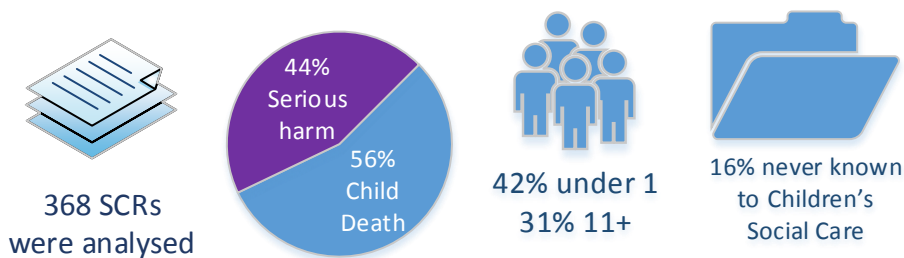# Complexity and challenge: a triennial analysis of SCRs 2014-2017

In March 2020, the Department for Education published findings from analysis of serious case reviews from 1 April 2014 – 31 March 2017.  You can read the full report here.

This document contains a summary of the key themes.

**368 SCRs were analysed**

44% Serious harm
56% Child Death

42% under 1
31% 11+

16% never known to Children's Social Care

81% of the Serious Case Reviews involved at least one of the parental characteristics below:

| Alcohol misuse | Drug misuse | Mental health problems | Adverse childhood experiences | Intellectual disability | Criminal record |
|---|---|---|---|---|---|
| 99 (36%) | 99 (36%) | 153 (55%) | 102 (37%) | 36 (13%) | 83 (30%) |

86% of the Serious Case Reviews included at least one of the family characteristics below:

| Parental separation | Domestic abuse | Social isolation | Transient lifestyle | Multiple partners | Poverty |
|---|---|---|---|---|---|
| 150 (54%) | 164 (59%) | 51 (18%) | 81 (29%) | 67 (24%) | 97 (35%) |

## Neglect

There was evidence of neglect in 74.8% of the 278 case reviews for which the full report was available.  A subset of 32 cases where neglect was a factor were analysed in more detail, from which the following themes emerged:

- Many of the case reviews identified poverty as an issue, but it was often overlooked by practitioners or addressed on an ad hoc basis

- There was an extremely high prevalence of adverse parental and family circumstances. Often there was not one single issue, but a combination of different parental and environmental risk factors which accumulated over time
- Adolescents living with neglect were particularly vulnerable to having their needs and the risks they faced overlooked.

*The analysis also identified learnings for policy and practice.*

- Parents often had previous negative experiences of statutory agencies, which could make them defensive when asked questions about their children.  Professionals need to be robust in addressing the strategies parents used to defend themselves and their families from scrutiny.
- Fathers and partners sometimes felt alienated and forgotten. Services need to find ways to become more male friendly to encourage involvement of men in their children's lives
- Opportunities for working with the family and wider community in preventative or protective interventions were often missed. Parents, family members and the wider community often have resources which can be used to help combat the impact of adverse circumstances.
- Professionals were sometimes reluctant to name or discuss neglect and poverty. Clear use of language is needed to encourage multiagency working and learning from case reviews.
- Services are increasingly fragmented, outsourced or cut and there are high caseloads and staff turnover. Managers and commissioners need to put in place structures to provide support, time and guidance for frontline practitioners.
- The complexity of families' situations and the high volume of information held by different agencies made it harder to identify and respond to the risks faced by children. A multi-agency approach to identification, assessment and support is needed.
- Practitioners sometimes focused on adolescents' behaviour rather than its underlying causes. Practitioners need to consider how young people might be vulnerable from neglect rather than seeing them as putting themselves at risk.

## Vulnerable Adolescents

31% of case reviews involved children aged 11 and over.  A subset of 25 cases involving adolescents were analysed in more detail, from which the following themes emerged:

- going missing was often a sign that there were other problems in an adolescent's life which required a safeguarding response
- young people experienced various forms of criminal exploitation including: moving drugs, violence, gangs, sexual exploitation, trafficking and radicalisation
- adolescents who had been exploited were vulnerable to, and had often experienced, multiple forms of abuse
- experiencing and perpetrating abuse were often very closely related and both required support and safeguarding
- social media provided a space and opportunities for children to be groomed and exploited

*The analysis also identified learnings for policy and practice.*

- Schools were key to noticing, alerting and managing potential harm to adolescents. However, when referrals didn't meet the threshold for a child protection response schools rarely challenged decisions. Clearer escalation policies and guidance on how to resolve disputes is needed.

- Relationships were key to working with adolescents. Prolonged and persistent engagement is needed, but a lack of resources and high caseloads make this hard to achieve. Voluntary organisations are often well placed to provide this long-term support.
- Clear transitions to adult services are needed to ensure young people receive the care and support they need as they age out of services for children.
- The signs that something was wrong were often there long before children reached adolescence. Early help and support can prevent issues from escalating.
- Adolescents often had access to multiple devices, making the monitoring of their online activity an unrealistic approach to protecting them from online harm. Any response to online harm needs to involve the ongoing education of parents, practitioners and children.
- Practitioners didn't always consider the reasons behind young people going missing from home. The young person's safeguarding needs should be identified and shared with relevant agencies to inform a holistic intervention.
- The decision not to pursue a criminal justice response to allegations of harmful sexual behaviour sometimes resulted in incidents being ignored. There must always be a therapeutic or safeguarding response to harmful sexual behaviour, regardless of whether a criminal justice response is pursued.

## Messages from Care and Court Cases

16% of cases involved children who were, or had previously been, looked after by the local authority. A subset of 10 cases involving children who were in care at the time of the harm, had previously been in care or were involved in care proceedings were analysed in more detail. The following themes were identified:

- Many children in care had substantial needs, but so did many of the children who went to special guardians, returned home or remained with their parents.  However, these carers may have fewer personal resources and less support than foster carers or residential staff to help children.
- Workloads and budgetary pressures threatened professional practice and children's safety and welfare.
- Tight timescales could sometimes undermine the thoroughness of assessments of potential carers, particularly kinship carers.

*The analysis also identified learnings for policy and practice.*
- Thorough assessments are needed, which consider what will help the child in the future as well as now, followed by ongoing monitoring and support.
- Cases revealed the importance of ascertaining and applying knowledge about background, culture, religion and 'personal identities' in assessments and planning.
- It was sometimes assumed that, because a court was involved, children were being offered a greater level of protection. Safeguarding professionals and other agencies may need help to understand legal orders and the significance of court involvement.

# Impact of Serious Case Review on Practice

Average of 7 recommendations in each SCR

Significant decline

Reduced from 47 in previous triennial review

To find out how these recommendations were implemented in practice, the researchers conducted a national survey, phone interviews and practitioner workshops. Findings included:

- concerns were expressed by practitioners about the pressure caused by recommendation overload, particularly when an area had carried out multiple SCRs
- many respondents felt that the type of recommendation mattered less than having a committed motivated team or champion to take them forward
- recommendations were easiest to implement when they were: few, specific, contextual and targeted
- the majority (87%) of respondents to a survey of all English Local Safeguarding Boards felt that SCRs had facilitated local change
- barriers to making meaningful changes included a preoccupation with process, a tick box response to action plans, and organisational change and shifting priorities in the time between the incident and the publication of the SCR.

Adapted from:

Complexity and Challenge: A Triennial analysis of SCRs 2014-17

And the associated Casper Briefing by the NSPCC.