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RESEARCH BRIEFING

PATHWAYS TO HARM, PATHWAYS TO PROTECTION: A TRIENNIAL ANALYSIS OF SERIOUS CASE REVIEWS 2011-2014

CENTRE FOR RESEARCH ON CHILDREN AND FAMILIES

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PATHWAYS TO HARM, PATHWAYS TO PROTECTION: A TRIENNIAL ANALYSIS OF SERIOUS CASE REVIEWS 2011-2014

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WHY IS THIS STUDY IMPORTANT?

A Serious Case Review (SCR) is a local enquiry undertaken by the Local Safeguarding Children Board (LSCB). It is carried out where a child has died/suffered from serious injury as a result of abuse or neglect and where there are concerns about inter-agency working. The purpose of SCRs is to identify what happened and why so that systems to safeguard children and young people can be improved. This study analysed all SCRS from 2011-2014, highlighted the latest findings and then placed them within the context of data obtained in the previous three biennial reviews, undertaken by the same research team, covering the period 2005-11. The findings shed light on the key safeguarding issues, challenges and implications for policy and practice that have emerged from analysis of these SCRs.

AIM OF THE STUDY

The primary aim of the current study was to provide professionals with evidence of key issues and challenges in cases where children had died or been seriously harmed and there were concerns about how agencies had worked together. In addition, the study sought to provide the government with evidence of what has really changed as a result of reforms to children's social care, and to identify areas where further change may be required to support organisations to learn from SCRs and keep children safe.

How was the study done?

This study examines the themes and trends emerging from the three years of SCRs studied (2011-2014) as well as cumulative learning since 2003 when the team first became involved in the national analysis of SCRs (this is the fifth consecutive national analysis of SCRs in England undertaken by the same research team). With the addition these cases from 2011-2014, the research team now has a continuous database of just over 1100 cases drawn from incidents dating back to 2003.

- Quantitative analysis of the 2011-2014 cases was undertaken along with an analysis of a sub-set of 175 SCRs (providing quantitative and qualitative data). Details, such as the child and family characteristics, child protection plan history, incident details, health, housing, and domestic violence were drawn from the Child Protection Database (CPD) and SCRs. This information was inputted into an SPSS (a statistical package for the social sciences) database and used to form conclusions and make policy and practice recommendations.
- A further 66 SCR final reports were also selected from the sub-set of 175 for detailed qualitative analysis. These cases were selected to reflect the spectrum of case characteristics in across the 175 cases, for example, age, gender, fatal or non-fatal incident and location of the incident Researchers summarised and then coded key feature related to the child, the family background, the parents' history and parenting capacity, the wider environment around the family, professional involvement, an analysis of interacting risk and protective factors.
- A systems methodology approach was taken to look beyond the detail of learning at an individual practitioner level to understand the deeper systems issues that may have led tothe child's death or serious harm. This helps shift focus away from individual blame towards the flaws in our systems for safeguarding children.

KEY FINDINGS

Working together, referrals and information sharing

- The study found that multi-agency working could be difficult when cases moved between services, for example because eligibility was disputed and opinions varied. Often, families felt they were left without a trusted, long-term relationship with practitioners.
- Sometimes practitioners were uncertain about legislation around information sharing and about what was relevant to share. In many SCRs, important information was not passed on and sometimes information that was received by children's services was treated as 'for information only' because it was not a formal referral.

Assessments

- Sometimes professionals saw assessments as a one-off event rather than an ongoing process and acted on single sources of information. Inter-agency tension could affect the quality of assessments.

Understanding vulnerability and risk

Most (55%) of the children and young people who were the subjects of SCRs were not involved with the child protection system at the time of their death or serious harm. Almost two thirds (64%) were or had previously been known to children's services. Twelve percent were subject to a child protection plan and a further 12% had been in the past. A further 14% of children were below the threshold for a service, their referral had not been accepted, or an assessment had not led to a service. Therefore, in 78% of the cases children's services were or had been aware of the child.

- In the cases known to social care, professionals sometimes mistook parental cooperation for evidence of change and prioritised keeping the family together at all costs.
- Babies and infants stood out as being particularly vulnerable to serious harm, as did adolescents. For children with disabilities, practitioners sometimes

misinterpreted signs of abuse as the result of impairments.

- The study also identified social media and virtual relationships as areas of risk for bullying and grooming. This did not feature in earlier national analyses of SCRs.
- A wide range of risk factors in the parents' backgrounds raise the risk to children including; domestic abuse, mental health problems, adverse childhood experience and patterns of multiple consecutive partners. These factors interact with each other and create cumulative levels of risk.

Dealing with uncertainty and poor engagement

- Many of the families in these cases had a history of poor engagement with services which sometimes prompted case closure because workers accepted excuses without challenge.
- Practitioners sometimes discounted concerns that could not be proved.
- Practitioners sometimes relied too much on family members to follow up on their recommendations. In some cases, support plans were unclear and it was difficult for parents to know what was expected of them.

Listening to children

- Many of the children in the SCRs were too young or not able to tell anybody in words about what was happening to them.
- Disabled children were particularly vulnerable when practitioners lacked the skills to communicate with them. In some cases, professionals attributed indicators of abuse to the disability.

Domestic abuse and parental separation

- Domestic abuse was a factor in more than half of the SCRs and the study found examples of improved practice compared to in earlier years
- The study found coercive control in intimate relationships to be a big issue. In some cases, practitioners focused on individual incidents rather than taking account of how victims and children were affected by the control itself.
- Abuse regularly continued after parental separation. This abuse was often because of conflict around child contact arrangements and triggered the fatal assault on the child in some cases.

Adolescent suicide

- This study looked in detail at 17 SCRs relating to suicide among adolescents, the largest cause of death in this age group. Loss and rejection were common threads in lives characterised by parental conflict and separation, domestic abuse and substance misuse.
- At the time of suicide, just over half the cases were open to children's social care and all but two of the 17 young people were involved with Child and Adolescent Mental Health Services (CAMHS).

Child Sexual Exploitation (CSE)

- The study found that the histories of children and young people involved in CSE had a lot in common with those that took their own lives.
- Practitioners often lost sight of the impact of these histories as attention shifted to behaviour.
- Overall, practitioners showed a lack of understanding of the dynamics and prevalence of CSE, assuming that the young people had the capacity to remove themselves from harm, for example.

<u>Key recommendations for policy and practice</u>

Working together, referrals and information sharing

- Professionals working with vulnerable children the child protection system need a rigorous focus on risk and vulnerability, must make clear plans with measurable outcomes, conduct regular reviews, and ensure meetings are well-chaired and minutes are circulated. A team is important, but a trusted individual is vital. Child protection agencies must feedback promptly to referrers and others involved in safeguarding.
- Professionals must take action in response to any information received relating to potential harm, even if this is not a formal referral. If an active decision is taken not to share information professionals must record their reasoning.

Assessments

- Practitioners must see assessment as an ongoing process and include all information from key agencies and family members.
- Practitioners must keep an open mind to different explanations for signs of abuse and avoid forming an opinion that they stick to in the face of new information. Assessments must look at the big picture and not just specific incidents, considering family history, underlying difficulties and what life is like for the child. Professionals need to understand the child's behaviour, health or disability in the context of the parenting they are experiencing.
- A decision to take no further action or downgrade a case is as significant as an escalation.

Understanding vulnerability and risk

- Practitioners need to understand risk and protective factors in the parent and wider environment with a focus on the impact on the child.
- Practitioners must be persistent in trying to overcome parental non-engagement, be vigilant to the child's needs, and maintain ongoing support for families.
- Significant change, such as a new partner or not attending appointments, is a cue for reassessing risk.

Dealing with uncertainty and poor engagement

- Unsubstantiated concerns, retracted allegations and inconclusive medical evidence should not lead to case closure without further assessment.
- Social workers are responsible for triangulating information – seeking independent confirmation of parents' accounts and weighing up information from a range of professionals.
- The study authors suggest a shift in terminology used to record missed appointments from 'did not attend' to 'was not brought', i.e. the child was not brought to the appointment by the parent or carer. This would maintain the focus on the child's vulnerability and dependence and the carer's responsibility to prioritise the child's needs. Professionals should not close cases because of non-attendance without reviewing risk and sharing information.

Listening to children

- Professionals should expect children to find it hard to talk and so take responsibility for communication.
- Disabled children were more vulnerable when practitioners lacked the skills to communicate with them. This could result in indicators of abuse, for example, physical injury and developmental delay, being attributed to the disability.
- Professionals need to observe children at home and be alert to non-verbal communication. Practitioners need to understand difficult behaviour in the context of the child's experiences over time and in the context of their current parenting.

Domestic abuse and parental separation

- Controlling or coercive behaviour in intimate relationships is now a criminal offence under the Serious Crimes Act 2015. Managers need to embed the use of this legislation in practice responses to domestic abuse.
- In private law proceedings as a result of acrimonious separation, professionals need to prioritise the needs of children above either parent.

Adolescent suicide

- Professionals must be aware of the risks which include; talking about self-harm, family conflict, school exclusion, homelessness, loneliness, and isolation.
- Young people appreciate ongoing support from one key person, but agencies need to work together to support vulnerable young people and review plans regularly.

Child Sexual Exploitation (CSE)

- Power is a key issue in CSE. Professionals need to understand the power of coercion used by perpetrators and the victim's fear of the consequences of refusing to do what the perpetrator wants. Practitioners also need to address the unmet emotional need that may be driving children and young people to put themselves at risk.

STRENGTHS AND LIMITATIONS OF THE STUDY

Strengths

The study is an update of an ongoing database with 293 SCRs from 2011-2014, making a total of 1100 SCRs since 2005. This gives an in-depth picture of change over time and a snapshot of the three years focused on in the present study.

Limitations

The recommendations from the study are based on the findings in SCRs and data were not collected directly from families or professionals involved. This means that conclusions have been drawn through the filter of the SCR authors' interpretation of events. Serious case reviews are not a reflection of typical child protection practice. The constellation of events and characteristics that came together in these cases to produce an outcome of fatality or grave injury cannot be distilled into a check list of risk factors that predict such an outcome. In most cases with similar characteristics a child will not come to such catastrophic harm.

FIND OUT MORE
FULL REPORT GOO.GL/MYH1YO
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