scottish universities insight institute

mobilising knowledge for a better Scotland

Learning the Lessons - Differently

June 2013

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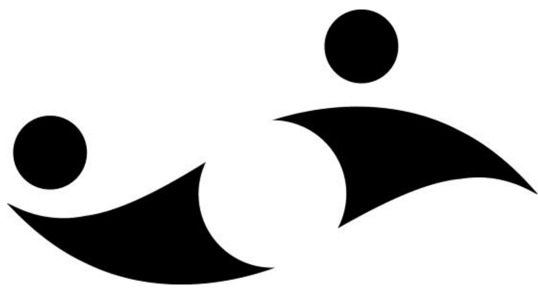

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1. Background

This project stemmed from recognition across many disciplines that the processes set up to learn lessons from child maltreatment deaths were not producing the desired outcomes in terms of reduction of maltreatment fatalities and levels of child abuse. Each year in the UK around 260 children die or are seriously harmed and £5 million is spent "learning the lessons". The same "lessons" have been emerging since the first UK child death inquiry in 1945 without noticeable impact on child fatalities.

Different processes apply across the UK and there had never been an opportunity for people working in this area to come together. Additionally there was little evidence of knowledge exchange amongst professionals from different disciplines involved in the investigation and review of child fatalities. Some longstanding problems were widely accepted (e.g. the challenges of running parallel criminal and review processes) but there had been little opportunity for professionals and experts to come together to address these.

The opportunity to bring experts and professionals together from a range of disciplines had long been sought and was welcomed by people working in this field, though it has to be noted that child fatality review is not a well-defined, recognised academic or professional field but rather an informal grouping of individual experts and agencies. Key figures, who have traditionally worked separately in their fields were keen for an opportunity to come together to hear fresh perspectives, opportunities to resolve problem areas and develop collaborations which will support Government policy and public interest in the protection of children.

Ideas emerged for a series of knowledge-exchange events bringing together the disparate professions along with experts in the field of learning (e.g. design, psychology, education) and experts from disciplines which who might bring a different perspective to the old challenges and approaches to reviewing maltreatment deaths (e.g. statistics).

2. Aims and Objectives : Initial

Child death review (CDR) processes in the UK have evolved almost exclusively from social work. Our plan was to think about child death review processes differently, bringing together expertise from the fields of forensic investigation, psychology, education, design, statistics, policing, law, social work and health. With practitioners and key stakeholders from Scottish Government and the Crown Office, we wanted to consider how we can capture, process and disseminate information in the aftermath of child tragedies in cost-effective ways that increase the likelihood of lessons being learned and fewer children dying, drawing also on the experiences of other UK and international jurisdictions.

Our original intention was to explore how the design and operation of CDRs can be optimised to capture the most relevant information, and to maximise learning, for example by looking at how people learn from traumatic events. CDR, particularly in relation to maltreatment deaths, is an area of policy priority for the

Scottish Government and of current interest to UK and US governments. Vincent's research shows other countries also struggle with the CDR process.

The key question we sought to answer was:

How can we improve the learning of lessons from Child Death Review (CDR) processes in order to keep children safe?

To address that question we arranged two one-day and one two-day seminars bringing together 39 participants from a range of disciplines, nearly half of whom were practitioners and policy makers, the rest academics. Together we wanted to explore:

- New areas of inter-disciplinary collaboration
- Maximising the capture of the most significant information from all forms of concurrent investigation of child harm/child fatality to enhance understanding of what turns a safe or risky situation into a dangerous or fatal one
- Using innovative approaches to knowledge transfer to enhance the dissemination and application of learning from CDRs
- Strengthening systems for the exchange of information across the forensic/criminal/child protection investigation processes while maintaining evidential integrity
- Means of evidencing effective and cost-effective processes for CDR
- What Scotland can share from its experiences of CDRs and what it can learn from systems across the UK and beyond

Overall we planned that through the cross-fertilisation of ideas, experience and knowledge in a field where little inter-disciplinary work existed and bringing to bear on this issue forms of expertise which have not previously been used to address the problem of why lessons are not learned from CDRs.

3. Aims and Objectives : Emerging

It became evident in the process of meeting, sharing and expanding knowledge that the we had to step back from, and redefine, our initial objectives. Some of the themes which emerged were:

- The lack of understanding of the roles of different professionals and of the constraints, obligations and legislation under which they operated;
- The lack of research and literature in the field of child death review and lack of knowledge of current work undertaken in the field;
- The challenge of keeping the child and the child's story at the heart of review processes;
- Lack of awareness of different approaches across the UK where some jurisdictions were working in collaborative ways that others assumed impracticable;
- The relationship of maltreatment deaths to all child fatalities in a population

As a result of these emerging issues, the events became focussed on:

- creating maps of the field of CDR
- understanding the roles and responsibilities of different professionals and agencies (Procurators Fiscal, paediatric pathologist, forensic anthropology police, child protection committees) and of operations within different jurisdictions
- exploring areas of future collaboration
- identifying areas for future research and policy development
- identifying lessons and strategies from other jurisdictions and nations

4. Activities and Outcomes

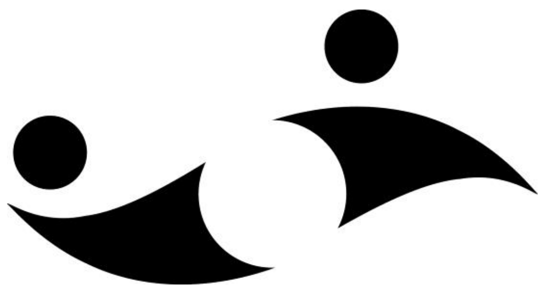
The events were built round a range of short presentations, with all participants or participating agencies contributing. At the end of each day, the themes, questions and issues of the day were ably distilled by Teri Covington (US Center for the Review and Prevention of Child Death) (days 1-3) and Marian Brandon (University of East Anglia) (day 4) who each added their own considered perspective as leading experts in their fields and visitors to Scotland.

The presentations were interspersed with group activities devised by Hazel White from Duncan of Jordanstone and her team and facilitated by Linda Walker, University of Dundee. Hundreds of multi-coloured post-its, recording questions, observations and ideas were produced from all the sessions. These were collated, categorised and distilled by a team of helpers including graduate students Catriona Davies and Rebecca Laing from University of Dundee.

Discussions and networking continued long after the sessions and gathered pace between them.

Three presentations made a particular impact and contributed to a refocusing of some research, policy and activity in work in Scotland.

1. Teri Covington's impressive evidence of the reductions in maltreatment and other child deaths in the US and other places through comprehensive national CDR programmes, gave momentum to the idea of establishing a whole population child fatality review process in Scotland.
2. Kate Morris and Marian Brandon's work on family involvement in SCRs brought home the necessity of finding ways to include families in reviews in meaningful ways
3. Martin Kirkpatrick's presentation on the child fatality research and data collection in Scotland's health services, and the consequences for child health programmes of gaps in data and knowledge again underlined the case for a whole population review programme



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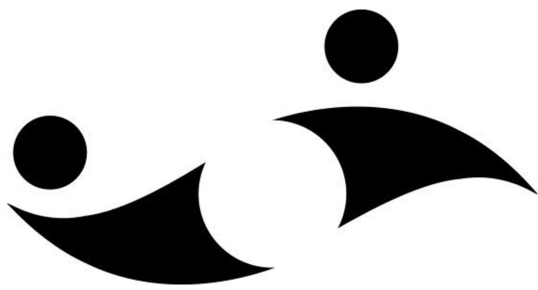
Interest Groups were set up in the course of the events and work was carried forward in them and carried by participants into other research and policy forums.

After the seminars, a number of follow-up events took place:

- SUII made it possible for Teri to return to Scotland three months later and run a simulation of a child death review at the University of Dundee. This was a two-hour process which impressed practitioners and policy makers in its cost-effectiveness, simplicity and thoroughness.
- A colloquium was held in Dundee to consider specifically the issue of involving families in reviews. This event was supported by SUII and by Scottish Government.
- Discussions took place with key stakeholders on the proposals to develop models for a national child fatality review process
- A research proposal, a collaboration between pathology, forensic anthropology and social work was developed for reviewing the post-mortem data of maltreatment fatalities to build up a better picture of pre-existing medical and social factors and precipitating factors in each death
- A website to host information exchanges between participants has been set-up at www.childfatalityreview.com

The following outcomes have been achieved to date as a result of the seminars, the follow-up activities and the knowledge and networking exchange amongst the professionals involved:

- The Scottish Government has drawn on the expertise of contributors to inform work on Significant Case Reviews and Child Death Reviews, which have in turn been informed by learning from the SUII events
- The learning on parallel investigation processes has informed the development of a protocol on collaboration between Crown Office, Child Protection Committees and Police which has been drafted in part by participants from the SUII events
- As a result of the collaboration begun with the SUII events, the US Center for the Review and Prevention of Child Death has offered to donate to the University of Dundee the operating system and software they use to record over 50,000 child fatalities a year, which has the potential to be adapted to hold data on all child fatalities in Scotland



- Scottish Government has agreed to fund a pilot project to carry out child death reviews in Tayside with the models being adopted from the discussions and knowledge exchange at the SUII events and being implemented by participants from the events
- An EU COST initiative on maltreatment deaths across 13 countries is being developed by one of the N Ireland participants which is drawing on and extending the embryonic network established at the SUII events
- Work is being taken forward on research into establishing a UK archive of inquiry and review reports.

5. Impact

The events did not answer satisfactorily the question initially posed as to why lessons were not learned from case reviews following child fatalities. However, the knowledge exchange opportunities did inform the research of a number of participants, including work being undertaken at the University of Huddersfield which will next year report on some of the possible reasons why lessons are not learned from case reviews.

The impact of the events, however, has surpassed all expectations. As a result of work done in these seminars, Scotland is about to pilot a process for holding reviews on all child fatalities in the country and collecting extensive data on each child's death to inform research into the causes of child fatalities, policy initiatives in health, safety and welfare and the prevention and investigation of child maltreatment deaths. The ultimate goal is to reduce child mortality in Scotland. The pilot project is drawing on the learning shared by experts such as Teri Covington, Sharon Vincent and Martin Kirkpatrick. Inspired and informed by the work of Kate Morris and Marian Brandon and the dialogue on the centrality of families in review processes at the events and follow-up colloquium, the pilot project is committed to developing tools for involving families in sensitive and effective ways in the review process.

Government policy has been informed and influenced by the discussion and exchange of information on working practices in other jurisdictions, research and the questions and themes that emerged from the events and colloquium.

A partnership has been developed with the US Center for the Review and Prevention of Child Death which promises in due course access for accredited researchers to the vast data sources held by the US agency and the potential for collaboration in the development of a cost-effective data collection and reporting system for Scotland's child fatality data.

The online presence (currently restricted to participants) has the potential to be a global resource for research and knowledge in the field of child death review.

Finally, at the SUII presentation event in June links were made with other projects in related fields. This has resulted in grant funding being secured by the University of Strathclyde to explore the model being developed for the pilot child fatality review being adapted for fire fatalities. The work is being developed in conjunction with two of the participants in the SUII events at the University of Dundee and has led to the establishment on an embryonic National Fatality Review Network.

The ripples moving out from these knowledge exchange events are steadily turning into waves which are in time to come going to have a major impact on work in Scotland and beyond to keep more children alive.

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