ABERDEEN CITY COUNCIL

COMMITTEE	Public Protection Committee
DATE	4 December 2019
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Significant Case Reviews - Aberdeen City Child Protection Committee
REPORT NUMBER	OPE/19/401
DIRECTOR	Rob Polkinghorne
CHIEF OFFICER	Graeme Simpson
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TERMS OF REFERENCE	1.1, 1.2, 1.3

1. PURPOSE OF REPORT

To inform the committee of the conclusion of Aberdeen City Child Protection Committee's Significant Case Review (SCR) in relation to the circumstances of Child D and to provide a summary of the recently published Triennial Report on national SCRs from the Care Inspectorate.

2. RECOMMENDATION(S)

That the Committee:

2.1 notes the content of the Aberdeen City Child Protection Committees (CPC) update in relation to the SCR and that the learning from this case will be incorporated into the Child Protection Programme 2019-2021;

2.2 notes that the case in relation to the SCR is sub-judice and therefore no further information can be publicly shared at this time;

2.3 notes the next steps in relation to the SCR are to compile an Executive Summary which can be published once the case is no longer sub-judice and to produce a detailed analysis of the Welsh Methodology that was used to conduct the SCR;

2.4 notes the summary of the Triennial report on national SCRs from the Care Inspectorate.

3. BACKGROUND

3.1 The full SCR report for Child D is sub-judice and has already been approved by Aberdeen City's Chief Officer Group for Public Protection (COG). An Executive Summary will be published in due course when the matter is no longer sub-judice.

3.2 Brief Case Summary

3.2.1 Child D was admitted to hospital because of profound failure to thrive. A Child Protection Investigation was initiated which concluded a multi-agency response was required. As a result of identified concerns, a Significant Case Review was recommended by CPC and commissioned by Aberdeen City's COG.

3.3 The review process

3.3.1 This SCR adopted a systemic approach based on the Welsh methodology for conducting SCRs. A key feature of this approach is to bring together agencies and practitioners in a collective endeavour to reflect and learn from what has happened in order to improve practice for the future. The focus is on accountability not culpability, on learning and not blame.

3.3.2 A Case Review Panel was convened to steer the process and the review was led independently, by one of the original authors of the Welsh Methodology. The Panel and the Lead Reviewer began the learning process by clarifying the questions and areas to explore. They also identified the practitioners and Senior Managers to be invited to the learning events, explained the process to them and helped them with preparation.

3.3.3 Participants at the learning events reflected on Child D's situation, identified emerging themes; looked at what worked well and why; explored challenges and considered any changes that were needed as a result of the learning from this review. The independent reviewer and chair of the review panel also met with the family involved. A full report has been prepared by the lead reviewer with learning areas identified.

3.4 Next steps

3.4.1 This case is sub judice and as such no information about this case and SCR can be shared out with the remit of the SCR sub committee, CPC, and the COG.

3.4.2 An Executive Summary is being compiled and this summary will be published in due course. Where possible, without breach of the sub-judice nature of this matter, identified learning has been or is in the course of incorporation into the Child Protection Learning & Development Programme.

3.4.3 Work is already underway, in conjunction with Centre for Excellence for Children's Care and Protection (CELCIS) and at request of COG, to analyse the Welsh methodology that was applied in this SCR. This analysis will be presented to the CPC, COG and at National Child Protection Committees

Scotland when it becomes available. This will help inform local and national use of this methodology in any future SCRs.

3.5 Triennial Report

3.5.1 On 11 June 2019 the Care Inspectorate published their Triennial report on Learning from SCRs. This is a report looking at the learning themes identified from SCRs and also the methodologies used to conduct these reviews across Scotland.

3.5.2 There were 25 SCRs conducted in Scotland over between March 2015 and April 2018. Aberdeen City CPC had no SCRs in that period. The report highlights a number of similar themes dating back to 2012. These include information sharing, thresholds for intervening with families, particularly in relation to neglect, and working with resistance and disguised compliance. The quality and use of chronologies was highlighted as was the need for earlier intervention when children remain in neglectful and/or harmful situations despite being known to services. Another key area linked to this was hearing the voice of the child and involving them in key CP processes.

3.5.3 A total of 73 Initial Case Reviews (ICRs) were undertaken during this period, meaning 48 of those did not proceed to an SCR based on the current national criteria. Aberdeen CPC conducted three ICRs during that period which included Child D. A breakdown of the methodologies used for the 25 SCRs conducted can be found in the table below:

Systems Methodology	**SCIE methodology**	**Hybrid model**	**No 'specific' methodology**
4	**7**	**5**	**9**

3.5.4 SCR final reports ranged in length from 19 pages long to 150 pages long and there is a clear message to be less descriptive and more analytical when compiling final reports. There were wide ranging timescales for SCRs to be fully completed; from eight months to 3 years. Some of these longer ones were dependant on court proceedings.

3.5.5 By way of comparison, the report of the local SCR conducted in relation to Child D is 24 pages long and the review took seven months to conclude. The publication of the Executive Summary will however be delayed due to legal proceedings and will therefore extend the duration of the SCR as subsequently reported by the Care Inspectorate.

3.5.6 The variables highlighted above and lack of consistency across the country is highlighted as barrier to learning. The areas identified as being core to an effective review are:

- A sharp focus on what caused something to happen and how it can be prevented from happening again.
- A concise account of critical points in the management of a case (rather than a lengthy chronology of undifferentiated events).

- A detailed analysis of what went wrong and why, including individual errors and system failures.
- Clear learning points and recommendations addressed to named people or organisations locally and nationally, including adult services where appropriate.
- Measures should be included to follow up and see whether these recommendations have been accepted and implemented.
- A focus on what the lessons should be for the services concerned, rather than a blow-by-blow account of what happened to a child.
- Proportionate to the case being considered when applying the points above. This is far more important than a blind adherence to a specific methodology.
- Prepared to highlight relevant failings and good practice and policy at all levels, not just those at lower levels.

3.5.7 As highlighted in this report Aberdeen CPC sought to ensure the SCR met the criteria for an effective review having researched the Welsh methodology. The CPC will consider the key points highlighted by the Care Inspectorate when producing the analysis of the Welsh methodology and how it was applied in this case.

4. FINANCIAL IMPLICATIONS

4.1 There are no financial matters arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 The case in relation to the SCR for Child D is sub-judice.

6. MANAGEMENT OF RISK

Category	Risk	Low (L) Medium (M) High (H)	Mitigation
Financial	None for this report		
Legal	The SCR for Child D is sub-judice.	M	No information is shared beyond the SCR sub committee, the CPC, and COG.
Employee	None for this report		
Customer	Required improvements and developments in practice are not identified and actioned.	L	Children, young people and their families can be assured that services in Aberdeen City are continually appraised in order to improve the quality of locally delivered services.

Environment	None for this report		
Technology	None for this report		
Reputational	Organisational failings in relation to child protection can bring significant media interest and scrutiny of services delivered to children and young people.	M	The public can be assured that: the Council ensures compliance with legal requirements, national standards and guidance; partners respond to self and external scrutiny; and identified areas for improvement are addressed.

7. OUTCOMES

Local Outcome Improvement Plan Themes	
	Impact of Report
Prosperous Economy	None
Prosperous People	The functions of the Child Protection Committee are central to supporting and assuring that the multi-agency Children's Services partners deliver on the outcomes of the LOIP Prosperous People - Children are our Future and that they have "the best start in life"; they are "safe and responsible" and "protected from harm". Children who are adequately protected from threats to their health, safety and economic wellbeing are more likely to prosper than those who are not.
Prosperous Place	None

Design Principles of Target Operating Model	
	Impact of Report
Customer Service Design	None
Organisational Design	None
Governance	Appropriate oversight of services delivering public protection provides assurance to both the organisation and the public in terms of meeting the council's

	statutory duties, and also contributes to compliance with agreed standards.
Workforce	A proactive learning approach is taken to support staff understanding of the range of child protection issues identified locally and nationally.
Process Design	None
Technology	None
Partnerships and Alliances	Services to children and young people are delivered on a multi-agency basis and the scrutiny, challenge and learning requires all agencies to work in partnership with each other.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Equality & Human Rights Impact Assessment	Not required
Data Protection Impact Assessment	Not required
Duty of Due Regard / Fairer Scotland Duty	Not required

9. BACKGROUND PAPERS

None

10. APPENDICES (if applicable)

Care Inspectorate - Learning from Significant Case Reviews 2015 to 2018

11. REPORT AUTHOR CONTACT DETAILS

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