SERIOUS CASE REVIEW RESEARCH

INTRODUCTION

The purpose of this briefing is to summarise the report "Analysing Child Deaths and Serious Injury through Abuse and Neglect: what can we learn? A biennial analysis of serious case reviews 2003 – 2005"

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BACKGROUND

Serious Case Reviews (SCRs) are carried out when abuse or neglect are known or suspected factors when a child dies (or is seriously injured or harmed), and there are lessons to be learnt about inter-agency working to protect children. The review should establish what improvements can be made to the way in which professionals and agencies work together to safeguard children and identify how these will be acted upon.

Every 2 years, the government commissions an analysis of all SCRs undertaken. This study by Brandon et al is the third overview analysis and examines 161 reviews notified between April 2003 and March 2005. The study looked at an "intensive sample" of a sub-group of 47 cases. A central theme of this review was to learn from the analysis of interacting risk factors present in the cases under review, and to transfer this learning to both everyday practice and to the process of SCRs.

Sinclair and Bullock's biennial analysis of SCRs (2002) identified recurring failings in elements of inter-agency working, in collecting and interpreting information, in decision making, and in aspects of relations with families. Their findings confirm that *"child abuse is rarely related to a single cause but rather to the interplay of several factors in particular circumstances"* (p.26).

In relation to family involvement, Sinclair and Bullock made the criticism that families were excluded from the SCR process and efforts have been made to redress this in *Working Together (2006).* In the present review, in 9 of the 47 cases studied in depth, families were involved in the SCR process.

KEY DATA

66% (106) of the 161 children died and 34% (55) were seriously injured.

47% of the children were aged under 1, but 25% were over 11 years, including 9% who were over 16. This is a reminder that older children are also at risk of death or serious harm.

Out of the 106 children who died, the combined number of children who died in the under 1 age group and 1-5 age group accounted for 66% (70). Surprisingly, there were more children aged 16+ who died than those in the 6 -10 age group. Nearly all of the reviews for those aged 16+ were undertaken where a young person had died, most notably as a result of suicide.

Among the various types of injury/harm, 35% of children were the subject of reviews due to a physical assault; 21% neglect; and 16% head injury (shaken baby syndrome).

12% (20) of children were on the child protection register. 12 out of the 20 registered cases were registered under the neglect category. This is a reminder that children living with the serious risks of harm are rarely within the ambit of formal safeguarding procedures. 55% of children were known to children's social care services at the time of the incident. 83% of the families had been previously known to children's social care.

74% of the children were white/white British, while 13% were black/black British, 5% Asian/Asian British, 6% of mixed ethnicity and 1% were 'other' ethnicities.

47% of the children were living at home with both parents, 20% living with a lone mother and 13% with one natural and one step-parent. The other children were in a variety of other living situations, eg relatives, foster carers etc.

5% of children were reported to have a disability.

A number of the children in the intensive sample had difficult beginnings to their life, with 19% recorded as having spent time in a special care baby unit.

In cases where the information was available, well over half of the children had been living with domestic violence, or parental mental ill health, or parental substance misuse. These 3 problems often co-existed. The potential impact should inform both assessment and intervention.

Themes Emerging from the Intensive Sample of 47 Cases

Cases tended to cluster into the following broad groups:

1. Neglect (15 cases)

2. Physical assault (17 cases)

3. Older children (aged 13 or over) & 'agency neglect' (15 cases).

None of these categories are mutually exclusive.

1. Neglect cases (15)

These were cases which had features of neglect in the circumstances leading to the review and in past history. They included cases involving 'overlying', illness, accidents, house fires, as well as other more commonplace indicators of neglect or emotional harm. Many of the families were well known to children's social care services over many years and often over many generations,

family histories tended to be complex, confusing and overwhelming for professionals. The families' problems were frequently compounded by poverty and poor living conditions. The difficulties in deciding when "enough is enough" in cases of neglect is well documented, and in the study there was evidence of workers feeling helpless and at times fearful of families, which led to avoidance and drift in decision-making.

The 'start again' syndrome is one way practitioners managed these dynamics. In these situations, little consideration is given to the parents' past histories and the focus is on present circumstances, leading to a lack of systematic analysis of parental capacity and the children's experience of harm. So, a new pregnancy or a new baby would be seen to present a fresh start. In one case, the child's mother had already experienced the removal of 3 children because of neglect, but her history was not fully used in considering her and her partner's capacity to care for this child. Instead, agencies were more focused on supporting the mother and the family to 'start again'.

There was evidence that behavioural approaches focusing on the present and family strengths were being used as part of the 'start again' syndrome. The principle of concentrating on strengths, and breaking down desired parental change into small achievable targets is appealing and appears to offer stigmatised families a chance to prove their ability as parents. However, although apparently successful for families with low level needs, this approach can have serious drawbacks when used with families with deeper more entrenches problems, not least the dangers of setting aside family history in the focus on the present and not taking into account a lack of progress.

Referral on to short term programmes can be a coping mechanism for practitioners and managers who feel overwhelmed by families. These programmes are unlikely to produce the long term changes needed in families to protect children from harmful impact of serious neglect.

2. *Physical assault cases (17)*

These were cases where physical assault was the cause of the death or injury and was also a dominating feature of the case. Almost half of the cases involved head injuries to young babies ('shaking injuries'). Most of the other physical assault cases related to children who were younger than 10 years. Although the profiles of these 17 cases shared similarities with cases where neglect featured, there were also important differences. The key difference in the physical assault cases was the presence of "volatility", which frequently erupted into violence. Involvement with children's social care services tended to be less, but there was often a history of a previous injury, illness or admission to Accident and Emergency for the baby or child.

3. *Older children (aged 13 or over) & 'agency neglect' (15 cases)*

This third group from the intensive sample of 47 were described as 'hard to help' older children. Most of these had a long history of involvement with children's social care services, some with periods of being looked after. Many had presented with very challenging behaviours after traumatic histories. Agencies often appeared to run out of helping strategies and "give up" on the young people. Arguments about which agency was responsible, including between adult and children's services, and whether thresholds for intervention were met, and failures to respond in a sustained way to the young people's extreme distress (eg, manifested as suicide attempts, self hard, sexual exploitation), often led to neglect of these extremely vulnerable young people's needs.

Suicide was the known or probable cause of death for 14 of the 161 children in the full sample and some of these cases were found in the intensive sample of 47 cases.

Domestic violence, substance misuse and mental health difficulties among parents and carers

The examination of the intensive sample of 47 reviews showed that families shared many similar characteristics, particularly in the preponderance of domestic violence, mental health difficulties and substance misuse among parents and carers. The reviews revealed that it was much more common for these features to exist in combination rather than singly. In over a third of the intensive sample there was evidence that all 3 factors were present.

ASSESSMENT

As with previous studies, assessments of the children and families were frequently deficient. There was some evidence of an accumulation of facts based on the assessment framework. But there was little evidence of a dynamic analysis of the interaction of protective and risk factors, including a hypothesis of the nature, origin and cause of the concerns that can be reviewed and evaluated in the light of new information. The authors acknowledge that "the recent use of the Common Assessment Framework and lead professional roles, has raised awareness of the possibility of staff from any agency identifying a child's needs for additional services so that early help can be provided. If staff from all agencies grasp the dynamics of interacting risk and protective factors they are more likely to understand the impact of different forms of parental behaviour on children and the risks of harm they might face. This approach may also help practitioners to decide whether it is more appropriate to carry out a common assessment or to simply report an incident, for example, of family violence".

They suggest the need for an "ecological transactional" perspective, which focuses on interactive risk factors. A key message is the need for practitioners undertake detailed, analytical and theoretically informed assessments that include the relationship and developmental histories and processes that have shaped people's lives. The authors comment that detailed descriptions of the parent's developmental, attachment and relationship history appear to be under-represented in the SCRs. Reflection on the emotional impact of the work on professionals is essential. The authors suggest that effective and accessible supervision is essential if staff are to be helped to put practice the critical thinking required to understand cases holistically.

Working with neglect

Many of the families where neglect featured were well known to children's social care services, mostly over many years. The histories of families where children experienced neglect were complex, confusing, and often overwhelming for practitioners. The authors suggest that practitioners from all agencies struggled to engage properly with children and parents in these circumstances and address the harm children were experiencing. It is recognised that neglect is notoriously difficult to work with in a clear, systematic fashion. The 'start again syndrome' prevents practitioners and managers from having a clear understanding of a case informed by the knowledge gleaned from past history which can be matched to present understanding. The authors state that the risks of recurring maltreatment are higher with neglect than other types of abuse. Also, that the policy emphasis on early intervention and prevention can make it harder for practitioners and managers to make difficult decisions about removing children from home in cases of severe neglect.

Key messages:

- Early detection of parenting difficulties is crucial so that timely help can be offered;
- Patterns of help seeking can be warning signs of parenting difficulties and abuse. These can include (for babies and young children in particular): admissions to Accident and Emergency, a history of injuries, or a history of illness;
- The families of very young children who were physically assaulted tended to have the least, or the briefest, contact with children's social care services which puts a greater onus on universal agencies to recognise signs of harm to children;
- Accessible early intervention programmes like Sure Start may be helpful in containing parental stress in families with less severe problems, while intensive and focused intervention can be effective for families with more severe problems;
- Hard to reach families need flexible, individually tailored services;
- For older children, including hard to reach young people, the effects of early maltreatment and trauma need to be acknowledged and addressed by all agencies working with young people and their networks;
- Staff in specialist adult services like substance misuse services, the police and adult mental health services must also prioritise children and work together with colleagues from children's social care services;
- Substance misuse, mental ill health and domestic violence may co-exist. Practitioners should understand that this may increase the risk of harm to children but does not predict serious injury or death.

Professional implications for Kent

1. Importance of practitioners appreciating the dynamics of interacting risk factors.
2. Importance of analytical assessments to include important issues in family histories. This would include detailed descriptions of parent's developmental, attachment and relationship history. The study noted in several SCRs, no formal assessment of parenting had yet been undertaken. Also, the accumulating evidence clearly pointed to the need for a comprehensive multi-agency assessment.
3. Chronologies on all agency case files are essential as contributing to multi-agency assessments. Lord Laming (2003) included chronologies as a recommendation in the Victoria Climbie Inquiry report.
4. Older children are at risk of serious harm too. Symptoms of how this may be manifested need to be picked up and services being flexible in their approach.
5. Agencies must not be defensive and argue about who has responsibility and be clear about thresholds of intervention.
6. Neglect has also been highlighted as a key issue in Kent. Local research linked parental substance misuse as being prevalent in neglect cases.

7. Shaken baby syndrome – A&E staff need to pick up the signs and assessment needs to be out into a wider context of risk assessment.

8. The Common Assessment Framework will prove of central importance in early intervention.

9. Supervision needs to be effective in talking through complex cases in order to help practitioners be clear about risk, methods of intervention and adequacy of progress.

Lord Laming said: "child protection cases do not always come labelled as such".

References

HM Government (2006) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children.*

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