

BRIEFING

Key Issues from Biennial Reviews:

Improving Safeguarding Practice: Study of Serious Case Reviews 2001 – 2003

Objectives of Biennial Review:

- To identify key themes common to the recommendations
- To ascertain whether reports resulted in action plans based on findings, and whether those action plans were implemented within timescales
- To consider what helped or hindered the implementation of action plans
- To ascertain whether reviews resulted in changes to local policy or practice
- To identify from the reviews studied any lessons for national policy & practice.

Setting Up, Conducting and Learning from Serious Case Reviews:

A significant part of this biennial review focuses on the administration of Serious Case Reviews by ACPC. A number of ways are identified to make Serious Case Reviews more effective:

- LSCBs to achieve more consistency about decisions to hold SCRs, and to be clear from the beginning about the purpose of each SCR. Ofsted and regional government offices to play a role in developing consistency across LSCBs.
- Generally, fully independent chairs of SCRs are desirable. However, the current arrangements for identifying suitable independent chairs are informal and arbitrary. DCSF/Government Regional Offices are invited to take a lead in developing a resource of trained credible experts, and maintaining an accessible register of such experts.
- Management and overview reports could be improved with the provision of training for those expected to complete them. Exemplars or templates should be developed to improve quality: this could also be a role of DCSF/Regional Government Offices.
- On occasions, SCRs did not include chronologies or genograms; when they were included, they were sometimes poorly presented. Chronologies often did not make reference to whether the child had been seen.

- The SCRs considered pre-dated the 2006 Working Together requirement to invite members to contribute to case reviews. LSCBs need to consider how to plan, resource and facilitate this involvement. It is suggested that a key worker be appointed to work with families throughout the process to provide information, to assist their contribution, and to take them through the executive summary.
- Action plans were rarely specific about what needed to change, and what objective was to be achieved. Auditing progress is necessary, and the NSPCC audit framework is recommended.
- Managing the outcomes of SCRs was often problematic. Authors found executive summaries difficult to write, as they are intended for a range of purposes: for family members of the child, local media, and use in training. Careful judgments are required as to who has access to reports, and who should be briefed. Sharing of information about practice between LSCBs would be helpful in this area.
- It is recognised that SCRs are resource intensive. However, there was no evidence of cost influencing the decision to hold reviews, nor a factor in how reviews were conducted. Hard, therefore, to comment on “value for money”. Similarly, cost implications of recommendations rarely appear to have been considered by ACPC.
- Whilst most reviews had findings that reflected the analysis that had taken place, it was sometimes hard to find linkage between the findings and the recommendations. Recommendations often appeared to focus on procedural issues (e.g. failure to have appropriate procedures in place, or failure to follow procedures), but seemed less likely to address issues of management, supervision, and resources, skills, knowledge and experience within organisations.
- The deciding factor in whether or not action plans were effectively implemented was clear and strong leadership from the ACPC.
- There were examples of good practice within individual ACPCs in ensuring that lessons were learned locally. Regional Government Offices are identified as having a role in facilitating links between local authority areas, and between local and central government to ensure that policy development can be informed by local experiences.

Children in the Study:

There were 45 children in the study of SCRs from 2001 – 2003. 73% of the reviews take place following the death of a child. Of these deaths, two were suicides by adolescents, and one was a toddler who drank mother’s methadone. Nearly two thirds of the children considered were male, and the ages during the periods considered by the reviews are grouped as follows:

- 47% were children aged 2 years or under, of whom two thirds were less than one year old;
- 9% were aged three to four years;
- 24% were in the five to ten year band;
- 20% were children and young people aged 11 years or older.

Most children were not subject to “statutory” intervention. Eight of the children were the subject of child protection plans at the time of the incident leading to the SCR, and four children had been subject to interim care orders. In addition, one child was accommodated by the Local Authority and one child had been adopted and was living with her adoptive parents.

Five children in the sample were identified as disabled, although the true figure may have been higher, as a significant number of reviews did not record this data.

Key Lessons from the Study:

Children with disabilities: A theme in most of the SCRs dealing with children with disabilities related to the quality of assessments. In particular some of the assessments appeared to be limited in scope, and did not encompass all aspects of the child’s welfare. Some SCRs dealing with children with disabilities demonstrated that agencies had not always identified links in households between disability and a combination of other factors such as a young or single mother coping alone, further pregnancy, domestic violence, substance misuse or depression.

Some overview reports drew attention to the “rule of optimism” applied by some practitioners to this particularly vulnerable group of children. One overview report stated:

Children with Disabilities are under represented on the Child Protection Register both locally and nationally. This case has highlighted why this maybe so. A number of experienced practitioners reviewed the issues that were presenting in this case and did not trigger the Child Protection system, there is little doubt that if a child without a disability was presented with some of the similar circumstances, the Child Protection system would be triggered. There are clearly attitudinal and training issues which need to be addressed.

The study highlights the following issues for practice and policy arising from SCRs dealing with children with disabilities:

- Comprehensive multi-agency assessments should be undertaken that take account of all the strengths and the pressures a child and other family members may be experiencing.
- Assessments should acknowledge a disabled child’s changing needs over time, and the varying impact on the wider family. Assessments are likely to require both adult and children’s services, both universal and specialist.

- Resultant plans should involve the whole family, and be focused on the child. A lead professional should coordinate the delivery of the plan.
- The plan should be regularly reviewed with the involvement of family members and all agencies.

Older Children: Nine of the children in this study were over 11 years, and five of these were young people over the age of 15. Clearly, this is not a representative study, and should not be regarded as indicating that there is an increase in the number of older children becoming the subjects of SCRs. However, it was felt that SCRs concerning older children deserved specific attention in the study, as their circumstances and the issues raised by the SCRs were often different than those for younger children.

When working with older children/young people, agencies and practitioners are encouraged to bear in mind that there can be different perceptions about the incidence and impact of abuse and neglect on adolescents, when compared to younger children, for example:

- Adolescents ought to be better able to care for themselves, should be able to avoid physical harm, keep out of the way, or ask for help;
- Perhaps adolescents have “brought the abuse on to themselves”, or have at least in some way contributed to the harmful situation (in some SCRs, consideration of issues such as non school attendance, or involvement in juvenile offending seemed to focus solely on the adolescents’ behaviour and not on the wider circumstances in which they were growing up);
- SCRs on adolescents at times noted the absence of a full assessment, and no consideration as to whether the young person had required a safeguarding plan.

Failure to consider the impact of such perceptions on agencies’ work with adolescents may result in risk not being identified, and services necessary to safeguard a young person not being made available.

Children Experiencing Harm in the Context of Neglect and Domestic Violence: The study highlighted that all of the children and their families, prior to the incident of significant harm that led to their being the subject of a serious case review, would have been children in need as defined under the Children Act 1989. However, many of these children and families had never received services under s17 of the Children Act, and had only received targeted services if/when they had met the threshold for consideration for a child protection plan or becoming Looked After. The study notes that a number of SCRs found agencies to be “reactive” rather than “proactive” in these cases, e.g. noting concerns when they were raised by families or universal agencies, but not initiating assessments.

A number of SCRs found little or no evidence of children having been spoken to when agencies were gathering information about them and their families. All agencies and LSCBs are urged to consider the support and training that might be required to encourage their staff to engage meaningfully with children and young people when gathering information.

Some overview reports found that professionals were not confident in identifying thresholds for intervention in cases of neglect. In one instance, agencies were found to have “tolerated a poor level of care of the children”. The study concludes that the six core areas of expertise identified by government across the Children’s Workforce should impact on training, management and supervision practice in the identification of child neglect and its impact. The study also highlights the work of Stevenson (1998, *Neglected Children, issues and dilemmas*), who identifies three main thresholds in neglect cases:

- Where some elements of neglect are found and services to the family should appropriately be provided on the basis of the children being in need;
- Where the neglect is serious, the children need to be safeguarded by a child protection plan;
- Where it is necessary, to take court action which may lead to the removal of the children from their families.

A number of SCRs considered in the study concerned children living in situations where domestic abuse was a factor. In almost everyone of these cases, domestic abuse was accompanied by some degree of parental substance misuse. This combination of factors (“co-morbidity”) was regarded as significantly increasing the vulnerability of the child.

The SCR overviews often draw out a clear relationship between domestic violence and behaviours that children are exhibiting, such as poor school attendance, bullying, aggression or offending. However, they also note that agencies appeared to be focusing more on these behaviours in their responses, rather than on the domestic abuse and its likely impact on the child. The role of universal services (schools, health visitors, GPs) as sources of information about the history of domestic abuse is noted on a number of occasions. However, it is also noted that these sources of information were often not approached as part of the assessment process.

A number of policy, management, practice and training issues relating to neglect and domestic abuse were noted. It is acknowledged that some of these have been identified in previous studies, but they are common themes arising from the 2001 – 03 study:

- keeping a child or children in focus when there may be understandable attention being given to complex and pressing adult family members’ needs;

- gathering knowledge about family history as an essential part of assessing and understanding what is happening and what may be family patterns of behaviour in stressful situations;
- ensuring that children are seen by practitioners, and that children are acknowledged as important contributors as part of safeguarding work with a family;
- recognising the emotional impact, and its consequences, of work with children and families experiencing severe difficulties, particularly where violence and conflict are inherent in family interactions;
- reinforcing the importance of all practitioners assessing a child within a developmental/ecological framework and ensuring appropriate training;
- addressing issues of risk of harm in the context of evidence from systematic reviews of risk factors, particularly for the recurrence of maltreatment (see Hindley et al 2006);
- giving careful attention to the processes of analysis of information, decision making and planning (see Jones et al 2006);
- addressing interagency communication and the factors which facilitate or inhibit effective interagency working (see Hudson et al 1999).