Executive Summary

from a

Significant Case Review

Undertaken on behalf of

Fife and Edinburgh Child Protection Committees

on

Child MK

21st April 2015
Lead Reviewer: Moira McKinnon

Contents

1. Background to Review

On 16th January 2014, three year old MK was reported missing by his mother (Ms A) and Police Scotland initiated a missing person inquiry. Police efforts were supported by hundreds of local volunteers who assisted the police in the search for the child. MK's body was found on 17th January 2014.

At the High Court in Edinburgh on 25th July 2014 Ms A admitted to the death of her son and pled guilty to culpable homicide and was later sentenced to 11 years imprisonment. The local community assisted greatly in the search for MK and the child's death not only impacted on the child's family but also the community in which he lived.

At the time of MK's death the family were receiving support from Fife Social Work Services on a voluntary basis.

This Significant Case Review was commissioned by Fife and Edinburgh Child Protection Committees in accordance with Interim Guidance for Child Protection Committees for Conducting a Significant Case Review 2007. The review was led by an external review officer. A Significant Case Review is intended to discover whether lessons can be learned about the way child care and protection systems work together, where a child has died or experienced significant harm.

2. Remit

Fife and Edinburgh Chief Officers agreed the remit of the Significant Case Review as follows -

- History of agency involvement with MK and his family
- Response to initial concerns that led to the children becoming looked after and accommodated
- Support and engagement with the family and children from all agencies
- Quality of assessments and decision making undertaken regarding planning for the children
- Information sharing and cross boundary issues
- Role of the Children's Hearing system in decision making and the information provided for the Hearings that took place
- Adherence to policies, protocols and practice guidance

3. Joint Inter Agency Review Team

A joint inter agency review team was established to provide support and a reference point for the review officer. The following agencies were represented –

- Social Work Services Fife and Edinburgh
- NHS Fife and Lothian
- Police Scotland
- Scottish Children's Reporter Administration (SCRA)
- Children's Hearings Scotland
- Education Services Fife and Edinburgh

Agencies were requested to undertake a single agency initial review and submit a chronology of events. The reports were analysed by the Review Team and the information gathered informed the Terms of Reference and the structure of the Review.

4. Data Protection and Publication

This executive summary report contains an overview and actions from the Significant Case Review relating to MK. In the interests of transparency, every effort has been made to disclose as much of the full report as is lawfully possible.

Disclosure of sensitive personal data in respect of this Case Review cannot be justified under the Data Protection Act 1998. As there have been criminal proceedings and extensive media coverage of this case, a significant amount of personal data and sensitive personal data is publicly available. However, any disclosure of sensitive personal data contained in the full report must comply with the Data Protection Act.

Consideration has been given as to whether information is sensitive personal data, and whether its inclusion in the Executive Summary report complies with the Data Protection Act 1998. Consideration has also been given to the right to respect for private and family life in terms of Article 8 of the European Convention on Human Rights. Any information contained in the report relating to MK and other people whose history was closely linked to MK should only be released if it is lawful, necessary and proportionate to do so.

In the light of the above considerations and having taking specialist legal advice, all partners in this Review have concluded that it would not be appropriate to release the full report. The narrative of the full report could not be redacted so as to remove all information carrying an identification risk or the possibility of causing harm to third parties. It was also considered that removing all such information would lead to the report being at best meaningless and at worst misleading.

5. The Process

The Review was conducted in two phases with the first phase involving the reading of agency case files and relevant policy and practice documents. Phase two involved discussions with relevant professionals which commenced at the conclusion of criminal proceedings.

Key professionals met with the review officer to discuss their involvement with the case and to reflect on practice. A senior manager from the respective agency sat in on these discussions and contributed additional information and comment. The review officer also met with members of the family and Ms A.

6. Analysis Overview

The purpose of this review was to establish whether the care and protection systems involved with MK and his family could or should have foreseen the circumstances leading up to MK's death.

The Review Team were fully in agreement that there was no evidence in reviewing this case that workers could have predicted that Ms A would have caused the death of MK. There was no history of Ms A using physical punishment against MK or any of his siblings, and there was corroborative evidence that MK was physically well cared for and his basic needs fully met. The home conditions

were of a high standard. The Review Team were of the view that Ms A's behaviour towards her son was unprecedented and out of character.

At all times this case was the responsibility of Fife Social Work Services, however, as the family moved to reside in Edinburgh discussion did take place with Edinburgh Social Work Services around the future transfer of MK's case once the child had returned to the care of his mother and compulsory measures of supervision were in place. The family were in contact with both NHS Fife and NHS Lothian.

MK and his family had limited contact with services up until February 2012. Prior to this time MK was known to NHS Fife health visiting services and no concerns were noted by that service. The Review Team noted during this period that information held by the Fife GP with regard to concerns was not passed to the Fife health visitor as there were no identified child protection concerns.

Between February 2012 and July 2012 Fife Social Work Services were contacted on two occasions about concerns. Joint home visits were undertaken by Fife social work and NHS Fife health visiting services regarding these.

The Review Team identified the joint approach by the Fife social worker and the Fife health visitor demonstrated good inter agency practice, but the level of assessment during this time relied heavily on self-reporting. There was no multi agency meeting at this time to bring together those professionals in contact with the family and had such a meeting taken place, this would have ensured a comprehensive assessment of need and risk and informed what intervention was necessary.

Assessment by Fife social work and Fife health visiting service was ongoing when in July 2012 Ms A left her children unattended and this was notified to Fife social work. This resulted in MK being cared for by Fife Social Work Services under Section 25 of the Children Scotland Act 1995. MK remained in the care of the Local Authority under a voluntary arrangement until August 2013 when they returned to the care of Ms A.

From July 2012 to August 2013 MK resided with foster carers. A referral had been made to Scottish Children's Reporter Administration and social work services were recommending compulsory measures of care and were awaiting a Children's Hearing before returning MK to the care of his mother.

The Review Team acknowledged that assessment is an ongoing process, and an overall assessment of the family's circumstances is contained within reports to the Children's Hearing. However, in this case a stand-alone comprehensive parenting assessment was not undertaken, and there was no structured observation of contact by professionals.

The Review Team noted that while awaiting the Children's Hearing in August, contact arrangements were not increased and the Review Team felt that this should have been undertaken and used as an opportunity to test out and monitor Ms A's ability to manage her parenting responsibilities. A review looked after children's meeting was not held prior to the Children's Hearing.

At the Children's Hearing in August 2013 it was noted that Ms A had made good progress and that she was aware of the need to ensure the safety and well-being of MK. It was agreed that MK would return home under a home supervision order and the Children's Hearing requested that the case be reviewed in three months, as there was consideration by the Hearing, that compulsory measures of care may not be required.

Fife social work services did not advise the school until November 2013 that MK was a Looked After child or that he had been in the care of the Local Authority until August 2013. However, Edinburgh Education Services did not have any concerns with regard to MK.

A further Children's Hearing took place in December 2013 when MK's home supervision order was terminated.

Following the return of MK to his mother's care in August 2013 he was seen regularly by the Fife social worker and Edinburgh health visitor. Ms A presented positively to health (Edinburgh), Education (Edinburgh) and Social Work Services (Fife). The family were visited on 5 occasions by Fife social work and on 2 occasions by the Edinburgh health visitor when no concerns were noted. There were no presenting factors that would have suggested that there was a level of risk that required child protection intervention.

The Review Team were of the view that there was a degree of optimism on the part of professionals with regard to Ms A's ability to cope without the need for additional supports. However, the family were seen on a regular basis by agencies during September and December 2013, and there were no external indications that she was struggling to cope.

The Review Team have identified examples of good practice and areas of learning which should be shared and discussed across agencies and services.

There was clear communication between Fife Social Work Services and both NHS Fife and NHS Lothian and there was evidence of information being shared on a regular basis.

Joint visits between the Fife social worker and the Fife health visitor ensured that there was a joint assessment of concern and agreed actions. This joint approach also included a visit by Fife and Edinburgh social work services to the wider family.

Planning meetings were used to oversee the management of this case and professionals found these useful in providing a forum for the sharing of information between themselves and with Ms A and her family. The meetings supported the on-going monitoring of the rehabilitation plan and it would have been helpful for these to have continued during the period MK was being cared for by the Local Authority.

There is evidence in the Fife social work file of team leaders reviewing the case and countersigning. The Child Protection Advisor in NHS Lothian also reviewed the case with the health visitor.

Following careful review of the circumstances, it is the conclusion of the Review Team that the circumstances that led to MK's death could not have been predicted. The Review Team considered it important to identify areas of good practice along with areas for future learning and action.

7. Areas for Future Learning and Action

The following actions have been identified by the Review Team as having the potential for practice and policy learning across Fife and Edinburgh child protection systems.

Action 1

Currently there is no agreed national case transfer protocol for non child protection cases across local authority areas. The Scottish Government should consider the need for the development of national guidance similar to that which exists in child protection. Children who are Looked After at Home require specific consideration within this.

Action 2

NHS Fife should in discussion with GP services, review current GP training which focusses on the identification and management of potential concerns regarding the safety and well-being of children and young people where adult vulnerability, such as mental well-being concerns, have been identified. The Girfec practice model highlights the need for professionals to identify child well-being concerns at the earliest stage possible and to share these with the named person.

Action 3

NHS Fife should review how information, which sits below the child protection threshold but which impacts on the child's well-being, is shared between GP and health visiting services where an adult patient with child care responsibilities presents with mental well-being difficulties. Assessment should be fully informed by all relevant information to ensure that interventions are proportionate and well-being concerns addressed**.**

Action 4

The NHS Fife Universal Health and Wellbeing Tool should be reviewed with regard to its implementation across the health board area to ensure that staff are fully conversant with its use and that consistency is being achieved and outcomes for children and their families informed by its use.

Action 5

NHS Fife should ensure that staff are fully aware of case transfer guidance with regard to Looked After and Accommodated children who are placed out with the health visitor's caseload area. The health visitor should transfer the case to the child's area of residence and the health visitor within that locality unless the child's placement is known to be temporary.

Action 6

Fife Education Services should ensure that all information contained in the child's education files is transferred to the new educational establishment and should include all "care and welfare" referrals/information.

Action 7

Fife Social Work Services should ensure that Looked After and Accommodated reviews are undertaken as detailed in Fife Social Work Looked After and Accommodated Procedures. Timeframes for reviews should be adhered to, and the standard principle should be that no child should return home without a LAAC review having taken place unless legal or other exceptional circumstances prescribe otherwise. The LAAC review should agree the child's plan and identify agency roles and responsibilities.

Action 8

Getting it right for every child has been implemented in Fife, however, implementation is still bedding in. Fife Social Work Services should ensure that practitioners are consistent in undertaking assessments which reflect the Girfec practice model and the use of well-being to assess both need and risk.

Action 9

Fife Social Work Services should ensure that rehabilitation plans for looked after children include an explicit assessment of parenting capacity that addresses amongst other issues the quality of parent/child interaction and any issues relating to parental attachment.

Action 10

Fife Social Work Services and Scottish Children's Reporter Administration should review how cases are managed where delays in the Children's Hearing process have been identified. Regular liaison between the Reporter and Social Work Services is necessary to review the progress of the case.

Action 11

This case highlighted the challenges for both health and social work services to deliver service through periods of organisational change. Senior Managers from NHS Fife and Fife Social Work Services require to ensure that structures are robust and processes are in place to ensure staff are supported with their workload and that continuity of service is maintained at a local level during periods of structural and workforce change.

Action 12

Fife health and social work files did not fully reflect the work undertaken. NHS Fife and Fife Social Work Services require to reinforce their single agency recording policies to ensure that case records are up to date, reflect analysis and detail the care plan for the child.

Action 13

NHS Fife and Fife Social Work Services should further consider the approach to the use of chronologies. While single agency chronologies were available, these were not brought together in to a single multi agency chronology. The Girfec practice model should be reviewed to ensure clear guidance for practitioners as to when a multi-agency chronology is required to support the assessment of need and risk.