AGENDA ITEM No. 9

NORTH LANARKSHIRE COUNCIL

REPORT

TO: Social Work Committee	Subject: Finding of a Child Protection Inquiry into a Child Death in Scotland
FROM: Director of Social Work	
DATE OF COMMITTEE: 24 May 2001	
REPORT AUTHOR: M Fegan	
REF: MF/MY	

1 CONTENT AND PURPOSE OF REPORT

1.1 To advise Committee of the findings of a Child Protection Inquiry into a Child Death in Scotland and to consider the implications for Child Protection within North Lanarkshire.

2 BACKGROUND

2.1 Following the death of a three year old child last year the Child Protection Committee of the relevant local authority commissioned an immediate inquiry into the circumstances which led up to her fatal injury. The object of the inquiry was not to apportion blame but to learn lessons which will help to protect other children from abuse and neglect in the future.

2.2 The inquiry closely followed the format laid down in the document 'Working Together to Safeguard Children' in England and Wales which should be instituted where a child dies in circumstances where abuse or neglect are known or suspected to be a factor. Although the process is not currently a statutory requirement in Scotland, the format covered many areas which required to be reviewed following the child's death.

2.3 The Children (Scotland) Act 1995 places a duty on local authorities to safeguard and promote the welfare of children in their area who are in need.

2.4 Child Protection Committees are non statutory bodies which are multi agency in nature and which develop policies, procedures, practice and promote joint working in respect of children at risk, They also have a remit to oversee and promote best practice.

3 OVERVIEW OF THE CHILD'S CIRCUMSTANCES

3.1 The child was approximately three years of age when she died. She lived at home with her mother, siblings and her mother's partner (who was not her natural father).

3.2 The playgroup noted a change in her demeanour, she was later presented to her GP and hospital with injuries (explained away by family). She had also ingested her mother's medication.

3.3 The couple were latterly hostile and aggressive towards agencies, although this was not considered to be relevant to the subsequent management of the case.

3.4 The child was admitted to the local accident and emergency unit as an emergency, later dying in hospital.

3.5 The child was not on the Child Protection Register or a 'looked after child' at the time of her death. She died three and a half months after the first referral from the playgroup.

4 GENERAL FINDINGS

4.1 The Inquiry concluded that whilst the child's violent and sudden death could not have been accurately predicted, it could have been prevented. It also concluded that no one individual or agency was responsible for the child's death.

4.2 It was noted that the Local Authority had in place Child Protection Practice and Procedures in keeping with current guidance.

4.3 General findings included:

- lack of effective communication and joint decision making
- lack of effective documentation and presentation and clarity of medical evidence
- inappropriate reliance on the opinions and advice of others
- overconfidence in decision taking and a failure to recognise the need to introduce checks and balances by testing out theories and plans with experienced colleagues
- unchecked assumptions about the involvement and views of others
- heavy workloads and problems with the availability of professional/specialist support.

5 INQUIRY RECOMMENDATIONS

5.1 Two sets of recommendations were produced following the Inquiry, one for the agencies involved with the child and her family and the other for national consideration.

5.2 In relation to social work nationally the report noted the need for:

- meticulous attention to detail in investigating child abuse
- effective sharing of information

- the need for regular and meaningful supervision - which takes priority even at times when the urgency of difficult cases may threaten to displace it recognising that these are also the times when hasty inappropriate judgements may be made
- team building and training within social work as well as between agencies to facilitate meaningful joint working and decision making.

5.3 In respect of inter-agency observations the Inquiry concluded that it is not enough to have in place combined and integrated services and clear agency and interagency guidelines. To be successful, child protection services need to establish meaningful and well understood joint working practices and ensure ready access to expert advice when required. This will require different solutions in different areas depending on geography, local expertise etc.

6 NORTH LANARKSHIRE'S POSITION

6.1 Since the Council was established a number of developments have taken place to improve child protection practice:

- Social Work Child Protection procedures have been developed and revised taking account of changing legislation, policy and practice

- Inter-agency Child Protection training has recently taken place to launch the new procedures

- Education and Community Services have developed Child Protection procedures for staff, and this process is ongoing in Housing

- The North Lanarkshire Child Protection Committee has recently broadened its remit and reviewed a case involving a number of agencies to promote best practice

- **A** workload management policy is being developed

- A Departmental supervision strategy is being developed

- A guidance document is being produced on recording practice

6.2 The revised Social Work structure should assist improve services to vulnerable children and their families.

- a new senior officer post has been created within the child care section at headquarters with a lead responsibility for Child Protection matters. This will include monitoring of high risk and child protection cases, address the training needs of staff, provide professional support to staff and liaise with other agencies. The officer will be a key member of the Child Protection Committee.

- the introduction of the new reception services will enable child care seniors and social workers to have a greater focus on high risk family and child care situations.

- the role of the senior child care officers within the area teams has been given greater focus with some leading on fieldwork/child protection support to operational staff.

- following the member/officer recruitment and retention consultation exercise, a recommendation will be made to a future Committee to consider the appointment of a small number of senior practitioners - social workers who might specialise in work with high risk families.

6.3 The recruitment and retention of qualified social workers is central to Child Protection. The recruitment of thirty social work assistants, whilst not the long term answer to current vacancies, will allow social workers to focus on high risk cases.

6.4 The Department is developing a Human Resources Strategy.

6.5 The North Lanarkshire Child Protection Committee will also review the Inquiry report to consider lessons to be learned.

7 CONCLUSION

7.1 In the report commentary, the Inquiry is set in the context of previous inquiries into child abuse tragedies recognising the similarities and potential prompts to identifying the risk of fatal outcome in the child's case. This was intended to highlight the need to learn lessons from research and inquiries and not to simply apportion blame to a few individuals. The Inquiry report also noted "it also sets as a reminder that, however good our systems we will never be able to predict or prevent all child deaths at the hands of their carers, just as we cannot prevent all child deaths from accident or illness".

8 RECOMMENDATION

The Committee is asked to note the contents of the report.

Jim Dickie
Director of Social Work
3rd May 2001

For further information on this report please contact M Fegan, Head of Social Work Services (TEL: 01698 332001)