

# A **report** on the deaths of looked after children in Scotland **2012-2018**

An overview from notifications and reports submitted to the Care Inspectorate

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January 2020



HAPPY TO TRANSLATE

# Foreword

We report publicly on the learning from notifications of the deaths of care experienced children and young people in Scotland. We examine the arrangements made for the child's welfare during the time they were looked after and seek to identify any lessons that need to be drawn to the attention of the local authority.

Sadly, a small number of children who are looked after by local authorities die each year. This is a traumatic experience for the families, carers, friends and relatives of these children and we recognise the commitment of the many staff and carers in providing highly effective support to children, young people and families involved in such difficult situations.

Although numbers are very small, an overview of the deaths of looked after children and young people over several years has enabled us to identify common themes and some key messages.

Our report is published at a time when Healthcare Improvement Scotland and the Care Inspectorate are working to establish a national hub to review the deaths of all children in Scotland. This presents an opportunity to modernise and streamline review processes following the deaths of care experienced children and young people, and benefit from the contribution of clinical expertise.

I hope this report and the key messages it contains will make an important contribution to our understanding of what we do well and what we can do better to improve outcomes for looked after children, young people and care leavers.

A handwritten signature in black ink, appearing to read 'Peter Macleod'. The signature is fluid and cursive, with a large initial 'P' and 'M'.

Peter Macleod  
Chief Executive

## Section 1: Introduction

This report draws attention to themes emerging from notifications of the deaths of 61 care experienced<sup>1</sup> children and young people over seven years from 2012 to 2018. It contains key messages for all those with corporate parenting responsibilities including practitioners, leaders of services for children and young people, scrutiny bodies and policy makers. Learning points are based on an analysis of notifications, reports and associated documents submitted to the Care Inspectorate about circumstances surrounding the deaths of 42 looked after children and young people over the seven-year period 2012–2018 and notifications of the deaths of a further 19 young people in receipt of continuing care and aftercare over a four-year period from 2015–2018.

We discuss common themes, some of which apply to the care experienced population as a whole, while others are relevant to one of three distinct groups of looked after children and young people: those whose deaths could be anticipated due to a life shortening condition or terminal illness; those whose deaths were unexpected due to misadventure or were unexplained; and those young people whose harmful actions culminated in an untimely death. While we can reach no statistically valid conclusions as numbers of deaths are so small, the experiences of these children and young people, their carers and the staff providing them with help and support provide us with valuable learning and good practice examples that merit wider dissemination.

This report aims to support our collective endeavours to improve outcomes for care experienced children and young people.

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<sup>1</sup> Looked after children, young people and care leavers wish to be referred to collectively as care experienced. In this report, we use this term to refer to all those children and young people who are looked after and those who have previously been looked after up to the age of 26 years.

## Section 2: Background

### Legal status of care experienced children and young people

#### Looked after children and young people

There are many, often complex, reasons why a child or young person becomes looked after. Usually, it is to:

- protect them from some form of abuse, neglect or exploitation
- improve the quality and consistency of care they receive, and
- promote their wellbeing and life chances.

The definition of a looked after child is set out in Section 17(6) of the Children (Scotland) Act 1995.

- **A child or young person under 21 years of age can be looked after by a local authority through the provision of accommodation under Section 25 of the Act to safeguard or promote their welfare.** In the context of this report, children and young people typically become looked after under this section of the legislation when parents of children and young people with complex and enduring disabilities enter into a voluntary agreement with a local authority to provide regular overnight residential respite. Such arrangements forming part of a package of family support.
- **A child or young person under 18 years of age becomes looked after when they are subject to a compulsory supervision order made by a children's hearing. This requires the child or young person to reside in a specified place with additional support from services. This may be in their own home or in a care placement including kinship care, foster care, a residential children's house, residential school or secure accommodation.** The main reason why children and young people in this report became looked after and subject to compulsory supervision orders was because of child protection concerns associated with parental substance misuse, parental mental illness, exposure to domestic violence and poor parenting.

#### Care experienced young people in receipt of continuing care and aftercare

In recognition of the need to improve the life chances of looked after children and young people, the Children (Scotland) Act 2014 further strengthened transition arrangements for young people leaving care placements.

The 2014 Act introduced a new duty on local authorities to provide continuing care. This enables young people who cease to be looked after between 16 and 18 years of age to remain in an existing care placement up to 21 years of age or until such time as they are ready and willing to move on to independent living. Continuing care arrangements do not apply to young people looked after at home or looked after and accommodated in secure accommodation.

Amendments to the 2014 Act also extended eligibility for the receipt of aftercare to all categories of young people who cease to be looked after on or after their sixteenth birthday up until their twenty-sixth birthday. If the young person is 19 years of age or older, they must apply for aftercare support

which is subject to a pathway assessment. Those under 18 are automatically entitled to aftercare support and guidance.

## **Corporate parenting**

The concept of corporate parenting of care experienced children and young people has gained increasing recognition and commitment in recent years. The Children and Young People (Scotland) Act 2014 introduced a range of duties for corporate parents formalising previous arrangements. These aim to ensure that the attention and resources of corporate parents are focused on safeguarding and promoting the wellbeing of Scotland's looked after children, young people and care leavers. The Act identifies 26 public bodies and individuals in Scotland as corporate parents. All corporate parents are required to prepare and publish plans detailing how they will fulfil their duties. Corporate parenting or champions' boards are well established in many local authority areas and publish their multi-agency plans in consultation with care experienced children and young people.

## **A national hub for reviewing and learning from the deaths of children and young people**

The Scottish Government has asked the Care Inspectorate and Healthcare Improvement Scotland to establish a national hub for reviewing and learning from the circumstances surrounding the deaths of all children and young people in Scotland. The aim is to co-ordinate all current review activity and we are collaborating with Healthcare Improvement Scotland to develop this.

The national hub will use a multidisciplinary and multi-agency approach and evidence base to deliver change. Reviews will be conducted on the deaths of all live-born children up to the date of their eighteenth birthday; or twenty-sixth birthday for care leavers in receipt of continuing care or aftercare at the time of their death.

The quality and consistency of different review processes taking place across the country in response to a child's death is variable and currently not all deaths are reviewed. The national hub will seek to establish minimum standards for carrying out reviews into the deaths of children and young people and to identify trends that could direct action to help reduce preventable deaths. The national hub will operate using existing review arrangements, rather than replacing or duplicating these.

## **Section 3: The role of the Care Inspectorate when a care experienced child or young person dies**

### **Notifications of the death of a looked after child or young person**

Under regulation 6 of the Looked After Children (Scotland) Regulations 2009<sup>2</sup>, local authorities have a duty to notify the Care Inspectorate of the death of a looked after child. The guidance on these regulations requires local authorities to submit a report and supporting documentation following notification of a death. The Care Inspectorate reviews the local authority's report to:

- examine the arrangements made for the child's welfare during the time they were looked after
- assess whether action taken or not taken by the local authority may have contributed to the child's death
- identify lessons that need to be drawn to the attention of the local authority that had responsibility for the child and/or other local authorities or statutory agencies.

This report addresses the Care Inspectorate's final duty as listed in the guidance to:

- draw attention to the potential need for reviewing legislation, policy, guidance, advice or practice in the light of a case, or trends emerging from the deaths of looked after children.

The Looked After Children (Scotland) Regulations 2009 require local authorities to notify the Care Inspectorate of the death of a looked after child within one working day of the child's death. Following such notification, the local authority is required to submit a full report within 28 days. Almost all local authorities have notified us within one working day. Most local authorities submitted reports within the 28-day timescale. However, post-mortem reports and toxicology reports generally take much longer than a month to complete. This meant that local authorities often undertook a review before the exact cause of the child's death had been established. In such circumstances, they provided supplementary information as this became available.

### **Notifications of the death of a young person in receipt of continuing care or aftercare**

Since 2015, local authorities are required to notify the Care Inspectorate of the death of a young person in receipt of continuing care or aftercare services. However, unlike notifications of the deaths of looked after children, there is no requirement to submit a report and supporting documentation for the Care Inspectorate to review. This severely restricts any potential learning from the deaths of young people in receipt of these services.

### **Notifications of deaths of care experienced children and young people by regulated care providers**

Regulated care providers are required to notify the Care Inspectorate of serious incidents including the death of a service users. These notifications include care experienced children and young people resident in regulated care services at the time of their death. The Care Inspectorate cross checks notifications of the deaths of care experienced children and young people by local authorities with

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<sup>2</sup> As amended in 2013 by Scottish Statutory Instrument No 14 'The Looked After Children (Scotland) Amendment Regulations 2013

notifications of serious incidents received directly from care providers. These regulated care services include fostering and adoption agencies, children's houses, residential respite resources, residential schools, school care accommodation, secure and supported housing accommodation. This process does not include those looked after at home or in kinship care. Nevertheless, we can be reasonably confident that the deaths of looked after children and young people in services registered with the Care Inspectorate are consistently notified to us.

We are less confident that the deaths of older young people (up to the age 26) and in receipt of after care are consistently notified. Over the previous three years from 2015 – 2018, local authorities, particularly through partnership working on corporate parenting boards, have been improving approaches to keeping in touch with care leavers and tracking systems are becoming more reliable.

## **Links with other review processes**

The deaths of care experienced children and young people can be subject to a number of other review processes such as:

- NHS significant critical incident reviews
- an initial case review and significant case review led by a child protection committee
- fatal accident inquiries
- police investigations
- independent investigations by the Police Investigations and Review Commissioner
- a death-in-prison learning audit and review held jointly within two weeks of a death in custody by the Scottish Prison Service and NHS.

As a result, there are some challenges for both those carrying out the different reviews and the Care Inspectorate in responding to these reviews.

## **Initial and significant case reviews**

When a looked after child or young person under 18 years of age dies and there are concerns about professional or service involvement, or lack of involvement, the area child protection committee carries out an initial case review to determine whether they need to undertake a significant case review. Of the 42 deaths of looked after children and young people covered by this report, child protection committees carried out an initial case review in 11 cases and the criteria were met for six of these to progress to a significant case review.

### **Key message 1**

The development of the national hub for reviewing and learning from the deaths of children and young people provides an opportunity to streamline current review processes following the death of a looked after child and to extend learning from the deaths of looked after children and young people to include reviews of those up to 26 years of age in receipt of continuing care and aftercare.

## Section 4: Profile of care experienced children and young people who died between 2012 and 2018

### Looked after children and young people

Local authorities reported 42 deaths of looked after children over the seven-year period from 1 January 2012 to 31 December 2018. In age, they ranged from less than a year to 17 years old, with twice as many boys as girls (Table 1).

**Table 1** Number, gender and age at time of death of looked after children and young people who died between 2012 and 2018

Age range	Number of children and young people	Boys	Girls
Under 5 years	13	10	3
5 to 11 years	5	2	3
12 to 16 years	19	13	6
17 up to 18th birthday	5	3	2
<b>Total</b>	<b>42</b>	<b>28</b>	<b>14</b>

Looked after children and young people who died lived in both rural and urban areas and came from 18 local authority areas. The remaining 14 areas did not report any deaths of looked after children between 1 January 2012 and 31 December 2018. Most of the children and young people who died were looked after in the community at the time of their death at home, in kinship care or foster care (Table 2). Some looked after children and young people had more than one placement at the time of their death, for example they were looked after at home or in kinship or foster care, and they were also provided with overnight residential respite. In such cases the primary placement is identified in Table 2.

**Table 2** Number of looked after children and young people who died by placement type in the seven-year period between 2012 and 2018

Type of placement	Number
Looked after at home	11
Kinship care	6
Foster care or adoptive placement	14
Residential or secure accommodation	5
Residential respite	4
Supported accommodation	2
<b>Total</b>	<b>42</b>

## Young people in receipt of continuing care and aftercare

Over the four-year period from 1 January 2015 to 31 December 2018 and following the change in legal requirements, we received 19 notifications of the deaths of young people in receipt of continuing care or aftercare (Table 4). Deaths of young men predominated among those in receipt of continuing care and aftercare. Almost all notifications were of the deaths of young people in receipt of aftercare. It would be helpful to know more about the lives of these young people and the circumstances surrounding their deaths. This would help in lessons to be learned and assess whether these children and young people were getting the appropriate level of support. However, without a report and supporting documentation to accompany these notifications, further analysis has not been possible.

**Table 3 Number and gender at the time of death of young people in receipt of continuing care and aftercare who died in the four-year period between 2015 and 2018**

Age range	Number of young people	Young men	Young women
18 up to 26 years	19	15	4

Engagement with young people and other stakeholders in developing the Staying Put Scotland guidance (2013) highlighted the importance of suitable, settled accommodation for looked after young people. This was seen as being critical to the success of their transition out of care, with many other outcomes (such as employment) contingent on them being able to access a range of appropriate, sustainable accommodation options, including the opportunities to stay in their care placement beyond the terms of their supervision order, or to return to care placements at a later date. Following the implementation of the Children and Young People (Scotland) Act 2014 and the duty on local authorities to provide continuing care, we do not yet know how long young people are remaining in continuing care and whether this may be contributing to a reduction over time in preventable deaths of care experienced young people under 21 years of age.

## Comparing the deaths of looked after children with deaths of children in the population

It is difficult to establish whether a child looked after by the state is more likely to die prematurely than a child in the general population. The number of looked after children who die prematurely is very small so we should exercise great caution in analysing the available data. Our understanding of the challenges faced by children and young people with experience of the care system is growing daily. However, at present we simply do not know whether a looked after child or young person is more likely to die in childhood than their peers and if so, why this is the case and what actions should be taken to reduce any deaths that are deemed to be preventable. The development of the national hub may help further our understanding in this area.

**Table 4 Looked after children aged 0-17 years who died in Scotland between 2012 and 2018 compared to deaths in the child population**

Year	Number of looked after children who died	Total number of children who died	Percentage of all children who died who were looked after
2012	2	348	0.8
2013	7	322	2.17
2014	8	328	2.4
2015	3	278	1.0
2016	5	321	1.5
2017	8	294	2.7
2018	9	296	3.0
<b>Total</b>	<b>42</b>	<b>2,187</b>	<b>1.9</b>

Very limited research into, or review of, the deaths of looked after children and young people means we simply do not know whether looked after children are more likely to die than their peers. The development of the national hub to oversee reviews of the deaths of children in Scotland, including the deaths of looked after children, should help to increase our understanding of trends and actions to reduce preventable deaths.

## Section 5: Learning from reviews of the deaths of looked after children and young people

### Local authority reports and supporting documentation

We evaluate the content of local authority reports on the deaths of looked after children and young people and provide them with feedback on practice, identifying strengths and any areas for improvement. Most reports provided an account of the child's journey from birth and noted the actions services had taken in response to concerns about a child or young person's safety and wellbeing. Although there was an appropriate level of detail, accounts were often overly descriptive with considerable variation in the depth and quality of analysis. In addition to their report, local authorities usually included a chronology of significant events in a child's life, the most recent comprehensive assessment of risks and needs, child's plans and minutes of meetings to review the progress of the plan. In analysing the accompanying documents, we often found important issues overlooked in the report itself. Given the complexity of these cases, current timescales may not be realistic for the submission of a thorough and comprehensive report.

In terms of ensuring a level of objectivity, there was variation in the extent to which the member of staff carrying out the review had been directly involved in working with the child or young person or was previously not involved. Most, but not all the reviews were signed off by a senior social work manager or the chief social work officer. Some were signed off by first line managers, while a few were written and signed off by the allocated social worker. We would expect all reviews to be signed off by the chief social work officer whose responsibilities include promoting values and standards of professional practice, and who advises on the appropriate systems required to promote continuous improvement. While there were some notable good practice examples of careful consideration being given to who was best placed to review the death of the individual child or young person, in many cases, it was unclear how such decisions were made.

Under the Looked After Children (Scotland) Regulations 2009 it is the local authority's responsibility to notify the Care Inspectorate of the death of a looked after child and for completion of the review report. The reviews submitted that informed this report were written predominantly from a social work perspective. In our view, this meant reviews were not sufficiently informed by contributions from other partners. In the best examples, a multi-agency approach was taken and this led to a more holistic approach to considering how well the child or young person's needs had been met. This approach also led to a more balanced evaluation of the effectiveness of partnership working. When a senior manager had oversight of this work, the quality of the report also improved.

The Care Inspectorate provides written feedback to the relevant local authority, taking account of advice from Education Scotland and a health consultant when this has been available. The effectiveness of joint working is recognised as critical to improving outcomes for care experienced children and young people. The guidance would benefit from revision that would see partners in a local authority area submit a single shared report and supporting documentation to reflect joint working and collective leadership responsibility as corporate parents. While timescales would need to be extended to support such an approach, the opportunity for partners to reflect on their practice together has the potential to support continuous improvement. Providing our feedback to leaders of

corporate parenting in a local authority area would encourage a joint approach to addressing any suggested areas for development.

## **How we work with other scrutiny bodies**

When a local authority reports the death of a looked after child or young person to the Care Inspectorate, we liaise with colleagues from other scrutiny bodies and organisations.

On our behalf, Education Scotland reviews the educational provision for looked after children and young people who have died. Education Scotland's expertise in examining education services and partnership working between schools, psychological services and Skills Development Scotland is essential to our work. Education Scotland often look for additional supporting documentation from the local authority about the child or young person's attendance, school exclusions, attainment and, where relevant, transition planning to achieve a positive and sustained school-leaver destination. In future, a single shared report and supporting documentation submitted by those with corporate parenting responsibilities in a local authority area would be more likely to include all the relevant information about a looked after child or young person's educational experiences.

### **Key message 2**

Part 9 of the Children and Young People (Scotland) Act 2014 in relation to corporate parents recognises the importance of collaborative working and shared responsibility. The current Looked After Children (Scotland) Regulations 2009 are out of step with this and would benefit from modernisation.

Until 2014, the Care Inspectorate retained the services of a specialist medical advisor to provide expertise in reviewing the deaths of looked after children and young people. However, this arrangement came to an end and there has been a significant gap since that time. Many of the deaths of looked after children and young people involve a complex health dimension whether that be the death of a looked after child with a life shortening condition or the death by suicide of a care experienced young person experiencing difficulties in relation to substance misuse and mental health. The development of the national hub provides an opportunity for the provision of clinical expertise for reviews.

### **Key message 3**

Establishing the national hub for reviewing and learning from the deaths of children and young people provides new opportunities to bring clinical expertise to reviews of the deaths of looked after children and young people whatever the cause.

## **How we work with the Crown Office and Procurator Fiscal Service**

We liaise with the Crown Office and Procurator Fiscal Service (COPFS) as it becomes involved following the death of a care experienced child or young person. At the discretion of the relevant procurator fiscal, the Care Inspectorate can complete a report or reach interim conclusions before the conclusion of a fatal accident inquiry. COPFS may use our reports to inform its decisions about next steps.

Generally, there are three sets of circumstances in which it would be necessary for us to discuss the death of a looked after child with the procurator fiscal.

- When we need a post-mortem report released to us to inform our work.
- Sharing our conclusions to help the procurator fiscal decide about actions they may take, such as ordering a fatal accident inquiry.
- Where the procurator fiscal asks us to delay our review until after a fatal accident inquiry has been held and findings made public.

## Section 6: Learning from the deaths of looked after children and young people

Based on an analysis of accompanying reports and supporting documentation, we can see that the deaths of looked after children and young people fall into three distinct categories.

- Those whose deaths while tragic, could be anticipated due to a life shortening condition or terminal illness.
- Those whose deaths were unexpected due to misadventure or where the cause of death was unexplained.
- Those young people whose risk-taking behaviours culminated in their untimely death.

**Table 4 Deaths of looked after children and young people by category, number and gender in the seven-year period between 2012 and 2018**

Category	Number	Boys	Girls
Anticipated deaths due to a life shortening condition or terminal illness	16	9	7
Unexpected deaths due to misadventure or where the cause of death was unexplained	12	10	2
Deaths of young people whose risk-taking behaviours culminated in an untimely death	14	9	5
<b>Total</b>	<b>42</b>	<b>28</b>	<b>14</b>

### Learning from practice where the death of a looked after child or young person could be anticipated due to a life shortening condition or terminal illness

The deaths of 16 looked after children and young people could be anticipated due to a life-shortening condition or terminal illness. Corporate parenting responsibility for these children and young people was spread across 12 local authority areas. At the time of their death, they ranged in age from 1 to 17 years of age and were evenly divided between male and female. Those with life-shortening conditions had complex care needs. Four of these children were cared for at home by their parents and provided with short overnight breaks<sup>3</sup>. Another eight were looked after and accommodated in kinship or foster care or residential placements as parents were unable to meet their needs fully and keep them safe. Kinship carers and foster carers for these children and young people were also supported by the provision of regular residential respite care. It was evident that children and young people with life shortening conditions and their carers benefited greatly from high-quality respite care tailored to meet their individual needs. Four looked after and accommodated young people in this category were diagnosed, usually in their teenage years, with a terminal illness and died a very short time later. These young people and their families received outstanding end-of-life care from staff and carers. At the time of their death, very few of the children and young people in this category were in hospital.

<sup>3</sup> Legislative context: Looking after children affected by disability (respite care) <https://www.gov.scot/publications/children-looked-local-authorities-legal-framework/pages/20/15>

They were at home, in a respite resource, a care placement or receiving palliative care in a children's hospice. This reflected the wishes of carers and the young people themselves where they were able to express their views.

There were many strengths in partnership working with this group of looked after children and young people, and commendable help and support was provided by individual members of staff from across services. Features of good practice are detailed below.

## **Engagement and trusting relationships**

- Staff formed sincere and dependable relationships with this group of looked after children, young people and carers, who in turn developed high levels of trust and confidence in their skills and professional judgement. This was facilitated by consistent membership of a small multi-agency group of staff (team around the child) working together to co-ordinate and improve the child or young person's wellbeing and provide help and support to parents, kinship carers and foster carers.
- Staff offered support to carers and other affected family members including brothers and sisters directly after the death of a looked after child or young person, often continuing to do so through the early stages of bereavement.

## **High-quality care**

- There were examples of excellent care provided by parents, kinship carers, foster carers and members of staff from across services that optimised every aspect of these children's and young people's wellbeing.
- Staff in educational establishments and respite resources benefited from additional training in the day to day individualised care required by a child or young person, including some medical procedures. This increased the confidence and competence of staff.

## **Implementing a Getting it right for every child (GIRFEC) approach**

- Identifying a member of staff to take on the role of health co-ordinator and to act as a single point of contact for health services significantly improved the management of cases involving a wide range of health specialists and improved joint working with education and social work services. When a health co-ordinator was involved in the team around the child, carers benefited from more effective communication and accessible advice from health services.
- Some children and young people had an individualised education plan while a few had a co-ordinated support plan. Overall, it was evident that children and young people were experiencing tailored and very well-planned learning opportunities including those attending special schools.
- Looked after child reviews were helpfully combined with reviews of education plans including co-ordinated support plans and health plans such as emergency medicine care plans. Such arrangements kept planning meetings to a minimum for young people and their carers and saved them repeating the same information to different professionals.

## Respite provision

- Respite for carers proved invaluable in sustaining them in demanding and stressful circumstances.
- When these looked after children and young people lived in households with other children, including their siblings, respite care was particularly helpful in enabling carers to spend time giving undivided attention to other family members.
- Respite took many forms and was provided by staff coming into a carers' own home, providing children and young people with support services and activities in the community and most commonly, through a series of short breaks in specialist residential resources. The voluntary sector made a significant contribution to resourcing high-quality respite care. Children, young people and their carers also benefited greatly from support provided by children's hospices.

## Sensitive conversations

- Plans were put in place for those with a life-shortening condition or terminal illness to ensure children and young people died with dignity and in accordance with the wishes of parents, kinship carers, permanent foster carers and importantly, the children and young people themselves when they were able to express their views. Anticipatory care plans (ACPs) helped to plan for the possibility of a death taking place at home, in hospital, a respite resource or hospice. Health services put child and young person acute deterioration management plans (CYPADMPs) in place to agree with carers and young people themselves on the most appropriate treatment and end-of-life care.
- It was helpful for police, with the consent of parents and carers, to be made aware of children and young people with ACPs and CYPADMPs so they could respond appropriately to notification of a death, especially if there was the possibility that this might occur in the child or young person's home.
- As part of end-of-life planning for looked after children and young people, staff often gave a great deal of consideration to the best way of informing estranged birth parents of the pending death, and the desirability of their involvement in funeral arrangements, taking the wishes of the young person themselves into account where possible.
- Some school staff kept in touch with children and young people who had frequent or lengthy absences due to illness or hospitalisation associated with a life-shortening condition or terminal illness. Young people appreciated the opportunity to continue with their learning if they felt able to do so, for example online. Others missed the social side of schooling and approaches to maintaining contact with their peer group and involvement in school activities helped them to maintain a positive mental attitude.

## Resourcing and cooperation across local authority areas

- Agile responses that overcame budgetary constraints to adapting homes, for example for wheelchair use, had a very positive impact on providing appropriate care at home or in care placements with kinship carers and foster carers.

- In some situations, looked after and accommodated children and young people were the responsibility of one local authority and placed with kinship or foster carers in another local authority area. Where this happened, for example for early education and child care provision, or adult services where a young person was in transition from children's services, a timely resolution to funding arrangements noticeably reduced the stress levels of carers.

## **Permanency planning**

- Timely permanency planning clarified the legal status of the child or young person and the rights of parents and foster carers to be involved in decision-making about end of life care. Securing this legal status was not always given enough priority when working with looked after children and young people with a life-shortening condition. In a few cases, this had the potential to lead to a conflict of interests between the child or young person, their birth parents and foster carers around the time of the child or young person's death and subsequent funeral arrangements.

## **Learning from practice where the death of a looked after child or young person was unexpected due to misadventure or unexplained, for example due to sudden unexpected death in infancy**

Three young people looked after at home, in kinship and foster care respectively died in tragic circumstances associated with road traffic accidents and open water. Such deaths emphasise the importance of preventative work carried out by Police Scotland and the Scottish Fire and Rescue Service. Joint inspections of services for children and young people led by the Care Inspectorate between 2012 and 2017<sup>4</sup> highlighted the positive impact of the work of these services in raising awareness among children and young people about keeping safe. This included many innovative approaches to prevention through partnership working with other agencies.

The majority of children in this category were under five years of age when they died and seven were under a year old. It is of note that nearly half of all child deaths in Scotland are children under a year old. Looked after children in this category were typically born prematurely with some diagnosed with neonatal abstinence or foetal alcohol syndromes in addition to other health complications. The cause of death was unexplained and most commonly attributed to sudden unexplained death in infancy (SUDI). Staff offered very sensitive support to all those grieving the loss of these very young children including birth parents when children were looked after and accommodated away from home.

## **Learning from practice where harmful actions culminated in an untimely death of looked after young people**

We were notified of the deaths of 14 looked after young people who died in tragic circumstances that were typically as a culmination of life-threatening behaviours including substance misuse, self-harm and attempted suicides. These young people ranged in age from 13 to 17 years at the time of their death and most were young men. We received notifications from nine different local authority areas about deaths of young people in this category. Half the young people had experienced placements

<sup>4</sup> Review of findings: joint inspections of services for children and young people 2012-2017 Care Inspectorate 2019

in secure accommodation or another setting with a high level of supervision, such was the level of concern about their safety and wellbeing.

The lives of these young people were commonly characterised by a combination of adverse childhood experiences often resulting in uncontainable feelings of anger and distress, such as:

- anxious, insecure attachments or multiple care givers
- separation and loss of significant people in their lives, including siblings, through death or major disruption in family relationships
- physical and emotional neglect associated with parental alcohol and drug misuse or parental mental illness
- exposure to domestic violence and parental relationships characterised by conflict
- physical or sexual abuse perpetrated by a close family member without a protective parent
- unstable and insecure family life with frequent changes of address including periods of homelessness exacerbating the detrimental impact of poverty and deprivation.

Our analysis of reports and associated documents confirmed the direction of policy and practice change in recent years to promote earlier identification and better co-ordinated intervention through the Getting it right for every child approach. From our oversight, we were also able to identify some areas for development and gaps in current services. It is important to remember that this report cannot take account of the number of looked after young people whose lives have been turned around, despite similar backgrounds, due to effective help and support from services working together to fulfil their corporate parenting responsibilities. Learning from the deaths of young people in this group can nevertheless help us to further improve practice by building on the strong commitment that exists across the country to improve outcomes. As described earlier, we have limited information about the circumstances of young people who die while in receipt of aftercare, but it does appear that they also had similar adverse experiences.

## **Earlier identification, more effective joint working and interventions**

Young people whose risk-taking behaviours culminated in their untimely deaths came to the attention of a wide range of services who offered help and support but then withdrew in response to a lack of engagement from the family and by the young person themselves as they got older. In recent years, as a result of implementing a Getting it right for every child approach, staff from a greater range of services have become increasingly alert to wellbeing concerns at an earlier stage. Greater understanding of the impact of past trauma on current behaviour is helpful and attitudes are shifting from asking 'What is wrong with this child?' to 'What has happened to this child?'. There is some evidence of more joined up working in response to child concerns with a multi-agency, team-around-the child approach, co-ordinated by a lead professional. Moreover, current practice is increasingly informed by several complementary and evidence-based theories about the importance of early childhood experiences in improving outcomes in later life, namely attachment and nurturing, relationship-based practice, the science of adverse childhood experiences and trauma-informed practice<sup>5</sup>.

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<sup>5</sup> Education Scotland: Nurture, Adverse Childhood Experiences and Trauma informed practice: Making the links between these approaches, 2018. (<https://dera.ioe.ac.uk/31839/1/inc83-making-the-links-nurture-ACES-and-trauma.pdf>)

## Vulnerable-young-person procedures

Child protection committees have increasingly adopted vulnerable-young-person procedures that were first introduced by the Glasgow child protection committee in 2000. The procedures were instigated in response to escalating concerns about some looked after young people. They have subsequently been developed and adopted more widely for young people considered to be at risk of significant harm through their own behaviour, or as a consequence of the behaviour of others towards them. When partners had vulnerable-young-person procedures in place, it triggered heightened awareness of the young person across services and systems similar to the effect of placing a child's name on the child protection register. Thorough and timely risk assessments and plans to manage and mitigate risk were put in place and reviewed and updated regularly. The child protection committee and chief officers groups were kept informed of young people subject to the procedures and resources were made available. In effect, this meant that these young people were given the highest priority in recognition of the level of risk. Clearly, in the cases covered by this report, the action taken was not able to prevent the death of the young person however, use of vulnerable young person procedures have the potential to make a significant contribution to de-escalating risks. It would be helpful if all areas' child protection committees considered whether practice would be strengthened by developing and implementing such procedures.

### Key message 4

Vulnerable-young-person procedures can be a useful tool in assessing and meeting the needs of young people whose behaviour may place them at risk. We would like to see them use adopted more widely; child protection committees that have not already done so may wish to consider whether practice would be strengthened by developing and implementing them.

## Persistence and continuity of relationships across service boundaries and moves of care placements

There were good practice examples of staff showing persistence in engaging and maintaining relationships with looked after young people. Care experienced young people tell us that sincere and enduring relationships are what makes the most difference to them. Achieving greater continuity of relationships with young people in this group presents significant challenges. They were frequently moving across service boundaries between health and social work teams, educational establishments and geographical areas including at the point of transition between children's and adult services. When they were living in the community, challenges were due to the chaotic lifestyles of the young people and their families. When they were looked after and accommodated away from home, they often experienced high numbers of unplanned placement moves due to disruptions associated with their behaviour becoming unsafe or unmanageable. Identifying a member of staff to continue working with a young person or maintaining the same team around the child to work peripatetically, regardless of other changes in these young people's lives would necessitate changes to conventional ways of delivering services.

## Services to improve mental wellbeing

A consistent feature of this group of looked after young people was long-standing needs in terms of mental wellbeing. From an early age, these young people were self-harming and frequently identified as experiencing suicidal thoughts or making actual suicide attempts. They were referred to child and adolescent mental health services but rarely diagnosed with a recognisable mental illness. The chaotic nature of their lives and those of their families proved incompatible with keeping appointments or receiving therapeutic help on a planned basis. A further complicating factor was that many of these young people were misusing alcohol and drugs. This could be understood to be a means of self-medicating to dull their pain and manage the impact of post-traumatic stress. A common theme was the significant gap in accessible community-based services to improve the mental wellbeing of looked after young people.

Another common theme concerned young people at high risk of self-harming and suicide who were said to have been placed inappropriately in secure accommodation because there was no available inpatient mental health facility. Moreover, there were limited options available to rehabilitate these young people from secure accommodation back into the community when they were discharged between 16 and 18 years of age. Some returned to live with family members with whom they had not lived for some time and had dysfunctional relationships, while others were provided with supported accommodation. There was a high probability of such arrangements breaking down with the young person then becoming homeless. Looked after young people often needed mental health services that could provide appropriate throughcare from 16 to 26 years of age to prevent them falling through the gap between children and adult services. There is a pressing need to ensure that vulnerable children and young people have appropriate mental and emotional health support.

### Key message 5

More needs to be done to ensure mental and emotional health services are available for vulnerable and looked after children and young people.

## Sustaining looked after young people within the local school community

The education of these looked after young people was fraught with difficulty. The impact of their emotional distress in school became increasingly concerning during primary school years. Despite this, staff worked extremely hard to keep them within mainstream schooling assisted by a strong empathy with the child's circumstances and successful approaches to nurturing. However, things frequently broke down for these young people in secondary school, typically in S1 and S2, resulting in a pattern of school exclusions associated with unacceptable behaviour. Consequently, many of these young people were not in full-time education for significant periods of time. When a school ceased to act as a protective factor in their lives, concerns about their safety and wellbeing escalated with many then being placed in very costly resources including residential schools, close-support units and secure accommodation. The attendance rates of those who remained in secondary school diminished, sometimes markedly, as they got older. As a result, they did not always achieve a positive and sustained school-leaver destination. The focus on these young people's behaviour often overshadowed additional learning needs and attainment. The question arises as to whether more of

these young people could have been sustained, not necessarily within their class, but within the wider school community. In recent years, a great deal of effort has gone into reducing school exclusions amongst care experienced young people. While trends are improving, school exclusion rates among looked after young people at secondary school continue to be disproportionate to rates of school exclusion for the child population<sup>6</sup>. Non-attendance at secondary school for whatever reason also meant that these young people did not have access to school-based services such as counselling and school nurse drop-in consultation.

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<sup>6</sup> Reference to CLAS trends on LAC school exclusions compared to the child population as a whole.

## Section 7: Conclusion

The death of a care experienced child or young person is always traumatic for families, friends, carers and staff. Each death has a far-reaching impact on all those striving to improve the wellbeing and life chances of this vulnerable group in our society. While the reviews that we considered had concluded that the young people's deaths could not be attributed directly to the actions or inactions of services, they nonetheless identified some important learning points.

From our unique overview of all deaths of care experienced children and young people we have been able to identify common themes and key messages. These are designed to strengthen the potential learning from future reviews of the deaths of care experienced children and young people, to promote effective partnership working with our scrutiny partners in Healthcare Improvement Scotland and Education Scotland and local authority areas and to make a positive difference to outcomes for care experienced children and young people.

## Key messages

1. The development of the National Hub for Reviewing and Learning from the Deaths of Children and Young People provides an opportunity to streamline current review processes following the death of a looked after child and to extend learning from the deaths of looked after children and young people to include reviews of those up to 26 years of age in receipt of continuing care and aftercare.
2. Part 9 of the Children and Young People (Scotland) Act 2014 in relation to corporate parents recognises the importance of collaborative working and shared responsibility. The current Looked After Children (Scotland) Regulations 2009 are out of step with this and would benefit from modernisation.
3. Establishing the National Hub for Reviewing and Learning from the Deaths of Children and Young People provides new opportunities to bring clinical expertise to reviews of the deaths of looked after children and young people whatever the cause.
4. Vulnerable young person's procedures have proved to be a useful tool in assessing and meeting the needs of young people whose behaviour may place them at risk. We would like to see their use adopted more widely; child protection committees that have not already done so may wish to consider whether practice would be strengthened by developing and implementing them.
5. More needs to be done to ensuring the availability of mental and emotional health services for vulnerable and looked after children and young people.

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