South Gloucestershire Safeguarding Children Board

Key Themes and Messages from:

Pathways to Harm, Pathways to Protection: A Triennial Analysis of Serious Case Reviews (SCR)

2011-2014 (May 16)

Introduction

The pattern of SCRs over time show that once a child is known to be in need of protection, for example with a child protection plan in place, the system is working well. However there are pressure points at the boundaries into and out of the child protection system.

The number of SCRs has increased since 2012, but this is in the context of increased child protection work.

293 SCRs in total: 63 in 2011-12, 95 in 2012-13 and 135 in 2013-14

Between 2011-14 two thirds of reviews related to a child/young person who died, and a third non-fatal harm

Findings: Pathways to Harm

Most serious and fatal child maltreatment takes place within the family with children living at home or with relatives.

Particularly at risk are the youngest infants and adolescents. For babies the added pressures of low birth weight, illness, or maternal drug misuse pose additional pressures.

88% of the adolescents had mental health problems.

Children with disabilities were identified as particularly vulnerable, where signs of abuse and neglect were masked by, or misinterpreted as, due to underlying impairments

Larger families (4+ children) are over-represented in SCRs when compared to the proportion of lager families nationally

55% reviews concerned girls; 45% boys.

Cumulative Risk of Harm

Multiple parental and environmental risk factors present over periods of time. Past reviews have highlighted the combination of domestic abuse/substance misuse/mental health (Toxic Trio) but other risks to consider are:

- Adverse experiences in parents' own childhoods
- History of violent crime
- Pattern of multiple consecutive partners

- Acrimonious separation
- Social isolation

Practitioners need to explore all cumulative risks of harm to children.

A step change is required in how we understand and respond to domestic abuse. There is a need to move away from incident-based models of intervention to a deeper understanding of the ongoing nature and impact of coercive control.

Domestic Abuse was seen as a factor in cases from all categories of serious and fatal maltreatment.

12% of children were subject of a Child Protection Plan at time of incident.

A further 12% had been in the past.

64% of children were or had previously been known to children's social care

14% were below the threshold for a service, but were 'on the radar'

In total 78% of the cases children's social care had been aware of the child

In 22% of cases social care had never been involved or alerted

Being at School

Attending school provides a buffer against adversities for the child. Children not in school due to

- Poor attendance
- Home schooling
- Exclusion

Can be vulnerable due to 'invisibility' or social exclusion. Where neglect or maltreatment is already occurring absence from school increases risk.

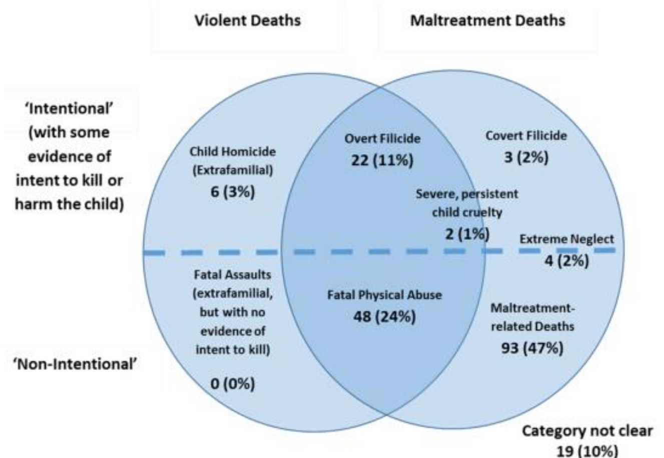
'Managed moves' between schools have potential to damage supportive and established relationships.

Four SCRs for children who were **home schooled**. Similarities in cases included:

- Social Isolation
- Parental deception/concealment
- Combinations of neglect/abuse
- Professional uncertainty
- Awareness in the community of the child's situation

Categories of Abuse

Violent and Maltreatment Deaths in Serious Case Reviews 2011-14



Non-Fatal Harm

96 cases of non-fatal harm.

52% - physical abuse (Perpetrators: 37% Mother; 22% Father; 7% Mother's partner; 19% both parents; 15% unclear)

14 cases of Neglect – however on detailed analysis neglect has been underestimated and although not the primary cause was found to be a factor in 87% of cases.

For many cases **multiple** types of abuse co-existed.

Sexual Abuse often co-existed with other types of harm. There was evidence of sexual abuse in 53% of cases relating to children aged 1 and above.

Adolescence 49 cases. (32 fatal/17 non-fatal)

Fatal Cases included:

17 cases of suicide/suspected suicide

3 cases - death followed risk taking behaviour

4 cases – young person killed by someone outside the family (2 associated with CSE)

Non-Fatal Cases included:

4 cases sexual abuse

5 cases - CSE

4 cases – neglect

3 cases – young person is a perpetrator

Learning Points:

- Parental conflict/separation can have a significant impact on young people, even older adolescents
- Listening to child's voice is crucial, not just looking at circumstances which might appear improved
- Improved school attendance is not an indicator of emotional wellbeing
- Self-Harm and/or suicide attempts preceded all but one of the suicides
- The best practice approach for work with adolescents is relationship based practice that is consistent, holistic and available over a long period of time.
- Behaviour should be view in context of other underlying problems and difficulties
- Practitioners from all agencies need to recognise and act on signs of vulnerability including signs of sexual exploitation

Findings: Pathways to prevention and protection

Professionals should focus on children's needs and identifying vulnerable families. Space to hear the voice of the child as well as the immediate and wider family must be created.

A culture of communication is important. Clear systems and guidance are needed so that information is verified, shared promptly with all relevant parties and used to guide decision making.

Assessments should be planned, comprehensive, and timely and involve all professionals working with the family. They should be ongoing and inform decision making.

Professionals from a complex mix of agencies can work with a family, often in relative isolation. Pathways between services should be planned to maintain support for vulnerable families.

Professionals should have a wide view of their own responsibility and not make assumptions about the actions or views of others, including parents.

All leaders and managers need to think creatively to support front-line workers in the context of limited resources.

The ongoing nature of vulnerability needs to be recognised. There is a need to shift from an episodic service to a culture of long term continuous support.

The cases highlighted by SCRs are complex. To respond to this professionals at all levels should take an authoritative approach:

- exercising their own judgement
- taking responsibility for their own role
- respecting the roles of others
- building a relationship of trust with families and children
- challenging situations from a supportive base

Non Engagement

- All non-engagement central to a child's welfare should be seen in context of carrying potential harm to the child
- Non-compliance may be a parent's choice, but that does not mean it is the child's choice
- Shift in terminology is needed from 'Did Not Attend' to 'Was not Brought'
- Repeated cancellation and re-scheduling of appointments should be seen in same light as repeated non-attendance

Thresholds

Differences in perceived thresholds for child protection intervention leads to frustration and breakdown in effective multi-agency working. If Early Help is to be effective there needs to be a clear pathway for escalation and de-escalation.

Information Sharing

Effective communication is central to safeguarding practice

Child Protection agencies must feedback promptly to referrers and others participating in safeguarding

Information must be triangulated and verified

Practitioner forums may provide opportunities for professionals to discuss cases and share information in a safe environment.

The increasing fragmentation of primary care services requires creative discussion at a local level to identify processes and structures to enable effective sharing of information

Coping with Limited Resources

The impact of increasing workloads in the face of limited resources places an imperative on leaders and managers to think creatively about how systems and structures can support front line workers

Effective supervision becomes increasingly important as workloads rise

Simplicity and clarity in published guidelines can help ensure that professionals are enabled to work effectively

Consideration needs to be given as to why guidance is not regularly followed.

Quality of serious case reviews

The SCRs analysed included 9 different types of review methodology which resulted in several different types of report.

There has been a trend towards shorter reviews with fewer recommendations.

Many SCRs take a systems approach focussing on the identification of learning opportunities. This means findings can be presented in a more accessible way and analysed more deeply by practitioners. However sometimes specific recommendations may still be necessary.

There is much better engagement of family members than in previous biennial reviews.

Good quality SCRs should include:

- Lessons learnt which are clearly linked to findings.
- Questions for the Local Safeguarding Children Board (LSCB) which aim to promote deeper reflection.
- Specific recommendations where there is a clear need for change.
- A strategy for dissemination which will enable learning to reach relevant practitioners and managers.
- Requirement for the LSCB for develop a response and action plan based on the learning from the SCR
- LSCBs need to find out whether learning has been sustained and what, if any, changes have been achieved
- Succinct summary of key learning, separate to the report

SCR Recommendations

Overall there has been an improvement in recommendations, however there is still a great variation in quality.

Recommendations must be specific and appropriate, but an emphasis on making them SMART may reduce professional judgement and add layers of prescriptive activity.

For recommendations to be effective they must be targeted at the LSCB or its constituent members

Action plans are the place for auditing and checking that recommendations have been achieved

Recommendations from analysis

The report recommends an approach that moves away from analysing whether serious harm could have been prevented, to recognising that there is always room for improvement in our systems. This involves understanding that children are harmed within a complex context of vulnerability but also knowing that there are many opportunities to protect them.

> For many of the children, the harm they suffered occurred not because of, but in spite of, all the work that professionals were doing to support and protect them.