
Report To:	Health and Social Care Committee	Date: 27 August 2009
Report By:	Robert Murphy Acting Corporate Director, Social Care	Report No: SW/24/09/LW/BK
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Subject:	SWIA Annual Report on Deaths of Looked After Children 2006/2007	

1.0 PURPOSE

- 1.1 This report is to advise Members of the contents of the first annual report produced by the Social Work Inspection Agency, (SWIA), which reviews the deaths of all Looked After Children in Scotland, between 30.03.06 and 30.03.08

2.0 SUMMARY

- 2.1 The report considers the circumstances of 29 children and young people who died during the above period and who were Looked After at the time of their death. It draws some conclusions based on this information which will be considered by Social Work Services.
- 2.2 It is important to note that there have been no deaths of children looked after by the Council in this time frame. The Service however acknowledges the importance of ensuring appropriate risk assessments are undertaken and that we consider the implications of the report in the development of our service to children who are looked after.

3.0 RECOMMENDATION

- 3.1 That Members note the contents of this report.

Robert Murphy
Acting Corporate Director, Social Care

4.0 BACKGROUND

- 4.1 Local authorities are required under Regulation 15 of the Children (Scotland) Act 1995, to report any death of a looked after child or young person to SWIA. In such instances SWIA act on behalf of Scottish Ministers to consider the circumstances surrounding the death and to identify any practice issues or other lessons which may be learned. In doing this they work with HMIE and the Scottish Government Health Directorate.
- 4.2 For the first time SWIA have brought together all the information about the deaths of looked after children in order to:
- Describe the groups of children/young people and the reasons for their deaths
 - Consider the circumstances of their deaths
 - Comment on the content and quality of reports which local authorities provide to SWIA in such circumstances
 - Identify any implications for the care of children and young people who are looked after.
- 4.3 There were 29 deaths of looked after children reported to SWIA between 30th March 2006 and 30th March 2008 between the ages of 1 year to 17 years with the majority being aged 15 to 17 years. These children/young people came from a total of 18 local authorities. 14 local authorities including Inverclyde did not report any deaths during this period.
- 4.4 The causes of death for these children and young people fell broadly into three groups:
- 17 children and young people died from life limiting illnesses
 - 4 died as a result of road accidents
 - 7 died as a result of self harm or as the result of an undetermined intent as defined by the Registrar General
 - One child was murdered.

The reports on children with life limiting conditions indicated that the majority had received very good care from their families, foster carers or in units. Of those who died as a result of intentional self harm or as the result of an event of undetermined intent, all but one were male and aged between 13 and 16 years and all but one had given previous indications of their intention to harm themselves. The majority died between 11.30p.m. and 3a.m. Most had had long involvement with social work services and many of their families had significant problems with alcohol and substance misuse. Most, but not all, were accommodated the largest group under voluntary arrangements rather than through the Children's Hearing System.

- 4.5 The report reached some conclusions about practice.
- It indicated that where there is a risk of self harming, that risk assessments and management plans should be regularly reviewed.
 - It recognised that night staff have a key responsibility for responding to young people who are in distress and that this should be recognised in training, support and supervision
 - it confirms the importance of assessing potential kinship carers before a related child is placed with them.

Finally

- It highlights some complex legal issues for local authorities in such situations when they have parental responsibilities and rights for young

people who die while in care in respect of turning off life support systems, giving consent for the retention of body parts and funeral arrangements.

5.0 PROPOSALS

5.1 Children and Families services have considered the conclusions in the report. Managers will ensure that through our regular supervision of staff and associated training that fieldwork and residential staff members are supported to manage the risks identified by the risk assessment undertaken on the most vulnerable looked after children and young people.

6.0 IMPLICATIONS

6.1 Legal: There are no legal implications.

Finance: There are no financial implications.

Personnel: There are no personnel implications.

Equalities: The issue of equalities is integral to the delivery of Social Work Services.

7.0 LIST OF BACKGROUND PAPERS

7.1 SWIA Report on Deaths of Looked After Children 2006 & 2007.



Deaths of Looked after Children annual reports for 2006 and 2007.

Introduction

This report reviews the deaths of all looked after children whose deaths occurred between 30 March 2006 and the 30 March 2008.

The purpose of the report is to:

- describe the groups of children who have died and the reasons for their deaths
- to consider the circumstances of their deaths
- to recognise the respective roles of SWIA, HMIE and the role of the NHS Professional Group in the Directorate of Health, in reviewing the deaths of looked after children
- to comment on the content and quality of reports which local authorities provide to SWIA
- to identify any implications for the care of children and young people
- to conclude with comments on the overall process of the review of deaths of looked after children.

1. Background

1.1 The role of the respective agencies; SWIA, HMIE, HEALTH.

Regulation 15 of the Children (Scotland) Act 1995 regulations and guidance requires local authorities to notify SWIA when a looked after child dies. SWIA acts on behalf of Scottish Ministers and when notified of the death of a looked after child works together with HMIE and Scottish Government Health Directorate to:

- examine the arrangements made of the child's welfare during the time he/she was looked after
- assess whether action taken or not taken by the local authority may have contributed to the child's death
- identify lessons which need to be drawn to the attention of the authority, immediately concerned and/or other authorities or statutory agencies and
- review legislation, policy, guidance, advice or practice in the light of a particular case or trends emerging from the deaths of children being looked after.

Local authorities are required to notify SWIA within one working day of the death of a child. Within 28 days the local authority should submit a detailed report to SWIA together with supporting information.

1.2 Role of HMIE

HMIE, at the request of SWIA, undertakes reviews of the quality of educational provision for looked after children and young people who die.

1.3 Role of Scottish Government Health Directorate

A designated medical advisor reads the material provided by the local authority and forms conclusions on the quality of medical care provided to the child. On occasions further medical information is requested.

From a health perspective, as indicated by the statistics on age and cause of death, looked after children that die can be grouped into two broad categories: those aged under one year with life limiting illness or disability; and those in their teenage years who die from external causes including intentional self harm or road traffic accidents.

Overall, the nature of need in infants with serious disabilities meant that health services were often a lead agency in providing care. Where issues were identified in the reviews these tended to be specific and technical, related to the management of unusual conditions.

For the older children at risk from alcohol, drugs and accidents, reviews of health service involvement led to identification of areas for improvement: particularly in relation to health involvement in multi-agency review and reporting, and the early provision of accessible psychological, drug and alcohol, and mental health services that are able to work to engage these children.

2. Profiles of the children who have died between 30 March 2006 and 30 March 2008.

29 deaths of looked after children were reported to SWIA in this period. Their ages ranged from one year old to seventeen years.

The children lived in rural and urban areas and came from a total of 18 local authorities. Seven came from one large local authority. Two smaller authorities had deaths of three children and one of two children, the remaining local authorities reported one death each. 14 local authorities did not report any deaths of looked after children between 30 March 2006 and 30 March 2008.

The numbers of deaths of all children in Scotland in 2006 and 2007 varied between local authority areas. The total numbers of all children in Scotland who died in 2006 and 2007 are set out below.

Table 2.1 deaths of all children in Scotland in 2006 and 2007
(Figures from Registrar General of Scotland)

Numbers of children	All 2006	All 2007	Boys 2006	Boys 2007	Girls 2006	Girls 2007
Under one year	248	272	145	154	103	118
1-4 years	47	57	21	25	26	26
5-9 years	29	29	18	16	11	11
10-14 years	38	45	21	31	17	14
15-19 years	152	177	112	127	40	50

The death rates for children in Scotland have fallen steadily since 1950 in particular infant deaths have declined from 50.5 per 1,000 in 1950 to 5.2 per 1,000 in 2005.

Nearly all local authorities had recorded infant deaths but some did not have any recorded deaths of children between the ages of one to ten years and others had very few i.e. under five deaths in this age group.¹

The local authorities with the highest numbers of child deaths were those with large urban populations, Glasgow city, Edinburgh, Fife, North and South Lanarkshire. Clackmannanshire was the only local authority in Scotland to have no recorded deaths of children under 15 years in 2007.

Table 2.2 age range of looked after children at time of death

Age range	Numbers of children	Boys	Girls
5 years and under	5	3	2
6 to 10 years	2	2	0
11 to 14 years	7	5	2
15 to 17 years	5	1	4
total	29	21	8

The children were in a range of placements set out below. None of the children were resident in secure units although some had previously been in secure units. Of those living at home most had been looked after away from home at an earlier period in their lives.

¹ Registrar General tables 5.2 deaths by sex, age and administrative area, Scotland 2006 and 2007.

Table 2.3 placement of children at time of death

Placement	Numbers of children
Foster care	7
Living at home or with relatives	7
Residential school or unit	6
Respite units hospice	6
Homeless	1
Total	29

The causes of death fell broadly into three groups, children with life limiting conditions who were in the majority and road accidents and children who died as a result of intentional self harm or as the result of an event of undetermined intent². One child was murdered.

Table 2.4 causes of death

Cause of death	Numbers of children
Life limiting illness or disability	17
intentional self harm or undetermined intent	7
RTA	4
Murder	1
Total	29

The reports on children with life limiting conditions indicated that the majority had received very good care from their families, foster carers and in respite units.

The children who died as a result of intentional self harm or as the result of an event of undetermined intent were between the ages of 13 and 16 years all but one were boys. All but one of the children had given previous indication of intention to harm themselves and some had over- dosed before their final attempt. The majority died between 11.30 pm and 3 am.

The reports of the care of these children indicated that most had had long involvement with social work services and many of their families had significant problems with alcohol and substance misuse.

Very few (two) of the children's deaths were the subjects of fatal accident inquiries at the time of this report, although for some decisions on holding an FAI are still to be made.

Table 2.5 Legal status of children at time of death (Children (Scotland) Act 1995)

² These are the terms used by the Registrar General

Section 25	Section 25 for respite	Section 66	Section 70	Section 86	Total
15	4	1	6	3	29

The majority of children were subject to Section 25, with four children who became looked after for purposes of respite care.

3. Responses by the local authorities

The Children (Scotland) Act 1995 requires local authorities to notify SWIA within one day of the child's death and to follow up with a report in 28 days. Most local authorities informed SWIA in the appropriate time but about half did not achieve the target date of 28 days for the follow up report. SWIA requested additional information in about a third of all reported deaths and a small number of authorities were slow to provide this. Sometimes the delay was caused by a difficulty in finding the required data and delays by other agencies. If there is court proceedings pending this can delay the progress in completing reports and if there is to be a fatal accident inquiry the process can be delayed for many months and sometimes years.

3.1 The quality of reports received by SWIA

The reports are required to cover a range of issues relating to the child and their family, assessment, care management, reviews, medical and educational reports. Many reports failed to show evidence of multi-agency collaboration, health issues should always be included.

All reports provided appropriate material but the depth and quality of the analysis varied. Some reports contained long descriptions of the child's circumstances with little analysis of the issues which may have affected the child.

The most appropriate reports gave relevant detail of the child's life discussed assessment and care management and where necessary commented on the circumstances which led to their death. Some reports contained detailed and sensitive accounts of how the authority had supported the family and or carers after their child had died. There were some complex relationships between foster carers and birth families which appear to have been approached with great care and sensitivity.

Where the child had who died as a result of intentional self harm or as the result of an event of undetermined intent the reports concluded that the circumstances of the child's death could not have been foreseen. Although most of the children had made threats of self harm or had previously harmed themselves. Not all reports were clear that there had been a risk assessment and a management plan for the child.

SWIA requested further information from the local authority in half of all the reported deaths. In some instances this was because not all the required material was available at the time of the submission of the first report to SWIA, e.g. post mortem reports. In others SWIA staff required greater detail from the local authority to enable them to reach a conclusion.

3.2 SWIA responses to local authorities

SWIA staff are unable to reach a conclusion on behalf of Scottish Ministers until they have read and considered all relevant material and have heard the outcomes of any other legal procedures for example court proceedings and FAIs. Therefore there are some long delays of months and occasionally over a year before SWIA can respond. The policy of SWIA being unable to complete a report on a child until after a Fatal Accident Inquiry had been held has recently changed. In consultation with the relevant Procurator Fiscal SWIA may now be in a position to complete a report into the death of looked after child before the completion of a FAI process.

4. Trends

The number of deaths of looked after children have averaged 14 per year between 2000 and 2007.

Table 4. 5 numbers of deaths of children between 2000 and 2007

2000	2001	2002	2003	2004	2005	2006	2007
18	17	13	8	11	13	19	10

Local authorities use different legislation to offer respite care/ short breaks to children and their families. Some children become looked after only for the period of their care away from home. In some authorities the child is not 'looked after' whilst in respite care. Therefore the deaths of all children in respite care may not be reported to SWIA.

5. Issues

Numbers are very small and this therefore limits any generalisations which can be made about the causes of death or care of the children. Reviewing the deaths of looked after children over a two year period has however led to the identification of a number of themes.

5. 1 Legal context

Local authorities who looked after children who died who were subject to a PRO (Section 86) had some complex legal issues with respect to parental consent in three areas, turning off life support systems, giving consent for retention of body parts and funeral arrangements. The records indicated that local authorities were advised that legally consent could only be given by the birth parents despite the child having been in the care of the authority for some years. In one example this led to some concern on the part of hospital staff who were looking for a quick decision in respect of ceasing intrusive medical intervention for a child to allow him to die peacefully. The local authority had considerable difficulty contacting his parents.

Where SWIA was given details of funeral arrangements for the child, these appear to have been made with sensitivity between the local authority, foster carers and birth families. However as there is uncertainty by local authorities about their legal powers there is potential for disagreement or dispute between the authority and the birth family about arrangements for the child's funeral.

Fatal accident inquiries are held into only very few of the deaths of looked after children including those who have committed suicide in a local authority unit or in a resource commissioned by the local authority. Fatal Accident inquiries are always held when a prisoner in a Scottish prison commits suicide.

There may be implications for local authorities from the implementation of the Corporate manslaughter and corporate homicide Act 2007. (Appendix 1)

5.2 Education

Education reviews have led to the identification of areas for improvement in pastoral care and communication between schools and partner agencies responsible for the care of looked after children. The reviews have also identified an improving trend in supporting systematically, looked after children in both mainstream and special schools. Most schools now have a designated member of their senior management team who monitors the educational achievements of looked after children and acts as a point of contact between partner agencies who support children and the school. Most schools, including residential schools, hold regular reviews of care plans for looked after children.

5.3 Local authority care

Some of the children were in local authority foster care or other provision; others were placed in commissioned services provided by other local authorities or in the voluntary and independent sectors. The quality of this care as reflected in the reports received by SWIA was for many children judged to be appropriate and meeting their needs.

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

Some of the children were living at home, other were in residential units. The majority of children died between late evening and early morning. Most had self harmed in the past and the majority of the reports we received did not specifically discuss the risk assessment or management process for the children. Some children had been referred to CAMHS services but had not been willing to take part in any assessment or treatment. Working with hard to reach young people is a very challenging area. We are aware that some authorities are

working with health professionals to develop informal methods of contacting and keeping in touch with young people e.g. by text messaging.

The reports did not tell us how much staff training had been devoted to self harm and suicide prevention and we consider these are training areas which all agencies should review, particularly for night staff who have a challenging role in responding to young people.

Many of the children in this group had long histories of disrupted care, patterns of alcohol and substance misuse amongst parents and relatives and other family members who had died through violence or suicide. We were concerned to find that some children had been moved from one family member to another over a number of years before substitute care had been found for them. Whilst for some children kinship care has much to offer, local authorities should always undertake an appropriate assessment of the family members involved in the plan to care for the child.

The circumstances of all children who die as a result of intentional self harm or as the result of an event of undetermined intent who are looked after and accommodated are investigated by the police and a report is always sent to the Procurator Fiscal. The Fiscal then considers a range of matters before recommending whether or not a Fatal Accident Inquiry should take place.

Conclusion

Looked after children who died in 2006 were 3.6% of all children who died in Scotland. In 2007 looked after children were 1.75% of all children who died in Scotland. The majority of these children had life limiting conditions or serious illnesses. A smaller group of children died as a result of intentional self harm or as the result of an event of undetermined intent.

- The reports we received indicate that local authorities should review their risk assessment and management plans for each child where there is evidence of or a risk of self harming.
- Night staff have a key responsibility for responding to young people in distress and the importance of their role should be recognised in training supervision and support by their managers.
- An appropriate assessment of potential kinship carers should be undertaken before a child is placed with relatives.
- We found in this review that local authorities face some complex legal issues with respect to the interpretation of their powers in respect of Section 86 of the Children (Scotland) Act 1995.

Cr/12/04/2009

Appendix 1

Corporate manslaughter and corporate homicide 2007

http://www.opsi.gov.uk/Acts/acts2007/ukpga_20070019_en_1

1 The offence

(1) An organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised—

(a) causes a person's death, and

(b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.

(2) The organisations to which this section applies are—

(a) a corporation;

(b) a department or other body listed in Schedule 1;

(c) a police force;

(d) a partnership, or a trade union or employers' association, that is an employer.

(3) An organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach referred to in subsection (1).

(4) For the purposes of this Act—

(a) "relevant duty of care" has the meaning given by section 2, read with sections 3 to 7;

(b) a breach of a duty of care by an organisation is a "gross" breach if the conduct alleged to amount to a breach of that duty falls far below what can reasonably be expected of the organisation in the circumstances;

(c) "senior management", in relation to an organisation, means the persons who play significant roles in—

(i) the making of decisions about how the whole or a substantial part of its activities are to be managed or organised, or

(ii) the actual managing or organising of the whole or a substantial part of those activities.

(5) The offence under this section is called—

(a) corporate manslaughter, in so far as it is an offence under the law of England and Wales or Northern Ireland;

(b) corporate homicide, in so far as it is an offence under the law of Scotland.

(6) An organisation that is guilty of corporate manslaughter or corporate homicide is liable on conviction on indictment to a fine.

(7) The offence of corporate homicide is indictable only in the High Court of Justiciary.

Relevant duty of care

2 Meaning of “relevant duty of care”

(1) A “relevant duty of care”, in relation to an organisation, means any of the following duties owed by it under the law of negligence—

(a) a duty owed to its employees or to other persons working for the organisation or performing services for it;

(b) a duty owed as occupier of premises;

(c) a duty owed in connection with—

(i) the supply by the organisation of goods or services (whether for consideration or not),

(ii) the carrying on by the organisation of any construction or maintenance operations,

(iii) the carrying on by the organisation of any other activity on a commercial basis, or

(iv) the use or keeping by the organisation of any plant, vehicle or other thing;

(d) a duty owed to a person who, by reason of being a person within subsection (2), is someone for whose safety the organisation is responsible.

(2) A person is within this subsection if—

(a) he is detained at a custodial institution or in a custody area at a court or police station;

(b) he is detained at a removal centre or short-term holding facility;

(c) he is being transported in a vehicle, or being held in any premises, in pursuance of prison escort arrangements or immigration escort arrangements;

(d) he is living in secure accommodation in which he has been placed;

(e) he is a detained patient.

Child-protection and probation functions

(1) A duty of care to which this section applies is not a “relevant duty of care” unless it falls within section 2(1)(a), (b) or (d).

(2) This section applies to any duty of care that a local authority or other public authority owes in respect of the exercise by it of functions conferred by or under—

(a) Parts 4 and 5 of the Children Act 1989 (c. 41),

(b) Part 2 of the Children (Scotland) Act 1995 (c. 36), or

(c) Parts 5 and 6 of the Children (Northern Ireland) Order 1995 (S.I. 1995/755 (N.I. 2)).

(3) This section also applies to any duty of care that a local probation board or other public authority owes in respect of the exercise by it of functions conferred by or under—

(a) Chapter 1 of Part 1 of the Criminal Justice and Court Services Act 2000 (c. 43),

(b) section 27 of the Social Work (Scotland) Act 1968 (c. 49), or

(c) Article 4 of the Probation Board (Northern Ireland) Order 1982 (S.I. 1982/713 (N.I. 10)).