Learning & improvement Winter 2017/2018

IN THIS BRIEFING

Serious Case Reviews

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Serious Case Reviews (SCRs) are statutory reviews commissioned when:

- Abuse or neglect of a child is known or suspected; and

- Either, the child has died or the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so we understand what works well. When things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that lessons can be learnt and services improved to reduce the risk of future harm to children.

Working Together to Safeguard Children (2015) - the statutory guidance on SCRs outlines the following principles by which these reviews should be conducted.

These principles are;

- There should be a culture of continuous learning and improvement,

- The approach taken should be proportionate to the case under review,

- Reviews of serious cases should be led by individuals who are independent of the case and the organisations whose actions are being reviewed,

- Professionals must be fully involved in reviews and invited to contribute their perspective without fear of being blamed for actions they took in good faith,

- Families, including surviving children, should be invited to contribute,

- Final reports must be published in order to achieve transparency,

- Improvements must be sustained through regular monitoring and follow up.

What, why and how

This briefing paper provides information about case review activity in West Sussex. It outlines what Serious Case Reviews are, including why and how they are commissioned. It also offers some headline findings about reviews from a national and research perspective.

Further information

Working together to safeguard children: statutory guidance 2015

Local case review activity

The briefing also provides details about learning from recent SCR activity in West Sussex and can be used as a prompt for discussion, learning and reflection in team meetings as well as individual supervision.

Hyper-links take you to further reports, guidance and procedure (local & national) or research.

Context & research

Serious Case Reviews are commissioned by the Local Safeguarding Children Board and the decision to conduct a review is made by the Independent LSCB Chair. The LSCB has a Case Review Group which over-sees this work.

- Nationally, of the 433 serious incidents notified to Ofsted between 01/04/16 – 31/03/17, 113 became SCRs. There has been a year on year increase in the number of SCRs commissioned.

- The most frequent overall cause of serious harm was non-accidental injury by a parent/carer. The second most frequent category was incidents of sexual abuse or child sexual exploitation,

- The majority of serious harm notifications, and SCRs were, and remain, about children under one year.

- Disabled children are particularly vulnerable to abuse and neglect.

- Infancy remains the period of highest risk for serious and fatal child maltreatment.

- More recently a higher proportion of girls, rather than boys were subject to serious incidents and reviews.

- A minority of children who suffer serious or fatal child maltreatment were on a child protection plan at the time of the incident.

- Almost two-thirds of children who suffered serious or fatal child maltreatment, and were subject to a SCR, were or had previously been known to children's social care.

- Most serious and fatal child maltreatment occurs within the family home. In later adolescence there are increasing risks outside the family home.

- Very little serious or fatal maltreatment involves strangers unknown to the child.

FURTHER INFORMATION & RESEARCH

Pathways to harm, pathways to protection: a triennial analysis of SCRs

The role of SCRs in improving the child protection system

Case Reviews: NSPCC

Case review activity in West Sussex

Since 2015 West Sussex LSCB have commissioned six SCRs. In order to ensure anonymity SCRs are typically named using numbers or letters, and occasionally using names. The true identity of the child, family and professionals is hardly ever published in a final SCR report. In West Sussex we have;

SCR John – 2015

SCR Key – 2017

SCR N – 2017 (not yet published)

SCR O – 2017

SCR S – 2017 (not yet published)

SCR Q – 2017 (not yet published)

West Sussex has also contributed to two neighboring authorities LSCBs reviews. These have both been for Brighton & Hove LSCB and were;

SCR Liam – 2015

SCR A – 2017

In addition to these SCRs there have been a number of other case reviews completed relating to individual children, but where the threshold for conducting a statutory review has not been met. These have either been conducted by the LSCB or by the most relevant single agency that had the greatest involvement with the child. Findings from these reviews are also fed into the learning and improvement framework. One example being a review of a child who have been subject to sexual exploitation and who has been known to services for many years; another being challenges associated with a transfer-in child protection conference from another authority.

West Sussex Safeguarding Children Board

Further information on SCR John

SCR John final report

SCR John LSCB response

Further information on SCR Key

SCR Key final report

SCR Key LSCB response

SCR Key learning handout

FAST FACTS

40 - 85%

It is expected that 40 – 85% of children will engage in at least some sexual behavior before 13 years of age (Cavanagh, T., 2015)

14 - 15 years

Is the age range that children most commonly come to the attention of services as victims of CSE (CEOP, 2011)

FOR MORE INFORMATION

Pan Sussex Procedures:

Children who harm other children

Child sexual exploitation

Sexual abuse and sexual exploitation

SCR John concerned the sexual abuse of multiple children, over a period of time, by another child. The perpetrator was finally prosecuted however the multiple victims needed a high level of support in order to go through with Police interviews and give evidence. Some of the main learning points for the professional network to emerge from this review were;

- Practitioners & managers did not have knowledge and understanding of the procedure to follow relating to children who abuse other children.

- Joint working between Police and Children's Social Care was less focused and less effective when CID or uniformed Police respond, instead of the Police CP Team.

- There was less clarity about professional roles & responsibilities when the threat to children's safety is external to the family and from an alleged child perpetrator.

Question: *Do you know where to find the procedures relating to child on child abuse, and are you familiar with them?*

Question: *How can you use the learning from this review to inform your day to day work?*

Question: *How do you assess the difference between child sexual abuse and child sexual exploitation?*

SCR Key concerned the sexual exploitation of a number of girls, over a three year period, by two perpetrators. Both were found guilty of rape, sexual assault and sexual activity with a child and received lengthy prison sentences. Over 250 children and young adults were interviewed as either victims or witnesses in the enquiry. Some of the main learning points for the professional network to emerge from this review were;

- The use of challenge and escalation between agencies was inadequate.

-The responses from Police and Children's Social Care were found to have their roots in the agencies attitudes at the time.

- Children were seen as troublesome rather than troubled. Potential criminal activity or safeguarding concerns were dismissed.

- The roots of those weaknesses lie in the issues of attitude, resourcing, leadership, training and lack of professional robustness.

Question: *What is the protocol if you need to challenge and escalate a professional concern or difference of opinion?*

Question: *How do you ensure you are as robust as possible in the assessment work you undertake?*

Adolescent vulnerability & suicide

Some children may feel like there is no hope or might think about ending their life. Whilst thinking about suicide is relatively common, very few young people will actually attempt to take their own lives. However even having suicidal thoughts clearly shows someone is unhappy and needs help and support.

It can be difficult to understand what causes suicidal feelings but they're often triggered by upsetting experiences such as:

- living with mental illness

- experiencing abuse

- being bullied

- bereavement after losing a loved one

- being forced to marry

- having very low self-worth

For more information

NSPCC Learning from case reviews: Teenage suicide

FAST FACTS

90 %

Up to 90% of children who've been abused will develop mental health issues by the time they're 18 years.

Serious Case Review A

concerned the suicide of a 17 year old male who had spent the majority of his life living in care. He was accommodated in a therapeutic children's home and a transition for him into foster care was being planned. Whilst this review was commissioned and completed by a neighboring authority there is significant learning that can be used in West Sussex. This especially relates to:

- The quality of our pre-placement enquiries and how these are then incorporated into the decision-making process, for all children who are placed outside of the County. As a follow on from this, we must consider how we quality assure 'out of county' placements.

- How we ensure that adequate considerations have been made and arrangements are in place for all children approaching a major transition in placement, especially when placed out of the County? Following on from this, how can we incorporate contingency plans are made and all relevant information is provided to the next placement?

- How can we ensure that our children in care have access to specialist mental health services when placed out of the County? How are other area arrangements assessed and quality assured in order to influence decision making prior to placement?

Question: *When placing children in 'therapeutic placements' how do you assess the quality of therapeutic provision, initially, and on an ongoing basis?*

Question: *What does 'therapeutic placement' mean to you, and in practice?*

For more information

SCR A Final report and LSCB response

Serious Case Review Q

concerned the suicide of a 17 year old Bangladeshi female. In the year prior to her death Child Q had contacted a range of agencies asking for help for her brother who had mental health difficulties. From those contacts there was evidence that the brother was abusive to Child Q and her parents.

The review found that the separation of Services means that it is hard for professionals to 'think family' and recognise adolescents as children. In this context contact with Adult Social Care, Children's Social Care, MASH, Police, GP, Mental Health services operated in relative silos. Whilst information was available, it was rarely shared or used to consider what life was like in the house-hold for someone who was still a child but behaved like a young adult.

The review also found that domestic abuse is a complex issue and the nature of current service provision may make it harder for some families to access support. As the domestic abuse in this case was being perpetrated by a young adult son, which did not fit the normal mould of domestic abuse, services were not best placed to either understand, or respond effectively.

The review found that there are challenges for professionals in identifying when 'emotional distress' may indicate a risk of suicide. This reflects national research and the challenges for undertaking assessments.

The review noted that the challenge for professionals in gaining sufficient understanding of culture and religion when assessing risk. In particular it highlight the continued discomfort and lack of confidence for professionals asking questions of families around culture and religion; often due to a fear of being seen as intrusive, rude or racist.

Question: *When working with children and families whose first language is not English, or they have a different cultural or religious background, how do you ensure your assessment of risk is the best it can be?*

For more information

Pathways to harm, pathways to protection: a triennial analysis of SCRs – page 100 (Adolescent suicide)

SCR Q report – not yet published

Vulnerability during pregnancy & early infancy

West Sussex LSCB has commissioned three recent SCRs concerning the death or serious harm relating to very young infants. Whilst two of these have yet to be published due to ongoing criminal investigation, we are able to share the learning that has emerged from all three SCRs. Two further SCRS have also just been commissioned, both relating to the death or serious injury of very young infants.

Serious Case Review O

concerns the death of a new born baby through strangulation. The mother was found guilty of infanticide. The SCR focused on how an older sibling had become invisible to services, was not engaged in any pre-school provision and was not registered to begin attending school. The main learning points for the professional network to emerge from this review were;

- There was a lack of clarity regarding the nature and type of assessment needed when a woman presents late in pregnancy since child protection procedures do not differentiate sufficiently clearly between late booking and concealed pregnancy.

- There are continuing challenges involved in making it easier for services to engage with Eastern European families.

Question: *How does your service engage with families from different religious, ethnic and cultural origins?*

For more information

SCR O final report - LSCB website

SCR O - LSCB response

NSPCC Learning from case reviews: people whose first language is not English

Serious Case Review N

concerns the serious and non-accidental injury of a 4 week old baby. The main learning points for the professional network to emerge from this review were;

- When considering the impact of a mental health issue on parenting, it is the symptoms of treatment of the condition, and not the diagnosis itself that should be considered when assessing the needs/risks to a child

- When one parent has mental health issues which affect their ability to care for a child, the assessment and pan needs to consider this and the impact on the other parent

- The impact on professionals of working with parents with complex and emotionally powerful issues needs to be acknowledged in supervision.

- Robust information sharing and the swift transfer of records is essential when a child in need and their family move. There is likely to be an increased risk at this time due to changes in the professional network

- Clarity is required regarding the need for a pre-birth assessment in cases where there is a child in need and parental risk factors which may impact on the care of the child they are expecting

- When a new baby is expected and sibling is on a child in need plan, there needs to be an assessment of the new baby, but also a reassessment of the older child to consider the impact

- Professionals need to identify when parental cooperation with a plan for assessment and support is superficial. Consideration then needs to be given to the impact of this limited engagement on the child.

- Professionals undertaking assessments should seek to understand the nature of parenting relationships from the point of view of both parents/adults and the child. It is not enough to simply focus on the parenting capacity of the child's mother

- All agencies need to ensure their systems (including recording templates), procedure and practice ensure engagement with, and consideration of, both parents/adults in a family regardless of gender

- Professionals need to challenge their own practice and their organisational culture to ensure that service provision considers the child's day to day experience

- Non-accidental injury should be considered as part of a differential diagnosis

Question: *On what basis can information be lawfully shared without consent of the individual it relates to?*

Question: *How do you identify and assess vulnerability for pregnant mothers? How can you meaningfully involve fathers in your work? What factors lead you to re-evaluate your assessment once the child is born?*

For more information

Pre-birth assessment procedures

Professional disagreements protocol

SCR N report – not yet published

Serious Case Review S

concerns the serious and life threatening ingestion by a 7 month old infant of cocaine, amphetamines & alcohol. The main learning points for the professional network to emerge from this review were;

- Practice that is entirely mother focused does not give a full understanding of the risk/protective factors within a family for a child

- If co-sleeping is identified as an issue, the attitudes of both parents should be established and considered

- Professionals report that the perceived experience, expertise or status of other professionals can have an impact on how confident they feel in challenging or escalating differences of opinion

- Professionals need to be aware that babies and children may be given drugs by their parents/carers

- When there are no current or obvious concerns about a child, professionals outside of CSC do not always undertake checks with other agencies

- There are often barriers to information sharing. For example when considering why GPs are not always contacted professionals stated that; they probably don't know the child, they won't share anything if the matter is not s.47, it is often hard to speak to a GP in person

- Professionals need to be clear about what information should, and can be shared – be clear about why you are requesting information

- Although it is rare for a referral to be lost, it is the responsibility of all those who make referrals to ask what happened next if the information has not been shared

- Professionals can have a perception of drug users and what they look and act like.

- Professionals need to be curious, not accept things on face value, and check with other professionals what a parent is saying if their history may indicate potential safeguarding concerns

- It is important to establish what 'likely, possibly, probably' and other such statements means so that an informed judgement can be made

- Health professionals need to be more explicit when speaking to the MASH if abuse or neglect is part of a differential diagnosis for a child

- When a very ill child is referred to the MASH, and the non-accidental pathway remains a consideration as part of a differential diagnosis, the lead clinician with responsibility for the child and MASH should speak within 24 hours.

Question: *What steps does your service take to demystify, or to promote working relationships with other professionals?*

Question: *Where there is a difference of opinion between professionals how easy is it for you to resolve this?*

Question: *Do you encourage other professionals to come back to you, to obtain an update on progress when working with children and families?*

For more information

Information sharing guidance

Information sharing & confidentiality

SCR S report – not yet published

A final word …

Whilst it is right and proper that we examine, reflect and learn what happened in cases where children have either died or been seriously harmed, we need to keep in mind that the majority of children are well cared for; the majority of children are safe, healthy and happy.

There are an estimated 12 million children in the UK and approximately 6% of those children are classed as in need (2016 – 2017 data). Of that 6% only 0.01% are examined as Serious Case Reviews.

It is therefore really important to keep case review activity in perspective.

-Celebrate your good practice on a day to day basis.

-Notice and reflect on effective interventions and when something worked well.

-Commend colleagues, whether within WSCC or other agencies, when having a positive impact on the work with children and families.

-Remain open and receptive to new ideas.

References and further information

NSPCC briefings on learning from case reviews, NSPCC

Understanding children's sexual behaviors: what's natural & healthy, Cavanagh Johnson, T., 2015, Library of Congress

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University of Warwick & University of East Anglia, Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 – 2014, Pathways to harm, pathways to protection

Research in Practice, Serious Case Reviews

NSPCC & SCIE, Quality markers for conducting reviews, 2016, Quality markers