

Protecting Children & Young People:
Interim Guidance for Child Protection
Committees for Conducting a
Significant Case Review

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1. INTRODUCTION

1. Recommendation 6 of the Audit and Review of Child Protection *It's Everyone's Job to Make Sure I'm Alright*¹ asked for the Scottish Executive to “consult on how child fatality reviews should be introduced in Scotland. This should include consultation on how they should be conducted, how review teams should be constituted, to whom they would report and what legislative framework is required to ensure their effectiveness”. This guidance is the product of the consideration that has been given by the Scottish Executive and its partners to delivering that recommendation.

2. Reviews of significant cases are already undertaken by agencies involved in child protection, whether singly or jointly, although there is no standard approach to when and how these are tackled. Local areas and individual agencies will have their own processes and procedures in place but across Scotland there is a degree of inconsistency in how decisions are made on:

- when to call for a review;
- what type of review to hold;
- the management of the process;
- the skills and expertise required to undertake the review;
- the reporting requirements of the review; and
- the implementation of the review's findings.

3. This guidance should help provide more clarity and consistency on what should be done and how best to act on the lessons learnt from a Significant Case Review (SCR), both locally and across Scotland.

Purpose of the Guidance

4. The purpose of the guidance is to provide a systematic and transparent approach to the review process. The overarching objectives of a review are to:

- Establish whether there are lessons to be learnt about how better to protect children and young people and help ensure children get the help they need when they need it in the future – reviews should be understood as a process for learning and improving service as well as a means of recognising good practice;
- If and when appropriate, make recommendations for action (albeit that immediate action to improve service or professional shortcomings need not await the outcome of a formal review);
- Consider how any recommended actions will be implemented;
- Address the requirement to be accountable, both at the level of the agency/agencies and the occupational groups involved;
- Increase public confidence in public services, providing a level of assurance about how those services acted in relation to a significant case about a child; and
- Identify national issues where appropriate including good practice.

¹ *It's Everyone's Job to Make Sure I'm Alright*, Scottish Executive 2002

5. This guidance supports these objectives by helping those considering undertaking a review, or actually doing so, to:

- Undertake the review at the level which is necessary, reasonable and proportionate;
- Adopt a consistent, transparent and structured approach;
- Identify the skills, experience and knowledge that are needed in the review process and consider how these might be obtained;
- Address the needs of the many different people and agencies who may have a legitimate interest in the process and outcome; and
- Take account of the evidence bases.

6. A review may reveal staff actions or inactions which are of sufficient seriousness that they need to be brought to the attention of the employer. The reviewing body has a duty to do this, irrespective of the SCR process.

Who is this Guidance for?

7. Protecting children and young people is an inter-agency and inter-disciplinary responsibility. While it is social work services who usually lead on the discharge of local authorities' legal responsibilities in respect of safeguarding children², any agency (including voluntary sector organisations) or profession may be the initiator of the review process detailed here.

8. Nevertheless, in every case, it is the local inter-agency Child Protection Committee (CPC) - which works on behalf of the Chief Officers in health, police and the local authority in that area - which has overall responsibility for the formal review of a significant case. It is the CPC, on behalf of the Chief Officers Group, which decides whether an SCR is warranted; the manner in which the review is conducted; and then either undertakes the review itself or commissions it to be done externally (although ownership always ultimately remains with the CPC). This guidance is therefore targeted at CPCs.

9. CPCs are not constituted as statutory bodies, but are comprised of membership drawn from statutory and voluntary agencies. The authoritative role CPCs play in handling an SCR stems from the requirements placed on them in *Protecting Children and Young People: Child Protection Committees*³, where CPCs are required to:

- Undertake a range of multi-agency functions including taking the decision on whether to proceed to an SCR; and
- Subsequently manage the review process, including its communications, report handling and follow through.

10. In addition, one of the Quality Indicators (QI 5.4) for the joint inspection of child protection services⁴ uses the example of an SCR to illustrate how senior managers and the CPC must “actively and systematically take a leading role in ensuring improvement both within and across services.”

² S22(i) of the Children (Scotland) Act 1995: “A local authority shall – (a) safeguard and promote the welfare of children in their area who are in need”

³ *Protecting Children and Young People: Child Protection Committees*, Scottish Executive, 2005

⁴ *How well are children and young people protected and their needs met?*, HMIE, October 2005

11. This guidance should also prove relevant to all those involved in the delivery of children's services, including those working in the voluntary and independent sector. From time to time, they may be involved in contributing to an SCR.

The Status of a Significant Case Review (SCR) Relative to Other Linked Investigations

12. There are sometimes reasons why a review cannot be easily progressed or concluded, e.g. where there is an ongoing criminal investigation or where there are links to a Fatal Accident Inquiry or Children's Hearings Proceedings (see **Annex 1** for kinds of formal investigation). Section 9 considers this in more detail. Criminal investigations always have primacy. To help establish what status an SCR (including the Initial Case Review) should have relative to other formal investigations there should be ongoing dialogue with the police, Procurator Fiscal or others to determine how far and fast the SCR process can proceed in certain cases. Good local liaison arrangements are important. Issues to be considered include how to:

- Link processes;
- Avoid witness contamination;
- Avoid duplicate information being collected; and
- Decide whether a parallel process should mean that an SCR should be adjourned.

13. Regardless of whether or when an SCR takes place, it is important that any obvious areas for improvement of practice identified by the immediate evidence should be addressed as soon as possible. Following the death of a child or the identification of serious concerns relating to a child, agencies should immediately assess the circumstances of the case to identify if there are any immediate actions that need to be taken. If action is required, it should be proportionate and taken at local level as far as possible.

14. It is important that the review process which this guidance sets out is carried out in good time – not least to reduce stress on the child (if they are still living); their family or carers; and the staff of the agencies involved in the SCR.

2. CRITERIA FOR IDENTIFYING WHETHER A CASE IS SIGNIFICANT

A 'Significant' Case

15. A significant case need not comprise just one significant incident.

Criteria

16. Any of the circumstances below could suggest that a Significant Case Review (SCR) may be required. An Initial Case Review (ICR) should first determine whether an SCR is merited. The detail and level of review will depend on the individual case and circumstances. A review should not be escalated beyond what is proportionate taking account of the severity and complexity of the case.

17. What is provided in this section is a guide for helping CPCs, professionals, and all agencies make judgements about the way forward. The list should not be seen to exclude cases that may not precisely fit the criteria but which have nevertheless clearly triggered significant professional concern. These cases should be left to professional judgement and a CPC decision on how to proceed.

18. **When a child dies and:**

- Abuse or neglect is known or suspected to be a factor in the child's death;
- The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear to the Child Protection Committee that the child having been on the CPR has no bearing on the case;
- The death is by suicide or accidental death;
- The death is by alleged murder, culpable homicide, reckless conduct, or act of violence⁵;
- The child was looked after by the local authority⁶;

and, in addition to this, the incident or accumulation of incidents (a case) gives rise to serious concerns about professional and/or service involvement or lack of involvement.

19. **When a child has not died but** has sustained significant harm or risk of significant harm, under one or more of the categories of abuse and neglect set out in *Protecting Children – A Shared Responsibility: Guidance for Inter-Agency Co-operation*. Bear in mind that

⁵ With regard to death by murder, where the murder is by a stranger, there should be an assumption that an SCR is not appropriate. If, during the investigation of the crime, any information emerged that might indicate that the parents/carers had failed to protect the child or that the alleged offender was known to protection agencies, an SCR should be considered.

⁶ Reviewing and reporting the death of a Looked After Child is a statutory duty under regulation 15 of *The Children (Scotland) Act 1995 Regulations and Guidance*, Scottish Office 1997. This guidance does not replace that duty. Every effort should be taken to avoid duplication of two processes in these cases, only one of which (the LAC Report) has a legal basis.

cumulative inaction or wrong action may be more difficult to evidence but nevertheless should be considered to the best extent possible,

and, in addition to this, the incident or accumulation of incidents (a case) gives rise to serious concerns about professional and/or service involvement or lack of involvement.

20. It is expected that CPCs would consider any request made to them for a review, even if the case had been considered at the Initial Case Review to require no further action (see Sections 3 and 4).

21. It would also be expected that any concerns raised by families and similar interested parties would be addressed through the normal complaints procedures for each agency involved.

Definition of a Child

22. For the purpose of this document a child is a person under the age of 18.

3. INITIAL CASE REVIEW

23. An Initial Case Review (ICR) is a process carried out by the Child Protection Committee (CPC) after receiving a report of a possible significant case.

Stage 1 – Notification

24. Where a case arises which appears to meet the criteria set out in Section 2, the Reporting Officer must notify the CPC using the Initial Case Review (ICR) Report template (see **Annex 2**). The Reporting Officer should notify the CPC within 1 working day of identifying the case, where this is feasible. It is understood that sometimes it may not be appreciated immediately that the case is significant.

25. The Reporting Officer should, at the same time, notify all other agencies or persons known to be involved with the child of their report to the CPC using the template at Annex 2. All these agencies or persons should submit their own report(s) to the CPC within 10 working days, also using the ICR Report template (see **Annex 2**).

26. If the Reporting Officer or agencies cannot reasonably complete the ICR Report for the CPC within the suggested times, that should not detract from agencies taking whatever urgent action is required to protect any other children who may be at risk.

Stage 2 – Gathering Further Information, if Required

27. The CPC will consider whether the information is sufficient to reach a decision on the need for an SCR or whether further information is required before a measured decision can be taken. In order to decide whether more information is necessary, the CPC may find that preparing a co-ordinated chronology brings out the need for such information.

28. If the CPC decides that more information is necessary, it will stipulate what this is, and will decide which agencies must provide it. This information should be provided within 20 working days, where this is feasible.

Stage 3 - Taking a Decision on Whether or Not to Proceed to a Significant Case Review (SCR)

29. An SCR should only be undertaken when the criteria in Section 2 are met. If the ICR leads to the conclusion that an SCR is warranted, the CPC must initiate the SCR process as soon as possible.

30. In cases where it is contested within the CPC as to whether or not to progress to an SCR, the final decision rests with the CPC Chair.

31. In the case of a decision to proceed to an SCR, it is the responsibility of the CPC to advise the child and/or family/carers of the CPC's intentions.

A Note on Timescales

32. The assumption throughout this guidance is that the CPC should proceed as speedily as feasible at all stages of an ICR and SCR, and that agencies should proceed likewise. It is recognised that the complexity or circumstances of certain cases may result in the preferred timescales not being met. Where any of these deadlines have to be extended, for example in circumstances where other proceedings intervene, this should be recorded and a new deadline agreed by the CPC for appropriate follow up.

33. For every case, the CPC should agree a deadline for when reports should be produced in the light of the circumstances and context of that particular case.

Conducting an ICR

34. The ICR should deal with the following matters:
- A brief description of the case and the basis for referral;
 - A co-ordinated chronology of events;
 - A note of agency/professional involvement;
 - A statement about the current position of the child, and if they are alive what actions have been or will be taken on their behalf;
 - Any other formal proceedings underway;
 - Any elements of poor practice;
 - Any elements of good practice;
 - Any particular sensitivities (e.g. from the PF or Police about cases where there are likely to be disciplinary proceedings);
 - Lead contacts for each agency; and
 - The CPC's decision as to whether or not to proceed to an SCR, with reasons.

Record Keeping on ICRs

35. An ICR should lead to a written record of the items considered in paragraph 34.

36. Each CPC should maintain a register of all potentially significant cases referred to it in order to:

- Evidence the decisions made;
- Monitor the progress of the reviews undertaken;
- Monitor and review the implementation of recommendations; and
- Identify contextual trends (e.g. prevalence of substance misuse).

37. The ICR may lead to a number of outcomes:

- No further review;
- No further review needed but follow-up action desirable;
- Initiation of local action to rectify an immediate issue; or
- An SCR, and the CPC to decide on which kind of SCR to commission.

38. In every case, the CPC should notify the Chief Officers Group of the outcome, by means of the written record described in para 35.

39. Other relevant interested parties should also be advised of the outcome of the ICR using the template at Annex 3.

An Operational Protocol for Managing ICRs

40. CPCs should develop a local operating protocol for handling ICRs to underpin this guidance. It should include who from the CPC structure has delegated authority to accept the initial notification and/or instruct any further information-gathering and/or make a decision on whether to proceed to an SCR. Each local ICR operating protocol should be agreed with the CPC's Chief Officers' Group. It should firmly reflect the national principles set out in this guidance but retain sufficient flexibility to suit local structures.

4. THE CHILD PROTECTION COMMITTEE (CPC) DECIDES NOT TO PROCEED TO A SIGNIFICANT CASE REVIEW (SCR)

41. Once the CPC has assessed the information it possesses and has decided against conducting an SCR, it may decide to take no further action, or it may conclude that some follow up action is necessary, short of an SCR. This section deals with these issues.

No Further Review Needed

42. This CPC decision is appropriate where:

- The criteria for an SCR, as set out in Section 2, are not met;
- Single agency action is deemed appropriate; or
- The information provided indicates that appropriate action has already been taken.

43. If this is the outcome of the CPC's decision-making process, the CPC should notify the Chief Officers Group and all the agencies involved in the case that there will not be an SCR, and that fact should then be recorded on the case files for that case and the cases of relevant adults.

44. The decision should be included in the statistics on Initial Case Reviews (see Section 8, the Learning Cycle). Issues of confidentiality will need to be considered and resolved so that the case may be included in statistical returns and in the Annual Report.

45. Good practice findings should be recorded and reported in Annual Reports.

No Further Review Needed, but Follow-up Action Desirable

46. This CPC decision is appropriate where the conditions are as set out in para 42 but, in addition, it is identified that the CPC may have some follow-up work to do. For example, it may be clear that there has been a misunderstanding of guidance, or that local protocols need to be reinforced. It could also arise that the Initial Case Review demonstrates a familiar theme coming through and it is felt by the CPC that it would be useful to draw appropriate guidance to staff's attention or to consider reviewing training/protocols in respect of that theme.

47. In these cases, the CPC should take the same actions as set out at paras 43-45. In addition, the agreed follow-up action required of the CPC (e.g. revising guidance in a particular area) should be undertaken or should be scheduled into the CPC's future work programme.

5. THE CHILD PROTECTION COMMITTEE (CPC) DECIDES TO PROCEED TO AN SIGNIFICANT CASE REVIEW (SCR)

48. The CPC considers that the criteria at Section 2 have been met and is considering how the public interest is best served and also the interests of children in the area. This section guides the CPC on whether to hold an internal or an external SCR.

The CPC Decide to Undertake an Internal SCR

49. The CPC may be more likely to decide in favour of undertaking an SCR themselves where the circumstances of the case, based on the evidence of the Initial Case Review, suggests that any recommendations are likely to have mainly local impact.

50. In this case, the staffing resources for the SCR would probably be drawn mainly from within the CPC's members. An external specialist or consultant may also be used for some part of the process.

51. The CPC should notify the Chief Officers Group and all the agencies involved in the case that there will be an internal SCR, and that fact should then be recorded on the case files for that case and the cases of relevant adults.

52. The decision should be included in the statistics on SCRs (see Section 8, the Learning Cycle). Issues of confidentiality will need to be considered and resolved so that the case may be included in statistical returns and in the Annual Report. Good practice findings should be recorded and reported in Annual Reports.

The CPC Commissions an External SCR

53. The CPC agree it would not be appropriate or proportionate for them to lead the SCR, as the case may benefit from being considered and investigated by an external team. The criteria which may persuade a CPC to commission an external SCR include:

- There are likely to be national as well as local recommendations;
- Local recommendations are likely to be multi-agency rather than for a single agency;
- The case is already high profile, or is potentially likely to attract a lot of media attention;
- Councillors or MSPs or other elected members have voiced their concerns about services locally;
- The CPC is facing multiple reviews; and/or
- The child's family/carers or significant adults may have already have expressed concerns about the actions of the agencies.

54. Where an SCR is commissioned externally, it continues to be owned by the CPC.

55. The CPC should notify the Chief Officers Group and all the agencies involved in the case that there will be an externally-commissioned SCR, and that fact should then be recorded on the case files for that case and the cases of relevant adults.

56. The decision should be included in the statistics on SCRs, as set out in para 52.

6. THE SIGNIFICANT CASE REVIEW (SCR) PROCESS

57. Research and experience indicate there are key areas where good preparation and planning are important to ensure the objectives of the SCR are met:

- A. Developing the Remit
- B. Identifying the Review Team
- C. Commissioning the Review Team
- D. Resources
- E. Managing the Process
- F. Producing, Handling and Delivering the Report
- G. Follow-up
- H. Family/Carers
- I. Staff

58. Each of these is looked at in more detail in the following sections.

A - Developing the Remit

59. The outcomes of the review should be to:

- Identify whether inter-agency working can be improved to better protect children; and
- Contribute to the development and sustainability of robust quality assurance procedures and continuous improvement.

60. The clearer the remit the easier it will be to manage the expectations of those involved in contributing to the SCR and the wider audience for the outcome of the review. It is recognised that the degree of complexity and/or which people to involve might not become clear until some initial work has been undertaken – especially in the case of an external SCR. Consequently, the remit to commence the process may need to be reviewed as the information develops during the process. If changes are made to the remit over time, this should be agreed and appropriately documented.

61. The remit will relate to the purpose of a review as described in Section 1. The review should seek to:

- Establish a chronology of agencies' and professionals' contact with the child. Once the chronology has been established, it should be circulated to the agencies and professionals to check for accuracy;
- Establish the circumstances leading to and surrounding the death/serious harm of the child. It is recognised that this may be difficult if there are parallel inquiries taking place, e.g. a criminal investigation;
- Examine the role of all the agencies involved in providing care, welfare and protection services, and analyse and assess the circumstances drawing out the implications and issues. If the child or other children are being interviewed as part of this examination, consideration should be given as to whether special measures should be deployed for this element of the work;

- Establish whether there are lessons to be learned from the case, or good practice to be shared, about the way in which agencies work individually and collectively to safeguard children;
- Identify lessons, how they are to be acted on and what is expected to change as a result. This should consider whether there are gaps in the system and whether services should be reviewed or developed to address those gaps; and
- Make recommendations for local action (which could be single agency or multi-agency) and perhaps also for national action, spelling out resources that may be required to implement them (see Sections 6 and 7).

B - Identifying the Review Team

62. In the case of either an internal or external SCR, identifying the right reviewer and review team will be crucial. SCRs are resource-intensive and require a dedicated lead with the appropriate specialised support from the principal agencies to provide the necessary understanding of procedures and practice. In some cases it may also be necessary to have specialist input, whether as part of the team for the duration of the SCR or to provide advice as required; the Review team may wish to consult other CPCs and agencies.

63. It is important that the reviewer or someone in the review team has a broad knowledge of children's services as well as the necessary skills to lead/undertake the review. The interviewing of significant witnesses takes time and must be undertaken with perseverance and with sensitivity.

64. The best person to lead a review may be a recognised professional or external consultant who can bring a team together. It is important to assemble a mixed team so that the key agencies feel confident that their specialist issues are understood. The different perspectives of a mixed review team can add to the depth of enquiry.

65. Within a CPC, there may already exist a standing group that considers all potential significant cases (before it is determined whether or not they require a SCR). This standing group might then comprise the main reviewing team for an internal SCR, led by a member of the CPC or by the person with the best knowledge of the main areas that likely to be pertinent to that particular significant case. Nobody should investigate a situation in which they themselves were substantially directly involved professionally.

66. The lead reviewer and the review team will, between them, need to have the skills and competencies to undertake an SCR. These will differ according to the circumstances of each case but the reviewer/review team will need to be able to:

- Gather relevant evidence from a wide variety of sources and be prepared to negotiate if information is not forthcoming;
- Have skills of investigation;
- Test the validity of the evidence and sift the evidence;
- Interpret information from a wide variety of sources;
- Make sound judgements on information collected;
- Analyse the root cause of/factors that contributed to the significant case;
- Liaise with other bodies and establish a good working relationship;

- Demonstrate sensitivity to national and local level issues; and
- Appreciate the need for clarity about the difference of remit and task of an SCR as opposed to other ongoing proceedings relating to that case such as a criminal investigation.

C – Commissioning the Review Team

67. Here is a checklist of issues that are involved when commissioning a review team:
- Confirm that the remit clear and deliverable;
 - Establish clear reporting lines and agree handling of the review itself and the report;
 - Identify milestones and agree the various elements of the process;
 - Consider whether indemnity cover is required;
 - Provide for appropriate administrative support;
 - Agree the method for obtaining additional resources if it becomes clear that these are necessary;
 - Confirm that if issues arise that need urgent action, the CPC (and agencies) will be so advised;
 - Require external reviewers to be registered with the Data Protection Office; and
 - Establish a named contact person within the team.

D – Resources

68. The 2005 guidance for CPCs⁷ states that Chief Officers have a collective responsibility to ensure that their CPC has the resources, including staff time and finance, to fulfil its roles and responsibilities (paras 2.6 and 2.7). Conducting an SCR falls within this area of responsibility. A checklist of resourcing issues to be addressed is provided here:

- Agree any formal contractual arrangements. The Chief Officers Group will consider which agency will enter into the contract;
- In the case of an internal SCR, CPCs should consider the potential of an external person to supplement the review team;
- Consider whether there are any training or information requirements;
- Agree how the review team's expenditure will be managed;
- Agree how the review team will be financed;
- Arrange for any accommodation/space requirements the review team require;
- Provide for secure storage arrangements for files/documents;
- Agree the methodology to be used to record, index and retain documents and evidence in an easily retrievable format;
- Agree the methodology to be used to record, index and retain documents and evidence in an easily retrievable format;
- Establish how often, to whom and in what format the review team should provide interim reports;
- Agree timescales with the principal stakeholders; and
- Agree a communications plan.

⁷ *Protecting Children and Young People: Child Protection Committees*, Scottish Executive, 2005

E – Managing the Process

69. Addressing the what, where and when issues of the SCR are vital to its successful operation. The issues to be discussed and agreed cover:

- The Review team should discuss the case with the Police and the Procurator Fiscal;
- What the remit of the review is (paras 59-61);
- Over what time period events will be reviewed. The family history/background information will help to decide this;
- To what extent will the review team have access to the commissioning CPC for on-going discussion;
- For externally commissioned SCRs, how the contract will allow CPCs to reserve the right to proof-read the final draft to correct factual errors or misunderstandings;
- What interim reporting arrangements are put in place - how often, in what format and to whom should interim updates be sent and received;
- What timescales are agreed for receipt of the interim and the final report;
- What arrangements are there for reporting any unforeseen delays;
- What arrangements are made between the CPC, as the commissioner and owner of the SCR report, and the review team for speaking to the press regarding the review, and at what stage(s) of the SCR process;
- Who on the CPC has delegated responsibility for handling FOI requests and who the contact should be if the findings of the SCR were to be used as evidence in civil proceedings that might arise out of a case;
- Who will make the links with relevant interests outside the main statutory agencies;
- Who the key contacts are for any review team across all the involved agencies. These could be designated SCR contacts who can also advise on, and broker access to, relevant practitioners and information, provide any agency information that may be relevant (protocols/guidance) and generally act as a liaison point;
- What protocols on confidentiality are specified to which the review team signs up;
- Whether there are likely to be issues of access to case records and how that will be addressed;
- It would be expected of agencies that they will assist the Review team in conducting the Review because the outcome is intended to be a learning document;
- Whether the review team need to conduct interviews or whether it is sufficient for them to look at the files to establish the facts of the case;
- Which agencies and professionals should contribute to the review, and who else should be asked to submit a report or otherwise contribute. This will be based on the chronology of who has been in touch with the child and family/carers;
- Whether family members are to be invited to contribute to the review;
- Who the liaison point for the child (if alive) will be, and/or for their family/carers. CPCs will wish to consider whether it is preferable for this person not to have had prior involvement with the child/family/carers. CPCs will also wish to consider whether it is preferable for this person not to be involved in the SCR investigations;
- Where interviews with contributors will take place;
- What briefing will be provided for contributors, and by whom. A briefing will normally be an oral discussion about the purpose of the Review. CPCs will need to consider whether contributors should receive information about the areas to be covered in advance of the interview and whether the files should be available to them for reference;

- What arrangements are in place for feedback to the contributors, including the child and their family/carers, and what mechanism will be used to enable contributors to check the accuracy of what is recorded as it is drafted up for the interim and/or final reports; and
- What procedure will be adopted if the SCR uncovers evidence of criminal acts or civil negligence unrelated to the case under review.

F – Producing, Handling and Delivering the Report

70. Where an SCR has been external, the report is delivered to the commissioning CPC. The CPC should deliver the report to the Chief Officers Group.

71. It is important that there is a degree of consistency to the structure and content of reports. This makes it easier for people to identify and use the findings and for read-across to other reports to be made. The report will include:

- An introduction – summarise the circumstances that led to the review, state the remit and a list of contributors to the review suitably anonymised;
- A separate executive summary and list of recommendations (and who the recommendations are for);
- A chronology of agency/professional involvement;
- The extent of family/carers' involvement;
- A list showing, on each occasion of contact with the child or family/carers or significant adults, whether the child's views and wishes were sought and if they were expressed;
- Analysis;
- Conclusions; and
- Recommendations. These should be few in number, focused, specific and capable of being implemented. It would also be helpful to identify who these are aimed at and any resource implications.

72. The Chief Officers Group should decide to whom full versions of the report are made available. As the SCR report is the key document identifying the issues, the learning points and the good practice found, it would normally be expected that final versions of each report would be published by the CPC (but detailed information on names and circumstances should be anonymised before publication).

73. Even if the Chief Officers Group decide that it does not best serve the public interest nor the purposes of improving service delivery to publish the whole SCR report, it would be always be expected that the Executive Summary and Recommendations would be published. This summary document should be sufficiently detailed to provide a reasonable oversight and analysis of the significant case.

74. It would be expected that an SCR report would be unanimous in its findings and conclusions.

75. The review team and CPC will wish to take account of the requirements of the Freedom of Information Act and Data Protection Act in both the conduct and reporting of the review.

76. The points below, while not exhaustive, highlight the key considerations and responsibilities for clearing and issuing the report of the SCR:

- The CPC must decide how and with whom to share the draft interim and final reports to check for accuracy/other issues;
- The CPC should propose to the Chief Officers Group a distribution list for the full report. This proposed list should have regard to the provisions set out in Section 7;
- The CPC will consider any internal/external communications or briefing required before publication (see Section 7) and advise the Chief Officers Group accordingly; and
- The CPC will consider how media interests will be handled (see Section 7).

G – Follow-Up

77. Having published the report of an SCR, there are a number of issues which CPCs should consider:

- Prepare action and implementation plans and establish a means of monitoring progress;
- Prepare briefing for the Scottish Executive, inspectorates, and others as required;
- Decide on a mechanism for dissemination within and across agencies to capture learning and ensure this is reflected in communication, guidance and training (see Section 8);
- Review the action plan and identification of outcomes;
- Define any actions to be taken if a progress review is not appropriate;
- Agree who will review progress on follow-up activities and when and how this will be done; and
- Provide annual analysis, as a minimum, of all cases referred for a SCR (as well as earlier Initial Case Reviews) to the Scottish Executive, Children & Families Division, Area 2B(North), Victoria Quay, Edinburgh, EH6 6QQ.

H – Family/Carers

78. The family/carers of the child involved should be kept informed of the various stages of the review and the outcomes of these where this is appropriate. Clearly, there will be occasions where the family could be subject to investigation or part of the problem relating to the significant case which triggered the SCR. In these cases information may require to be limited. Close collaboration with the Police and the Procurator Fiscal will be vital.

79. There may also be cases where families are looking to take legal action against an agency or agencies that are the subject of the SCR. Individual agencies' complaints procedures should be made available to the family at the outset of their involvement with the family, and throughout any SCR investigation, as deemed necessary and appropriate. This should not be the responsibility of the CPCs or specifically of the review team.

80. Care should be taken about where and when a child or their family/carers are interviewed. Reviewers should be experienced in communicating with children. It may also be useful to assign a member of staff to be a liaison point throughout the review. The person

carrying out this liaison role should be fully aware fully of the sensitivities and background of the case. This person's role could include advising the family of the intention to carry out an SCR and making arrangements to interview the child, family/carers or significant adults involved.

81. As set out in paras 72-75, the expectation is that the full report will normally be published and that the Executive Summary and Recommendations will always be published. Family/carers and/or other significant adults in the child's life should receive a copy of any report in advance of publication. Consideration should be given as to whether an oral briefing in advance of publication is required. This is particularly the case where there is likely to be interest in the case amongst the wider public.

I – Staff

82. During the review process staff should feel informed and supported by their managers. There may be parallel processes running which staff are involved in (e.g. disciplinary proceedings) as well as the SCR so sensitive handling is important.

83. Each organisation should have its own procedures in place for supporting staff, but below is an illustration of the types of support that could be provided. The line manager should always consider:

- The health and well-being of staff involved;
- Provision of welfare or counselling support;
- Communications with staff and keeping people informed of the process in an open and transparent way;
- The need for legal/professional guidance and support; and
- Time to prepare for interviews and for follow up.

84. This guidance should be given to staff involved in a review, together with a copy of the local operational protocols in place in their CPC area to support this guidance. Once the review has been completed the staff involved in the case should be given a debrief on the review and the findings before the report is published.

7. SIGNIFICANT CASE REVIEW (SCR): COMMUNICATIONS STRATEGY

85. The Initial Case Review (Section 3) is an internal document. The SCR Report, however, is a document intended for shared learning, and hence requires a communications strategy. The first responsibility of the CPC is to report to the Chief Officers Group. But the CPC has wider responsibilities and must consider the wider reporting requirements.

86. It is important to be clear who needs to be aware of the review, what information they need, and when and how this will be provided. Section 7 is provided to help work through this process. Each CPC should agree with local agencies who the contact points should be and their role in the process, i.e. whether it is communication for information or decision-making.

87. Users of this guidance document should note that the communications guidance provided in this section is elementary and agencies should prepare their own press and legal guidance for each particular SCR circumstance.

Who Needs to be Aware of the SCR Report?

88. The CPC should seek to inform all those who will input and who have a legitimate interest in the SCR at each stage of the process. As each significant case will be different, the names of those with an interest might vary. Throughout the process, consideration should be given as to whether there is anyone else who should be informed, or the extent of the information offered to different interests in the SCR. The distribution list should be proportionate to the individual case.

89. Those with responsibility for local service delivery and review probably will include:

- The local Child Protection Committee;
- Chief Officers: Chief Executive of Local Authority/Chief Executive of Health Board/Chief Constable;
- Director of Social Work/Chief Social Work Officer/Senior Managers in the Police, Education and Health Service;
- Staff involved in the review;
- Crown Office and Procurator Fiscal Service;
- Children's Reporter/Scottish Children's Reporter Administration (SCRA);
- Inspectorates – HM Inspectorate of Education Services for Children Unit, Social Work Inspection Agency, HM Inspectorate of Constabulary, NHS Quality Improvement Scotland, Care Commission; and
- Voluntary organisations and independent providers, where they are involved in the case.

90. Those with wider interests in the SCR report could include:

- Family/Carers and/or significant adults of child involved;
- Local Councillors/Health Board Chairs/Chairs of Police Authorities;
- Local Authority, Health Board and Police press officers;
- Scottish Executive;

- Other Child Protection Committees;
- Professional representative bodies;
- Legal representatives; and
- Unions.

91. Other key interests are likely to be:

- The general public;
- Elected members, e.g. MSPs, MPs and Councillors; and
- The media.

When Will Information Become Available?

92. The CPC will advise relevant parties of the outcome of all Initial Case Reviews on completion. A template is provided in **Annex 3**.

93. In some cases information may already be widely known because of the nature of the case (e.g. where the press have released information before the review process has been commenced/completed).

94. On completion of the SCR the information distribution list should include all of the main stakeholders identified plus any other organisation/people who may have become involved with the review (see paras 89-92). In addition, it is important that those to be involved in the review process are briefed at the right time and have an understanding of the process. This is covered in Section 6 under ‘Managing the Process’ (para 69).

Media Handling

95. Most agencies will have media liaison/spokespeople for the agency and any protocols/handling issues should be developed in conjunction with those arrangements.

96. The media can help promote more effective prevention and intervention to protect children by raising public awareness of the circumstances that can occur which contribute to harm and what members of the community can do to mitigate these risks.

97. In responding to media enquiries, CPCs must have regard to wider interests over which they have no direct control. You should anticipate dealing with press enquiries and refer this to your press team.

98. It is important to add an element of calm and focus and not to add to any sense of alarm or confusion.

8. THE SIGNIFICANT CASE REVIEW (SCR) AND THE LEARNING CYCLE

99. One of the key objectives of an SCR is to establish whether there are lessons to be learnt. Once these have been identified in the report it is important that action is taken by CPCs to implement these lessons and to ensure improvements are made to practice. Existing good practice should also be shared.

100. Each agency and CPC should be monitoring practice and procedures, making improvements as required. Recommendations and learning from SCRs should be fed into this same process of continuous improvement and quality assurance. On occasions there will be recommendations which are relevant for action at a national level, for the Scottish Executive or others to take forward in conjunction with agencies.

101. The CPC and local agencies will need to look at recommendations for any lessons from individual reviews as well as across reviews in their own and other areas. CPCs will need to determine:

- A timeframe for action;
- The scope of change required;
- Who and/or what service(s) and organisations are responsible for change; and
- The resource implications.

102. The changes required may involve:

- Management;
- Policy;
- Protocols;
- Practice;
- Operating conditions;
- A combination of any of these; and
- Communications with other CPCs and/or the Scottish Executive.

103. CPCs will wish to consider how to promote commitment to change:

- Consider identifying one senior person to champion change;
- Communications to interested parties;
- Support and acknowledge good practice within and between organisations/service areas; and
- Determine the impact on individuals or organisations (risk factors) as a result of change.

104. In addition, CPCs will need to consider how to:

- Build public confidence;
- Identify, plan and implement the required training; and
- Produce and implement long and short term action plans. Action plans can be fed directly into Children's Service Plans.

105. CPCs will need to consider how to sustain change by:

- Monitoring and evaluation including linking into reporting and action planning cycles;

- Engagement with stakeholders; and
- Supporting staff.

106. The CPC should produce a summary of cases sent to them over the course of the year and introduce these into the learning cycle, whether the decision was to undertake a SCR or not. CPCs will determine the urgency for action planning and implementation within the learning cycle according to the significance of the issues raised to protecting children and young people.

107. After some SCRs it may be necessary for other CPCs to review their own guidance and procedures in light of the findings and recommendations from a review. This could be facilitated through the meetings of the quarterly CPC Chairs Group or by specially convened meetings depending on the need for urgency.

108. Some recommendations from reviews may be for consideration at national level and will need to be led by the Scottish Executive. In addition the Executive will be in receipt of the CPC Annual Reports (including the annual analysis of cases) and will be able to pick up any trends from these and feed them back to CPCs and to the inspectorates more widely as appropriate.

109. Learning from reviews will also be important for the inspectorates as they have a role inspecting services and can evaluate how well recommendations have been implemented and the learning put into practice. Reports sent to the Scottish Executive will be circulated to inspectorates as appropriate.

110. Some recommendations from reviews may be for consideration at national level and may have implications for a range of bodies, for example, universities and colleges, NHS Education, or regulatory bodies such as the Scottish Social Services Council. The Scottish Executive will communicate with these organisations and facilitate change as required.

9. THE SIGNIFICANT CASE REVIEW (SCR) AND THE WIDER CONTEXT

111. There are a number of other processes that could be running in parallel with an SCR and this raises a number of issues including:

- the relationship of the SCR with other processes, such as criminal proceedings or SCRA reports;
- Securing co-operation from all agencies, including relevant voluntary sector interests in relation to the release and sharing of information;
- Minimising duplication; and
- Ensuring a sufficient degree of rigour, transparency and objectivity.

112. Depending on the case, there could be a number of processes which come into play which are driven by considerations wider than service failure or learning lessons across agencies. These can include a criminal investigation, report of death to Procurator Fiscal (PF), a Fatal Accident Inquiry, and a Death of a Looked After Children Review. Further details of these processes are at **Annex 1**.

Interdependencies

113. There is a potentially complex set of activities which may be triggered by a significant case – most likely, the death of a child. It is important that local services do not interfere or contaminate that activity, especially in relation to evidence gathering where there is, or there is the potential for, criminal investigation – whether of staff involved in a case or a third party. The key requirement is that good local ongoing dialogue is maintained with the Procurator Fiscal and/or police to ascertain where they are in their considerations and agree what can be progressed in the SCR. Efforts should be made to minimise duplication and ensure, as far as is practicable, that the various processes are complementary albeit their purpose could be somewhat different. It would be expected that in the case of a significant case which does not involve a death, there is less likelihood of these inter-related processes taking place.

114. In *Protecting Children and Young People: Child Protection Committees*⁸, the Crown Office and Procurator Fiscal Service recognised the importance of child protection and encouraged the involvement of Procurators Fiscal with CPCs – especially in relation to investigations and proceedings on the death of a child. If not already the case, CPCs should seek to ensure they have a named contact in the Procurator Fiscal’s office to be able to pursue such ongoing dialogue as is required to meet the objectives of each type of activity.

115. There will also be agency-specific work that is routinely undertaken, particularly on the death of a child, for example, when this occurs in hospital or is unexpected such as in the case of sudden unexpected deaths in infancy. It will be important that any SCR is co-ordinated to dovetail with such work to avoid duplication of effort and unnecessary further review.

⁸ *Protecting Children and Young people: Child Protection Committees*, page 16 paragraph 4.8; Scottish Executive February 2005

Criminal Investigations (CI)

1. Within Scotland the core functions and jurisdiction of the police are specified by the Police (Scotland) Act 1967. This includes a duty to protect life and property. The police are an independent investigative and reporting agency to the Crown Office and Procurator Fiscal Service and to the Reporter to the Children's Panel (SCRA). The police have a duty to investigate both crimes/offences and also any unexplained sudden deaths.

Crimes and Offences

2. Should the police receive information, by whatever means, that a crime or offence has been committed, they are duty-bound to investigate that occurrence. Principally the role of the police is to establish the following:

- a) Whether or not a crime or offence has been committed;
- b) Whether there is sufficient evidence to support a criminal charge;
- c) Whether grounds exist for referral to the Reporter to the Children's Panel, under the terms of the Children (Scotland) Act 1995, Sect 52;
- d) Whether there is sufficient evidence to justify the detention and/or arrest of the alleged offender; and thereafter to
- e) Submit a report to the Procurator Fiscal and/or the Reporter to the Children's Panel.

3. Where allegations of physical, sexual and emotional abuse are made involving children, the police consider, in collaboration with other agencies the following before initiating the investigation:

- The immediate safety and well being of the child or other children;
- The need for medical attention, immediate or otherwise;
- The opportunity of access to the victim and to other children by the alleged perpetrator;
- The relationship of the alleged offender to the victim;
- The proximity in time over which the alleged abuse has occurred;
- The need to remove the child or other children from the home, although this will only take place after discussion between the supervisor on duty in both the police and the relevant Social Work Departments; and
- The need to obtain and preserve evidence.

4. After consideration of the above, which should ascertain the risks and needs of the child, the investigation will begin. In many such cases a Senior Investigating Officer (SIO) will be appointed to oversee the investigation.

5. In matters where a serious crime or offence has been committed, the investigation will usually be conducted by specially trained officers of the Criminal Investigation Department, and should the crime involve the abuse of a child, support will be given to these officers by officers from the Family Protection Unit, who are trained in the investigation of such criminality.

6. Good practice would always suggest that a Family Liaison Officer is appointed to work with and support the child and family and to act as the single point of contact between them and the police.

7. The evidence of the crime or offence will be gathered in a variety of ways such as the obtaining of statements from witnesses who have knowledge of the events under investigation, the gathering of forensic evidence such as DNA, fingerprints, hairs, fibres, etc. and the interviewing of those person(s) suspected of being responsible.

8. Upon conclusion of the investigation the police will prepare a report of the circumstances and this will be submitted to the Procurator Fiscal and/or the Reporter to the Children's Panel. Decisions will also be made as to whether the accused should remain in police custody pending his/her appearance in court, whether they should be released on Undertaking which may specify certain restrictions/provisions or whether they should be released pending report and summons.

Unexplained Sudden Deaths

9. Sudden Deaths are best defined as any death which occurs suddenly, is unexpected and not preceded by any known illness or disease, which occurred anywhere, either from violence by others, suicide or accident, where the cause of death is unknown or undetermined and where the circumstances give rise to suspicion.

10. Where the circumstances of the death are known, or where the death was expected due to illness or disease and where there is no cause for suspicion or concern then the attending medical practitioner, on occasions in consultation with colleagues, will grant the necessary death certificate, confirming time, date, place and cause (s) of death which will then allow the relatives to make the necessary arrangements for registration and burial or cremation. This process will not involve either the police or the Procurator Fiscal.

11. However, in all other such circumstances, where the death has been confirmed (pronounced life extinct, time, and date) by a qualified medical practitioner and where a death certificate has not been granted as the cause of death is undetermined and/or suspicious, intimation will be forwarded to the Procurator Fiscal, in practice by the medical practitioner and/or the police if they have already been informed.

12. Upon intimation, the Procurator Fiscal will immediately instruct the police to carry out preliminary investigations into the matter on his/her behalf and to make the necessary reports to the Procurator Fiscal by the next lawful day. Invariably and in most cases the body of the deceased will be taken possession of and the Procurator Fiscal will order a post mortem examination to be carried, the purpose of which is to determine the time, date and exact cause of death. Normally this procedure is carried out after intimation and the receipt of preliminary information by the Procurator Fiscal but not always as the sequence of the events are sometimes dictated by the circumstances of the specific case.

13. It should also be noted that at this early stage of the investigations, criminal intent, culpability, recklessness, negligence, etc are not what is under consideration. They may already feature or feature later as a result of the police investigations but are not seen as a pre-requisite at this stage. It is the death that is under investigation. Clearly these factors will influence the later decision making processes of each agency.

14. Post mortem examinations are normally carried out by a single Pathologist acting on behalf of the Crown. He/she will in conjunction with the information provided to him by the police and/or the Procurator Fiscal, carry out an examination of the body and this should normally determine the cause of death, subject to the need for further testing, toxicology etc. His/her findings will be communicated to the Procurator Fiscal and/or the police and will form the basis for the granting of a death certificate. Parental and/or relative consent is not necessary, albeit in practice they are informed of this process.

15. In circumstances where the death is considered to be suspicious, the Procurator Fiscal may direct that a two Doctor post mortem examination be carried out for corroboration purposes of the finding. This would be an essential element in the chain of evidence, particularly where criminal investigations and/or proceedings were to be instigated later.

16. Should the circumstances subsequently become explained and no longer suspicious, the Procurator Fiscal will order the release of the body to the relatives, arrange for the death certificate to be provided, thus allowing registration, burial or cremation.

17. If the post mortem examinations confirms the death was in fact suspicious, avoidable and in particular at the hand of another(s) then the body may not be released at that time, further investigations and enquiries will be ordered, some of which the Procurator Fiscal may specify and the matter would normally become a criminal investigation. In any case, the Procurator Fiscal will require further information so as to determine his/her course of action and in most cases, the police will be the investigating agency directed to conduct these investigations.

18. Normally, a Senior Investigating Officer (SIO) will be appointed to investigate suspicious deaths and specially trained officers would carry out these investigations. These investigations may well identify criminality and also those who may be responsible and in these circumstances the police would follow their well established investigative procedures.

19. Good practice would always suggest that a Family Liaison Officer is appointed to work with and support the family and to act as the single point of contact between them and the police.

20. In child death cases, the procedures applied and followed are in fact the same, albeit, the services of a Paediatrician and/or Paediatric Pathologist would be sought. On many occasions, such specialists are not readily available and accessible and in many cases the body of the deceased may well have to be transferred to such centres of excellence.

21. Once all the investigations have been conducted, the Procurator Fiscal will make his/her determination as to criminal proceedings, on many occasions, particularly where a death is involved this will be in conjunction with the Crown Office. All such deaths are fully reported to them.

Fatal Accident Inquiry (FAI)

22. Procurators Fiscal must investigate all sudden, suspicious, accidental, unexplained and unexpected deaths and in particular all deaths resulting from an accident in the course of

employment or occupation, deaths whilst in legal custody and deaths occurring in circumstances ‘such as to give rise to serious public concern’. The Lord Advocate has discretion to instruct a FAI where it appears to be in the public interest that an Inquiry should be held into the circumstances of the death. An FAI would not automatically be held in respect of a child death.

23. The purpose of a FAI is the enlightenment of those legitimately interested in the death, i.e. the relatives and the dependents of the deceased, as to the cause of death; and the enlightenment of the public at large as to whether any reasonable steps could or should have been taken to avoid the death, in order that lessons may be learned. The PF in the area where the death occurred leads the Inquiry in front of a Sheriff, but in a different role from the usual one of prosecutor. The access to and availability of evidence to legitimately interested parties enables those parties to establish negligence or other culpability.

24. The findings available to a Sheriff at its conclusion are restricted to those directly relating to the circumstances of the death and any actions or systems that caused or contributed to that. The Court has no power to make any finding as to fault or to apportion blame between any persons who might have contributed to the accident. The Sheriff has the power to make recommendations as to steps which ought to be taken to prevent a death occurring in similar circumstances in future.

25. While there is no compulsion on any person or organisation to take such steps, it would be unusual for a Sheriff’s recommendations to be disregarded.

Looked After Child Review (LAC)

26. This review is triggered by the death of a child who is looked after by the local authority. The purpose is for the local authority to assure itself and others, including Ministers, that it acted promptly and competently in the particular case and identify any necessary improvements. There may be public interest which needs to be taken into account.

27. This is an internal inquiry, based on guidance to LAs, with submission of as full a report as soon as possible after the death to the Scottish Ministers and which should not be delayed beyond 28 days.

Ministers are empowered to:

- Examine the arrangements made for the child’s welfare during the time he or she was looked after;
- Assess whether action taken by the local authority may have contributed to the child’s death;
- Identify lessons which need to be drawn to the attention of the authority immediately concerned and/or other authorities or other statutory agencies; and
- Review legislation, policy, guidance in the light of a particular case or any trends emerging from deaths of children being looked after.

The Reporter should notify the CPC using this template within one working day of identifying a potential significant case for review. The Reporter should also use this same template to notify all other agencies known to be involved. These involved agencies should in turn use this same template to submit their own reports to the CPC within 10 working days.

INITIAL CASE REVIEW REPORT

ANNEX 2

Name of Agency notifying potential Significant Case for Review

Child's Name/Identifier:
Date of Birth:
Name of Parents/Carers:

Brief description of incident and basis for referral:

Key facts/background to the case:

Agency/professional involved:

Summary of findings of the initial case review:

Any other statutory proceedings underway:

Lead contacts for each agency:

Date issued to Agency:

Person completing this form:

Date returned to Chair of CPC:

Copy to be retained in Child's record

Copy to Executive Lead for Agency

Copy to Senior Local person in agency

TEMPLATE FOR REPORTING COMPLETED CASE REVIEWS

ANNEX 3

Draft letter from the CPC Chair to those with responsibility for local services delivery and review to inform them on the outcomes of a Child Protection Committee Initial Case Review

Significant Incident Review

[Insert name of CPC] Child Protection Committee has assessed the case of [name of child or young person] whose case was brought to its attention on [insert date].

Following an initial review of the local reports provided, it has been agreed that [delete as appropriate]:

- No further action is required in this case but the case will be included in the CPC annual statistics on the review of Significant Cases;
- No review is required by the CPC but it will be undertaking follow-up actions [insert] and the case will be included in the CPC annual statistics on the review of Significant Cases;
- The CPC will be undertaking a review of the case and will produce a formal report by [insert date]. This will be led by [insert name] and a remit and timescale is currently being developed; or
- An external review of the case is required and will be undertaken by [insert name] and will produce a formal report for the CPC by [insert date].

If you require information as this work progresses, you can contact [insert contact details].

CPC Chair

GLOSSARY

CPC	Child Protection Committee
CPCR	Child Protection Committee Review
FAI	Fatal Accident Inquiry
ICR	Initial Case Review
LAC	Looked After Child
PF	Procurator Fiscal
SCRA	Scottish Children's Reporters Administration
SIO	Senior Investigating Officer
SCR	Significant Case Review

MEMBERSHIP OF THE WORKING GROUP

John Elliot, Solicitor (Chair)

Detective Inspector Fraser Lamb, Strathclyde Police

Tim Huntingford, SoLACE until 14 March 2006

Detective Superintendent Iain Livingstone, Lothian and Borders Police until 14 March 2006

Detective Superintendent Malcolm Graham, Lothian and Borders Police from 24 January 2007

Doctor Stewart Forsyth, Clinical Director of Paediatrics, Ninewells Hospital and Medical School

Moira McKinnon, Social Work, Glasgow City Council

Alastair Carmichael, Crown Office and Procurator Fiscal Service

Gill Ottley, Deputy Chief Social Work Inspector, Social Work Inspection Agency

Stuart Bond, Social Work Inspections Agency from 27 February 2007

William Spence, retired Chief Constable

David McMillan, West Dunbartonshire Council

Martin Kettle, Children and Families Services Manager, South Lanarkshire Council

Sheriff Gail Patrick

Liz Sadler, Scottish Executive Justice Department

Ian Bashford, Scottish Executive Health Department

Catherine Rainey, Children & Families Division, SE until 14 March 2006

Catherine Henderson, Children & Families Division, SE until 14 March 2006

Maggie Tierney, Children & Families Division, SE from 24 January 2007

Gaynor Davenport, Children & Families Division, SE from 24 January 2007

Nicola Macnaughton, Children & Families Division, SE from 24 January 2007