anonymised, collated and analysed, ensuring at all times that is done in appropriate, safe and proportionate ways, in line with current data protection legislation and guidance.

5.19. Scottish Government programmes, such as, Realigning Children's Services (RCS) can assist local authorities and relevant health boards in the development of local assessment. The RCS team helps local areas to: (1) collect data on wellbeing directly from children and parents; (2) map children's services that are currently provided and how much they cost; and (3) deliver a development and facilitation programme for community planning partners. This may be a useful resource for some Child Protection Committees. Identification of patterns and trends in referrals where there are concerns about abuse and neglect at a local level from a range of sources can inform strategic planning forums. The use of Information Technology systems across organisations also provides an opportunity to explore sharing data sources over a number of interlinked areas - for example, educational attainment, school exclusion rates, household deprivation, neighbourhood crime, missed health appointments, Accident & Emergency admissions, and missing from home incidents which could all be used to establish a picture of what is impacting locally on children and allow for more effective planning of services. This provides a wealth of information for Child Protection Committees where there is analytical capacity.

5.20. The 14 health boards in Scotland, under the auspices of the three Regional Planning Groups, have developed three regional Managed Clinical Networks (MCNs) for child protection, to support and facilitate the delivery of consistent, equitable, high quality services to meet the needs of children and young people who may have experienced abuse and their families. It was recognised that scant data existed across health boards to capture standardised information on all paediatric forensic activity, to provide the basis for robust governance, accountability and audit arrangements. The three regional MCNs have developed a standardised data collection tool with a minimum dataset which doctors who perform child protection assessments on children and young

people will be expected to complete, from January 2017. The information collected will feed into and relate to other data collection systems to inform the work of Child Protection Committees. It could also enhance the ability to 'horizon scan' for future risks for children; for example, sexual exploitation of children via the internet will evolve further with future technological advances.

5.21. Building on the expertise of data linkage programmes used in other public services arenas, there is also an opportunity to develop better understanding of children and young people's wellbeing at an individual, as well as a macro level, through connecting health, education, social work and other relevant information sources to gain a holistic understanding of children's lives to develop services that will meet their individual needs.

5.22. Information which might provide an earlier holistic overview of all matters affecting a child, and potentially highlight emerging risk at a very early stage, is not available from any one central record. Separate records relevant to each child or young person are held by the organisations employing each professional working with the child or young person. Access to these records is not given to the professionals in other organisations. Criminal Justice social workers do have access to a national Information Technology (IT) system which holds information from across all local authorities on the adults they are engaging with, but social workers working in child protection can only access the social work information held by their own local authority IT system. Records of adult social work engagement with adults in a family where there are children are also retained separately. The professionals in police, health and education cannot access each other's systems or social work records and there is no national IT facilitated access sharing of appropriate relevant information, while maintaining necessary constitutional independencies and data protection requirements, such as occurs between police, prosecutors, courts, criminal justice social workers and prisons. This is an area which would benefit from further consideration by the proposed National Child Protection Leadership Group.

Recommendations on Developing a Learning Culture

Recommendation 7

The Care Inspectorate should become the central repository for all Initial and Significant Case Reviews and should explore the development of a 'Community of Practice' portal on the Care Inspectorate website to enable secure access to all Reviews by child protection professionals in all relevant organisations.

Recommendation 8

The Scottish Government should explore a new tiered approach to and methodology for, Initial Case Reviews and Significant Case Reviews, based on the 'Child Practice Review' model used in Wales.

Recommendation 9

A set of National Standards should be developed setting out the skills and competences required of those reviewers undertaking Initial Case Reviews and Significant Case Reviews. Appropriate involvement of the child or young person and their family should be a key component of training for reviewers and a Good Practice Guidance Note should be developed on how to engage with children, young people and families involved in Child Protection processes. This should ensure all Reviews are timely, proportionate and contribute to an on-going learning culture.

Recommendation 10

The National Child Protection Leadership Group and Child Protection Committees Scotland should support local areas to deliver robust continuous improvement programmes. This should include working with relevant organisations to synthesise and share learning from different sources including inspection, research, reviews and local practice.

The Data and Evidence work stream of the Scottish Government Child Protection Improvement Programme should develop a strategic programme to deliver robust data sets to support child protection improvement. Scottish Government should develop a national resource for advice on using child protection data for local planning and service development.

6. Shared Values

Supporting Children and Young People

6.1. The United Nations Convention on the Rights of the Child (UNCRC) 1989 requires states to protect children from all forms of violence, abuse, neglect and mistreatment (Article 19) and protect children from sexual abuse and exploitation (Article 34). The Getting it Right for Every Child (GIRFEC) approach is underpinned by early intervention and supporting families at times of difficulty. This applies to children from birth to eighteen years old. Children and young people can experience abuse and neglect at any stage of their childhood or find themselves in harmful situations and governments must take a preventative approach, alongside providing support for those children who have experienced abuse and neglect.

6.2. Research indicates that the majority of abuse and neglect of children occurs within families (Gilbert et al., 2009). For some children and young people, physical, sexual and emotional abuse occurs out with the family; for example, by an adult in a position of trust known to the child or young person (such as a teacher, nursery worker, youth worker, cleric, residential worker), a person within the community and, to a lesser extent, 'stranger' abuse. There is an increasing awareness about children or young people who are being sexually exploited and abused via the internet. Child protection concerns are also about those who have been abused through human trafficking. In a minority of children and young people's experiences, abuse can be inflicted by another child, rather than an adult.

6.3. International research estimates that disabled children face a three to four-fold increased risk of abuse compared to their non-disabled peers (Jones et al., 2012; Sullivan and Knutson, 2000). Yet little is known about disabled children's experiences of formal child protection processes and it is imperative to make the child protection system more accessible and sensitive to disabled children's needs (Stalker et al., 2010; Taylor et al., 2015).

6.4. There has been little attention focused on children and young people's experiences of formal child protection processes in Scotland and the rest of the United Kingdom (Action for Children et al., 2010; Bruce, 2014; Cossar et al., 2011; Elsley et al., 2013). As highlighted in the Munro Review of Child Protection in England,

> 'Children and young people are a key source of information about their lives and the impact any problems are having on them in the specific culture and values of their family. It is therefore puzzling that the evidence shows that children are not being adequately included in child protection work' (Munro, 2011:25).

6.5. In a small-scale Scottish qualitative study, eleven children and young people (six aged between twelve and fifteen years, five aged sixteen years or over) were interviewed about their experiences of the child protection system in one Scottish local authority (Woolfson et al., 2010). Their recommendations for improving the child protection system included: involving children and young people more in the decision making process; ensuring that outcomes which were initially agreed between the authorities and young people should either be carried out or explanations given as to why this will not occur; allowing young people an opportunity to attend, or to be represented, at Child Protection Case Conferences; providing full information throughout the child protection process; and encouraging families to have greater involvement in decision making.

6.6. The National Guidance for Child Protection in Scotland is explicit about the involvement of children in child protection processes:

> 'Children should be helped to understand how child protection procedures work, how they can be involved and how they can contribute to decisions about their future. This may be supported by accessing advocacy services. Taking into account the age and maturity of the child or young person, they will often have a clear perception of what needs to be done to ensure their own safety and wellbeing. **Children should be listened to at every stage of the child protection process and given appropriate information about the decisions being made** (Scottish Government, 2014:92).'

6.7. Children and young people should be provided with information about the child protection processes to ensure they understand the procedures and have opportunities to participate in the process. There were strong messages from some Review Group members, and organisations supporting children and young people in advocacy roles, that **current practice of involving children and young people in child protection processes was not consistent or widespread and could be improved**. Local examples of good practice in involving children were shared with this Review; but these varied across different areas and did not include information in a range of formats for younger children, for children and young people whose first language was not English, or those children with a range of communication needs. Development of a series of national resources could avoid repetition and duplication of effort for local areas and support the sharing of innovative practice.

6.8. There has been growing interest in the use of Family Group Conferences and the 'Signs of Safety' approach where a child has been identified as being at risk of significant harm (see Bunn, 2013; Frost et al. 2014; Salveron et al., 2015). These approaches have been explored primarily by local authorities either 'in house' or as a commissioned third sector service. A minority of local authorities have an independent advocacy service for children (aged 5 to 16 years old) involved in child protection meetings. In these examples, skilled and sensitive workers support children via careful preparation to express their views in person, at meetings via their advocate, in written form or more user-friendly technology (such as creating a short video and sometimes by the child or young person being represented by an 'avatar' character).

6.9. The role of the Chairperson at the Case Conference is critical in creating a positive and supportive environment for a child to participate. These meetings can be upsetting or distressing for a child or young person, especially if they are unprepared and unsupported. Where children did not attend in person, positive examples were given of the impact on professionals and family members of sharing a video made by the child expressing their views or the

simple use of a photograph of the child being shown throughout the meeting to ensure that everybody stays focused on the needs of the child.

6.10. The provision of advocacy for children and young people involved in child protection processes is limited. There was no information seen by the Review Group suggesting consistent provision of independent advocacy for very young children or young people over the age of 16. A Strengthening Families Conference model has been piloted in England which uses a strengths based, outcome focused, approach underpinned by the child's or young person's right to participate (Aldridge, 2012). As the model evolved, a shift from 'opt in' to 'opt out' independent advocacy service for children was provided. To date, the Review Group is unaware of this complete model being used in Scotland, although there was reference to different components being implemented in some locations. Another model described is the use of a 'child buddy' system for child protection where a person who is already known and trusted by the child or young person is supported to take on an advocacy role where there are child protection meetings. One of the advantages of this approach is the on-going supportive relationship the adult has with the child or young person.

Working with Families

6.11. The Getting it Right for Every Child (GIRFEC) approach is underpinned by providing the right help, at the right time from the right people to children, young people and their families from birth to eighteen years old. Families and communities are the fundamental foundation of providing the everyday care for children. All families can face unexpected challenges and circumstances can change quickly; for example, a child may become at risk of significant harm due to the behaviour of a parent's new partner or an adolescent's risk-taking behaviour may become a serious cause for concern.

6.12. Work with parents and carers needs to be underpinned by a partnership approach using the National GIRFEC Practice Model where resilience, as well as vulnerabilities, in families is identified and supported. The participation of

parents in child protection processes can be framed by a wider discourse on service user participation, alongside a recognition that 'active parental involvement in intervention is more likely to lead to better outcomes for children at risk of abuse and/or neglect' (Jackson et al., 2016:2). However, it is recognised that there is a balance in supporting the involvement of families, whilst meeting the duty of care to protect children from abuse and neglect.

6.13. A small-scale qualitative study with twelve parents subject to statutory child protection intervention measures was conducted in one Scottish local authority. Initial Child Protection Case Conferences were experienced as 'distressing, intimidating, humiliating, frightening and disempowering' for parents and expressing their views was very difficult (Jackson et al., 2016:12). However,

> 'Parents were generally complimentary about their social workers and other professionals they worked with on an individual basis and often made a point of highlighting it was the process of a case conference that was problematic and not the individual professionals in attendance' (Jackson et al., 2016:13).

This study concludes, 'there was consensus amongst parents that professional intervention had *ultimately* been a good thing that had 'made a difference' (ibid.:14).

6.14. There are a range of approaches that can be used in child protection processes to support parental and wider family participation. There is international evidence that many families can engage positively in family decision making processes where there are child welfare concerns (Frost et al., 2014). Originating in New Zealand, the Family Group Conference model (FGC) consists of four distinct parts: preparation with the family; information giving stage at the start of the conference; private family time to develop a plan; sharing the plan with the co-ordinator and professionals for agreement. Increasingly there is recognition that a further step may be required for the family group to reconvene to discuss progress on implementing the plan at a later stage. The quality of the independent coordinator in mediating with family members is considered to be critical to the success of the FGC process. Whilst acknowledging that more research is required to demonstrate the outcomes of

children involved in FGC, the authors conclude that the evidence of participation is compelling:

> 'Studies of the experience of children and families using the FGC model suggest that FGC is a family-centred and strengths-based approach that promotes partnership between family and State, and can consequently act as an empowering process' (Frost et al., 2014:506).

6.15. One Western Australia model 'Signs of Safety'© aims to work collaboratively and in partnership with families and children to conduct risk assessments and produce action plans for increasing safety and reducing risk and danger by focusing on strengths, resources and networks that the family have. The approach is based on the use of Strength Based interview techniques, and draws upon techniques from Solution Focused Brief therapy (SFBT). There is no set time frame for the intervention. There is an ongoing evaluation of Signs of Safety approach in England (Bunn, 2013). A six year study on the implementation of Signs of Safety found a cultural shift in the ways in which child protection services were provided (Salveron, et al., 2015).

6.16. The views of parents and carers should always be recorded and taken into account, as stated in the National Guidance for Child Protection in Scotland (Scottish Government, 2014). Provision of independent advocacy for parents with learning disabilities should always be considered (where available). Good Practice Guidelines have been developed in collaboration with parents with learning disabilities who have experienced child protection processes as additional support is required to ensure parents can fairly participate in an often complex bureaucratic process (Scottish Consortium for Learning Disability, 2015).

6.17. The involvement of families in Significant and Initial Case Reviews requires careful ethical consideration in many instances. This is a particularly difficult and distressing time for families. In cases of child fatalities, there is likely to be high levels of media interest, political scrutiny and in some instances, criminal investigation. The reviewer needs clarity of purpose and sensitivity in approach when engaging with families. There were mixed views on families' experiences of this process and no known research conducted in Scotland. The Care

Inspectorate review (2016) noted an increase in families being asked to be involved in SCRs and this being recorded in over half of all cases. International models for child death reviews rarely involve families and Scotland and the rest of the UK are unique in promoting the involvement of children and families regarding individual cases (Vincent, 2013). The Review Group considered that Scotland should be critically reflective about the value for families participating in these individual processes and the wider impact on learning.

6.18. The publication of SCRs does not usually take place but publication of Executive Summaries with recommendations does take place in some cases and that can be highly distressing for families. In some circumstances, examples were given where SCRs were concluded well over a year after the event and the publication reignited media interest and intrusion into their lives. There were examples where this was particularly distressing for other children involved in the case. In many cases, families could be easily identified due to associated court proceedings or local community knowledge.

Strengthening and Valuing Front-line Professional Practice

6.19. Starting with For Scotland's Children: Better Integrated Children's services (Scottish Executive, 2001), there has been continuous striving for more effective and integrated services to improve outcomes for children. There was a significant shift in the recognition that everybody had a responsibility for protecting children after the publication of 'It's everyone's job to make sure I'm alright': Report of the Child Protection Audit and Review' (Scottish Executive, 2002) and the subsequent reform programme. These steps have supported the ethos and value-base for the national approach to improving outcomes for children, Getting it Right for Every Child (GIRFEC). There is widespread recognition that what is needed is a whole system approach and professionals cannot work in silos when they must have a shared aspiration to improve outcomes for all children and young people.

6.20. Collective decision-making is a critical factor in supporting professionals when protecting children. This is demonstrated in the value of Child Protection Case Conferences where a group of professionals decide to place a child or young person on a Child Protection Register and thus instigate a Child Protection Plan. In cases where the risk of harm is posed within families, the professional judgement in assessing parental capacity to change within a timescale that does not have a detrimental outcome of a child's development requires a highly-skilled professional workforce (Ward et al., 2014). In working together, families often recognise that many professionals (and often wider family members) had shared concerns that a child was at risk of significant harm. A child or young person and family are supported by a Core Group of those professionals who are involved in delivering the support outlined in the Child Protection Plan. However the Review Group observed that in some instances, committed participation in Case Conference Review meetings and Core Group meetings of all professionals who had been at the Initial Case Conference had not happened.

6.21. The Revisiting Child Protection in Scotland programme, led by Professor Vivien Cree and Dr Fiona Morrison at the University of Edinburgh, has developed excellent resources for social work practitioners to communicate with children in their everyday practice (see Talking and Listening to Children website for more details and access to free resources). Based on ethnographic research, the study highlighted the critical importance of the quality of the relationships children and young people have with their social workers and importance of value-based practice based on honesty, reliability and consistency (Morrison, 2016). The research also highlighted the need for social work offices to become 'child-friendly' spaces allowing for opportunities for children and social workers (and child protection professionals) to communicate in a comfortable and confidential setting.

6.22. Developing and sustaining trusting relationships with children, young people and families is critical in supporting families where change is needed to protect children and young people. The Child Protection Plan has to have clear agreed actions for a programme of work. The volume and complexity of caseloads for

front-line professionals requires good management as excessive workload can impact on their ability to develop good quality relationship-based practice.

6.23. The personal and professional anxiety for staff involved in SCRs and ICRs was recognised by the Review Group. The lengthy timescales of some reviews added to uncertainty; however, much depends on how frontline staff are engaged and consulted with throughout the process. In some circumstances, frontline staff are involved in multiple concurrent processes. As highlighted in section 4.11, given the issues raised regarding local and national learning, variability and timescales the Review Group recommends the Scottish Government should explore a new three tiered approach to Initial Case Reviews and Significant Case Reviews, based on the 'Multi-Agency Child Practice Reviews' used in Wales (Welsh Government, 2012; see Appendix F for more information). This would involve establishing: multi-agency professional forums, concise reviews and extended reviews. It is anticipated that this approach would deliver a more streamlined, flexible and proportionate approach to reviewing and learning from what are inevitably complex cases.

Recommendations on Shared Values

Recommendation 11

The Children and Young People's Commissioner Scotland should be invited to work with partners to develop a programme of work to understand children's experiences of formal child protection systems in Scotland. This work should include the further development of accessible tools and information directly for children to support their participation in decision-making and events held to support front-line practitioners working with children. This work should include the development of a Good Practice Advocacy Guide for child protection.

Recommendation 12

Child Protection Committees should ensure children, parents and wider families are part of the decision-making processes and explore a range of strengths-based participatory approaches to Child Protection Case Conferences to achieve this.

Chief Officers, Heads of Service and senior management should support front-line professionals to participate in all stages of Case Conferences, Core Group meetings and Children's Hearings.

7. Conclusions

7.1. A shared aspiration across our society is to make Scotland the best place in world for children and young people to grow up. As part of strengthening the many systems which help deliver this aspiration, this Review Group was asked to consider the main components of the current child protection system. These are: Child Protection Committees; Child Protection Registers and Case Conferences; and Significant and Initial Case Reviews. The Review Group were clear that when children or young people are identified as being at risk of, or subject to, significant harm then the child protection system in Scotland works well and the components that the Group were asked to review are capable of delivering the support needed for these vulnerable children and young people. There are thousands of examples each year of front-line professionals working across areas of expertise and organisational boundaries to reach decisions on when and how best to step in to prevent further serious harm to a child or young person, or to reduce the risk of serious harm occurring.

7.2. The professionals involved in making child protection arrangements bring a variety of skills and expertise from practice in their own organisations and come together to collectively decide on the optimum course of action for the particular child or young person and to deliver the support they need. Their interventions often succeed in making children and young people safer. However the issues the system deals with are complex and sensitive. It involves thousands of front-line staff engaging with children, young people and their families. The landscape is constantly changing - for example, new threats emerge; changes to legislation and practice are introduced - all adding to already challenging work.

7.3. There is a need to ensure that child protection work remains an absolute priority for all organisations working on the delivery of wellbeing and safety for children and young people. Professionals working in child protection know that new risks become apparent suddenly and that their front-line staff need to be

aware of, and able to recognise, multiple dangers which emerge. Society generally also needs to be able to recognise risks to children and young people, when circumstances suggest there should be concern about safety and how to access appropriate support. Post-devolution there has been public policy and professional agreement that early intervention can considerably reduce the levels of significant harm or risk facing children and young people.

7.4. The Review Group observed that those working in the system are constantly assessing how risks can be mitigated and improvements delivered and recognise that commitment to and support of collaborative working by professionals across organisations is essential. The recommendations from this Review Group are offered as practical next steps on the journey to strengthen and support further improvements to ensure that organisations and professionals are appropriately aligned to move forward together to create the best chances of all children and young people to receive the right help, at the right time from the right people.

Appendix A: Review Group Membership & Terms of Reference

The Review was Independently Chaired by Catherine Dyer CBE (Former Crown Agent and Chief Executive of the Crown Office and Procurator Fiscal Service) and supported by Dr Louise Hill (CELCIS, University of Strathclyde) and Katherine Hudson (Scottish Government).

Review Group Members

Colin Anderson, Independent Chair of Glasgow Child Protection Committee
Tam Baillie, Children and Young People's Commissioner in Scotland
Alan Baird, Chief Social Work Advisor, Scottish Government
Detective Chief Superintendent Lesley Boal, Head of Public Protection, Police Scotland
Jackie Brock, Chief Executive, Children in Scotland
Mike Burns, Head of Strategy (Children) Health and Social Care Glasgow
Professor Brigid Daniel, Centre for Child Wellbeing & Protection, University of Stirling
Peter Diamond, Orkney Council & ADES Representative
Trisha Hall, Country Manager, Scottish Association of Social Work (Part of BASW)
Helen Happer, Chief Inspector (Strategic Scrutiny), Care Inspectorate
Anne Houston, National Chair, Child Protection Committees Scotland
Neil Hunter, Principal Reporter/Chief Executive, Scottish Children's Reporter Administration
Jillian Ingram, Lead Officer, North Ayrshire Child Protection Committee
Sally Ann Kelly, Chief Executive, Aberlour and Third sector representative for the Coalition of Care & Support Providers in Scotland
Susan Maclaren, Chief Social Work Officer and Head of Integrated Children's Services, Moray Council & Vice Chair, Child Protection Committees Scotland
Kevin Mitchell, Executive Director Scrutiny and Assurance, Care Inspectorate
Dr Jacqueline Mok, Chair of the Child Protection Committee, Royal College of Paediatrics & Child Health Scotland (RCPCH)
Anne Neilson, Director of Public Protection, NHS Lothian
Jane O'Donnell & Lauren Bruce, Policy Managers, COSLA

Kate Rocks, Chair of Social Work Scotland: Children & Families Standing Committee & Chief Social Work Officer and Head of Service, East Renfrewshire Local Authority

SCOTTISH GOVERNMENT

CHILD PROTECTION SYSTEMS REVIEW:

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

TERMS OF REFERENCE

1. The Child Protection Systems Review (herein 'the Review') will examine what changes or improvements may be needed to these underpinning processes and structures in order to protect children effectively. Our overarching objectives are:

   - Our child protection system works effectively to support families to keep children safe
   - Our child protection system protects and promotes the rights and wellbeing of children
   - Our child protection system is a consistent, transparent and learning system

2. The Review will focus on three key areas of the child protection system:
   - Child Protection Committees
   - Child Protection Registers and case conferences
   - Significant Case Reviews & Initial Case Reviews

3. The purpose of this Review is to examine what changes or improvements may be needed to these underpinning processes and structures in order to protect children effectively. This Review aims to strengthen the steps taken when children have experienced, or are at risk from, harm.

4. The Review will address the following questions and any other relevant questions which the Review Group identify:

- What do we know about children and families' views and experiences of the child protection system and how can they inform the work of the Review Group?
- What would improve children and families' experiences of child protection processes of these 3 aspects of the child protection system?
- How far do existing processes and structures improve the child's wellbeing and uphold their rights?
- How well does the child protection system identify children and families who are in need of support and protection, and how could this be improved?
- How does the child protection system interact with adult services? What could be done to improve this?
- How well does the system support children and families once they have been identified?
- How do these elements of the system work for children experiencing different types of concerns - e.g. neglect, abuse? How do we ensure an appropriate response to all concerns?
- How do we ensure systems and processes are able to respond effectively to the changing nature of risk?
- How far is there consistency of practice across the country and what are the advantages and disadvantages of this?
- What role does, or should, leadership, play?
- How can the child protection system be a learning system and balance accountability and learning?

The Review Group will consider and make recommendations on:

- For each element of the existing system what would need to change in order to deliver that? Is this about practice, legislation, policy or systems? Do we need to retain these elements of the system or is there a better way of doing this?
- What would we need to do to implement any proposed changes? What are the challenges?
- Do any elements of the system need to be put on a statutory basis?

5. On the basis of the Review's conclusions, the Scottish Government will consider any changes required to guidance or legislation. Any suggested changes in law or regulation will be subject to public consultation. The Scottish Government will be responsible for drafting any consultation paper.

MANAGEMENT OF REVIEW

6. The Review will be chaired by Catherine Dyer CBE (Former Crown Agent and Chief Executive of the Crown Office and Procurator Fiscal Service). The chair will be supported by Katherine Hudson (Scottish Government - the 'Review Manager') and Dr Louise Hill (CELCIS). The Review Group will be made up of sector experts. The Review Group will follow a programme of structured working meetings, with each meeting considering structured questions around an element of the review informed by inputs such as evidence and option papers.

7. Options for engaging a wider group of stakeholders in the work of the review will be developed.

8. The Review will meet at least five times between August and December 2016. The agenda will be set by the Review's chair and manager, to ensure that all relevant issues are adequately addressed. The chair and Review members will direct discussion at each meeting and will determine final recommendations based on the outcome of discussions at each meeting. The Review's recommendations will be presented to Scottish Government Ministers, and a response prepared by Scottish Government officials.

9. The permanent membership of the Review will made up of representatives from:
    - Child Protection Committee Chairs
    - Child Protection Lead Officer Group
    - Office of the Chief Social Worker
    - Social Work Scotland
    - Scottish Association of Social Workers
    - Police Scotland

- National Chair of Child Protection Committees Scotland
- Health Representatives
- Scottish Children's Reporter Association (SCRA)
- Commissioner for Children and Young People in Scotland
- Scottish Government
- Local Authorities
- COSLA
- Care Inspectorate
- Centre for Child Wellbeing and Protection, University of Stirling
- Coalition of Care and Support Providers in Scotland
- Children in Scotland
- Royal College of Paediatrics and Child Health Scotland

10. Input from other relevant organisations and universities will be requested on specific issues as required. The group will consider how best to ensure the experiences and views of children, young people and families with experience of child protection are reflected in the Review.

Appendix B: An Overview of Legislation and International Treaties

The UK Government ratified the United Nations Convention on the Rights of the Child (UNCRC) 1989 in 1991. Under Article 19, the state must protect children from all forms of violence, abuse, neglect and mistreatment and Article 34 requires states to protect children from sexual exploitation and sexual abuse.

The Children (Scotland) Act 1995 has provided the main legal framework for child welfare and protection in Scotland. Local authorities have a duty to safeguard and promote the welfare of children in their area. Section 19 sets out the responsibilities for each local authority to prepare plans for children's services in their area.

The Local Government in Scotland Act 2003 outlines the duty on local authorities to establish and maintain a process of community planning and the power to enhance well-being.

The Commissioner for Children and Young People (Scotland) Act 2003 creates the post of Commissioner for Children and Young People with the general function of promoting and safeguarding the rights of children and young people. This includes everyone in Scotland up to the age of 18, and those up to 21 years who have been "looked after" by a local authority.

The primary policy objective of the Protection of Children and Sexual Offences (Scotland) Act 2005 is to improve the protection given to children and young people from those who would wish to cause them sexual harm, or exploit them for sexual purposes. The Act also aims to improve the protection given to adults and children alike from those convicted of sexual offences who still pose a risk of sexual harm.

Under the Adult Support and Protection (Scotland) Act 2007 (section 42), Adult Protection Committees have been placed on a statutory footing. In some areas, there has been integration with Adult Protection Committees and Child Protection Committees.
Notifying the death of a looked after child is a statutory duty of the local authority looking after that child under regulation 6 of the Looked After Children (Scotland) Regulations 2009. The local authority must, as soon as reasonably practical, notify the Scottish Ministers and Social Care and Social Work Improvement Scotland (known as the Care Inspectorate).

The Adoption and Children (Scotland) Act 2007 modernised the system of adoption in Scotland and introduced Permanence Orders as an additional long term option alongside adoption to provide long-term security for children who could not live with their families.

The Sexual Offences (Scotland) Act 2009 creates new statutory offences of rape, sexual assault by penetration, sexual assault, sexual coercion, coercing a person to be present during sexual activity, coercing a person to look at an image of sexual activity, communicating indecently, sexual exposure, voyeurism and administering a substance for a sexual purpose. The Act also creates new "protective offences" which criminalise sexual activity with a person whose capacity to consent to sexual

activity it either entirely absent or not fully formed either because of their age or because of a mental disorder. Separate “protective” offences are provided for in respect of sexual activity with young children (under the age of 13) and older children (from age 13 to age 15). In addition, the Act makes it an offence of “abuse of position of trust” for a person in a position of trust (over a child or person with a mental disorder) to engage in sexual activity with that child or person.

The Children’s Hearings (Scotland) Act 2011 sets out the duties and powers of local authorities, constables, courts and other persons to refer all children who may be in need of compulsory measures of supervision to the Scottish Children’s Reporter Administration. When actions are required to protect children from abuse and neglect, Child Assessment Orders, Child Protection Orders and Interim Orders are used under 2011 Act.

The Police and Fire Reform (Scotland) Act 2012 creates a single police service and a single fire and rescue service. Under section 37(1), the policing principles are to improve the safety and well-being of persons, localities and communities in Scotland. There is a requirement for the chief constable to make arrangements for local policing, including establishing a new formal statutory relationship with each local authority and designating a local commander for each local authority area (section 44-47).

The Public Bodies (Joint Working) (Scotland) Act 2014 requires councils and NHS boards to create an integration authority to be responsible for the strategic planning of adult social care services, some health services and other functions delegated to it. It is also responsible for ensuring the delivery of those functions. The Integration Joint Board (IJB) also has an operational role as described in the locally agreed operational arrangements set out within their integration scheme. The Act also allows councils to integrate children’s and families' services and criminal justice social work.

The Children and Young People (Scotland) Act 2014 outlines the duties and planning arrangements that should be in place for children’s services to safeguard, support and promote the wellbeing of children and young people (from 1st April 2017). The Child’s Plan – which can include a Child Protection Plan – is required when a child has a wellbeing need that requires a targeted intervention as set out in Part 5: Child’s Plan of the 2014 Act. Notifying the death of a person being provided with aftercare under section 29 (10) of the Children (Scotland) Act 1995 became a statutory duty of the local authority under section 29(10) of the 1995 Act when section 66 of the Children and Young People (Scotland) Act 2014 came into force. Notifying the death of a person being provided with continuing care became a statutory of the local authority under section 26A (10) of the 1995 Act when section 67 of the 2014 Act came into force.

The Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 makes provision for the holding of public inquiries in Scotland with respect to fatal accidents, deaths of persons in legal custody, sudden, suspicious and unexplained deaths and deaths occurring in circumstances that give rise to serious public concern. This replaces the earlier Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976.

Appendix C: Key Reports, Inquiries & Policy Developments for Protecting Children and Young People

Author	Year	Report/Inquiry/Policy	Description
Scottish Executive	2001	For Scotland's Children: Better Integrated Children's services	Sets out an aspiration for all Scotland's children where which local authorities, the NHS and the voluntary sector can work together to create a single children's services system.
Scottish Executive	2002	"It's Everyone's Job to Make Sure I'm Alright": Report of the Child Protection Audit and Review.	Audit and review of child protection practice across Scotland.
Scottish Executive	2004	Protecting Children and Young People: Framework for Standards	The Scottish Executive's Child Protection Reform Programme (2003-2006) resulted in several guidance documents following the Audit and Review (2002). The Charter was developed from research conducted by Save the Children providing ten key messages from children and young people across Scotland.
Scottish Executive	2004	Protecting Children and Young People: The Charter	
Scottish Executive	2005	Protecting Children and Young People: Child Protection Committees	
HMIE	2009	How well do we protect children and meet their needs?	Findings from the first national programme of joint inspections to protect children.
Scottish Government	2008	Getting it Right for Every Child National Practice Model	The National Practice model (Wellbeing Wheel, the My World Triangle and the Resilience Matrix), provides a holistic understanding of the child's developmental needs and how these can be met.
Scottish Government	2012	National Risk Framework to Support the Assessment of Children and Young People	Provides an assessment model where there may be child protection concerns. This holistic approach builds on the GIRFEC National Practice Model for practitioners to approach the task of risk identification, assessment, analysis and management with confidence and competence.
Vincent, S & Petch, A	2012	An audit and review of Significant Case Reviews	This report presents the findings from an audit and analysis of 56 Significant Case Reviews (SCRs) and 43 Initial Case Reviews (ICRs) conducted in Scotland since 2007.
Care Inspectorate	2013	How well do we protect children and meet their needs?	Findings from the second national programme of joint inspections of services to protect children 2009-2012.

Scottish Government	2014 (Updated from 2010)	National Guidance for Child Protection in Scotland 2014	Provides a national framework for agencies and practitioners at a local level to understand and agree processes for working together to safeguard and promote the wellbeing of children. It also sets out expectations for strategic planning of services to protect children and young people and highlights key responsibilities for services and organisations, both individual and shared. This guidance incorporated the Framework for Standards and Child Protection Committee Guidance.
Care Inspectorate	2014a	A report on the effectiveness of child protection arrangements across Scotland	The Care Inspectorate reported on the effectiveness of adult and child protection arrangements to Scottish Ministers following the inspection year 2013/14.
Care Inspectorate	2014b	How well are we improving the lives of children and young people? A guide to evaluating services using quality indicators.	This guide provides a framework of quality indicators to support self-evaluation which leads to improvement across services for children, young people and families.
Jackie Brock (Children in Scotland)	2014	The Brock Report - Safeguarding Scotland's Vulnerable Children from Child Abuse: a review of the Scottish system	Independent report to the Cabinet Secretary to consider the development of safeguarding children and promoting well-being since 1995 in Scotland.
Scottish Government	2014 & 2016	Child Death Review Report : Scottish Government Child Death Review Working Group & Follow up report: *Child Death Reviews: Steering Group Report*	A report by a Scottish Government short-life working group which explored current practice in Scotland and considered whether Scotland should introduce a national collaborative multi-agency system for reviewing the circumstances surrounding the death of a child.
Scottish Government	2015	National Guidance for Child Protection Committees on Conducting a Significant Case Review	Guidance to support Child Protection Committees in the process and governance of Significant and Initial Case Reviews.
Care Inspectorate	2015a	Inspecting and Improving Care and Social Care Work in Scotland 2011-2014	First triennial review presents findings from scrutiny and improvement work including child protection.
Care Inspectorate	2015b	Code of Practice for the Review of Significant Case Reviews for children and young	Developed by the Care Inspectorate to improve consistency and quality in Significant Case Reviews.

		people in Scotland	
Care Inspectorate	2016	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	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.

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Appendix E: Acronyms & Glossary

Acronyms

APC	Adult Protection Committee
ADP	Alcohol and Drug Partnerships
COG	Chief Officers' Group
CPC	Child Protection Committee
CPO	Child Protection Orders
CPP	Community Planning Partnerships
CPR	Child Protection Register
CSO	Compulsory Supervision Order
FAI	Fatal Accident Inquiry
GIRFEC	Getting it Right for Every Child
ICR	Initial Case Review
IJB	Integration Joint Boards
IRD	Initial Referral Discussion
LSCB	Local Safeguarding Children's Boards (In England and Wales)
MAPPA	Multi-Agency Public Protection Arrangements
SCR	Significant Case Review (Scotland)
	Serious Case Reviews in England & Wales (pre-2013). Child Practice Reviews (CPR) were introduced in Wales in 2013.
UNCRC	United Nations Convention on the Rights of the Child

Glossary

Abuse & Neglect

Abuse and neglect are forms of maltreatment to a child as set out in the National Guidance on Child Protection in Scotland (2014). These include:

- **Physical abuse** is the causing of physical harm to a child or young person. This may include hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating.
- **Emotional abuse** is persistent emotional neglect or ill-treatment that has severe and persistent adverse effects on a child's emotional development.
- **Sexual abuse** is any act that involves a child in any activity that is for the sexual gratification of another person, whether or not it is claimed that the child consented or assented. The activities may involve physical contact, both penetrative and non-penetrative acts. They may involve non-contact activities, such as involving children in looking at or involved in the production of indecent images, or in watching sexual images, using sexual language towards a child or encouraging children to behave in sexually inappropriate ways.
- **Neglect** is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.

Child Protection

Child protection means protecting a child from abuse and neglect. Abuse and neglect need not to have taken place; it is sufficient for a risk assessment to identify the likelihood of risk of significant harm from abuse and/or neglect.

Child Protection Order

Authorises the applicant to remove a child from circumstances in which he or she is at risk or retain him or her in a place of safety.

Child Protection Plan

Agreed interagency plan outlining in detail the arrangements for attempting to ensure the protection of a child and supports to the family.

Children's Reporter

An independent person, employed by the Scottish Children's Reporters Administration who has statutory powers for the protection and wellbeing of children.

Compulsory Measures of Supervision

Statutory measures for monitoring and intervening where necessary.

Looked after child

A child is 'looked after' by a local authority when he or she is:

a) provided with accommodation by a local authority under section 25 of Children (Scotland) Act1995; or
b) subject to a compulsory supervision order or an interim compulsory supervision order made by a children's hearing in respect of whom the local authority are the implementation authority (within the meaning of the 2011 Act); or
c) living in Scotland and subject to an order in respect of whom a Scottish local authority has responsibilities, as a result of a transfer of an order under regulations made under section 33 of the 1995 Act or section 190 of the 2011 Act; or.
d) subject to a Permanence Order made after an application by the local authority under section 80 of the 2007 Act.

Looked after 'at home'

A child is either:

a) Child is subject to a Compulsory Supervision Order (CSO) with "no condition of residence".
b) Child lives with their parent(s), or other family member, under the supervision of the local authority.
c) Child is 'looked after' by the local authority for the duration of the CSO.

Looked after away from home

A child lives with carers 'away from' their parents or regular carers, under the supervision of the local authority, in kinship care, foster care or some form of residential care (including secure care). A child is either:

(a) subject to a Compulsory Supervision Order (CSO) with a condition of residence;
(b) provided with accommodation under section 25 of the 1995 Act;
(c) subject to a Permanence Order; or
(d) living in Scotland and subject to an order in respect of whom a Scottish local authority has responsibilities.

Procurator Fiscal

Public prosecutor who acts in the public interest and considers reports of a crime and investigates fatalities which require further explanation to decide whether or not to prosecute and/or raise Fatal Accident Inquiry proceedings.

Risk

Risk is the likelihood or probability of a particular outcome given the presence of factors in a child or young person's life.

Significant harm

Significant harm can result from a specific incident, a series of incidents or an accumulation of concerns over a period of time. Significant harm is a complex matter and subject to professional judgement that requires multi-agency assessment of the circumstances of the child and their family. Harm means the ill-treatment or impairment of the health and development of the child.

Schedule One Offenders

Offenders convicted of offences against children. This includes sexual and violent offences.

Appendix F: Multi-Agency Child Practice Reviews in Wales

Introduced in 2013, the 'Multi-Agency Child Practice Reviews' were developed as a new framework to replace Serious Case Reviews to improve the culture of learning from child protection cases across Wales. The main aspects of the new framework are:

- It involves agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability and not on culpability;
- It has the potential to develop more competent and confident multi-agency practice in the long term, where staff have a better understanding of the knowledge base and perspective of different professionals with whom they work;
- It strengthens the accountability of managers to take responsibility for the context and culture in which their staff are working and to see that they have the support and resources they need;
- It recognises the impact of the tragic circumstances of non-accidental child deaths or serious harm on families and on staff, and provides opportunities for serious incidents to be reviewed in a culture that is fair and just;
- It takes a more streamlined, flexible and proportionate approach to reviewing and learning from what are inevitably complex cases;
- It allows a more constructive and appropriate use of resources than in the previous system and works to shorter timescales;
- It draws on learning from other related review processes and increases compatibility with different review systems;
- It focuses on key learning identified through the review process which results in relevant recommendations and action to improve future practice, recorded in anonymised reports which are published by Local Safeguarding Children's Boards.

The new Learning and Reviewing framework involves a three tiered approach for Local Safeguarding Children's Boards (LSCBs):

Tier	Description
Multi-Agency Professional Forums	A continuous programme for learning together of multi-professional facilitated events for practitioners and managers, primarily to examine case practice and provide opportunity for consultation, supervision and reflection, and to disseminate findings from child protection audits, inspections and reviews, in order to improve local knowledge and practice and to inform the Board's future audit and training priorities.
Concise Reviews	A Board must undertake a concise child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has –died; or sustained potentially life threatening injury; or sustained serious and permanent impairment of health or development; **and** the child was neither on the child protection register nor a looked after child on any date during the 6 months preceding – the date of the event referred to above; or the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development. The purpose of a review is to identify learning for future practice and involves practitioners, managers and senior officers in exploring the detail and context of agencies' work with a child and family. The output of a review is intended to generate professional and organisational learning and promote improvement in future inter-agency child protection practice. A concise review is made up of a number of interconnected activities described below, all of which contribute to the rigour of the process and to the learning drawn from the case being reviewed. • The review is managed by a *Review Panel* and a reviewer is appointed to work with the *Panel.* The review engages directly with children and family members, as they wish and is appropriate, so their perspectives are included, and it involves practitioners and their managers who have been working with the child and family. A planned and facilitated practitioner- focused learning event is a key element of the review, conducted by a reviewer independent of the case management, to examine current case practice within a limited timeline and using a systems approach. • A draft anonymised child practice review report and an outline action plan are produced and presented to the LSCB. Board members of the LSCB consider, challenge and contribute to the conclusions of the review, and identify the strategic implications for improving practice and systems to be included in the action plan. • The final report is approved by the LSCB and submitted to the Welsh Government and then published by the LSCB. The process will be completed as soon as possible but no more than six months from the date of a referral from the Board to the

	Review Sub-Group. • The action plan is finalised within four weeks of the final report, approved by the LSCB, and submitted to the Welsh Government. The implementation of the action plan is regularly reviewed and progress reported to the Board. • Action plans should lead to improvements in child protection practice and the Board needs to ensure they are carefully audited to see whether actions are being carried out and with what effect, and whether they are making a difference.
Extended Reviews	A Board must undertake an extended child practice review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has – died; or sustained potentially life threatening injury; or sustained serious and permanent impairment of health or development; **and** the child was on the child protection register and/or was a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding – the date of the event referred to above; or the date on which a local authority or relevant partner6 identifies that a child has sustained serious and permanent impairment of health and development. The review follows the same process and timescale as a concise review, engaging directly with children and families, in so far as they wish and is appropriate, and involving practitioners, managers and senior officers throughout. There is an additional level of scrutiny of the work of the statutory agencies and the statutory plan(s) which were in place for the child or young person. • The review is undertaken by two reviewers working closely together, appointed by the *Review Panel*. They will have responsibility for examining how the statutory duties of all relevant agencies were fulfilled, and reporting on this to the *Review Panel* and the LSCB. • An anonymised child practice review report is considered and approved by the LSCB, submitted to the Welsh Government and published by the LSCB. The process will be completed as soon as possible but no more than six months from a referral from the Board to the *Review Sub-Group*. • The action plan is finalised within four weeks of the final report, approved by the LSCB, and submitted to the Welsh Government. The implementation of the action plan is regularly reviewed and progress reported to the Board. • Action plans should lead to improvements in child protection practice and the Board needs to ensure they are carefully audited to see whether the actions are being carried out and with what effect, and whether they are making a difference.
Welsh Government (2012) Protecting Children in Wales: Guidance for Arrangements for Multi-Agency Child Practice Reviews, Cardiff: Welsh Government (Pages 5-7).	

Appendix G: Recommendations Matrix Table

	Whole System	Child Protection Committees	Child Protection Registers & Case Conferences	Significant Case Reviews and Initial Case Reviews
Leadership, Governance and Accountability	***Recommendation 1*** A National Child Protection Leadership Group should be established in order to further support, strengthen and improve, from a national perspective, activity on child protection across Scotland. This group should report and account to Scottish Ministers. ***Recommendation 3*** It is critical that the Chief Executive of each local authority, working with the Chief Officers' Group, ensures that Chief Social Work Officers have sufficient support to provide professional leadership, advice and scrutiny across all public protection matters (including child protection) given their key statutory responsibilities within the local authority.	***Recommendation 2*** Chief Officers should be supported by the National Child Protection Leadership Group and Child Protection Committees Scotland to strengthen delivery of their responsibilities, as set out in the National Guidance for Child Protection in Scotland (2014), and to identify areas where further work may be required, such as: • Clarity of reporting mechanisms between Child Protection Committees and Chief Officers' Groups • Descriptions of the roles and responsibilities of Child Protection Committees (including that of Chairs of CPC's) and COGs • Supporting Child Protection Committees to carry out their roles and functions in line with the requirements set out in National Guidance. Chief Officers should pro-actively engage with and report to elected members and other local scrutiny bodies as the local representatives of their communities and provide	***Recommendation 4*** The Scottish Government should review both the measures available to protect 16 and 17 year olds and whether the Children's Hearings (Scotland) Act 2011 should be amended to allow any young person aged 16 and 17 years old to be referred to the Principal Reporter where there is a need for compulsory measures. ***Recommendation 5*** When a Child Protection Case Conference is held, whether or not a child is placed on the Child Protection Register and at any subsequent points when the child protection plan is reviewed, a referral to the Reporter should be considered and the decision on referral should be clearly recorded. ***Recommendation 6*** The development of a National Child Protection Register that can be securely accessed by all appropriate professionals should be explored. In the short term, it should be ascertained whether it is possible for Police Scotland to use a flagging system on the National Police Vulnerable Persons	

		opportunities to listen to community concerns and hold learning events at local level.	Database to identify all children placed on a local Child Protection Register.	
Developing a Learning Culture	***Recommendation 10*** The National Child Protection Leadership Group and Child Protection Committees Scotland should support local areas to deliver robust continuous improvement programmes. This should include working with relevant organisations to synthesise and share learning from different sources including inspection, research, reviews and local practice. The Data and Evidence work stream of the Scottish Government Child Protection Improvement Programme should develop a strategic programme to deliver robust data sets to support child protection improvement. Scottish			***Recommendation 7*** The Care Inspectorate should become the central repository for all Initial and Significant Case Reviews and should explore the development of a 'Community of Practice' portal on the Care Inspectorate website to enable secure access to all Reviews by Child Protection Professionals in all relevant organisations. ***Recommendation 8*** The Scottish Government should explore a new tiered approach to and methodology for, Initial Case Reviews and Significant Case Reviews, based on the 'Child Practice Review' model used in Wales. ***Recommendation 9*** A set of National Standards should be developed setting out the skills and competences required of those reviewers undertaking Initial Case Reviews and Significant Case Reviews. Appropriate involvement of the child or young person and their family should be a key component of training for

	Government should develop a national resource for advice on using child protection data for local planning and service development.			reviewers and a Good Practice Guidance Note should be developed on how to engage with children, young people and families involved in Child Protection processes. This should ensure all Reviews are timely, proportionate and contribute to an on-going learning culture.
Shared Values	***Recommendation 11*** The Children and Young People's Commissioner Scotland should be invited to work with partners to develop a programme of work to understand children's experiences of formal child protection systems in Scotland. This work should include the further development of accessible tools and information directly for children to support their participation in decision-making and events held to support front-line practitioners working with children. This work should include the development of a Good Practice Advocacy Guide for child protection.	***Recommendation 12*** Child Protection Committees should ensure children, parents and wider families are part of the decision-making processes and explore a range of strengths-based participatory approaches to Child Protection Case Conferences to achieve this.. Chief Officers, Heads of Service and senior management should support front-line professionals to participate in all stages of Case Conferences, Core Group meetings and Children's Hearings.		

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