

## BRIEFING

### **Analysing child deaths and serious injury through abuse and neglect: what can we learn?**

#### **Biennial analysis of serious case reviews 2003–05**

#### **Introduction:**

This summary of the second of the recently published biennial reviews of SCRs is based in part on a presentation by Marion Brandon, an author of the report.

#### **Aims of the review:**

To answer the following questions:

- What are the themes and trends across reviews reports?
- What can we learn about inter-acting risk factors?
- What are the lessons for policy and practice? (and can these types of cases be prevented/reduced)

#### **Methodology:**

The researchers had access to records of 161 SCRs completed during 2003 – 05. However, for many of these there was a lack of accurate data. 47 SCRs that contained the most complete data provided most of the material referred to in qualitative analysis.

#### **Children in the Study:**

Of the 161 SCRs recorded:

- 19 (12%) concerned children who were subject to child protection registration;
- 89 (55%) were known to Local Authority Social Services at the time of the incident;
- 26 (16%) of the SCRs were triggered by head injuries to babies;
- 34 (21%) of the SCRs featured house fires, accidents, care giver illness, *in combination* with neglect concerns;
- Approximately one third of children experienced neglect (usually known to many agencies);
- Approx one third experienced a physical assault (usually known to few agencies);

- Most older children considered experienced “agency neglect” (long history of agency involvement, hard to engage, some agencies had given up, exhibited self neglect, including suicide and in some instances had a history of violence towards others).

**Problems faced by Care Givers/Parents:**

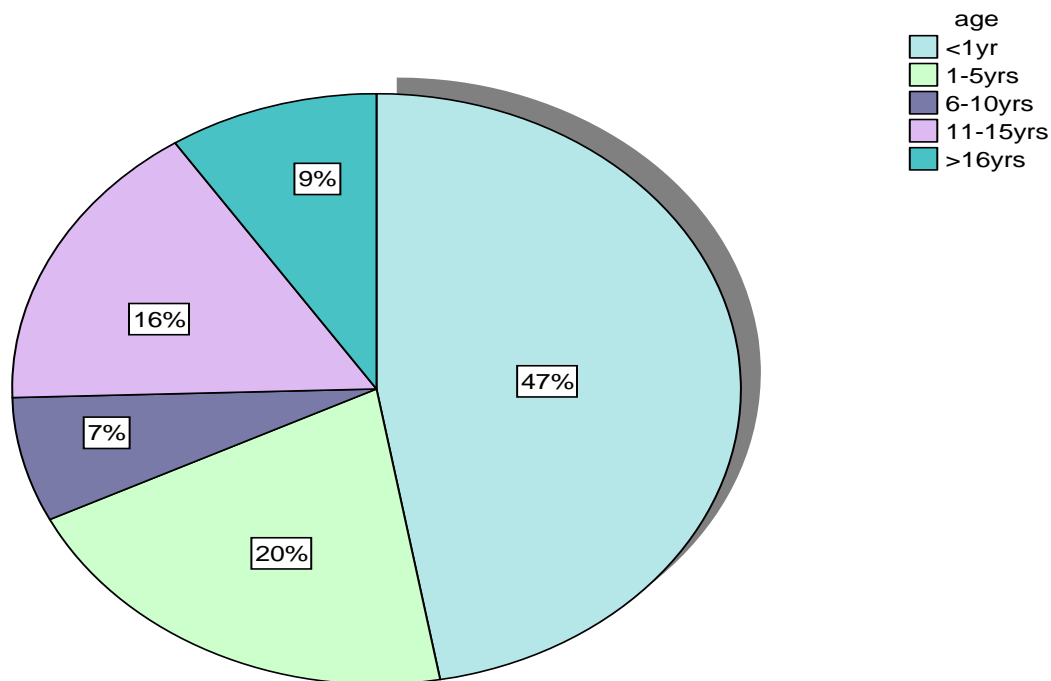
The “second tier” of cases (47 in number) provided sufficient data to clearly identify the presence of problems compromising the ability of parents/care givers to meet the child’s needs:

- 31 (66%) of children were living with adults experiencing domestic abuse;
- 26 (55%) of children were living with parents with mental health problems;
- 27 (57%) of children were living with parents who were substance abusing
- In 16 (34%) of cases, all 3 of the above factors (Domestic abuse, parental mental ill health & parental substance abuse) were present.

**Engagement of Families with Services:**

Of the 47 “second tier” cases, 32 families were identified as overtly hostile or uncooperative towards workers.

**Child’s Age at time of death/Serious Incident:**



### **Interacting Risk Factors require a sophisticated perspective:**

The children considered by the SCRs experienced a range of vulnerabilities and precipitating incidents. For younger children, these included: birth prematurity, frequent admissions to hospital, head injuries resulting from assaults. For older children and adolescents vulnerability factors/precipitating incidents identified included: self neglect, chronic ill health, sexual exploitation, "going missing", involvement in bullying (perpetrator or victim), and suicide.

These children were experiencing these vulnerabilities within homes/environments where a number of adverse factors were present, including:

- combinations of domestic abuse, parental mental ill health, parental substance misuse;
- fathers with histories of hostility and criminal convictions;
- families that displayed hostility, lack of cooperation and/or disguised compliance towards agencies;
- family histories of a previous child death
- families experiencing poverty, frequent changes of address, poor living conditions and a history of accidents (e.g. house fires).

A number of the serious case reviews showed that agencies trying to intervene positively in these complex situations were hampered by practice, professional and organisational factors, including:

- agency capacity compromised by organisational change;
- a pre-occupation with thresholds, e.g. children and families not getting a service unless "CP thresholds" are met;
- professional anxiety about working with hostile families resulting in a reluctance to act, or challenge family behaviours;
- shortcomings in staff supervision, and in particular the quality of support for staff dealing with challenges of ethnicity, or when considering positive interventions in neglect cases;
- disruption of organisations' responses when dealing with mobile families – the "start again syndrome";
- Professionals not confident about ensuring that the child is **seen and heard**.

To have successfully engaged with many of the families considered in the SCRs, agencies and professionals would need to be able to: **recognise** the child's vulnerabilities, **engage** with families that are hostile and exhibiting multiple adverse factors ("co-morbidity"), and **ensure an effective agency/professional response**. The report authors suggest that to achieve this requires a sophisticated understanding within the agency of:

- Parental psychology
- The historical context of the family and the dynamics within this context; and
- Analytical assessment leading to confident engagement and interventions.

### **Levels of Intervention:**

The authors remind the reader of Lord Laming's observation in the Victoria Climbié report that "child protection does not come labelled as such". The cases considered were spread across all levels of agency intervention, from universal services for all children and families, through children and families with additional needs (CAF) and children with complex needs (threshold for children's social care child in need involvement), up to services for children at high risk. This has implications for the level of awareness of safeguarding for all services working with children and families, and emphasis is put on the importance of ensuring the effective implementation of the Common Assessment Framework (CAF) across all such agencies. It is particularly important that there is an appreciation developed of how the vulnerability of children is amplified when multiple risk factors are inter-acting.

### **Family Cooperation:**

It is recognised that certain agencies are more likely to be treated with suspicion by some families, and it is important that all agencies working with families emphasise the importance of engagement with the full range of appropriate services. Individual and inter-agency training needs to assist staffing understanding the significance of patterns of poor cooperation or hostility presented by some families.

### **Conclusions – Knowledge:**

- Most cases were too complex for serious injury or death to be predictable
- The co-existence of domestic violence, parental mental ill health and substance misuse increase the risks of harm to children but **do not** predict death or serious injury
- Family volatility and a history of previous admission to A&E for the child present warning signs of abuse.

### **Conclusions – Practice:**

- Community and hospital based staff need a greater awareness of the dangers of domestic violence to children's safety.
- Staff working with babies and their families, particularly midwives, health visitors and GPs, have a key role in safeguarding.
- Staff working with early needs are part of the safeguarding continuum.
- Beware 'drift' with long term neglect cases and adopting the 'start again syndrome'.
- Some older adolescents are beyond the reach of existing services and their vulnerability is not being recognised or taken sufficiently seriously by professionals.

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