SCOTTISH EXECUTIVE

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See attached consultation list at Annex C

13 September 2006

Dear Colleague

SIGNIFICANT INCIDENT REVIEWS GUIDANCE – CONSULTATION

Attached is a copy of the draft guidance on Significant Incident Reviews developed by a Working Group commissioned by the Child Protection Reform Programme Steering Group (membership attached).

Protecting children and young people is an inter-agency and inter-disciplinary responsibility. While it is the social work services who largely lead on the discharge of local authorities' legal responsibilities in respect of safeguarding children, any agency or profession may be the starting point for the review process detailed here. Local inter-agency Child Protection Committees (CPCs) work on behalf of the Chief Officers in health, police and the local authority in their area and have a key role to play in ensuring agencies work together effectively to ensure children get the help they need when they need it. This guidance is primarily targeted at CPCs and their role in helping ensure appropriate action is taken as well as being aimed at those who need to initiate action and contribute to the review process.

As well as input from the Working Group there was considerable discussion of the draft guidance with a number of groups earlier in the year which has contributed to the draft attached.

The purpose of the guidance is to put in place a consistent, transparent and structured approach to these reviews building on the practices and protocols already in place to ensure we learn the lessons, locally and nationally, from such reviews. The guidance focuses on the structure and process for the review procedure, not on the detail of who, what or how the necessary case information is accessed, shared and presented locally.

This is primarily an issue for each area and each case and is being addressed locally as this work is taken forward.

Over the consultation period, we will be considering underlying legal issues particularly in relation to information sharing powers and confidentiality and what the guidance might usefully say in respect of such issues to support local action.

Responses are required by 8 November and should be sent to:

Gaynor Davenport
Scottish Executive
Children and Families Division
Area 2B (North)
Victoria Quay
Edinburgh
EH6 6QQ

Or to the child protection reform programme mailbox : cprp@scotland.gsi.gov.uk

If you have any queries or comments on the consultation process, please contact Gaynor Davenport as above on 0131 244 4906.

This consultation, and all other Scottish Executive consultation exercises, can be viewed online on the consultation web pages of the Scottish Executive website at http://www.scotland.gov.uk/consultations. You can telephone Freephone 0800 77 1234 to find out where your nearest public internet access point is.

The Scottish Executive now has an email alert system for consultations (SEconsult: http://www.scotland.gov.uk/consultations/seconsult.aspx). This system allows stakeholder individuals and organisations to register and receive a weekly email containing details of all new consultations (including web links). SEconsult complements, but in no way replaces SE distribution lists, and is designed to allow stakeholders to keep up to date with all SE consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We would encourage you to register.

Handling your response

We need to know how you wish your response to be handled and, in particular, whether you are happy for your response to be made public. Please complete and return the Respondent Information Form as this will ensure that we treat your response appropriately. If you ask for your response not to be published we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Executive is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any

request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

Where respondents have given permission for their response to be made public, these will be made available to the public in the Scottish Executive Library by 22 November 2006. We will check all responses where agreement to publish has been given for any potentially defamatory material before logging them in the library or placing them on the website. You can make arrangements to view responses by contacting the SE Library on 0131 244 4565. Responses can be copied and sent to you, but a charge may be made for this service.

What happens next ?

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us develop the final guidance for Significant Incident Reviews.

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to me at the above address.

Yours sincerely

Gaynor Davenport

ANNEX A

RESPONDENT INFORMATION FORM: A CONSULTATION ON DRAFT GUIDANCE FOR SIGNIFICANT INCIDENT REVIEWS

Please complete the details below and return it with your response. This will help ensure we handle your response appropriately. Thank you for your help.

Name:

Postal Address:

1. Are you responding: (please tick one box)
   (a) as an individual ☐ go to Q2a/b and then Q4
   (b) **on behalf of** a group/organisation ☐ go to Q3 and then Q4

INDIVIDUALS

2a. Do you agree to your response being made available to the public (in Scottish Executive library and/or on the Scottish Executive website)?
   Yes (go to 2b below) ☐
   No, not at all ☐ We will treat your response as confidential

2b. Where *confidentiality is not requested*, we will make your response available to the public on the following basis (**please tick <u>one</u>** of the following boxes)

Yes, make my response, name and address all available ☐
Yes, make my response available, but not my name or address ☐
Yes, make my response and name available, but not my address ☐

ON BEHALF OF GROUPS OR ORGANISATIONS:

3 The name and address of your organisation ***will be*** made available to the public (in the Scottish Executive library and/or on the Scottish Executive website). Are you also content for your **response** to be made available?

Yes ☐
No ☐ We will treat your response as confidential

SHARING RESPONSES/FUTURE ENGAGEMENT

4 We will share your response internally with other Scottish Executive policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for the Scottish Executive to contact you again in the future in relation to this consultation response?

Yes ☐
No ☐

THE SCOTTISH EXECUTIVE CONSULTATION PROCESS

Consultation is an essential and important aspect of Scottish Executive working methods. Given the wide-ranging areas of work of the Scottish Executive, there are many varied types of consultation. However, in general, Scottish Executive consultation exercises aim to provide opportunities for all those who wish to express their opinions on a proposed area of work to do so in ways which will inform and enhance that work.

The Scottish Executive encourages consultation that is thorough, effective and appropriate to the issue under consideration and the nature of the target audience. Consultation exercises take account of a wide range of factors, and no two exercises are likely to be the same.

Typically Scottish Executive consultations involve a written paper inviting answers to specific questions or more general views about the material presented. Written papers are distributed to organisations and individuals with an interest in the issue, and they are also placed on the Scottish Executive web site enabling a wider audience to access the paper and submit their responses[1]. Consultation exercises may also involve seeking views in a number of different ways, such as through public meetings, focus groups or questionnaire exercises. Copies of all the written responses received to a consultation exercise (except those where the individual or organisation requested confidentiality) are placed in the Scottish Executive library at Saughton House, Edinburgh (K Spur, Saughton House, Broomhouse Drive, Edinburgh, EH11 3XD, telephone 0131 244 4565).

All Scottish Executive consultation papers and related publications (eg, analysis of response reports) can be accessed at: Scottish Executive consultations (http://www.scotland.gov.uk/consultations)

The views and suggestions detailed in consultation responses are analysed and used as part of the decision making process, along with a range of other available information and evidence. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

Final decisions on the issues under consideration will also take account of a range of other factors, including other available information and research evidence.

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.

[1] http://www.scotland.gov.uk/consultations

ANNEX B

Membership of the Child Death and Significant Case Review Group

John Elliot, Solicitor (Chair)

Dr Stewart Forsyth, Clinical Director of Paediatrics, Ninewells Hospital and Medical School

DCC Bob Ovens, ACPOS (now retired)

DI Fraser Lamb, Strathclyde Police

Tim Huntingford, SoLACE

Moira McKinnon, Social Work, Glasgow City Council

Alastair Carmichael, Crown Office and Procurator Fiscal Service

Gill Ottley, Deputy Chief Social Work Inspector, Social Work Inspection Agency

Bill Spence, retired Chief Constable

Martin Kettle, Children and Families Services Manager, South Lanarkshire Council

Sheriff Gail Patrick

Elizabeth Sadler, Scottish Executive Justice Department

Dr Ian Bashford, Scottish Executive Health Department (involved in several meetings)

Support

Catherine Rainey, Children and Families Division

Gaynor Davenport, Children and Families Division

ANNEX C

Significant Incident Review Consultation List

- CPC Chairs
- CPC lead officers
- Chief Executive of Local Authorities
- Chief Executives of Health Boards
- Chief Constables
- ACPOS
- ADSW
- ADES
- Children's Rights Officers
- Advocacy Groups
- Key Voluntary Organisations
- Sheriff's Association
- Royal College of GPs
- Royal College of Paediatrics and Child Health
- Child Health Commissioner
- Child Protection Nurse Advisors
- Inspectorates
- Scottish Executive core consultation recipients

Protecting Children & Young People: Significant Incident Review

Draft guidance for consultation

September 2006

Ministerial foreword

[to be drafted following formal consultation]

Contents

1 INTRODUCTION

1.1 Reviews of significant incidents are undertaken by agencies involved in child protection – whether singly or jointly. However, there is no standard approach to when and how these are tackled. In the report of the Audit and Review of child protection, *It's Everyone's Job to Make Sure I'm Alright*[1], recommendation 6 was that 'the Scottish Executive should consult on how child fatality reviews should be introduced in Scotland. This should include consultation on how they should be conducted, how review teams should be constituted, to whom they would report and what legislative framework is required to ensure their effectiveness'.

1.2 Many local areas and individual agencies have their own processes and procedures in place. However, across Scotland there is uncertainty and inconsistency in decision-making on when and what type of review to hold, the management or oversight of the process, the skills and expertise required to undertake the review, reporting requirements and implementation of findings. This guidance should help us all by having more clarity and consistency on what should be done and how we best act on the lessons to be learned, both locally and across Scotland.

Purpose of this review guidance, structure & process

1.3 To provide a systematic and transparent approach to the review process. The overarching objectives of any review are to:

- establish whether there are lessons about how better to protect children and young people and help ensure children get the help they need when they need it in the future;
- make recommendations for action;
- meet the different requirements of learning and agency/ occupational accountability;
- seek to increase public confidence in public services; and
- identify national issues where appropriate including good practice.

1.4 This guidance supports these objectives by helping those considering or undertaking a review to:

- identify what skills, experience and knowledge are needed in the review process and how these might be obtained;
- consider and address the needs of the many different people and agencies who may have a legitimate interest in the process and outcome;
- undertake a level of review which is proportionate; and
- take account of the evidence bases.

[1] *It's Everyone's Job to Make Sure I'm Alright*, Scottish Executive 2002

Who is this guidance for?

1.5 Protecting children and young people is an inter-agency and inter-disciplinary responsibility. While it is the social work services who largely lead on the discharge of local authorities' legal responsibilities in respect of safeguarding children[2], any agency or profession may be the starting point for the review process detailed here. Local inter-agency Child Protection Committees (CPCs) work on behalf of the Chief Officers in health, police and the local authority in their area and have a key role to play in ensuring agencies work together effectively to ensure children get the help they need when they need it. This guidance is primarily targeted at CPCs and their role in helping ensure appropriate action is taken.

1.6 This role relates to the functions in *Protecting Children and Young People: Child Protection Committees*[3], where CPCs are required to undertake a range of multi-agency functions including:

- ⇒ developing polices, procedures and protocols
- ⇒ promotion of good practice
- ⇒ training and staff development
- ⇒ having in place mechanisms to identify and disseminate lessons from past and current practice including systematic reviews of significant cases
- ⇒ ensuring that these lessons directly inform training and staff development; and
- ⇒ identify opportunities to share these lessons more widely.

This role includes managing the review process, communication and report handling and follow through.

1.7 This work also relates to the Quality Indicators for inspection of child protection as in *How well are children and young people protected and their needs met?*[4] In particular QI 5.4: Leadership of change and improvement, where the illustration of very good performance is where:

- "Senior managers and the CPC actively and systematically take a leading role in ensuring improvement both within and across services…they commission critical case reviews when necessary and act on the outcomes. They use the review of cases to encourage open and honest discussion about practice in a safe, confidential environment."

1.8 This guidance is relevant to all those involved in the delivery of children's services as they may be involved in undertaking or contributing to reviews from time to time, as well as those specifically involved in child protection work.

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[2] S22(i) of the Children (Scotland) Act 1995: "*A local authority shall – (a) safeguard and promote the welfare of children in their area who are in need"*

[3] *Protecting Children and Young People: Child Protection Committees*, Scottish Executive, 2005

[4] published by HMIE in October 2005

1.9 It is important to note at the outset that there can often be reasons why a full review cannot be progressed, for example where there is an ongoing criminal investigation. However, It is important that all action that needs to be taken should be taken at the appropriate level as soon as it is feasible to do so. This may require ongoing dialogue with the police, Procurator Fiscal or others to determine how far and fast the review process can proceed in certain cases. Good local liaison arrangements are important.

1.10 It should also be noted that, through the Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Act, the Scottish Ministers may request an inspection of:

- all children's services in the relevant area;
- such children's services provided in the relevant area as they may specify; or
- such children's services provided to a particular child or particular children as they may specify.

It is important, however, that action is proportionate and taken at local level as far as is possible and appropriate. Implementation of this guidance should help ensure that this is the case and provide reassurance that a systematic approach to identification, consideration and conduct of a review into a case is taken.

2 CRITERIA AND DEFINITION OF A SIGNIFICANT INCIDENT

2.1 It is important to be clear about the criteria to be applied to trigger a significant incident review (SIR). These have to be sufficiently prescriptive to ensure a degree of consistency in the assessment of whether an SIR is appropriate, yet flexible enough to allow professional knowledge and judgement and local context to be taken into account in each case.

2.2 Following an incident, the first requirement is an Initial Case Review (ICR) of the incident to determine if:

- the criteria for a SIR may have been met; and
- there is any immediate local action which may be required.

2.3 It is important that issues are identified and dealt with at the appropriate level. Reviews should not be escalated beyond what could be considered to be proportionate taking account of the severity and complexity of the case.

Definition of a child

2.4 For the purpose of this document a child is a person under the age of 18 or, is a person under the age of 21 and who was looked after by the local authority when they ceased to be of school age.

Criteria

2.5 Any of the circumstances below require a Significant Incident Review, though the detail and level of review will be dependent on the individual case and circumstances:

When a child dies and:

- abuse or neglect is known or suspected to be a factor in the child's death;
- the child is on, or has been on, the Child Protection Register (CPR) or a sibling is on the CPR. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear that having been on the CPR has no bearing on the case;
- the death is by suicide;
- the death is by murder;
- the child was being 'looked after' by the local authority[5].

[5] Reviewing and reporting the death of a looked after child is a statutory duty under regulation 15 of *The Children (Scotland) Act 1995 Regulations and Guidance*, Scottish Office 1997. This guidance does not replace that duty but recommends this should all be seen as broadly subject to the same processes.

When any child has not died but:

- has sustained any of the following:

    - physical injury;
    - sexual abuse;
    - emotional abuse; or
    - physical neglect;

and, in addition to this, the incident gives rise to concerns about professional and / or service involvement.

2.6 It is expected also that the CPC would consider any formal request made to them for a review - even if the incident had been considered at the Initial Case Review to require no further action. It would be expected that any concerns raised by families and similar interested parties would be addressed through the normal complaints procedures for each agency involved.

2.7 The definitions of the categories of abuse and neglect in this criteria, as defined in *Protecting Children – A Shared Responsibility: Guidance for Inter-Agency co-operation*[6], are attached at Annex 1.

[6] From *Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation,* Scottish Office 1998

3 AN INCIDENT: Initial Case Review

3.1 Where an incident which meets the criteria in Section 2 has occurred ie, a significant incident, the agency where it is first identified must notify the Chair of the CPC within 1 working day of the incident being known. This notification should provide an indication of all the agencies who have been involved with the child, who should be copied into this notification also, and the basic facts. All agencies involved must then complete the Initial Case Review template (at Annex 2) within 3 working days of the notification to the CPC, and the completed forms sent to the Chair of the CPC.

3.2 The CPC will consider whether the information is sufficient to reach a decision on the need for a Significant Incident Review or whether a fuller report is required. If the latter, the Chair will identify a lead agency to coordinate a Joint Case Review report for the CPC which includes information from all agencies involved, including a recommendation of whether the case should be progressed to a Significant Incident Review. This action should be completed within 5 working days of the request from the CPC for a Joint Case Review Report.

3.3 If sufficient information is available from the initial reports provided, or when the fuller Joint Case Review report is received, this will be taken forward as at Section 4.

3.4 All Initial Case Reviews should be recorded in a standardised way and the short report should include:

- a brief description of incident & basis for referral;
- the key facts/background to the case;
- agency/professional involvement;
- summary of findings of local review;
- any other proceedings underway;
- any particular sensitivities; and
- lead contacts for each agency.

3.5 If, during the process of the Initial Case Review, any immediate issues regarding practice and procedure are identified these should be addressed locally immediately and agencies should not wait for a fuller review to take place.

3.6 The Initial Case Review may have a number of outcomes:

- initiation of local action to rectify an immediate issue;
- initiation of disciplinary action; and/or
- referral to the CPC for consideration for a Significant Incident Review.

3.7 In every case, however, even where escalation to a SIR is unlikely, the CPC should be notified of the incident and templates (Annex 2) provided. This will allow the CPC to see the range of incidents arising and consider whether there are any trends developing or need for consideration of action such as review of protocols or training.

Timescale

3.7 The fact that there has been an incident requiring an Initial Case Review **should be notified to the CPC, no later than 1 working day after the incident has come to light.**

The Initial Case Review templates from each agency involved should be sent to the CPC within 3 working days of the notification of the ICR being issued.

The **CPC should notify the agencies of the need for a fuller report, if appropriate, and agree who should coordinate no later than 5 working days from receipt of the templates.**

The Joint Case Review Report should be completed **no later than 5 working days after the CPC has indicated this is required.**

In summary:

Day 1 : incident identified

Day 2: CPC notified with basic information

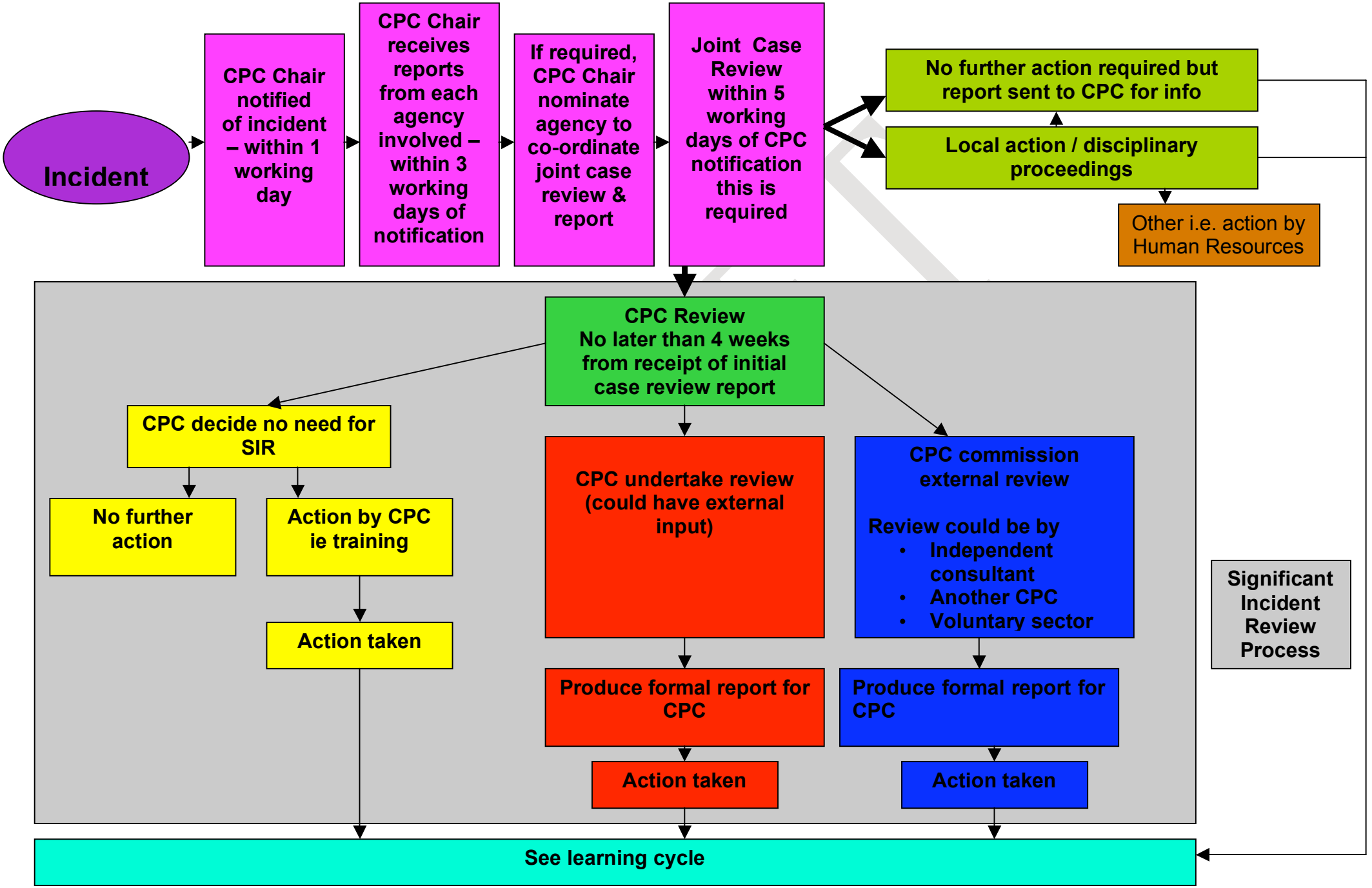
Day 5: ICRs (Annex 2) to CPC

Day 10: CPC request JCR or moves to decision on SIR

Day 16: JCR to CPC (if required) then moves to decision on SIR

Where any of these deadlines have to be extended, for example in circumstances where other proceedings intervene, this should be recorded and a timescale noted for appropriate follow up.

Disciplinary process : The Initial Case Review could lead to the initiation of disciplinary proceedings. These would be carried out in accordance with local procedures for each agency /professional codes and are not addressed here.


Incident
CPC Chair notified of incident – within 1 working day
CPC Chair receives reports from each agency involved – within 3 working days of notification
If required, CPC Chair nominate agency to co-ordinate joint case review & report
Joint Case Review within 5 working days of CPC notification this is required
No further action required but report sent to CPC for info
Local action / disciplinary proceedings
Other i.e. action by Human Resources
CPC Review
No later than 4 weeks from receipt of initial case review report
CPC decide no need for SIR
No further action
Action by CPC ie training
Action taken
CPC undertake review (could have external input)
Produce formal report for CPC
Action taken
CPC commission external review
Review could be by
Independent consultant
Another CPC
Voluntary sector
Produce formal report for CPC
Action taken
Significant Incident Review Process
See learning cycle

4. THE REVIEW PROCESS: Child Protection Committee Review (CPCR)

Action by the Child Protection Committee

4.1 Working within the accountability structures of their respective organisations, Chief Officers in each locality must work collectively to identify and commission inter-agency activity with respect to protecting children and young people. They must account for this work and its effectiveness. Operating on behalf of Chief Officers, the CPC has overall responsibility for the formal review of a significant incident and the decision on how this should be undertaken.

Child Protection Committee Guidance: Chief Constables and Chief Executives of Health Boards and Local Authorities are responsible for ensuring that their agencies, individually and collectively, work to protect children and young people as effectively as possible.

4.2 In every case, on receipt of the notification of an incident and the subsequent templates, the CPC, or those delegated with authority on behalf of the CPC such as a standing sub-group for example, must, in the first instance, confirm whether the information is sufficient for them to decide on the need for a SIR. Where the information is **insufficient**, the CPC must:

- require a Joint Case Review Report, agree the lead agency to co-ordinate this, and commission this to be provided within 5 days.

- 4.3 Where the information is sufficient from the Initial Case Review reports, or following receipt of the Joint Case Review report – whichever is appropriate, the CPC will:

- confirm whether the matter is a significant incident & so must be reviewed;
- consider what type of review is appropriate taking account of the local report and wider issues they may be aware of eg whether there have been similar cases;
- agree action with Chief Officers, or other as delegated according to local arrangements;
- notify their decision to the designated contacts according to agreed local communications strategy (see section 6) and then progress as agreed.

Action: CPCs will develop an operating protocol to underpin this guidance describing the communication and handling strategy – especially in terms of who in which agencies should lead, be informed, require to be involved in decision-making etc. and agree with Chief Officers.

Timing

4.4 The initial CPC Review should be completed **not later than 4 weeks from receipt of the initial templates or joint report (where that has been commissioned)**. If, for example, another process means that a decision cannot be taken this should be recorded and the reasons stated for the delay and when this will be followed up.

Outcomes from a CPCR

4.5 There are a number of possible outcomes from a CPCR and these are:

- No further review
- No further review but action for the CPC
- CPC undertake review
- CPC commission external review.

4.6 The following section provides a summary of the key characteristics of each of these outcomes. It is important to emphasise that different types of review does not imply a sequential approach.

4.7 More detailed information on the commissioning, conduct and reporting arrangements for each of the reviews is provided in Section 5. However, a brief summary is given here of the key elements and differences. In every case, the basis for the decision should be recorded.

No further review

This is where the criteria for a SIR, as set out in section 2, are not met, or where single agency action is deemed appropriate or where the information provided indicates that appropriate action has already been taken. The CPC could conclude there is no requirement for their involvement with the case (at this stage).

If this is the outcome of the CPCR, the CPC should notify all the agencies involved in the case that there will be no formal SIR. The decision should be included in the statistics on Initial Case Reviews which should form part of the annual report of the CPC (see Section 7, the Learning Cycle).

No further review but action for the CPC

This is where criteria for a SIR are not met, or where single agency action is deemed appropriate, or where appropriate action has already been taken **but** it is identified that the CPC may have a role.

For example, if it was clear that there had been a misunderstanding of guidance or there was a need to reinforce the local protocols to be followed. It could also be that the case is one of a number where similar themes are coming through and there could be a need to draw some guidance to people's attention or consider reviewing training/protocols.

If this is the outcome of the CPCR, the CPC should notify all the agencies involved in the case that there will be no formal SIR. The decision should be included in the statistics on Initial Case Reviews which should form part of the annual report of the CPC (see Section 7, the Learning Cycle) and the agreed action required by the CPC undertaken/scheduled into future work programme.

The CPC undertake review

The criteria for a SIR have been met and the CPC agree it is appropriate and proportionate for them to lead a review and recommendations are likely to have mainly local impact.

In this case, the resources for the review probably would be drawn mainly from within the CPC, or from local agencies or external specialists or consultants, or a combination of these to support a CPC-led review.

CPC commission external review

The criteria for a SIR have been met and the CPC agree it would not be appropriate and proportionate for them to lead a review - it is more appropriate for significant external scrutiny.

The level of communication with all stakeholders will be of a high order. There are likely to be national as well as local recommendations.

Selecting the type of review

4.8 The following list of questions may help in considering the type of review required:

- are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/agencies who will be required to participate in the review (an external review)
- will the case give rise to other parallel investigations? How can a co-ordinated review process address the relevant questions in the most economical and proportionate way?
- how should the review process take account of the wider context ie. criminal investigation or proceedings related to the case?
- What appear to be the most important issues to address in trying to learn from this specific case? How can the relevant information best be obtained analysed and disseminated?
- How would the public interest best be served?

5 REVIEW PROCESS: CPC review or external review

5.1 There are key components in the commissioning, conduct and outcomes of any review that will be common – although the scale and complexity will vary depending on the case and type of SIR initiated. For example, common to all is the need to consider:

- development of remit & agreed timescale;
- identification of review team and team leader of the review;
- arrangements for oversight/management of the review process, release of resources;
- conduct of the review;
- communication strategy and media handing;
- components of the report, handling and dissemination;
- monitoring progress on implementation; and
- contributing to the learning cycle.

5.2 Research and experience indicate there are 5 key areas where good preparation and planning are important to ensure the objectives of a review are met:

A developing the remit & timescale
B identifying the review team
C managing the process
D production, handling and sign off of the report
E taking receipt of the report and what happens thereafter.

Each of these are looked at in more detail in the following sections.

A - Developing the remit

5.3 The broad remit for the review will relate to the purpose of a review as described in section 1. The review should seek to:

- Establish the facts of the case, a chronology, the role of agencies and professionals etc.
- Analyse and assess these facts drawing out the implications and issues.
- Establish whether there are lessons to be learned.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Make recommendations (always for local action, could be for single or multi-agency, and may be also for consideration nationally) where appropriate spelling out resources that may be required to implement them.

Annex 3 provides some prompts to help consideration of what the remit of a CPC or external review might consider.

5.4 It is important from the outset to consider fully the scope and a remit for the review given the implications this will have for:

- who might need to be involved – skills/professional mix;

- the commitment this might require – time & other resources; and

timeframe and management arrangements:

5. The outcomes of the review should:

- identify how inter-agency working can be improved to better protect children and young people;
- contribute to the development and sustainability of robust quality assurance procedures and continuous improvement; and
- build confidence internally and externally that there is a sound, consistent and transparent review process where a significant incident has occurred.

5.6 The clearer the remit the easier it will be to manage expectations, both of those who may be involved in contributing to the review and the wider audience for the outcome of the review. It is recognised that the degree of complexity/involvement of people might not become clear until some initial work has been undertaken – especially in the case of an external review. Consequently, the remit to commence the process may need to be reviewed as the information develops during the process.

B - Identifying the review team

5.7 In the case of either a CPC review or an external review, identifying the right reviewer/ review team will be crucial. In any review team it is important that the key agencies are represented (or there are contacts that the review team can consult) as they will have to have an understanding of procedures and practice. In some cases it may also be necessary to have specialist input, whether as part of the team for the duration of the review or to provide advice as required. It is important that the reviewer/ or someone in the review team has a broad knowledge of children's services as well as the necessary skills to lead/undertake the review. A recognised professional in a particular field will not necessarily be the best person to lead a review.

5.8 The reviewer/review team will need to have particular skills and competencies in order to undertake the review. These will differ according to the circumstances of each case but the reviewer/review team will need to be able to:

- gather relevant evidence from a wide variety of sources and be prepared to negotiate if information is not forthcoming;
- have skills of investigation;
- test the validity of the evidence and sift the evidence;
- interpret information from a wide variety of sources;
- make sound judgements on information collected;
- analyse the root cause of / factors that contributed to the significant incident and know how to apply results of case in prevention of another case; and
- demonstrate sensitivity to, and awareness of, national and local level issues and how to broker change and secure 'buy-in'.

C - Managing the process

5.9 In the case of the CPC-led review, there may already be a standing group that considers all significant incident cases which could itself comprise the main reviewing team. Depending on the particular incident, it may be necessary to call on others from various agencies to provide input to support that team. It may be the case that there is a pool of people locally identified who can be called upon by the CPC to be involved in a review. Or it could be that members of the CPC will find an appropriate resource from within their own agency to be part of the review team. People who have trained as Associate Assessors to support the joint inspection of child protection work could be a useful resource for such reviews. It will be important from the outset to identify what is likely to be needed and how that can be achieved. It would be expected that a member of the CPC would lead the review – whether the Chair or a designated Committee member.

Action: Each CPC should agree the approach that will be taken when a CPC-led review is agreed in terms of how they go about identifying the review team.

5.10 It is also important that there is a list of key contacts for any review team across the key agencies. These could be designated SIR contacts who can advise on, and broker access to, relevant practitioners and information, provide any agency information that may be relevant (protocols/guidance) and generally act as a liaison point.

Action: Each area should identify key contacts in each agency for liaising with the review team.

5.11 When a CPC commissions an external review, preparation and planning are even more important as is the consideration of other specific issues before the review commences. Annex 3 provides a checklist of issues that should be agreed in advance of the review commencing and should be included in the letter of contract for the reviewer/review team. In addition Annex 4 provide some prompts for consideration for the reviewer/review team themselves.

5.12 The list below can act as a prompt in preparing for the review and the conduct of the review and may be relevant whether it is a CPC-led or externally commissioned review:

<u>Preparing for the review whether a CPC or an external review</u>

- how are the review team selected – the reviewers themselves and support staff – to be selected? Is there a role for the CPC or for the review leader?
- are there formal contractual arrangements to be agreed, who needs to be involved ? any role for legal services/procurement?
- is there a need to provide some sort of induction of personnel?
- is any training needed for the reviewers?

- Who will meet any expenditure. How will any expenditure by the review team be managed and controlled?
- are there accommodation/space requirements for the review team?
- Are IT facilities required for the review team?
- are there secure storage arrangements for files/ documents?
- are research facilities required by the review team?
- what are the payment arrangements for the review team?
- are there equipment requirements for the review team?
- how often, to whom and in what format should the review team provide interim reports?
- what are the agreed timescales with principal stakeholders?
- have you agreed a communications plan?

Conduct of the review

- have you agreed with the review team how people giving information to the review should be treated – how information be used; what confidentiality does it have; how will it be recorded; will it be checked with those persons / corroboration sought from other sources; anonymity in the published report?
- what briefing will be provided for contributors, and who by? Will they have an opportunity to review their contribution as it might be recorded in the final report? How will that be done?
- has it been agreed what to do / who to go to if anything comes to light that requires immediate action?
- how should any public, family and media interest be handled – before, during and after the review? and who by?

D - Report: production, handling and sign off

Responsibility: Review Team

5.13 The report of the SIR will be the key document for identifying the issues and the learning points and, on most occasions, should be a matter of public record – especially where an external review has been undertaken. In saying that, there will be a need to consider carefully issues of confidentiality and identification of either staff or children and their families. Annex 3 provides a list of points the reviewer/review team might find useful to look at before commencing a review.

5.14 It is important that there is a degree of consistency on the structure and content of reports. This makes it easier for people to identify and use the findings and for read-across to other reports to be made. The report will include:

- **An introduction** – summarise the circumstances that led to the review, state the remit and a list of contributors to the review;
- **An executive summary & list of recommendations** (and who the recommendations are for);
- **The facts & professional/agency involvement** – including showing members of the family, extended family and household. A list showing on each occasion that the child was seen whether the child's views and wishes were sought and if they were expressed;

- **A Chronology;**
- **Analysis;**
- **Conclusions**; and
- **Recommendations** – recommendations should be few in number, focused, specific and capable of being implemented. It would also be helpful to identify who these are mainly aimed at and any resource implications.

5.15 Final versions of each report should be published but detailed information on names and circumstances should be anonymised before publication. It would be expected that a report would be unanimous in its findings and conclusions. However, where there is dissent, a minority report can be included. The review team and CPC will wish to take account of the requirements of the Freedom of Information Act and Data Protection Act in both the conduct and reporting of the review.

Finalising & issue of report

5.16 The points below, while not exhaustive, highlight the key considerations and responsibilities for clearing and issuing the report of the SIR.

Responsibility: Reviewer/Review team

- how and with whom to share draft to check for accuracy/other issues.

Responsibility: CPC

- distribution list (see Section 6);
- any internal / external communication / briefing required before publication (see Section 6); and
- media handling (see Section 6).

E - Taking receipt of the report & what happens thereafter

Responsibility: CPC

5.17 In preparing for the publication of the report there are a number of issues which should be considered. Not all of these will be relevant on every occasion:

Taking receipt & follow up:

- prepare response to findings
- prepare action and implementation plan and a means of monitoring progress
- liaison/ briefing for Chief Officers, Scottish Executive, inspectorates others as required
- mechanism for dissemination within and across agencies to capture learning and ensure this is reflected in communication, guidance, training (see Section 7).

Review of progress

- when, how and who by

- review of action plan & identification of outcomes
- define action to be taken if progress review not appropriate
- annual analysis, as a minimum, by CPC of all cases referred for a CPCR and copied to Scottish Executive [Children & Families Division, Significant Incident Review, Scottish Executive, Area 2B(North), Victoria Quay, Leith, EH6 6QQ].

The family/carers of child or young person involved

5.18 The family/carers of the child or young person involved should be kept informed of the various stages of the review and the outcomes of these where this is appropriate. Clearly there will be occasions where the family could be subject to investigation or part of the problem relating to the significant incident which triggered the SIR. The family/carers should receive a copy of any report that will be published before it is issued and consideration should be given as to whether an oral briefing in advance of publication is required. This is particularly the case where there is likely to be interest in the wider public domain.

5.19 It may also be useful to assign a member of staff to be a liaison point throughout the review. The person carrying out this liaison role should be aware fully of the sensitivities and background of the case.

6. SIGNIFICANT INCIDENT REVIEW: COMMUNICATIONS STRATEGY

6.1 It is important to be clear who needs to be aware of the review, what information they need, when and how this will be provided. The following section is provided to help work through this process. Each CPC should agree with local agencies who the actual contact points should be and their role in the process – i.e. is communication for information or decision-making.

Who?

6.2 From the start it is important to ensure that all those who will input and who have a legitimate interest in the SIR are informed at each stage of the process. Below is a list of internal and external interests. As each significant incident will be different, these might vary and consideration should be given as to whether there is anyone else who should be informed.

Those with responsibility for local service delivery and review

- Local Child Protection Committee
- Chief Officers: Chief Executive of Local Authority/ Chief Executive of Health Board/ Chief Constable
- Director of Social Work/ Chief Social Work Officer/ Senior Managers in the Police, Education and Health Service
- Staff involved in the review
- Crown Office and Procurator Fiscal Service.

Wider interests

- Family of child or young person involved
- Local Councillors/ Health Board Chairs/ Chairs of Police Authorities
- Voluntary Organisations – where they are involved in the case
- Local Authority, Health Board and Police press officers
- Scottish Executive
- Inspectorates – HM Inspectorate of Education Services for Children Unit, Social Work Inspection Agency, HM Inspectorate of Constabulary, NHS Quality Improvement Scotland, Care Commission
- Children's Reporter/Scottish Children's Reporter Administration (SCRA)
- Other Child Protection Committees
- Professional representative bodies
- Legal representatives
- Unions
- Family.

Other key interests

- Media
- General public
- Elected members e.g. MSP, MPs.

When?

6.3 In some cases information may already be widely known because of the nature of the case. For example if the media know of a case and have released information before the review process has been commenced/completed. The media handling section at Annex 11 gives some advice for dealing with the media.

6.4 On completion of the review, the distribution list should include all of the main stakeholders identified plus any other organisation/people who may have become involved with the review.

6.5 In addition to the notifications here, it will be important that those to be involved in the review process are fully briefed and have an understanding of the process. This is covered in Section 5 under conduct of the review and in Annex 7.

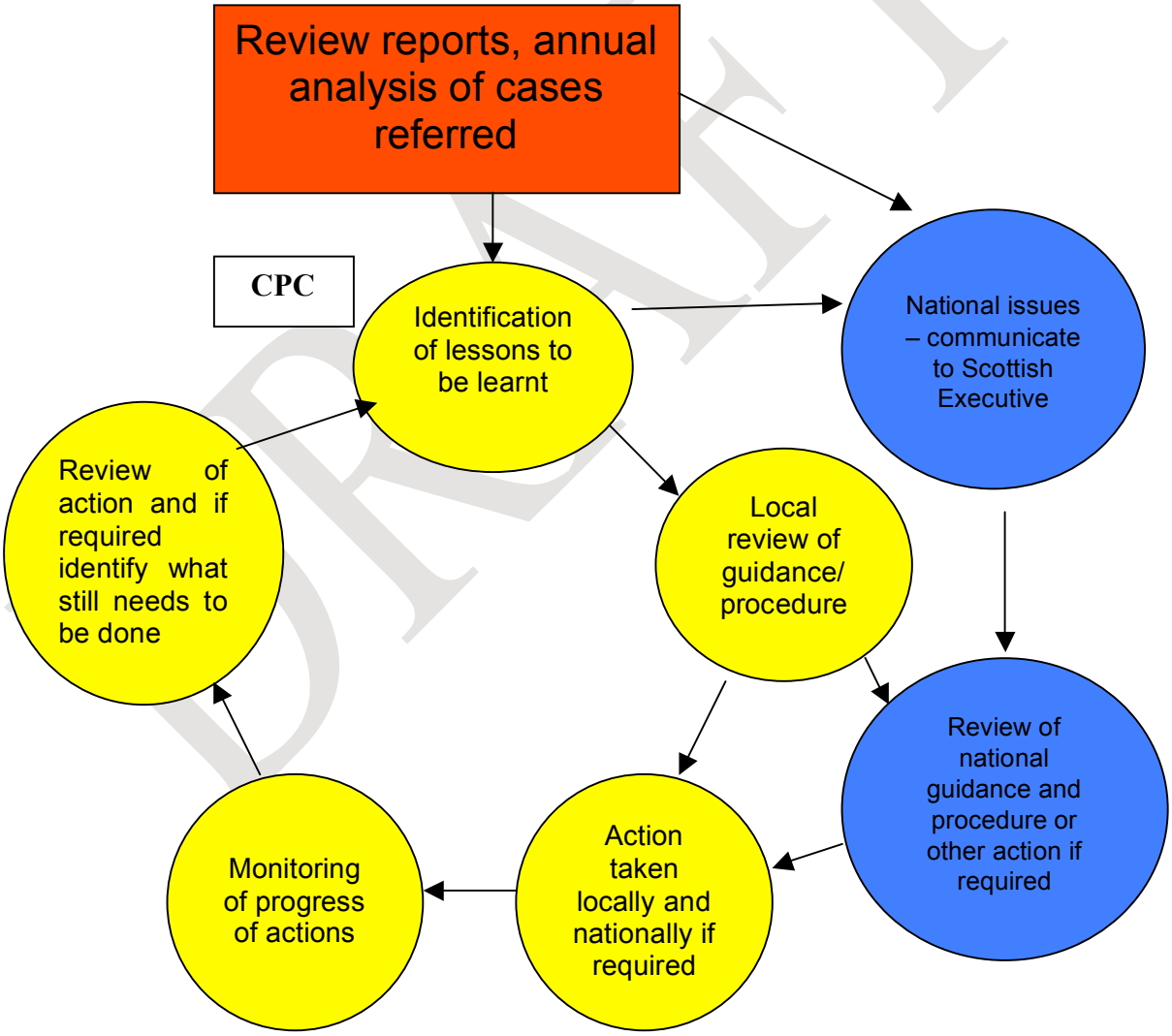
Examples of the following are provided in the annexes to this document which might be helpful to use during the process of the review:

- Draft letter to wider professional interests group to inform them of outcome of the CPCR. This could also be used to send to the list of wider interests when a CPC review and an external review are needed. This is at Annex 10.
- A leaflet that explains the process of the review including what the family involved could do if they are not satisfied with the outcome – how they could access agency complaints procedures. This is at Annex 10.
- Handling the media and some hints and tips are at Annex 11.

7 SIGNIFICANT INCIDENT REVIEW & THE LEARNING CYCLE

7.1 One of the key objectives of a significant incident review is to establish whether there are lessons to be learnt. Once these have been identified in the report it is important that action is taken to implement these lessons and improvements made to practice – and that this is monitored.

7.2 Each agency and CPC should be monitoring practice and procedures, making improvements as required. Recommendations and learning from Significant Incident Reviews should be fed into this same process of continuous improvement and quality assurance. On occasions there will be recommendations which are relevant for action at a national level, for the Scottish Executive or others to take forward in conjunction with agencies. The diagram below shows the information flows to assist continuous learning.



Learning from reviews

7.3 The CPC and local agencies will need to look carefully at recommendations and any lessons from individual reviews as well as across reviews in their own and other areas.

Determine:

- a time frame for action
- scope of change required and consider whether:
    - organisational
    - management
    - policy
    - protocol
    - practice
    - operating conditions
    - combination
    - communicate with other CPCs, Scottish Executive or a national dimension.

- who and/or what service/s and organisations are responsible for change
- how to promote commitment to change:
    - consider identifying one senior person to champion change
    - communication to interested parties
    - support and acknowledge good practice within and between organisations/service areas
    - determine impact on individuals or organisations (risk factors) as a result of change

- how to build public confidence
- how to identify, plan and implement the required training
- production and implementation of long and short term action plans – action plans could be fed directly into Children's Service Plans
- how to sustain change:
    - by monitoring and evaluation including linking into reporting and action planning cycles
    - by engagement with stakeholders
    - by supporting staff.

CPC

7.4 The CPC should produce a summary of cases sent to them over the course of the year and introduce these into the learning cycle - whether the decision was to undertake a SIR or not. CPCs will determine the urgency for action planning and implementation within the learning cycle according to the significance of the issues raised to protecting children and young people.

Other CPCs

7.5 After some significant incident reviews it may be necessary for other CPCs to review their own guidance and procedures in light of the findings and recommendations from a review. This could be facilitated through the meetings of the National Child Protection Committee Chairs Group or by specially convened meetings depending on the need for urgency.

Scottish Executive

7.6 Some recommendations from reviews may be for consideration at national level and will need to be led by the Scottish Executive. In addition the Executive will be in receipt of the CPC Annual reports (including the annual analysis of cases) and will be able to pick up any trends from these and feed them back to CPCs and to the inspectorates more widely as appropriate.

Inspectorates

7.7 Learning from reviews will also be important for the inspectorates as they have a role inspecting services and can evaluate how well recommendations have been implemented and the learning put into practice. Reports sent to the Scottish Executive will be circulated to inspectorates as appropriate.

Others

7.8 Some recommendations from reviews may be for consideration at national level and may have implications for a range of bodies, for example NHS Education, or regulatory bodies such as the Scottish Social Services Council. The Scottish Executive will communicate with these organisations and facilitate change as required.

8 SIGNIFICANT INCIDENT REVIEW & THE WIDER CONTEXT

8.1 There are a number of other processes that could be running in parallel with an SIR and this raises a number of issues including:

- the relationships with other processes, such as criminal proceedings;
- securing co-operation from all agencies in relation to the release of information;
- minimising duplication; and
- ensuring a sufficient degree of rigour, transparency and objectivity.

8.2 There must be clarity of roles and agreement should be made early on as to who does what. The process chart at annex 8 describes the review process. It is in 3 sections:

- the review process itself,
- inter-related processes, and
- learning, which describes what and how information should be shared, when and who with and in what form.

Inter- related processes

8.3 Depending on the incident, there could be a number of processes which come into play which are driven by considerations wider than service failure or learning lessons across agencies. These can include a criminal investigation, report of death to Procurator Fiscal (PF), Fatal Accident Inquiry, and a Death of a Looked After Children Review. Further details of these processes are at Annex 9.

Interdependencies

8.4 There is a potentially complex set of activities which may be triggered by a significant incident – most likely a death. It is important that local services do not interfere or contaminate that activity, especially in relation to evidence gathering where there is, or there is the potential for, criminal investigation – whether of staff involved in a case or a third party. The key requirement is that good, local ongoing dialogue is maintained with the PF and/ or police to ascertain where they are in their considerations and agree what can be progressed in the SIR. Efforts should be made to minimise duplication and ensure, as far as is practicable, that the various processes are complementary albeit their purpose could be different somewhat. It would be expected that in the case of a significant incident which does not involve a death, it is probable that there is less likelihood of these inter-related processes taking place.

8.5 In *Protecting Children and Young People: Child Protection Committees*[7], The Crown Office and Procurator Fiscal Services recognised the importance of child protection and encouraged the involvement of Procurators Fiscal with CPCs – especially in relation to investigations, proceeding or the death of a child. If not already the case, CPCs should seek to ensure they have a named contact in the PFS to be able to pursue such ongoing dialogue as is required to meet the objectives of each type of activity.

8.6 There will also be agency-specific work that is routinely undertaken, particularly on the death of a child, for example, when this occurs in hospital or is unexpected such as in the case of cot death. It will be important that any Signficant Incident Review is co-ordinated to dovetail with such work to avoid duplication of effort and unnecessary further review.

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

Annex 1

SIGNIFICANT INCIDENT REVIEW: Criteria and definition of abuse

Criteria

Any of the circumstances below require a Significant Incident Review:

When a child dies and:

• abuse or neglect is known or suspected to be a factor in the child's death;

• the child is on, or has been on, the Child Protection Register. Or a sibling is on the Register, whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear that having been on the CPR has no bearing on the case;

• the death is by suicide or murder;

• the child is being 'looked after' by the local authority[8].

When any child has not died but:

• has sustained any of the following:
• physical injury;
• sexual abuse,
• emotional abuse, or
• physical neglect;

and the incident gives rise to concerns about professional and / or service support or action.

• the CPC should consider any formal request for a review from a service provider - even if the case had been considered by an initial case review to require no further action.

The definitions of the categories of abuse and neglect in this criteria, as defined in *Protecting Children – A Shared Responsibility: Guidance for Inter-Agency co-operation*[9], are shown below.

[8] Reviewing and reporting the death of a looked after child is a statutory duty under regulation 15 of *The Children (Scotland) Act 1995 Regulations and Guidance*, Scottish Office 1997

[9] From *Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation,* Scottish Office 1998

Definition of abuse

In considering whether any of the criteria apply, the 1998 definition of categories of abuse for registration on the Child Protection Register from *Protecting Children - A Shared Responsibility: Guidance on Inter-Agency Co-operation* is helpful**.**

Physical Injury:

Actual or attempted physical injury to a child, including the administration of toxic substances, where there is knowledge, or reasonable suspicion, that the injury was inflicted or knowingly not prevented.

Sexual Abuse:

Any child may be deemed to have been sexually abused when any person(s), by design or neglect, exploits the child, directly or indirectly, in any activity intended to lead to the sexual arousal or other forms of gratification of that person or any other person(s) including organised networks. This definition holds whether or not there has been genital contact and whether or not the child is said to have initiated, or consented to, the behaviour.

Non-Organic Failure to Thrive:

Children who significantly fail to reach normal growth and developmental milestones (i.e. physical growth, weight, motor, social and intellectual development) where physical and genetic reasons have been medically eliminated and a diagnosis of non-organic failure to thrive has been established.

Emotional Abuse:

Failure to provide for the child's basic emotional needs such as to have a severe effect on the behaviour and development of the child.

Physical Neglect:

This occurs when a child's essential needs are not met and this is likely to cause impairment to physical health and development. Such needs include food, clothing, cleanliness, shelter and warmth. A lack of appropriate care, including deprivation of access to health care, may result in persistent or severe exposure, through negligence, to circumstances which endanger the child.

Annex 2

Initial Case Review Report

Name of Child Protection Committee

Child's Name/Identifier: Date of Birth: Referring Agency:

Brief description of incident and basis for referral:

Key facts/background to the case:

Agency/professional involved:

Summary of findings of the initial case review:

Other proceedings underway:

Lead contacts for each agency

Date sent to nominated contact:
Person completing this form:

Sent to Chair of CPC

Copy to be retained in Child's record
Copy to Exec Lead for Agency
Copy to Senior Local person in agency

Annex 3

Commissioning an external review - checklist for CPCs

It is important that when CPCs are commissioning an external review that they agree various issues at the beginning to avoid problems later on in the process – these could be outlined in the letter of contract for the reviewer/review team.

The following should be outlined:

• Remit of the review

• Review timescales including a date for receipt of interim and the final report

• Reporting arrangements for the review – how often, in what format and to whom should updates be received

• That the CPC, as the commissioner, owns the report and therefore only they should speak to the press regarding the review, unless otherwise agreed by the CPC and the reviewer/review team

• Salary / contract price for the reviewer/review team

• Admin support available to reviewer/review team should be clarified and who will pay for this support

• How other expenditure by the reviewer/review team should be managed and controlled

• Any local procurement requirements / invoicing etc

Annex 4

Checklist for the reviewer/review team

• Have you the skills or experience (or access to these) required to undertake/lead the review?

• Is the remit clear and deliverable?

• Are there clear reporting lines and agreement on handling – of the review itself and the report?

• Have milestones been identified / agreed for the various elements of the process?

• Do you need indemnity cover?

• Do you have appropriate admin support?

• Do you have know how to get approval for additional resources if it becomes clear that you require additional admin support etc?

• What contingency arrangements are in place/needed?

• Have a you a named contact person should issues arise?

Annex 5

Remit of the review

The remit for each review will be different depending on the circumstances of each case. A list is provided below with some suggestions for inclusion in a case review remit:

• To establish the facts about individual and multi-agency contact with [name of child or young person]

• To establish the circumstances leading to and surrounding the death/case of [name of child or young person]

• Examine the role of all the agencies involved in providing care, welfare and protection services

• To establish whether there are lessons to be learned from the case about the way in which we work together and individually to safeguard children

• To identify what those lessons are and to make recommendations as to how those lessons could be acted upon and what change could be expected as a result of the consequence if the recommendations are pursued.

It may also be appropriate to add something along the lines of:

It is not within the remit of review team to investigate the practice of any of the professionals involved. However, if, in the opinion of the members of the review team, there are specific issues with regard to professional standards or training of individual practitioners information will be provided in confidence to the appropriate agency for action.

Questions for the review team before beginning the review **Annex 6**

Better outcomes can be achieved if there is consistency of questions and issues to be addressed in a review and investment of time in scoping the review. This is especially true where an external review is being commissioned. A checklist of issues that could be considered for a review are given below:

• Over what time period should events be reviewed? How far back should inquiries cover and what is the cut-off point? What family history/background information will help to understand better the recent past and present which the review should try and capture?

• Which agencies and professionals should contribute to the review, and who else should be asked to submit a report or otherwise contribute?

• Should family members be invited to contribute to the review?

• Who will make the link with the relevant interests outside the main statutory agencies?

• Does the review team need to conduct interviews or will looking at the files be enough to establish the facts of the case?

Support to staff

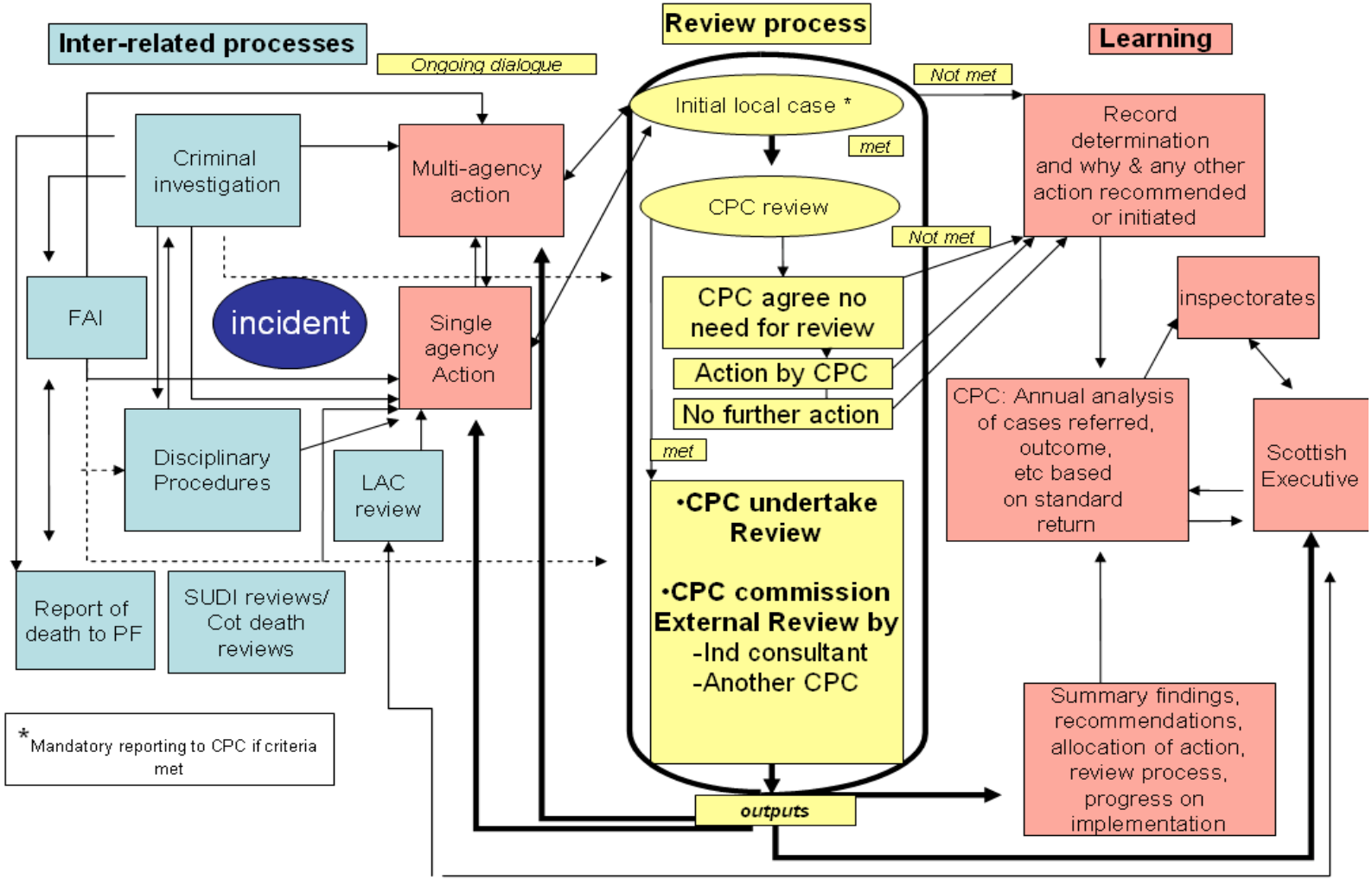
During the review process staff should feel informed and supported by their managers. There may be parallel processes running which staff are involved in – for example disciplinary proceedings as well as a Significant Incident Review, so sensitive handling is important. Each organisation should have it's own procedures in place for supporting staff, below is an illustration of the types of support that could be provided. Additional support should be put in place if necessary, for example where a child has died. The line manager should always consider:

- the health & well-being of staff involved;
- provision of welfare or counselling support;
- communications with staff, keeping people informed of the process in an open & transparent way;
- the need for legal/professional guidance & support;

and may consider:

- reducing their caseload;
- agreeing that the worker should no longer be directly involved in the case being reviewed; and
- allowing time off;

A leaflet at Annex ?? outlines the review process and could be localised and given to staff involved in a review. Once the review has been completed the staff and workers involved in the case should be given a debrief on the review and the findings before the report is published.


Inter-related processes
Ongoing dialogue
Review process
Learning
Criminal investigation
Multi-agency action
Initial local case *
met
Not met
Record determination and why & any other action recommended or initiated
CPC review
Not met
FAI
incident
Single agency Action
CPC agree no need for review
Action by CPC
No further action
inspectorates
Disciplinary Procedures
LAC review
met
•CPC undertake Review
•CPC commission External Review by
-Ind consultant
-Another CPC
CPC: Annual analysis of cases referred, outcome, etc based on standard return
Scottish Executive
Report of death to PF
SUDI reviews/ Cot death reviews
Summary findings, recommendations, allocation of action, review process, progress on implementation
outputs
*Mandatory reporting to CPC if criteria met

Inter-related processes **Annex 9**

Criminal investigation (CI) Lead role: Police

Within Scotland the core functions and jurisdiction of the police are specified by the Police (Scotland) Act 1967. This includes a duty to protect life and property and a duty to care and protect the most vulnerable people within society, including children and young people.

The police are very much an independent investigative and reporting agency to the Crown Office and Procurator Fiscal Service and to the Reporter to the Children's Panel (SCRA). The police have a duty to investigate both crimes/offences and also any unexplained sudden deaths.

Crimes and Offences:-

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

a) Whether or not a crime or offence has been committed;
b) Whether there is sufficient evidence to support a criminal charge;
c) Whether grounds exist for referral to the Reporter to the Children's Panel, under the terms of the Children (Scotland) Act 1995, Sect 52;
d) Whether there is sufficient evidence to justify the detention and/or arrest of the alleged offender;

and thereafter to,

e) Submit a report to the Procurator Fiscal and / or the Reporter to the Children's Panel.

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

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

After consideration of the above, which effectively should ascertain the risks and needs of the child, the investigation will begin. In many such cases a Senior Investigating Officer (SIO) will be appointed to oversee the investigation.

In matters where a serious crime or offence has been committed, the investigation will usually be conducted by specially trained officers of the Criminal Investigation Department, and should the crime involve the abuse of a child, support will be given to these officers by officers from the Family Protection Unit, who are trained in the investigation of such criminality.

Good practice would always suggest that a Family Liaison Officer is appointed to work with and support the child and family and to act as the single point of contact between them and the police.

The evidence of the crime or offence will be gathered in a variety of ways such as the obtaining of statements from witnesses who have knowledge of the events under investigation, the gathering of forensic evidence such as DNA, fingerprints, hairs, fibres etc and the interviewing of those person (s) suspected of being responsible.

Upon conclusion of the investigation the police will prepare a report of the circumstances and this will be submitted to the Procurator Fiscal and/or the Reporter to the Children's Panel. Decisions will also be made as to whether the alleged accused should remain in police custody pending his/her appearance in court, whether they should be released on Undertaking which may specify certain restrictions/provisions or whether they should be released pending report and summons.

Unexplained Sudden Deaths

"Sudden Deaths" are best defined as any death which occurs suddenly, is unexpected and not proceeded by any known illness or disease, which occurred anywhere, either from violence by others, suicide or accident, where the cause of death is unknown or undetermined and where the circumstances give rise to suspicion.

Where the circumstances of the death are known, or where the death was expected due to illness or disease and where there is no cause for suspicion or concern then the attending medical practitioner, on occasions in consultation with colleagues, will grant the necessary death certificate, confirming time, date, place and cause (s) of death which will then allow the relatives to make the necessary arrangements for registration and burial or cremation. This process will not involve either the police or the Procurator Fiscal.

However, in all other such circumstances, where the death has been certified (pronounced life extinct, time, and date) by a qualified medical practitioner and where a death certificate has not been granted as the cause of death is undetermined and/or suspicious, intimation will be forwarded to the Procurator Fiscal, in practice by the medical practitioner and/or the police if they have already been informed.

Upon intimation, the Procurator Fiscal will immediately instruct the police to carry out preliminary investigations into the matter on his/her behalf and to make the necessary reports to the Procurator Fiscal by the next lawful day. Invariably and in most cases the body of the deceased will be taken possession of and the Procurator

Fiscal will order a post mortem examination to be carried, the purpose of which is to determine the time, date and exact cause of death. Normally this procedure is carried out after intimation and the receipt of preliminary information by the Procurator Fiscal but not always as the sequence of the events are sometimes dictated by the circumstances of the specific case.

It should also be noted that at this early stage of the investigations, criminal intent, culpability, recklessness, negligence, etc are not what is under consideration. They may already feature or feature later as a result of the police investigations but are not seen as a pre-requisite at this stage. It is the death that is under investigation. Clearly these factors will influence the later decision making processes of each agency.

Post mortem examinations are carried out under the Procurator Fiscal's successful Petition to the Sheriff. Parental and/or relative consent is not necessary, albeit in practice they are informed of this process and their cooperation sought.

Post mortem examinations are normally carried out by a single Pathologist acting on behalf of the Crown. He/she will in conjunction with the information provided to him by the police and/or the Procurator Fiscal, carryout an examination of the body and this should normally determine the cause of death, subject to the need for further testing, toxicology etc. His/her findings will be communicated to the Procurator Fiscal and/or the police and will form the basis for the granting of a death certificate.

In circumstances where the death is considered to be suspicious, the Procurator Fiscal may direct that a two Doctor post mortem examination be carried out for corroboration purposes of the finding. This would be an essential element in the chain of evidence, particularly where criminal investigations and/or proceedings were to be instigated later.

Should the circumstances subsequently become explained and no longer suspicious, the Procurator Fiscal will order the release of the body to the relatives, arrange for the death certificate to be provided, thus allowing registration, burial or cremation.

If the post mortem examinations confirms the death was in fact suspicious, avoidable and in particular at the hand of another (s) then the body may not be released at that time, further investigations and enquiries will be ordered, some of which the Procurator Fiscal may specify and the matter would normally become a criminal investigation. In any case, the Procurator Fiscal will require further information so as to determine his/her course of action and in most cases, the police will be the investigating agency directed to conduct these investigations.

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

Good practice would always suggest that a Family Liaison Officer is appointed to work with and support the family and to act as the single point of contact between them and the police.

In child death cases, the procedures applied and followed are in fact the same, albeit, the services of a Paediatrician and/or Paediatric Pathologist would be sought. On many occasions, such specialists are not readily available and accessible and in many cases the body of the deceased may well have to be transferred to such centres of excellence.

Once all the investigations have been conducted, the Procurator Fiscal, will make her/her determination as to criminal proceedings, on many occasions, particularly where a death is involved this will be in conjunction with the Crown Office. All such deaths are fully reported to them.

FATAL Accident Inquiry (FAI)

Procurators Fiscal must investigate all sudden, suspicious, accidental, unexplained and unexpected deaths and in particular all deaths resulting from an accident in the course of employment or occupation, deaths whilst in legal custody and deaths occurring in circumstances 'such as to give rise to serious public concern'. The Lord Advocate has discretion to instruct a FAI where it appears to be in the public interest that an Inquiry should be held into the circumstances of the death. An FAI would not automatically be held in respect of a child death.

The purpose of a FAI is the enlightenment of those legitimately interested in the death, i.e. the relatives and the dependents of the deceased, as to the cause of death; and the enlightenment of the public at large as to whether any reasonable steps could or should have been taken to avoid the death, in order that lessons may be learned. The PF in the area where the death occurred leads the Inquiry in front of a Sheriff, but in a different role from the usual one of prosecutor. The access to and availability of evidence to legitimately interested parties enables those parties to establish negligence or other culpability.

The findings available to a Sheriff at its conclusion are restricted to those directly relating to the circumstances of the death and any actions or systems that caused or contributed to that. The Court has no power to make any finding as to fault or to apportion blame between any persons who might have contributed to the accident. The Sheriff has the power to make recommendations as to steps which ought to be taken

to prevent a death occurring in similar circumstances in future.

While there is no compulsion on any person or organisation to take such steps, it would be unusual for a Sheriff's recommendations to be disregarded.

Looked After Child review (LAC):

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

This is an internal inquiry, based on guidance to LAs, with submission of as full a report as soon as possible after the death to the Scottish Ministers and which should not be delayed beyond 28 days.

Ministers are empowered to:

• examine the arrangements made for the child's welfare during the time he or she was looked after;
• assess whether action taken by the local authority may have contributed to the child's death;

• identify lessons which need to be drawn to the attention of the authority immediately concerned and/or other authorities or other statutory agencies;
• review legislation, policy, guidance in the light of a particular case or any trends emerging from deaths of children being looked after.

Lead role: local authority & Social Work Inspection Agency.

Annex 10

Draft letter from the CPC Chair to those with responsibility for local services delivery and review to inform them on the outcomes of a Child Protection Committee Review

This could also be sent to the wider professional interests if a CPC review or external review is required.

Significant Incident Review

[insert name of CPC] Child Protection Committee has assessed the case of [name of child or young person] whose case was brought to its attention on [insert date].

Following an initial review of the local reports provided, it has been agreed that [delete as appropriate]

• No further action is required in this case but the case will be included in the CPC annual statistics on the review of Significant Incidents.

• No review is required by the CPC but it will be undertaking the following actions [insert] and the case will be included in the CPC annual statistics on the review of Significant Incidents.

• The CPC will be undertaking a review of the case and will produce a formal report by [insert date]. This will be led by [insert name] and a remit and timescale is currently being developed.

• An external review of the case is required and will be undertaken by [insert name] and will produce a formal report for the CPC by [insert date]

If you require information as this work progresses, you can contact [insert contact details].

CPC Chair

Annex 11

MEDIA HANDLING

This section provides some hints and tips to consider in relation to media handling. Most agencies will have media liaison/spokespeople for the agency and any protocols/handling issues should be developed in conjunction with those arrangements.

The media can help promote more effective prevention and intervention to protect children and young people by raising public awareness of the circumstances that can occur which contribute to harm and what members of the community could also do to mitigate these.

However, it is also possible that the media can report misinformation or incomplete information which can be unhelpful causing misunderstanding of the actual events or distress to family or those involved with individual cases. Consequently it is important to have clear policies and designate individuals to responds to media inquiries where a significant incident has occurred.

It is recommended that, wherever possible, there is a single spokesperson identified to deal with media inquires where there is a case undergoing a SIR. This person will need to have identified contacts in each agency and the review team to ensure only appropriate and up to date information is released – and that this is only done when appropriate.

Media priorities

Ideally those handling media inquiries should seek to build a good working relationship with the media – and not just have dealings with them when a problem/issue has been identified. Educating the media about the review process can be helpful and help build a constructive relationship. Breaking news is anything that is happening in real time and the media will press for instant responses to their queries. They will want the story now and, no matter what you provide, they will decide on their own 'spin' on the story.

Handling

It is important to add an element of calm and focus and not to add to any sense of alarm or confusion – keep things as simple and straightforward as possible. Do not be drawn into offering personal options or remarks. Remember that anything you say can be quoted or taken out of context, so stick to the facts and don't speculate or make up details because you are being pressed. There is no such thing as an" off the record" comment, even if you say so, the journalist may well use your comment using that statement.

Helpful hints and tips

Print interviews:

- Know the reporter, what else they've written so you have an insight into where they are likely to be coming from
- Know the reasons for the story and who else the reporter has interviewed
- Prepare quotable statements and try and avoid "no comment"
- Provide any statistical information that might provide a context
- Don't make "off the record comments"
- Don't give inaccurate information or information you are unsure of – indicate you will get back to them on that
- Be careful in respect of using names and maintaining confidentiality – whether for children and families involved or practitioners
- Make sure you let others who might be approached for a comment know what has been provided.

Writing a news release

- Be brief – one page
- Remember to include "Who, What, Where, When, Why"
- Include all the key information in the first 2 paragraphs
- Include background note with support for statistical information, contact for follow up etc
- Use quotes
- Be careful in respect of using names and maintaining confidentiality – whether for children and families involved or practitioners
- Make sure you copy to everyone who needs to know information is being released – preferably in good time to allow them to consider whether they ned to prepare any line in case approached.

Media interviews

- Deliver your message, whether or not it is asked for
- Have some short statements to cover your key points prepared
- Information is power and you are the source of information so you can control what is covered
- You can't control events; you can control responses
- Keep your answers short, don't feel compelled to fill any silences
- Avoid professional jargon
- Use examples and anecdotes where relevant
- Be careful in respect of using names and maintaining confidentiality – whether for children and families involved or practitioners.

Annex 12

Protecting Children and Young People: Significant Incident Reviews

An overview of the review process

Protecting children and young people is the responsibly a number of local services including health, social work, police and education.

Local Child Protection Committees (CPCs) work on behalf of Chief Executives of Health Boards and Local Authorities, and Chief Constables and have a key role in managing the Significant Incident Review process locally.

What happens when a child dies or there is a significant incident?

An initial case review of the incident is conducted within 7 working days after the incident has come to light. A report will then be submitted to the local CPC.

Once the CPC has a report they will assess the case and decide whether it is necessary to have a review of the case.

A Significant Incident Review should take place:

When a child dies and:

- abuse or neglect is known or suspected to be a factor in the child's death;
- the child is on, or has been on, the Child Protection Register. Or a sibling is on the Register, whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear that having been on the CPR has no bearing on the case;
- the death is by suicide or murder;
- the child is being 'looked after' by the local authority.
- **When any child has not died but:**
- has sustained any of the following:
- physical injury;

- sexual abuse,
- emotional abuse, or
- physical neglect;

- and the incident gives rise to concerns about professional and / or service support or action.

- the CPC should consider any formal request for a review from a service provider - even if the case had been considered by an initial case review to require no further action.

The CPC have decided there should be a review – what happens next?

The CPC can either undertake a Significant Incident Review themselves or commission an external review.

The CPC have decided that there is not a need to hold a Significant Incident Review - does this mean that nothing will be done ?

The CPC will record all cases that have an initial case review in their annual statistics. In addition having looked at the circumstances of the case the CPC may decide that an local procedures or training needs to be revised to plug the gap.

What will happen to a report once it has been written?

All reports should be published and it is up to local agencies or those organisations the recommendations directly refer to respond and act on the recommendations if appropriate.

Glossary

CPC	Child Protection Committee
CPCR	Child Protection Committee Review
FAI	Fatal Accident Inquiry
ICR	Initial Case Review
JCR	Joint Case Review
LAC	Looked After Child
PF	Procurator Fiscal
SCRA	Scottish Children's Reporters Administration
SIO	Senior Investigating Officer
SIR	Significant Incident Review