

BRIEFING

Key Issues from Biennial Reviews:

Understanding Serious Case Reviews and their impact - A biennial analysis of 2005-2007

Introduction:

This is the fourth in a series of biennial reviews of Serious Case Reviews (SCRs), and the second consecutive review to be conducted by a team from the Universities of East Anglia and Warwick. Both reviews undertaken by this team examine all the available SCRs from the period concerned, unlike previous studies that have focused on a smaller sub-set. This enables the authors to make direct comparisons between the findings of their research into SCRs conducted during 2003-05, and those conducted during 2005-07.

This briefing is based on the full report, published in June 2009, and on material made available by Marion Brandon, one of the authors, in her presentation at the National LSCB conference in 2009.

Objectives of biennial review:

The report authors draw out the following themes, and then offer conclusions based on their research:

- The serious case review process and its policy, practice and research context;
- The characteristics and circumstances of the children and their families, and agency involvement;
- Key themes, understanding the cases from an interacting risk perspective;
- The SCR and its impact;
- Understanding and protecting children.

The serious case review process and its policy, practice and research context

This study was published prior to the completion of the review of Chapter 8 of Working Together to Safeguard Children, which was conducted by the National Safeguarding Delivery Unit (NSDU) and the Department for Children Schools and Families (DCSF). Therefore, some of the comments made in this section have been overtaken by the revised guidance. An example of this relates to time scales for the completion of SCRs. The study recommends that a SCR should normally be completed in six months, rather than four months (the time scale in guidance for the period considered). The revised version of Chapter 8 of Working Together has now adopted a sixth month time scale for the completion of a SCR.

It is acknowledged that some of the serious case reviews considered occurred in authorities that had adopted Child Death Overview Panels (CDOPs) prior to such panels being mandatory for all authorities in England and Wales (April 2008). The report acknowledges that research drawing on similar processes in the United States suggests that a review of all child fatalities might enable better identification of the causes of child death, and lead to the introduction of initiatives for better prevention. However, study of "Early Starter" CDOPs (Sidebotham et al, 2008) found confusion about the links between child death and serious case review processes. The report writers expect that the next biennial review, focussing on a period when some of the cases will have been considered by CDOP in all authorities will provide information about the effectiveness of reviewing all deaths, and also indicate whether further guidance is required to clarify the links between the CDOP and SCR processes.

The report describes the Serious Case Review process that Local Safeguarding Children Boards must follow, and also the evaluation process undertaken by Ofsted. It is emphasised that however SCR processes may develop, they must continue to be focused on promoting learning, not on attributing blame.

There are positive references to an alternative method for undertaking serious case reviews, including "near misses" cases. This is the method proposed by the Social Care Institute of Excellence (Fish et al, 2008). Strengths of this modal, from its limited application to date, are identified as its focus on professional learning, drawing on systems theory to examine the wider practice context across all agencies involved with a family. However, it is acknowledged that this approach is time consuming, and would be unsustainable if a number of reviews needed to be undertaken concurrently.

The report authors advise the reader to exercise caution when considering findings and interpreting information in complex and multi-faceted cases. It should not be assumed that there is a causal connection between the characteristics of children or their families and the likelihood of serious injury or death. Whilst certain factors create risk which may be manageable if confident

professionals are able to work with the parents, a constellation of factors may heighten risk which needs to be recognised and actively managed.

The report writers note that previous studies of serious case reviews and other studies of child death and serious injury as a result of abuse identify recurring themes in terms of family characteristics and professional behaviour in such cases. It has been suggested that this calls into question the effectiveness of using learning from SCRs to alter practice. This has led the writers to try to understand more about the circumstances which might trigger the death or serious injury of the children and young people and the factors which influence the behaviour of practitioners who are working with them and their families. These issues were then considered using an "ecological-transactional" perspective¹.

The research process was carried out in 4 "layers":

- Layer 1 = 464
 - All notifications of safeguarding incidents to the DCSF child protection database.
- Layer 2 = 189
 - Those notifications which became serious case reviews.
- Layer 3 = 40
 - Those SCRs which provided sufficient data to be in the intensive sample (considering overview reports, chronologies and individual management reviews).
- Layer 4 = 17
 - Sub set of the 40 from which practitioners were interviewed for the report.

¹ *An ecological-transactional perspective views child development as a progressive sequence of age- and stage-appropriate tasks in which successful resolution of tasks at each developmental level must be co-ordinated and integrated with the environment, as well as with subsequently emerging issues across the lifespan. These tasks include the development of emotion regulation, the formation of attachment relationships, the development of an autonomous self, symbolic development, moral development, the formation of peer relationships, adaptation to school, and personality organization... Poor resolution of stage-salient issues may contribute to maladjustment over time as prior history influences selection, engagement, and interpretation of subsequent experience...*
(Cicchetti and Valentino 2006 p143)

Characteristics and circumstances of the children and their families, and agency involvement

THE CHILDREN AND YOUNG PEOPLE:

Two thirds were children aged under five and almost half were less than 12 months old at the time of the incident.

The risk for these children is maltreatment, arising mainly from physical assault, overlaid with issues of neglect. The vulnerability of very young children is confirmed by all previous reviews and thus this is not a new finding. Sudden unexpected deaths in infancy (SUDI) made up 16% of infants (3% of the full sample). Adolescents over 11 made up almost a quarter of the 189 cases and 11% were aged 16/17, most of whom died through suicide. Too frequently, their needs and distress were overlooked by agencies, particularly if they were seen as challenging. Sexual abuse was the primary concern in 1 out of 12 cases.

Type of injury/harm 2005-7 and 2003-5

Type of injury/harm	2005-2007 n=189	2003-2005 n=161	% change from earlier study
Head injury ('shaken baby')	18%	16%	+ 2%
Sudden infant death	3%	3%	-
Overlying	6%	4%	+ 2%
Physical assault	18%	35%	- 17%
Neglect (+accidents, house fires, RTA)	16%	20%	- 4%
Poisoning/ overdose	8%	4%	+ 4%
Suicide / self-harm	12%	9%	+ 3%
Sexual abuse	8%	4%	+ 4%
Gone missing	-	4%	- 4%
Other / unexplained	11%	2%	+ 9%

A relatively small proportion of children (17%) were subject to a child protection plan at the time of the incident but over one third had at some time been known to children's social care, with neglect as the most common pre-existing factor. However, 21% had one or more siblings who were subject to a child protection plan at the time of the incident and in almost one third of families either the child the subject of the SCR, or a sibling, were currently or had been the subject of a children protection plan. 13% were the subject of either a legal order or accommodated under section 20 of the Children Act 1989 at the time of the incident.

Disability, complex health needs, mental health problems and drug and alcohol misuse were identified as factors for a small proportion of children.

THE FAMILIES:

The authors examined 40 (a representative sample) of the 189 cases in a more detailed study. The information gathered through the SCR documents about parents was limited and they recommend that more detailed information about the parents' history may assist in a better understanding of the risk factors.

Almost half the families were highly mobile and living in poor conditions, one factor in mobility being escaping from violence in the home. Half the families had family members with criminal convictions. Domestic violence either current or in the past was a significant factor, together with past or present mental ill health of a parent and substance or alcohol misuse. Previous SCR overviews have identified that these factors, although not always reasons for removing a child, create a level of risk. Where domestic violence, substance or alcohol misuse and mental health co-exist, the risk is significantly greater. Nearly three quarters of the children lived in circumstances where one or more of these factors were present.

The level of parents' co-operation was scrutinised and revealed that some three quarters of the 40 families did not co-operate with services. The authors describe patterns of hostility and note particularly the impact of deliberate deception, disguised compliance and passive compliance on the effectiveness of agency intervention. Such behaviour by the parents may mislead and be perceived as sufficient co-operation, particularly if there were low expectations about the family.

Key themes, understanding the cases from an interacting risk perspective

The third chapter of the review draws out the learning from the intensive study of 40 children's cases. The team examined three interconnecting domains:

- factors relating to the child and their experience;
- family and environmental factors; and
- the interconnection with agency and professionals' practice in each child's case.

Then the team considered the influence of these three domains on the cycles of practice.

Case examples are given. The team suggest that this methodology for examining practice should be central to Local Safeguarding Children Boards' processes and multi-agency training programmes and pinpoints how chaotic or resistant behaviour in the child's family may be mirrored in professionals' thinking and actions, with the result that the child is not seen or is overlooked.

Key issues for professional practice which emerged include:

FULL HISTORY OF PARENTING BEHAVIOURS:

It is important to know about the parents' or other caregivers' history - including their own experience of being parented, past and potential patterns of behaviour or concerns – to identify factors which may point to enhanced risk or which may be protective. In addition, it is important to assess the impact on the parent of behaviours in the wider family network. This did not necessarily rule out capacity to change but where families were overwhelmed and struggling in an adverse environment, professionals need support to identify parental behaviour harmful to a child.

FIXED THINKING:

Examples of rigid or fixed thinking impacted on understanding the child's changing circumstances. An example is cases where neglect – both physical and emotional – is identified as the primary concern which then prevents professionals from considering and accounting for other forms of harm, such as physical injury. 'Rough handling', which had serious consequences for the child, was at times seen as careless parenting and not as an indicator of risk of physical harm.

Further examples of fixed thinking that the authors identify from SCRs include efforts not to be judgmental. In a number of SCRs considered it was felt that this resulted in a tendency towards justification and reassurance that all was well, rather than more objective consideration and investigation of what had occurred.

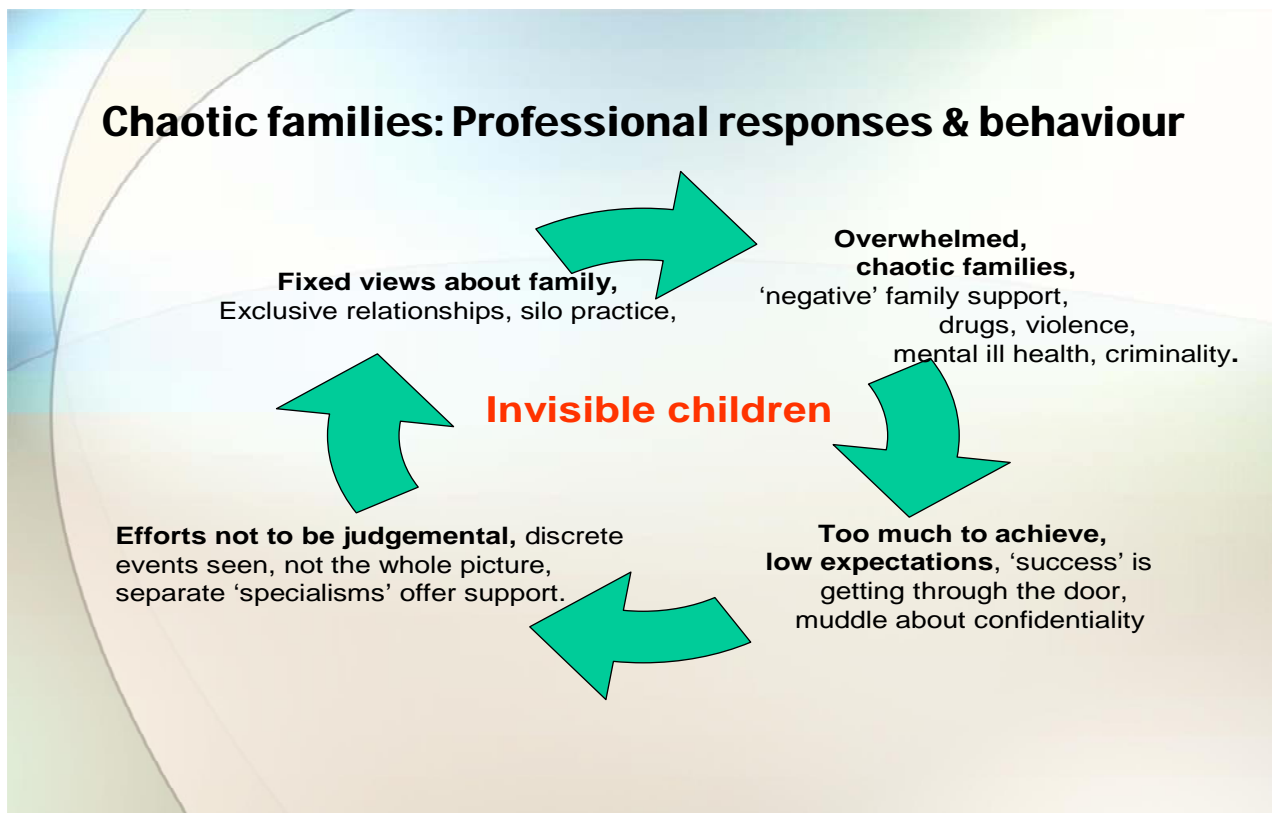
THE "INVISIBLE CHILD":

The report authors were struck that the "invisible child" – the problem of the child being "lost" in the considerations of professionals – was even more prominent in the 2005 – 07 study than the 2003 – 05 study. The theme of children not being seen or heard features in all studies of child deaths and SCRs.

SCRs offered a number of interpretations for children "lost" or invisible". These are grouped in the study as:

- Children and young people who were insufficiently consulted or spoken with;
- Siblings of the "index" child who were not interviewed or assessed;
- Young people who were not spoken to because they were out of the home;
- Young people who were kept out of sight;
- Children who chose not to, or were unable to, speak because of disability, trauma or fear.

Chaotic families: Professional responses & behaviour



MEN & MALE CARE-GIVERS:

The authors found there was a lack of information about fathers or male figures, not only in the serious case review material, but also in assessments. Even if the father is not living in the child's home, his presence and his role in the child's life needs to be accounted for in assessments. Lack of information coupled with rigid thinking about fathers and father figures as either 'good or bad' and also a tendency at times to see fathers and males as threatening undermines the foundation for informed decision making about risk to the child.

FAMILIES NOT INVOLVED WITH CHILDREN'S SOCIAL CARE:

In the sample of 40 cases just over half the children were at the threshold of receiving services from children's social care. Where families were receiving either universal services or additional services but not at the level of a referral to children's social care, professionals need to be alert to signs of behaviour or incidents indicating possible significant harm. Thus, professionals working within the Common Assessment Framework need to be able to understand and weigh up indicators of risk and to challenge decisions and actions of senior professionals in other agencies. Where families were highly mobile, the risks of warning indicators not being noted or acted upon were increased and significantly so if the parents were not co-operative with agencies.

Agency systems where missed appointments, particularly health appointments, were not followed up may result in reduced vigilance at a time when exactly the

opposite was needed. Co-operation by the parent with adult services whilst of value should not mask the possibility of continuing or increased risk to the child.

AGENCY CONTEXT:

To understand the professionals' perception and management of the risk and their collaborative work with the family, the authors consider that the issues of the 'capacity and the climate' of the agencies delivering services should also be addressed in the information upon which the SCR recommendations are made.

The serious case review and its impact

This chapter considers aspects of the serious case review process and the impact, for professionals, of being involved in a serious case review. Analysis is provided of 17 interviews with members of LSCBs involved with the SCR process in 17 of the cases from 2005-2007 and 7 interviews with practitioners from health and children's social care who had been involved with the child or family in some of these 17 cases

The review team concluded that the impact on professionals of being involved in the SCR process was profound and long lasting. Professionals frequently felt they were not adequately involved; good support was essential to recover confidence. This was both valued and necessary.

The focus of the overview SCR report on interagency working often meant there was insufficient information about the child and family making it difficult to have a clear understanding of the case. Furthermore, despite the focus on interagency working, the documentation included little to build an insight into the context and capacity of individual agencies to safeguard children.

The timescale of four months for SCRs to be completed, the authors conclude, is not achievable and they recommend a period of six months. This is consistent with their view that the child and family's history is highly relevant to understanding how risk was perceived and managed. They do recognise the need to make the timeframe and amount of material gathered in the Individual Management Reviews and Overview Review manageable, and acknowledge this raises issues about the balance between efficiency and a sufficiently long period in the family's life to make sense of the child's circumstances and the impact of the services provided.

What constitutes an independent author and their value in completing the Overview Review is a matter of uncertainty and the authors note a concern that reports may become 'formulaic' to meet requirements set by Ofsted to obtain a good grading. Involving families in the process may counterbalance a bureaucratic tendency: views about how best to do this varied and is an area for shared learning from experience.

There was inconsistency in practice about which staff had access to the final overview report and whether executive summaries were published. How well this process was managed and, thus, its impact on staff, directly and indirectly involved, was a factor in restoring professional morale and confidence. A media strategy under the direction of the LSCB was essential.

Generally, the learning from and monitoring of recommendations, which needed to be measurable and achievable, was taken seriously by LSCBs. Agency capacity was likely, however, to have an impact on the outcome of dissemination, training and future collaboration.

Understanding and protecting children:

The final chapter, building on the themes of the previous biennial review, addresses the implications of the study for policy development and day to day practice for professionals as well as the conduct of a serious case review. A key message given by the authors is that it is what is done with information about the child and their family within the environment in which they live, rather than the accumulation of information, which is crucial to analytical, reflective and safer professional practice.

Organisations need to deal supportively not defensively with the complexity of practice and decision making, allowing time to “puzzle over what is happening to families”. There is, the authors appreciate, a tension between this approach and ensuring high standards of service delivery measured by performance indicators and targets.

Regular and skilful supervision allowing for “structured sharing of uncertainty” is crucial for practitioners in social care, health and education, particularly when professionals may be managing risk below the threshold for social care input.

Acknowledged risks are not of themselves a prediction of death or serious injury. It is difficult to determine the factors which tip families, often unpredictably and suddenly, into a family who poses a high risk of harm to their child. This is particularly so where children are below the threshold for services from children’s social care and yet are living in families with a high level of vulnerability. Inevitably, professionals working with these families often carry a high level of anxiety.

Comment:

- This biennial review provides much material to inform on-going reviews both by Bradford Safeguarding Children Board and individual agencies of structures, procedures and skills, to identify barriers to effective safeguarding professional practice.
- The analytical tool used to examine the sample cases and the practice messages would strengthen aspects of multi-agency safeguarding training.
- Health service providers and commissioners will need to consider how best to support professionals who may be managing risk, where the child has additional needs identified through a Common Assessment Framework process.
- For all agencies, the response to missed appointments is critical: a lack of follow up procedures or a perception that a family is “hard to work with” may result in reduced professional oversight precisely at the point when greater risk is either emerging or is already present.
- How information is used by professionals is crucial. In a number of the cases, confusion about confidentiality meant that information was not shared with the right professionals at the right time. The authors express the view that guidance and organisational cultures often put more emphasis on the gathering of information than on understanding that information.
- There are useful suggestions for how LSCBs could apply methodologies used in this review to practice and learning audits of SCRs. One suggestion is to compare cases subject to SCRs with cases which had similar characteristics, but better outcomes for children. This may enable LSCBs to identify and focus on effective practice.
- The mobility of some families, matched by lack of continuity of professional involvement can lead to lack of decision making, or unfocused decision making at a time of greatest risk to children. Organisations need to consider this issue when considering how their structures impact on the transfer of cases.
- Neither this review, nor previous biennial reviews, have provided much information about the functioning of child protection case conferences.
- This biennial review emphasises the benefits of involving both professionals and families in the review process. This is viewed as both strengthening and embedding the learning in organisations.
-

Paul Hill,
Manager of BSCB
10th January 2009