

## EVIDENCE FOR THE 'INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATH DEATHS ETC. (SCOTLAND) BILL'

### Introduction

1. CELCIS is the Centre for excellence for looked after children in Scotland. We exist to improve the experiences and life chances of children and young people in Scotland who are 'looked after' by local authorities, and those who have left care. We do this by working alongside the professionals who touch their lives, and within the wider systems responsible for their care.

2. We welcome this opportunity to submit written evidence to the Scottish Parliament's Justice Committee, on the general principles of the 'Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Bill', which was introduced into the Scottish Parliament on 19 March 2015 (herein referred to as 'the Bill').

3. The Bill is relevant to looked after children and care leavers, as the death rate for these populations is above the average for Scotland's young people. Local authorities are under a duty to provide support and assistance to these populations of young people, and we believe it is essential that any accidental or sudden death (including suicide) of a looked after child or care leaver is investigated fully and openly. However we do not believe it is necessary to extend the provision for mandatory Fatal Accident Inquiries to all accidental or sudden deaths of looked after children and care leavers at this stage. This is because of concern about the additional burden this would place on the judicial system, without certainty that this would result in clear improvements for looked after children. We would instead recommend that documents accompanying the Bill (including any guidance developed following enactment) clarifies that the sudden or accidental death of a looked after child and care leaver should always be considered by the Lord Advocate in reference to the criteria for a discretionary inquiry. Moreover, in view of local authorities' legal responsibilities towards these children and young people, we would suggest that it should always be considered in the public interest for a Fatal Accident Inquiry (FAI) to be convened into a suicide of a looked after child or care leaver.

### 4. Key Statistics

- In 2011, 1.51% of all children who died were looked after at the time of their death<sup>1</sup>
- After life limiting conditions and health issues, suicide and accidental death were the most common causes of death among looked after children in 2011

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<sup>1</sup> Care Inspectorate (2013) A report into the deaths of looked after children in Scotland 2009 - 2011

- The deaths among looked after children, between 2009 and 2011, were highest for those in residential care (12 children). The second highest number of deaths was observed in children who are looked after at home or with relatives (11 children). One child out the 30 looked after children who died in 2011 was in secure care at the time of death.
- An analysis of the figures relating to deaths of children in care collected by the Social Work Inspection Agency (SWIA)<sup>2</sup> showed that at least two children in care have died from suicide every year since 2000. There is not a legal requirement to report care leaver deaths unless they are in receipt of services from the local authority social work department<sup>3</sup>. However, there is evidence that the number of suicides among care leavers is much higher than among those still in care.<sup>4</sup>

**5. Are the circumstances for mandatory FAIs provided for in the Bill are sufficient?**

7. We would agree with the Bill that there should be a mandatory requirement for a FAI for a child kept or detained in secure accommodation.

**8. Are the circumstances provided for in the Bill in respect of discretionary inquiries are appropriate?**

9. In respect to looked after children and care leavers, the state has assumed (differing levels of) responsibility for their welfare and wellbeing, and we would suggest that in many cases it would be in the public interest for the Lord Advocate to convene a FAI into a sudden or accidental death, in order for the full facts to be established. However we have not recommended extending the scope of mandatory FAI's to this group because of concerns about the additional burden this would create (for both the judiciary and other professionals), and in the absence of certainty that this would lead to improvements in services for looked after children and care leavers.

10. We believe the Lord Advocate should continue to determine whether a FAI is appropriate under the discretionary inquiry provisions, but would encourage the Scottish Government to set out clearly what is in the 'public interest' (section 4(1)(b) of the Bill). For instance we believe a suicide of a young person in the care of (or in receipt of support from) a local authority should always be followed by a FAI, as all parties need to understand the circumstances which led to the event, to ensure lessons can be learned.

**11. General Comments**

12. Section 12 of the policy memorandum states:

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<sup>2</sup> On 1 April 2011 the work of the Social Work Inspection Agency passed to a new body, Social Care and Social Work Improvement Scotland (SCSWIS)

<sup>3</sup> As of April 1<sup>st</sup> 2015 there will be a duty to report on deaths of care leavers who are engaged with services

<sup>4</sup> Cowan, C. (2008) Risk factors in cases of known deaths of young people with experience of care: an exploratory study. *Scottish journal of Residential Child Care*, 7 (1): 34-42.

*FAIs are judicial inquiries before sheriffs or sheriff's principal held in the public interest. The Procurator Fiscal leads evidence with a view to ascertaining the facts relevant to the death and possible recommendations. It is not the purpose of an FAI to establish blame or guilt in the civil or criminal sense. The purpose is simply to establish the facts surrounding the death, specifically the time, place and cause of death.*

13. We welcome the inclusion of this section, stating the purpose of the FAI. It provides clarity and provides an opportunity for learning in terms of the recommendations.

14. Section 13 of the policy memorandum states:

*In addition, however, the sheriff may make recommendations as to reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided; the defects, if any, in any system of working which contributed to the death or any accident resulting in the death; and any other facts which are relevant to the circumstances of the death. Such recommendations may be intended to prevent deaths in similar circumstances in the future. Sheriffs make such recommendations in around a third of all FAIs.*

15. The collation of information regarding the deaths of looked after children and care leavers is essential to developing our collective understanding of how our child welfare system supports (sometimes unsuccessfully) children and young people. Recommendations from FAI are valuable source of this information, and we would encourage sheriffs to provide recommendations wherever possible. This will enable more effective scrutiny of how organisations have changed practice in order to prevent deaths in similar circumstances in the future.

16. Section 41 of the policy memorandum, regarding the issues of compliance with the sheriff's recommendations, states:

*[...] the Scottish Government does not believe that it would be appropriate to make sheriffs' recommendations legally binding. The Bill does, however, contain proposals which are intended to foster accountability on the part of parties to whom sheriffs' recommendations are addressed and greater transparency in the process by obliging those parties to respond to recommendations, indicating how they intend to comply.*

17. For looked after children and care leavers, where the state is the corporate parent, there needs to be a transparent process for understanding how and in what way recommendations have been enacted. We welcome the proposal, in section 27, of compliance and expected response within a timeframe. However, in order to ensure that any recommendations *that may be intended to prevent deaths in similar circumstances in the future* are implemented, the recommendations from a FAI should be monitored and reported on. This should include the production of an annual report which includes the recommendations and responses to the recommendations, presented in a format accessible to the public. In this way, beneficial understandings about the implementation

of the recommendations could be shared, whilst at the same time enabling a process of monitoring and review.

18. Moreover, a centralised database of FAIs, which could be aligned with Significant Case Reviews, would provide more detailed information from which services and interventions could be targeted to support primary prevention and early intervention. Fish et al. (2015)<sup>5</sup>, at the recent British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN) congress, described the potential for improvement that serious case reviews (and arguably FAI) bring: *'serious case reviews and their equivalents are assumed to hold potential to underpin improvement activity and there are efforts to collate findings for greater impact. The equivalent of a national [child protection] observatory is a natural next step'*.

19. Under section 8 of the Bill there is a duty to give reasons in writing why a FAI is not held if requested by those matching the descriptions in section 8 (a) (b) (c). We propose that the reasons as to why a decision is made not to hold a FAI in all cases involving a looked after child or care leaver be outlined in writing. These reasons should be reported to the Scottish Minister and Chief Executive of the local authority of the last or most recent place of residence of the child/young person. This information could then be captured and reported in their mandatory 'Corporate Parenting' report. This would help Scotland to establish an up-to-date and accurate picture of the deaths of looked after children and care leavers.

**Thank you for this opportunity to contribute to this important inquiry. We would welcome any further discussions with Committee.**

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<sup>5</sup> Fish, S., Roscoe, H., Peel, S., (2015) Do we need a national child protection observatory? Paper presented at, 9th BASPCAN International Congress, *New Directions in Child Protection and Wellbeing: Making a Real Difference to Children's Lives*, 12th – 15th April 2015, University of Edinburgh.