ABERDEEN CITY COUNCIL

COMMITTEE	Public Protection Committee
DATE	7 December 2021
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Reviewing and Learning from the Deaths of Children and Young People
REPORT NUMBER	OPE/21/319
DIRECTOR	Rob Polkinghorne
CHIEF OFFICER	Graeme Simpson
REPORT AUTHOR	Graeme Simpson
TERMS OF REFERENCE	1.1.1

1. PURPOSE OF REPORT

1.1 To advise elected members of the establishment of the National Hub for Reviewing the Deaths of Children and Young People and its implications for the delivery of social work in Aberdeen City.

2. RECOMMENDATION(S)

That the Committee:

2.1 Note the contents of the report and how Aberdeen City Council social work staff will contribute to the review of deaths of children and young people.

3. BACKGROUND

3.1 Scotland has a higher mortality rate for under 18s than any other Western European country, with over 300 children and young people dying every year. Around a quarter of those deaths are considered to be preventable.

3.2 To date there has been no national system to support consistent reviewing and learning from deaths of all children and young people in Scotland. The Scottish Government commissioned Healthcare Improvement Scotland and the Care Inspectorate to establish a National Hub for Reviewing and Learning from the

Deaths of Children and Young People. The National Hub went live on 1 October 2021 and is working to:

- Ensure that the death of every child in Scotland is subject to a quality review.
- Improve the experience and engagement with families and carers.
- Channel learning from current review processes across Scotland that could direct action to help reduce preventable deaths.

3.3 The National Hub will ensure the death of every child and young person is reviewed to an agreed minimum standard. Reviews should be conducted on the deaths of all live born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of continuing care or aftercare at the time of their death.

3.4 Each Health Board in partnership with local partners (Local Authorities and Police Scotland) is responsible for establishing their own structures and processes for reviewing the deaths of children and young people. Local processes should however align to national guidance in order to enable good practice and lessons to be reflected and shared at a national level.

3.5 There are already well-established processes for the reviewing certain deaths of children and young people for whom the social work service has current or recent involvement with.

1. Deaths of Looked After Children – Local Authorities, in collaboration with relevant partners, have a duty to review the deaths of children and young people who die whilst they are looked after.

   The Children and Young People (Scotland) Act 2014), extended the duties on local authorities to review the deaths of care leavers (up to their 26th birthday) who are in receipt of continuing care and/or aftercare at the time of their death.

2. Children and Young People who have ***"died or sustained significant harm or risk of significant harm"*** as defined in the National guidance for child protection in Scotland 2021 are reviewed as part of a Significant Case Reviews (now Significant Learning Reviews). These arrangements will continue and are seen to be working well.

3. Drug-related deaths - Drug-related deaths in Scotland are recorded and examined by local monitoring groups. Each area has a data collection co-ordinator who works closely with the local critical incident monitoring group and other key partners to collate the information on drug-related deaths.

3.6 NHS Grampian also has in place existing structures and processes to review the deaths of children aged 0 to 16 years.

Implications for Practice in Aberdeen City.

3.7 Building on existing practice across colleagues from NHS Grampian, Aberdeen City, Aberdeenshire and Moray Councils have come together to agree systems and processes that enable reviews of children and young people who die to be undertaken. This group has also strong and effective links to Police Scotland who often can have a role investigating the circumstances of children and young people who die. The group is also engaging the with and benefiting from support from the Health Improvement Scotland's national team and the learning from the pilot areas – NHS Lothian and NHS Tayside.

3.8 To support the implementation of the National Hub each health board has been provided with some additional funding to support the collation of local data as required by the National Hub.

3.9 It is recognised that current systems don't readily identify when a care experienced young person, aged 18 – 26 years of age, who is in receipt of aftercare dies. Given the increased levels of mobility and independence of this group it is important that agencies collaborate effectively to identify when a young person within this group dies. Strong inter-agency relationships already exist and processes have been established to ensure we identify the deaths of young people in this group.

3.10 It is important that families are appropriately involved and informed of the learning stemming from any review. The National Hub is speaking with bereaved families and carers to improve care for future families by sharing their experiences following the death of their child. This will support more family and carer-centred process for organisations when they review the circumstances around the death of a child or young person.

4. FINANCIAL IMPLICATIONS

4.1 There are no financial implications arising out of this report.

5. LEGAL IMPLICATIONS

5.1 There are no legal implications arising from this report.

6. MANAGEMENT OF RISK

Category	Risk	Low (L) Medium (M) High (H)	Mitigation
Strategic Risk	No significant related risks.	L	n/a
Compliance	No significant risks identified.	L	A Grampian governance group has been established with appropriate representation from Aberdeen City Council.

Operational	No significant risks identified.	L	Existing processes for reviewing the deaths of young people for whom the social work services is involved are seen to work well and will continue exist and feed Aberdeen City Executive Public Protection Group.
Financial	No significant risks identified.	L	n/a
Reputational	No significant risks identified.	L	The report evidences strong compliance with our statutory duties.
Environment / Climate	n/a		n/a

7. OUTCOMES

COUNCIL DELIVERY PLAN	
	Impact of Report
Aberdeen City Council Policy Statement	Ensuring identified learning from the reviews of deaths of children and young people. has a direct relevance to the delivery of the following policy statements contained within the Council Delivery Plan: 2. UNICEF Child Friendly accreditation. 5. Appoint a mental health champion. 7. Commit to closing the attainment gap in education while working with partners across the city. 9. Promote diversion activities for youths and adults in our city with enhanced focused on our three locality areas.
Aberdeen City Local Outcome Improvement Plan	
Prosperous People Stretch Outcomes	Ensuring identified learning from the reviews of deaths of children and young people has a direct relevance to the following stretch outcomes in the LOIP: 5. 90% of children and young people will report that they feel mentally well by 2026. 6. 95% of care experienced children and young people will have the same levels of attainment in education, emotional wellbeing, and positive destinations as their peers by 2026.

	8. 25% fewer young people (under 18) charged with an offence by 2026.
Regional and City Strategies	Ensuring identified learning from the reviews of deaths of children and young people is an established component of our assurance processes and is considered relevant to Aberdeen City Council Delivery Plan, the Local Outcome Improvement Plan, and the Children's Services Plan.
UK and Scottish Legislative and Policy Programmes	Ensuring identified learning from the reviews of deaths of children and young people is an established component of our assurance processes. It also supports the Scottish Government's drive to #KeepthePromise. This wide ranging and ambitious programme impacts on a range of statutory duties on the Council in relation to vulnerable and care experienced children including those contained in the Children(Scotland) Act 1995, Children's Hearings (Scotland) Act 2011, Children & Young People (Scotland) Act 2014, Child Poverty (Scotland) Act 2017 and Children (Scotland) Act 2020.

8. IMPACT ASSESSMENTS

Assessment	Outcome
Impact Assessment	This report provides members with assurance on the Council's compliance with their statutory duties to review the deaths of children and young people as set out in legislation and does not require a full Equality and Human Rights Impact Assessment to be completed.
Data Protection Impact Assessment	Not required.

9. BACKGROUND PAPERS

National Hub for Reviewing and Learning from the Deaths of Children and Young People - National guidance October 2021	20200414-National-Hub-National-Guidance_(1).pdf

10. REPORT AUTHOR CONTACT DETAILS

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