Barking & Dagenham Safeguarding Children Board

Analysis of themes drawn from Serious Case Reviews published in 2013 across England, Wales, and Scotland

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Introduction

This paper provides a brief analysis of all the Serious Case Reviews (SCR) published in 2013 across the UK (excluding RoI).

The Executive Summary of these Reviews were read to identify key themes and draw out commonalities within these themes aimed at identifying factors that could assist practitioners in working with potentially dangerous families.

The themes themselves only provide a basis for further discussion and further assessment. There is a great deal of learning that can be gained from each individual Review when read in detail and the issues explored.

Whilst the themes and common factors identified as a collective across all the reviews allow us to gain better understanding of the issues affecting families of concern, it is recommended that practitioners routinely explore individual case reviews whenever they can in order to gain a wider insight into how these themes and issues bore direct impact on the cases themselves.

- Reports need to be recognised as valuable for learning by frontline staff. A recent survey by the British Association of Social Workers suggested the majority of social workers do not read serious case reviews and so miss out on what they teach us (BASW, 2013)

It is also important to remember that the fact that a family may have a number of these factors within the case does not automatically imply that a tragic event is waiting to happen.

Instead, it serves to provide us with an ability to be more mindful of the risk factors, to ensure that we are able to do what we can to help minimise risk, and to allow us to keep focussed on providing the necessary support to such families to enable them to minimise their own risks. Where common factors are multiple and there is an absence of improvement, we need to have the confidence and skills to take the appropriate action, at the appropriate stage, to safeguard children without delay. This can only occur by having good management, skilled staff, and an open and transparent approach in working with families.

Analysing Serious Case Reviews makes grim reading. However, it also reminds us of the need to remain child focussed and reaffirms the value and purpose of the work undertaken across the Country by children's workforce teams in doing what they can to safeguard and improve outcomes for all children.

Data for SCR's held in 2013

In 2013, a total of **49** SCR's were published across England, Wales, and Scotland

This involved **40** LA's, (**4** of which were London LA's).

The SCR's referred to **58** children and young people.

- **38** of which died
- **20** of which were seriously injured or hurt

This included **5** young people who were subject to an SCR following suicide. These young people were all aged 15 years + and all were known to services for previous self harm or suicidal ideation.

Ages

- **30** children involved in SCR's in 2013 were aged under 5 years
- **2** were aged 7 years old
- **2** were aged between 10 -14 years old
- **24** were aged 15 +

Gender

- **34** boys and **20** girls featured in the SCR s. (**4** children's ages were not disclosed)

Other relevant data

- **50%** of cases were attributed as the injury or death having been caused by a parent. The remainder were either, self harm, partner causing injury or death, or neglect through lack of awareness (co-sleeping etc)
- **33** children died as a result of serious trauma or non accidental injury.
- **9** cases were found to have occurred as a direct result of chronic neglect
- **4** cases involved LAC (either at time of death or injury, or prior to)

Issues

Neglect featured high in a number of the cases. A quarter of cases , **24%**, cited neglect as the contributory factor to the death or serious injury itself, most of the reports cited neglect as a significant factor in the family as a whole

Substance misuse also features high in a large number of these cases. Almost all the cases contained an element of substance misuse, including alcohol and cannabis, either by the parents or young people concerned, or those that visited the home. Cases referred to significant misuse of substances that were known to agencies but were tolerated or agencies felt powerless to do anything about

- The risks posed to the children by excessive alcohol consumption and drug-use were not fully recognised or acted upon by professionals. [This led to] a failure to challenge when the mother clearly minimised her alcohol consumption and deflected difficult questions about the care and supervision of the children. (Child FW, Worcester)

Parental Mental Health featured in **22%** of cases that directly linked this to the death or serious injury to a child. A further number of cases referred to parental mental health as a possibility but one which was undiagnosed and therefore not discussed with the family.

10% of the young people that committed suicide were known to have had previous self harm issues and elements of mental health.

- 'If potential risk factors associated with maternal mental health are not fully explored and assessed in the ante natal and post natal period, then the ability to judge parenting capacity could be significantly compromised' (Child G, Southampton)

'Unknown men' was another common feature. **16%** of cases made specific mention to the fact that unknown men were visiting the home or were in the family home but went unchallenged by agencies. A further number cited unknown visitors and frequent partner changes as another feature in cases where children subsequently died.

- 'A failure to involve men, or to recognise the significance of male presence in the lives of women and children' (Baby T IOW)

Domestic abuse was another significant feature. **26%** of cases cited this as a contributory factor in the death of the child or children, with a further number identifying this as an element in the case post review.

Child Sexual Exploitation was listed as a main factor in **10%** of the serious incident cases. This issue was a key feature in the Rochdale case (6 girls) and also in a number of other reviews where the young person involved was felt to be being exploited by adults around them

Learning the Lessons

The cases cited a number of common factors in the cases where practice could have been better or could be improved.

These included;

The need for agencies to take into account **family and social history**. A number of cases where children had died cited that there had been little or no previously known history of the family as a result of agencies failing to assess adequately and involve a wider professional network.

- To leave important questions about background information unanswered on an assessment form is unprofessional and potentially dangerous practice. Even if the relevant information is unavailable, it should be made clear why this is the case. (Child G, Southampton)
- Previous SCR's have highlighted the risks of the so-called "start again" syndrome, saying that whilst a fresh start can be a positive thing for families, there is a significant risk in ignoring past history. Studies of SCR's have also highlighted the so called "rule of optimism", where information which is contrary to a workers view of a parent is downgraded or ignored. Both these factors were present to a limited extent in this case and provide a useful reminder for practice (Baby J, Bournemouth)

There were also elements where agencies had failed to act on known information because of **hostility by parents** or a **fear that their relationship with the parents would suffer** as a result.

- MOTHER was perceived as having a difficult personality by all professionals who worked with her, she responded badly to any criticism or request for change, and this may be one reason why the Child Protection Plan and Core Group did not sufficiently focus on issues where change was required, and remained too occupied in attempting to achieving a partnership with Mother, consequently lacking focus on Child U. (Child U, Manchester)

This inaction featured in **10%** of cases where there was a clear reference to a failure to act or pass on information of concern. Sufficient information to allow decisions to be made were also absent on some of the referrals examined and reviewers felt that there was a reluctance on agencies to share the responsibility of information shared

- Whilst there is a responsibility on the part of a professional who shares information, to ensure that the information is passed in a timely manner, is accurate and relevant to the request, there is also a responsibility on the recipient of that information to check back, if it appears unclear or incomplete. (Child G, Southampton)
- There must be a robust method of information sharing and notification across all agencies and concerns must be discussed across partnership (DP, Coventry)

Domestic Abuse was a significant factor in so many of these cases and the recommendations draw on the need for agencies to recognise the impact this has on children.

Whilst progress has been made in understanding the emotional impact on children, a number of reviews felt that the real threat or risk of physical harm to children in violent relationships is not taken as seriously as it should.

This is then compounded in families where the violent history of parents is not thoroughly explored and with the inclusion of substance misuse, situations become very volatile.

- Domestic abuse/violence is always a child protection issue and must always be approached with this as the mind-set of professionals. (DP, Coventry)

The nature and understanding of Domestic abuse was also examined in the reviews and the need to acknowledge that families involved in Domestic Abuse will not always provide agencies with the full insight into what is taking place.

- The lack of understanding of the extent of the domestic abuse in the family remains a concern, along with the lack of information about Baby J's father. It appears from the evidence that Mr J played a greater part in family life than was fully reported by Ms J. Given the current understanding of the nature of domestic abuse, when Ms J spoke about her relationship and, in particular her fears, instead of taking the information at face value, a more enquiring approach about the underlying issues would have been helpful. (Baby J, Bournemouth)

There were a number of cases where children had sustained **previous serious injuries** prior to death. The review into DP, Coventry went as far to suggest that ***any*** facial or head injury to a child should always be viewed as worrying and concerning, irrespective of the cause

- Any facial injuries to a child must be viewed with concern, with physical abuse needing to be actively considered as a possible cause, and clear records, interventions or referrals made accordingly. To have no efficient system to collect and collate details of such injuries and actions will compromise later attempts to protect a child. (DP, Coventry)

Parental explanations of serious and unexplained injuries in too many cases were accepted without further challenge. There is a clear need to be able to balance the parental explanation of an injury with the evidence being presented. This includes examination of frequency of injury and discussions with other professionals when injuries occur.

- 'There was a willingness to accept parental explanations too easily' was once reviewers view and that there were ' difficulties in working with disguised compliance' (Baby T, IOW)

- Sole reliance on a parent's explanation of events and views about family relationships and associated risks to the children, must be balanced with the presenting objective information available or evidence sought to support or challenge parental assertions. To not do so will potentially leave children at continuing or un-assessed risk. (DP, Coventry)

The SCR's also noted on the **absence of the voice of children** in their reviews. Children must be seen and must be spoken with. Many of the reviews cited the absence of the voice of the child in assessments and in discussions around risk. This is a common aspect of reviews where the voice of children is not recorded on assessment or on case files.

- No assessment of risks within a family or to a particular child can ever be effective without direct engagement of that child as an integral part of the professional interventions, and in working hard to gain an understanding of their experiences, wishes and feelings. There must be a child focus to all interventions. (DP, Coventry)

- Children, however young or old, must be at the heart of a child protection process. This does not mean simply focussing on them as an object of concern, but allowing children to be heard through whatever means they can communicate and express themselves. This may be verbal, through behaviour and by observation. Child U was not afforded this opportunity. (Child U, Manchester)

There were a couple of reviews or so where there were clear failures and the report highlights the need for specific agencies to consider their actions that could have prevented the death or injury to a child. However, overall, the reviews whilst highlighting areas for improving practice, concluded that the event itself was either not foreseeable or preventable.

Conclusion

The scrs published in 2013 have highlighted tragic and violent episodes where children have suffered traumatic events leading up to or at the point of their deaths. The reviews have all made specific recommendations to the local authority undertaking them that aim to improve practice and learn lessons from these tragic events.

There are a number of common factors across them all, as indicated above. Domestic abuse, substance misuse, parental mental health etc. have all featured in so many reviews last year and featured in so many reviews in years before. Indeed, Learning the Lessons, published in 2010 cited similar themes drawn from Serious case Reviews between 2006 – 2010.

The fact remains that families can lead complicated lives enmeshed with issues that will draw on a number of the factors associated in case reviews. Not all these families will result in a child death or serious injury, but some will. The case reviews provide a basis for practitioners to consider these factors and to look at families in a holistic, historic, and in some case cases, futuristic way. Assessments are vital but only valuable if carried out correctly, openly, and thoroughly. **Time constraints** are inevitable but they must not get in the way of sound assessments

- All agencies and practitioners face high demand on their time, and can be tempted to focus on task rather than strategy. Trading time for competing demands is often given as a reason for not holding strategy meetings but the absence of one meeting, as evidenced immediately following the assault on Child U, can have a profound impact upon the multi-agency response to child abuse and, therefore, on how well children are ultimately. (Child U, Manchester)

The reviews state that some of the ways around this is to invest in **skilled and experienced practitioners** who can balance time restraints with gained knowledge and expertise.

- Confident professional practice, which proactively seeks out information and is prepared to challenge and question colleagues and parents or significant adults would have made a difference [in this case] (KW, Birmingham)

Sometimes, as some reviews have cited, better practice, better communication, and better assessments can prevent these events from happening. However, we need to also recognise that there are cases irrespective of how great the practice is, where tragic events just cannot be prevented.

- Violent acts that lead to the death of a children can occur without any prior indication (Child J, Child K, Surrey)

Finally, unacceptable as it is that children are subjected to harm, it just as important to recognise that good practice by Children's workforces also takes place every day across the UK, helping to improve outcomes for children, and safeguarding children day in and day out.

- Certainly, serious case reviews highlight the exceptional cases where things went wrong. We should remember that many children benefit from very good-quality social work and are better protected as a result. In addition to learning from what went wrong it is also important to put our energy into understanding what makes the vast majority of social workers get it right, so we can learn from that too and do more of it (Guardian , January 2014)

Summarised Themes

To summarise, these are the key themes drawn out from the 49 SCR's held in 2013.

- Domestic Violence
- Neglect
- Parental Mental Health – especially historic episodes relating to depression
- Substance Misuse
- Self Harming episodes
- Over reliance on parental engagement and explanation
- Transience in families
- Physical abuse that is not acknowledged, accepted as wrong, or fails to stop
- Unknown men, unknown visitors to families
- Offending – especially violent offenders
- Non-accidental injuries that are unexplainable
- The need for a skilled and experienced workforce
- Sound and holistic assessments
- Family and social history
- The challenges of identifying where parental separation is adversely affecting children and in particular the significance of rapidly deteriorating behaviours or relationships in either the adults or children involved.
- Clear understanding in agencies of mechanisms for making referrals to Children's Social Care and support by designated professionals/ line managers to make referrals.
- Thorough assessments which draw on all relevant agencies information, whether children's or adults services.
- Pre-birth assessments
- Abusive or hostile parents

Reference and Further Reading

Links to all SCR's published 2010-2013

- http://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/serious_case_reviews_2013_wda94557.html

Learning from Case Reviews where domestic abuse was a key factor:

- https://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/briefing-domestic-abuse_wda99478.html

Learning from serious case reviews involving people whose first language is not English

- https://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/briefing-english-language_wda100695.html

Learning from case reviews involving parental substance misuse

- https://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/briefing-substance-misuse_wda99489.html

Learning from case reviews around child sexual exploitation

- https://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/briefing-sexual-exploitation_wda99717.html

New learning from serious case reviews: a two year report for 2009-2011

- https://www.gov.uk/government/.../DFE-RB226_Research_Brief.pdf