A review of child death and significant child abuse cases in Scotland

Summary Report

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Section A: Introduction

This is the summary report of findings from research jointly commissioned and funded by Scotland's Commissioner for Children and Young People (SCCYP) and the University of Edinburgh/NSPCC Centre for UK-wide Learning in Child Protection (CLiCP), to map, review and analyse inquiries held into child deaths and significant abuse conducted in Scotland between 1960 and 2007. 10 Inquiry reports were reviewed with regard to:

- Circumstances leading to the inquiries being conducted
- Nature of the inquiries
- Funding arrangements for inquiries
- Length of inquiries
- Inquiry findings
- Inquiry recommendations
- Extent of implementation of the recommendations
- Initial conclusions about gaps and progress.

The following research questions were addressed:

- What were the key inquiries/reviews which have been undertaken in Scotland?
- What were the main circumstances surrounding the inquiries/reviews being set up?
- What is the nature of the inquiries/reviews which have been undertaken?
- Is there a pattern to the findings and conclusions reached?
- To what extent have the recommendations been implemented?
- Are there consistent messages?

Early in the process it became clear that assessing the extent to which individual recommendations had been implemented would not have been possible: many recommendations are local rather than national; some inquiries/reviews reported more than a decade ago. For these reasons, we focused primarily on the impact these inquiries and reviews have had on national child protection policy development.

This summary is divided into seven sections:

- Section A is the Introduction
- Section B describes the methods used to undertake the review of child death and significant abuse cases. It considers the way cases were selected for analysis and the way the analysis was undertaken
- Section C provides background information on the inquiry/review process and an overview of the findings from previous research undertaken on child death and significant abuse cases
- Section D discusses the characteristics of the 10 reports. It looks at what type of inquiry/review was undertaken and considers the nature of the cases reviewed
- Section E identifies key themes drawn from the 10 reports. It examines demographic features, social characteristics, psychiatric characteristics and disability, victim characteristics, situational features, prior family conflict and maltreatment, family history and prior contact with agencies
- Section F considers the main findings that can be drawn from the 10 reports. It discusses assessment, decision making and planning, information sharing and communication, accountability, staffing issues and the conflict between parents' and children's rights
- Section G considers what impact, if any, inquiries and reviews have had on child protection policy and practice and concludes by identifying a number of points we feel are worthy of further consideration.

Section B: Methods

10 reports satisfied the criteria and were included in the review. These were cases where one or more child (18 or under) had been killed or abused in Scotland, where there had been some sort of inquiry or review process resulting in a publicly available report. The 10 reports were as follows[1]:

- The Report of the Committee of Inquiry into the consideration given and steps taken towards securing the welfare of Richard Clark by Perth Town Council and other bodies of persons concerned (1975)
- The Report of the Inquiry into the removal of Children from Orkney (1992)[2]
- The Public Inquiry into the Shootings at Dunblane primary school on 13 March 1996 (1996)
- Edinburgh's Children – The Report of the Edinburgh Inquiry into Abuse and Protection of Children in Care (1999)
- The Child Protection Inquiry into the circumstances surrounding the death of Kennedy McFarlane d.o.b. 17 April 1997 (2000)
- The Report of the Caleb Ness Inquiry (2003)

[1] Appendix 1 provides background details on the 10 cases.
[2] The Orkney inquiry did not entirely fit our inclusion criteria since there was never any proof that the children involved in the case were actually abused but we decided to include it because we believed it had a significant impact on the direction of child protection policy at the time it was written.

- The Child Review report into the life and death of Carla Nicole Bone 07-04-01 – 13-05-02 (2003)
- The Report into the Care and Protection of Children in Eilean Siar (2005)
- The Review of the Management Arrangements of Colyn Evans by Fife Constabulary and Fife Council (2005)
- The Independent Inquiry into the Circumstances surrounding the death of Danielle Reid (2006).

In addition to the 10 inquiry/review reports we also refer to child death/abuse cases in England and Wales which have had a significant impact on policy and practice in Scotland.

We read all of the inquiry/review reports and developed a framework for analysis to capture the content of the reports in a systematic way. As well as analysing the findings and recommendations of the reports, we also revisited the actual content of the reports and reviews. While our findings reinforced other findings, messages and learning from the reports, we pulled out some findings that were new or some new slants on old findings. The content analysis was carried out manually. Information was collected under the following headings:

- Title and date of report
- Type of inquiry/review
- Funding
- Remit of inquiry/review
- Length of inquiry/review
- Methods
- Background details
- Findings
- Number of recommendations
- Recommendations.

Having read all the reports we then looked for common patterns in the data.

Section C: Background to the Inquiries and Reports

There are different types of inquiry with different legal powers and processes:

- Inquiries ordered by a Secretary of State
- Inquiries sponsored by a health or local authority but carried out by an independent panel of investigators
- Inquiries or reviews carried out internally by health or local authorities.

Until the 1990s most inquiries in the UK were concerned with the deaths of children who had been physically abused while living with parents or carers in the community. In the 1990s concern shifted to the abuse of children in residential homes and schools. This coincided with a reduction in the number of public inquiries into the abuse of children

in their own homes and a considerable increase in the number of inquiries into the abuse of children in residential care.

A number of research studies[3] have examined inquiries and reviews into child death and significant abuse cases. Common themes across these studies suggest:

- Very young children are most at risk of death or serious abuse and the child who is killed or abused is often the only or the youngest child
- Most children die as a result of physical violence but many have also suffered neglect and emotional abuse; sexual abuse is rare
- Most abusers are not in paid employment and are markedly more likely to be in the lowest social class classification compared to the general population; families often have financial and/or housing problems and move frequently
- There are often problems in the relationship between the adults living in households where children have been killed or seriously abused and domestic abuse is a common feature
- Abusers frequently have mental health problems and a high proportion are reliant on alcohol or illegal or prescription drugs; some have learning difficulties
- Abusive parents are usually young and many mothers of children who die or are seriously abused started to have children at a young age
- Families in households where children die or are seriously abused are often socially isolated or have poor support networks
- Non biological parents (mostly men who are co-habitees of the natural parent) are overrepresented among child killers or serious abusers
- Abusers often have criminal convictions
- Abusers often come themselves from abusive backgrounds and/or have been in care or separated from their own parents
- A number of victims have special needs, including health problems or behavioural or learning difficulties, and are often perceived by their abusers as being difficult to care for
- Many families have had long term involvement with a number of welfare agencies, but most families are not previously known to child protection agencies; some families withdraw from contact with the outside world prior to the abuse; other families, however, are seen as co-operative and keen to receive help.

In terms of the findings and recommendations of inquiry/review reports the following themes have been consistently identified in the literature:

- Lack of assessment, particularly risk assessment
- Poor planning and ineffective decision making
- Lack of information on significant males
- Problems in collecting, recording and analysing information
- Problems in interagency working; communication problems between and within agencies; inadequate sharing and management of information

[3] Please see main report for full list of references

- Too much emphasis on parents' rights and not enough on a child's need for protection
- Lack of continuity in professional involvement as a result of sickness, staff turnover and annual leave; lack of training and qualifications; lack of knowledge of child abuse, risks of harm and procedures; poor supervision

Many of these resonated with the findings from this review; there are some differences.

Section D: Type of Inquiry/Report

The 10 inquiries or reviews into child deaths or significant abuse can be categorised in three main ways. We examined three public inquiries ordered by a Secretary of State, four independent inquiries/reviews commissioned by Child Protection Committees (CPCs) and two reviews undertaken by inspection agencies (one requested by a CPC; the other by Scottish Ministers). The Edinburgh Inquiry in 1999 was the first inquiry to be held under the Children (Scotland) Act 1995. It was somewhat unusual in that it had the full range of powers of a statutory inquiry but took a less adversarial line than that taken by most other statutory inquiries.

Table 1: Type of inquiry/review

Type of inquiry/review	Report
Public Inquiry ordered by a Secretary of State	Richard Clark, Orkney, Dunblane
Independent Inquiry/Review	Caleb Ness, Kennedy McFarlane, Carla Nicole Bone, Danielle Reid
Inspection Agency Review	Eilean Siar, Colyn Evans
Other	Edinburgh

The main differences between the inquiry/review reports examined related to whether or not children were killed or abused in their home (See table 2). Four reports related to a child death in the home, three to significant abuse or suspected abuse in the home, two to child deaths in the community and one to historical abuse of children in residential care. Child deaths/abuse in the home do not usually result in public inquiries.

Table 2: Type of case

Nature of case	**Report**
Death in the home	Kennedy McFarlane, Caleb Ness, Carla Nicole Bone, Danielle Reid
Abuse at home/suspected abuse at home	Richard Clark, Eilean Siar, Orkney
Death in the community	Dunblane, Colyn Evans
Historical abuse	Edinburgh

Section E: Key Themes

In this section some of the main common themes emerging from the report are discussed.

The perpetrators of the abuse were all male and were most often the partner of the child's mother; children were also killed or abused by parents, family friends, residential care staff and strangers:

Table 3: Perpetrators' relationship to the victim

Perpetrator/alleged perpetrator's relationship to victim	Case	Number of cases
Mother's partner	Kennedy McFarlane, Caleb Ness, Carla Nicole Bone, Danielle Reid	4
Parent(s)	Eilean Siar, Orkney	2
Family friends	Eilean Siar, Orkney, Richard Clark	3
Residential care staff	Edinburgh	1
Stranger	Colyn Evans, Dunblane	2

A number of them were known to the police as violent individuals and had other criminal convictions:

Table 4: Criminal convictions/suspected criminal activity

Case	Physical violence	Sexual offences	Child neglect	Drug related offences	Other
Richard Clark	X		X		X
Eilean Siar		X			
Caleb Ness	X			X	X
Danielle Reid	X			X	X
Colyn Evans		X			X
Carla Nicole Bone					X
Thomas Hamilton	X	X	X		

A number of environmental factors were identified in a high proportion of reports: financial problems; housing problems/families moving frequently; criminal convictions/suspected criminal activity; mental health/disability/health problems; substance misuse (see table 5 below). In many cases three or four, even five, of these risk factors were present:

Table 5: Risk factors

Report	Financial problems	Housing problems/frequent moves	Criminal convictions/ suspected criminal activity	Mental health/ disability/health problems	Substance misuse
Richard Clark	X		X	X	X
Orkney		X			
Dunblane	X		X	X	
Edinburgh					X
Kennedy McFarlane				X	X
Caleb Ness		X	X	X	X
Carla Nicole Bone	X	X	X		
Eilean Siar	X	X	X	X	
Danielle Reid	X	X	X	X	X
Colyn Evans		X	X		X

Victims tended to be only children or the youngest child in the household.

There was limited evidence of domestic abuse but the mothers of the children tended to be particularly vulnerable.

Most of the perpetrators had a history of prior maltreatment or suspected maltreatment towards children.

Most of the families had contact with a number of agencies including health, education and social work; they were less likely to be on the child protection register. Table 6 below illustrates the contacts families or households in the reports had with various agencies. Some families disappear or cannot be contacted in the weeks leading up to the death or abuse of the child.

Table 6: Contact with agencies

Report	Agencies
Richard Clark	Social work children and families; social work criminal justice; Scottish Children's Reporter Administration (SCRA); education; health; police; voluntary agency; mental health
Orkney	Social work children and families; SCRA; education; police; health; voluntary organisation
Dunblane	Education; police; voluntary agency
Edinburgh	Social work children and families; voluntary agency
Kennedy McFarlane	Social work children and families; education; health
Caleb Ness	Social work children and families; social work criminal justice; police; health; voluntary organisation; housing
Carla Nicole Bone	Social work children and families; health
Eilean Siar	Social work children and families; social work criminal justice; social work community care; SCRA; education; police; health; voluntary agency; mental health
Colyn Evans	Social work children and families; SCRA; education; police; housing; health
Danielle Reid	Social work children and families; SCRA; education; health; police

Section F: Findings from Inquiries and Reviews

'It's everyone's job to make sure I'm alright', the report of the Scottish Child Protection Audit and Review, identified a number of common themes identified as problematic areas:

- assessment processes
- decision making
- information sharing across and between agencies
- recording of information
- information on significant males.

Table 7 considers the extent to which these themes were common to inquiry and review reports examined here.

Table 7: Themes from 'It's everyone's job to make sure I'm alright'

Theme	Inquiry/review report	Number of reports
Poor assessment processes	Richard Clark, Kennedy McFarlane, Caleb Ness, Eilean Siar, Carla Nicole Bone, Colyn Evans, Danielle Reid	7
Ineffective decision making	Richard Clark, Orkney, Dunblane, Edinburgh, Kennedy McFarlane, Caleb Ness, Eilean Siar, Colyn Evans, Danielle Reid	7
Lack of information sharing across and between agencies	Kennedy McFarlane, Caleb Ness, Eilean Siar, Carla Nicole Bone, Colyn Evans, Danielle Reid	9
Poor recording of information	Orkney, Edinburgh, Kennedy McFarlane, Caleb Ness, Eilean Siar, Carla Nicole Bone, Colyn Evans, Danielle Reid,	9
Lack of information on significant males	Kennedy McFarlane, Caleb Ness, Eilean Siar, Carla Nicole Bone, Danielle Reid	5

The main findings from the 10 inquiry/review reports were:

- Social work, police and health agencies often failed to undertake an assessment, or at least a full assessment, of need and/or risk. They frequently failed to take account of historical information and did not always adequately assess the risk of significant males
- Agencies often made flawed decisions and/or failed to formulate a plan of action. Erroneous decisions were sometimes made because the evidence was not considered as a whole. Whether a case was considered to be a child in need or a child protection case had an impact on what decisions and plans were made
- Communication and information exchange between different agencies, and even within the same agency, was sometimes problematic. There were particular problems where families had moved from a different area, sometimes even a different country. Professionals were often unclear what information they could share, particularly if a child was not involved in a child protection investigation
- Records were frequently lost, and where they were available, were not always accurate. Structures of accountability were often not clear in health. Some professionals failed to recognise that they had a responsibility for protecting children
- Professionals in all agencies often had insufficient experience or training and were not always well supervised; sometimes this was due to staff shortages. Smaller local authorities were not always able to provide a full range of services to vulnerable families
- Professionals often found it difficult to balance children rights with those of adults. Intervention often focused on the parent's needs rather than the needs of the child and professionals sometimes had an overoptimistic view of parents/carers' capacity to change. There were many instances where professionals did not listen to children.

Section G: The Impact of Inquiries and Reviews on National Policy and Child Protection Developments in Scotland

Our review of the content, findings, recommendations and conclusions of the 10 Reports and Reviews suggests that their impact across the time period on child protection policy nationally has been significant. Indeed, these inquiries have been perhaps the major drivers for policy and practice change in Scotland and the UK. Some of the major shifts associated with these major cases at different points in the timeframe are tracked below.

Early inquiries such as the Denis O'Neil inquiry in England in 1947 contributed to the establishment of unified local authority Children's Departments, while the Maria Colwell report in 1974, influenced the development of the child protection system as we now know it.

In contrast to the 1970s, when the state seemed reluctant to intervene in family life, by the 1980s the child's right to protection began to assume more prominence. This changed with the Orkney and Cleveland cases in the 1980s and early 1990s.

While earlier inquiries had focussed on the abuse of children at home by their parents, in the 1990s concerns were beginning to be raised about the abuse of children in other settings, for example in residential children's homes. This brought more acceptance of the phenomenon of child sexual abuse; also pressure to improve the safety and quality of care for children and young people in the care system.

Concerns in the earlier cases related to abuse of children at home and concerns were that professionals were not intervening enough in family life to protect children. By the end of the 80s these concerns were that they had too much power, were intervening too much and this resulted in existing procedures and mechanisms to remove children from home.

In the 1990s the importance of the concept of children's rights within the child protection system grew; recognition of this was perhaps demonstrated in the setting up of the offices of Commissioners for Children in each of the countries of the UK. Around this time, the Dunblane shootings and other high profile cases highlighted new issues resulting in legislative and policy change including: hand gun bans and licences, school safety; new procedures to vet adults wishing to work with children and ban those unsuitable.

In the 21 century, reform of the child protection system in Scotland was introduced following the Kennedy McFarlane case. The Audit and Review of Child Protection in Scotland attempted to address a number of factors including: findings from the McFarlane case; concerns and recommendations raised in earlier inquiries; findings from the inquiry into the case of Caleb Ness which occurred during the review process. Recommendations and new measures introduced included a central helpline, training in child protection for staff in frontline agencies, including drug workers, teachers, and criminal justice social workers to help them recognise their child protection responsibilities and measures to further enhance integrated working.

More recently, the interface between drug and alcohol use and child protection has been prioritised, as have measures to address the risk posed by sex offenders.

The 'Getting it Right for Every Child' proposals in Scotland claimed to be 'the programme for change that will revolutionise services for children' (Scottish Executive 2006). These have an emphasis on meeting the needs of all children, removing the distinction between children in need and children in need of protection. They attempt to remove barriers to joined up working and inter and intra agency co-operation.

'Getting it Right for Every Child' attempts to address many of the issues raised by inquiries and reviews. The extent to which these will achieve better outcomes for children remains to be seen. Indeed, the extent to which good policy and legislation is made in the wake of unique and complex cases is worthy of further discussion.

Some of the changes resulting from implementing the recommendations of inquiry reports and reviews have undoubtedly been positive. Authors point to improvements in staff selection and recruitment, in responding to allegations of abuse, whistle-blowing, monitoring, inspection and the promoting of children's rights (Corby, Doig and Roberts 2001). This has contributed to raised awareness of child abuse, development of better inter-agency systems, co-operation and communication.

However, it is also argued that change resulting from these major cases has not always been positive. Munro suggests that change brought about by the Climbie and other inquiries has brought about change that is largely structural, for example, clear accountability, closer monitoring to ensure compliance. Structural changes do not necessarily bring about improvements in quality (Munro 2004). Some of the practice in the Climbie case was extremely poor; suggesting perhaps that earlier new procedures introduced to improve practice were not successful here (Munro). With the Eilean Sair cases in 2006, the pendulum seems to have swung back. Here professionals were criticised for not acting decisively enough and the case has many parallels with the Richard Clark case in 1975. This may also raise questions about the effectiveness of legislative change introduced following unique and complex cases.

There is undoubtedly learning to be gained from the detailed scrutiny of major, complex and tragic cases; indeed it would be negligent not to do this. However, a parallel approach to change and development based on learning from the everyday practices and successes of social workers and other professionals working to turn around the lives of vulnerable children would constitute valuable parallel research activity.

Many of our findings have been previously identified and attempts have been made by policy makers to address them. We have not, therefore, made recommendations based on the main findings of our review. In the table below, however, we outline some findings we feel may have received less attention from policy makers and which may be worthy of further consideration and debate.

Findings Worthy of Further Consideration
Finding:- Inquiries have been a main driver in shaping national child protection policy. However, changes have tended to be structural and may not necessarily have led to improved outcomes for children. **Point for Consideration**:- While continuing to learn from inquiries and reviews, consideration should also be given to whether these are the best basis for legislative and policy change. Considering how best to learn from everyday practice and successful cases is also important.
Finding:- The risk posed by significant males towards children and women was not always identified. **Point for Consideration**:- Further debate is needed around how to better identify the risk posed by significant males.
Finding:- Mental health issues were a significant feature (amongst perpetrators and non perpetrators) in households where a child died or suffered significant abuse. **Point for Consideration**:- Consider how to provide better support to parents and carers with mental health issues.
Finding:- Housing and homelessness issues were prominent and many families had moved many times. **Point for Consideration**:- Housing has a significant role to play in identifying children's needs and ensuring their safety. It is important that housing professionals know what to look for, feel confident in acting and are clear about what information they are able to pass on to other agencies.
Finding:- Professionals do not always listen to children or do not recognise that unusual behaviour may be a cry for help. **Point for Consideration**:- Ensure that all professionals who come into contact with children are aware of the importance of listening to children and observing their behaviour. It is important to bear in mind that children may have their own ways of coping – for example, talking to friends. Support systems need to resonate with children's own resilient strategies.
Finding:- Professionals often struggle to balance children's and adults' rights. **Point for Consideration**:- Legislation may not always helpfully enable professionals to balance children's and parents' rights. Consideration should be given to how professionals might be enabled to do this more effectively .
Finding:- Professionals are unclear about what information it is possible for them to share. This is particularly so where a case has not been identified as child protection. **Point for Consideration**:- More guidance is required around confidentiality and data protection so professionals are clear about the information they can pass on.
Finding:- A scarcity of resources was identified in some small and/or rural authorities. **Point for Consideration**:- Children should be entitled to the same level of protection wherever they live in Scotland. Further debate is needed around how we can ensure children in small, rural areas have equal access to resources.
Finding:- There are no adequate systems for managing the risks posed by young sex offenders. **Point for Consideration**:- Further consideration needs to be given to how risks posed by young sex offenders who are dealt with by the Children's Hearing (rather than the criminal justice system) are managed.

Appendix 1: Background details on individual inquiries and reviews

Report	Type of case	Background details	Main findings
Report of the Committee of Inquiry into the consideration given and steps taken towards securing the welfare of Richard Clark by Perth Town Council and other bodies or persons concerned, (1975)	Physical abuse in the home. Perpetrator – carers.	Richard Clark suffered serious disability following significant physical abuse. Jean and David Duncan, family friends who were caring for Richard and his brother while their mother was in prison for stabbing their father, were convicted of the abuse. They had previously been found guilty of neglecting their own children.	The Duncans should not have been allowed to care for the boys The children should have been removed much earlier The social worker had an over optimistic view of the Duncans The boys needs should have been considered separate to those of the adults The social worker was inexperienced There was a lack of supervision
The report of the Inquiry into the removal of Children from Orkney in February (1991)	Suspected sexual abuse in the home. Perpetrator – parents and family friends.	A number of children who had been removed from home made allegations that nine children from four other families had been sexually abused. The children were all removed from their homes. Their parents and the local minister were questioned but not charged. The children were referred to a children's hearing. Their parents denied the grounds and the case was sent for proof. The sheriff held that the proceedings were incompetent and returned the children to their homes.	Professionals did not keep an open mind with regard to the allegations They did not consider the needs of the children individually There were inadequate records of the key decisions made The rights of the parents were not considered Children should have been allowed to take personal possessions, should not have been separated from their siblings and should have been allowed contact with their family
The public inquiry into the shootings at Dunblane Primary School on 13 March (1996)	Death of 16 children Perpetrator – adult stranger	Thomas Hamilton entered a primary school and shot and killed a teacher and 16 children in P1 before killing himself. 10 other pupils and 3 other teachers were also shot but survived. The attack had been carefully planned. Thomas Hamilton held a firearms licence. He had run a number of boys clubs since the 1970s and had been investigated by police, but not charged, following allegations of assault, neglect and photographing of boys.	Questions were raised as to whether Thomas Hamilton should have been permitted to own a firearm and whether his license should have been renewed The Inquiry recommended alterations to the licensing and use of handguns There were further recommendations around school safety and checks to ensure people were suitable to have unsupervised access to children
Edinburgh's Children – The Report of the Edinburgh Inquiry into Abuse and Protection of Children in Care, (1999)	Historical sexual abuse of children in residential care Perpetrator – residential care workers	In 1997 two former residential care workers were convicted of serious abuse of children in three residential units between 1973 and 1983.	Lack of supervision of officers in charge in residential units and poor recruitment practices Children tried to tell about the abuse on numerous occasions but were not listened to or staff were unable to pick up the signs The focus was on staff rather than the needs of children

Report	Type of case	Background details	Main findings
			Professionals working with adults need to know how to respond to allegations of historical abuse
Child protection Inquiry into the circumstances surrounding the death of Kennedy McFarlane d.o.b. 17 April 1997, (2000)	Death of child in the home Perpetrator – mother's partner	Kennedy McFarlane died after being physically abused by her mum's partner Thomas Duncan. She also had diazepam and ibuprofen in her blood. The nursery had noted a marked decline in Kennedy's welfare from the time that Thomas Duncan joined the household six months previously.	No-one could have predicted Kennedy's sudden and violent death but their were opportunities to identify the extent of the risks to her and her death could have been prevented A formal child protection investigation should have been instigated earlier There were major problems with joint working Health staff assumed other people within sand outside of health were taking appropriate actions
Report of the Caleb Ness Inquiry (2003)	Death of baby in the home Perpetrator – mother's partner	Caleb Ness died following traumatic injury probably caused by having been shaken by Alexander Ness. Alexander had a serious brain injury. Caleb's mother Shirley Malcolm had been a drug user for many years and Caleb was treated for neonatal abstinence syndrome after his birth. Shirley already had two other children in permanent care.	Caleb's death was avoidable Neither parent should have had unsupervised care of Caleb There was a failure to take account of background information about both parents Social workers failed to undertake a rigorous assessment of risk Criminal justice social workers failed to recognise they had any responsibility for child protection.
Child Review Report into the life and death of Carla Nicole Bone 07-04-01 – 13-05-02 (2003)	Death of child in the home Perpetrator – mother's partner	Carla died after suffering physical abuse by her mother's partner. The family was seen as vulnerable but no major child protection concerns had been raised.	Carla's death was not reasonably foreseeable by the agencies working with her There was no formalised or shared assessment of need Work focused on the vulnerabilities of the parent rather than the child Neighbours were reluctant to pass on concerns.
An Inspection into the care and protection of children in Eilean Siar (2005)	Abuse of children in the home Perpetrator – parents and family friends	A number of adults were arrested in relation to the alleged sexual, physical and emotional abuse and neglect of three children. All charges were dropped. The father of the children was a Schedule 1 offender.	The children should have been removed from home much earlier There was no assessment of the suitability of relatives to care for the children Professionals were over optimistic about the capacity of family members to overcome their live adversities and be good enough parents. There was an unhelpful balance in the weight given to the rights and duties of parents as against the needs and rights of children.
Review of the Management Arrangements of Colyn Evans by Fife Constabulary	Death of young woman in the community Perpetrator – 17 year old	Colyn Evans was 17 when he murdered 16 year old Karen Dewar. He had been subject to supervision until he was 16 and thereafter	The risk of Colyn committing a murder could not have been predicted Risk assessments were not carried out

Report	Type of case	Background details	Main findings
and Fife Council (2005)	stranger	received throughcare support. He had a number of charges relating to sexual offences.	The decision taken to discharge Colyn's supervision requirement was questioned The management of Colyn after his supervision requirement was terminated was not co-ordinated by the agencies concerned The case highlighted issues in relation to the management of juvenile non registered sex offenders
Danielle Reid Independent Review into the Circumstances Surrounding her Death	Death of child at home Perpetrator – mother's partner	In January 2003 a body of a child was found in a canal and later identified as that of Danielle Reid. The body had been immersed in water for around two months. Danielle had been physically abused by Lee Gaytor.	Danielle's death was not directly preventable by any of the individuals concerned People in the community failed to report their concerns Professionals were reluctant to share information due to data protection, particularly where a child was not formally under child protection procedures The case highlight issues around the tracking of children in health and education.