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## Building on the learning from serious case reviews: a two-year analysis of child protection database notifications 2007-2009

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### INTRODUCTION

Serious case reviews (SCRs) are local enquiries into the death or serious injury of a child where abuse or neglect are known or suspected. They are carried out under the auspices of Local Safeguarding Children Boards (LSCBs) so that lessons can be learnt locally. Every two years an overview analysis of these reviews throughout England is commissioned to draw out themes and trends so that lessons learnt from these cases can inform both policy and practice. This is the 5<sup>th</sup> such biennial analysis of reviews, and it presents an analysis of 268 serious case reviews undertaken in England relating to incidents which occurred during the period 1<sup>st</sup> April 2007 – 31<sup>st</sup> March 2009. 152 (57%) of the children or young people died and the remaining 116 were seriously harmed.

The current review complements the two earlier biennial reports undertaken by the same authors, covering 2003-2005 and 2005-2007. Over the six years we have built up a dataset of 618 serious case reviews relating to incidents which occurred between 1<sup>st</sup> April 2003 and 31<sup>st</sup> March 2009. Being able to carry out three consecutive biennial analyses has provided helpful continuity, and has enabled us to develop a close understanding of serious case reviews and of the different sources of information kept in relation to these reviews and the child at the centre of the process.

### KEY FINDINGS

- There is a 43% increase in the number of deaths, and a 111% rise in the number of serious harm cases, which were subject to a serious case review between 2003-05 and 2007-09.
- The characteristics of the children, and their families, are very similar to those found in the earlier biennial reviews; there was, for example, a similar proportion of children with child protection plans, and a similar age range.
- Approximately half of all serious case reviews are in relation to babies under one year of age, underlining the importance of effective universal services provision for young children e.g. health visitors and early-years services such as Sure Start Children's Centres.
- A quarter of the reviews concerned older young people who are likely to pose a risk to themselves and/or others, and whose needs are not always recognised, or met.
- As in previous studies domestic violence, substance misuse, mental health problems and neglect were frequent factors in the families' backgrounds, and it is the combination of these factors which is particularly 'toxic'.
- While more than three quarters of the children were killed or harmed at home, just over one in five incidents (21%) took place in a 'community context'.
- The incident that prompts a serious case review is not always preceded by practice failings.

- Little difference was noted between those notifications for serious injury which became a serious case review and those which did not.
- New ways of thinking about safeguarding practice emerged from the analysis over the six years. Other recurring messages are reminders about what is known about good practice.
- The ecological transactional approach to analysing information provides a theoretical framework for thinking about the dynamics of interactions between children, carers and agencies and the way that different risk factors for harm combine and interact to influence children's development and safety.

## **BACKGROUND**

This analysis is briefer than previous biennial reviews since it has been undertaken during a period of transition when new ways of carrying out national analysis to prompt better learning were being considered (Sidebotham et al, 2010). During these deliberations we have kept this biennial review modest and manageable, focusing primarily (but not exclusively) on the analysis of the child protection database notifications relating to all serious case reviews in the two year period. Since this is the third biennial review undertaken using the same methodology we now have six years worth of comparable data on *all* available serious case reviews. This amounts to a total of 618 cases, providing robust baseline material for any future analysis or comparisons.

The analysis of the brief information contained in the child protection database notifications provides little context to each case and tends to lose the reality of the children's experiences and the human tragedy that underlines each of these serious case reviews. For this reason, we have, additionally, carried out a very modest piece of qualitative analysis about the children and young people who died or were seriously harmed not at home but at a community level. This has gone some way to bringing more detail about the children and young people back into the foreground.

## **AIMS**

The objectives for the analysis of serious case reviews from 2007-09 were:

- To collate and describe data from the child protection database reports on all notifications which progressed to a SCR during this two-year period.
- To analyse the data to produce descriptive statistics and identify themes and trends.
- To consider the cases from the perspective of family-level harm or community-level harm.
- To provide an analysis and preliminary categorisation of cases of serious injury only (i.e. not child death cases), to complement the analysis previously undertaken on child death cases in the biennial report for 2005-07.
- To compare those notifications of serious injury cases which did and did not become a serious case review.
- To link the findings for 2007-09 to those presented in the 3<sup>rd</sup> and 4<sup>th</sup> biennial analyses, and to reflect on the emerging themes and how lessons can be learnt to improve the way that individuals and agencies work to safeguard and promote the welfare of children.

## **METHODOLOGY**

A mixed methods approach was used to carry out the inter-linking parts of the research. The initial task was to scrutinise all 675 notifications of incidents which had been made to the former Department for Children, Schools and Families, in order to identify those which went to a serious case review. Key information relating to each case was entered into a dataset, which was analysed using SPSS (statistical package for the social sciences).

A qualitative analysis of the community or family context in which harm occurred was undertaken, and the sub-sample of 55 cases of community level harm was explored in greater depth. A classification of the 116 cases of serious, but non-fatal, injury was also developed.

Case study vignettes were created to illustrate pertinent issues, and are anonymous and composite, being based on a number of cases which shared similar features. They provide a background to the case, along with learning and key messages drawn both directly from the reviews and from our own analysis and research knowledge.

An ecological transactional approach was used to provide a theoretical framework for thinking about the dynamics of interactions between children, carers and agencies and the way that different risk factors for harm combine and interact to influence children's development and safety. This approach weaves a dynamic, developmental attachment perspective into the analytic process.

Finally, the two previous biennial reviews were revisited to draw out the overarching themes and messages relating to the SCR process itself, recurring findings around the children, their families and agency involvement with them, and ways of thinking about safeguarding practice.

## **FINDINGS**

### **How many reviews were held?**

268 serious case reviews are considered in this biennial report, a substantial increase from previous biennial reports, particularly in relation to non-fatal incidents. There could be a number of explanations for this increase, including a lower threshold for holding a review, and our improved access to the total set of reviews. The growth in the number of reviews arguably diverts funds from operational services that can protect children. It has to be asked whether this increased cost, in particular for serious injury cases, is now beginning to outweigh the benefits to be gained from the learning,

On occasions there appeared to be some debate or confusion about which notifications should lead on to a serious case review, and when the in-depth analysis of serious injury cases was undertaken, it seemed that there was little to distinguish between those cases which progressed to a serious case review and those which did not. Despite notifications meeting the criteria set out in Working Together (HM Government, 2006), Local Safeguarding Children Boards (LSCBs) sometimes decided not to initiate a serious case review. Instead, an alternative review was occasionally proposed as a better method of learning lessons; for example a 'lessons learned review' or 'near miss review procedures'. The reports from these other processes for learning tend not to be published.

### **The children and their families**

152 children and young people died, and 116 were seriously injured or harmed. As in earlier studies, just under half (119) of the 268 incidents which led to a review related to a child who was under the age of one year, and nearly half of that group were aged under three months. The preponderance of very young babies in the cases highlights their vulnerability, particularly to physical assault, and the key role of midwives, health visitors and GPs. Fewer than one in ten of the children were aged between six and ten years old.

A quarter of the reviews (24%) concerned children and young people aged eleven years and over, who often posed a risk to themselves and to others, and whose often longstanding needs may not have been recognised and met.

As in previous studies domestic violence, substance misuse, mental health problems and neglect were frequent factors in the families' backgrounds, and it is the combination of these factors which is particularly 'toxic'. The incidence of these risk factors is, however, likely to be under-recorded in the notifications.

### **Was there agency involvement with the children and their families?**

At the time of the incident, 42 (16%) of the children were the subject of a child protection plan and a further 33 (13%) had been the subject of a plan in the past. Nearly a quarter (23%) of these plans recorded multiple categories of abuse, while nationally only 8% of child protection plans in England record more than one category. This further highlights the particularly complex nature of these cases, where there are multiple concerns.

While the majority of children were not on a legal order at the time of the incident, a total of 32 children were either the subject of a legal order or accommodated under section 20 of the Children Act 1989. Some further notifications recorded orders made under Youth Justice or mental health legislation. Most orders concerned older children who are especially hard to help and keep safe.

### **Community level violence and harm**

While more than three quarters of the children were killed or harmed at home, just over one in five incidents (21%) took place in a 'community context'. A qualitative analysis of these 55 cases produced learning in relation to themes connected with:

- Older young people - often engaging in risky adolescent behaviour including suicide and self harm, alcohol and drug misuse, street level violence and gang violence.
- Younger children – where there might be risks of harm from unsuitable carers, or harm by parents or inadequate staff care in supervised settings like hospitals. Some harm in foster and respite care was linked to unsatisfactory or neglectful care of disabled children.
- Sexual abuse in the community – where non-family members about whom there were known serious concerns visited the family, or where a known sex offender, who could be a person in authority, posed a risk of harm.

### **The characteristics of the 116 cases of serious injury and harm**

Most international studies of serious child abuse focus solely on child fatality, and the United Kingdom is unusual in combining reviews of cases where children are seriously injured through maltreatment with cases where children die. The previous biennial review for 2005-07 included a classification of child deaths, and in this review for 2007-09 a parallel classification of the 116 serious injury cases which progressed to serious case review was undertaken.

A five-fold classification was explored:

- 1) Physical assault accounted for 66 (57%) of the 116 incidents of serious injury, primarily inflicted on babies aged under one year within a family context.
- 2) Sexual assault was the primary concern in 20 (17%) of the 116 reviews, 17 of which related to girls. This was the form of harm most likely to occur outside the family setting.
- 3) Neglect was the primary feature of 14 reviews (12%), and occurred across all age groups. In contrast to the other categories of serious injury, most of these children (10 of the 14) had a current or past child protection plan.
- 4) Risk taking or violent behaviour by a young person characterised 9 (8%) of the cases, nearly half of which took place in a 'community context'.
- 5) Parental suicide attempt with the child, or the child witnessing a parent's murder featured in 7 (6%) of the reviews. Almost half had known child protection concerns.

Serious case reviews conducted for serious injury and harm are more likely to feature neglect and sexual abuse than reviews undertaken for children who die. Approximately three in ten serious-injury reviews arise primarily from neglect or sexual abuse, in comparison with only a very small number of the fatal reviews. However, neglect is an underlying feature in the majority of serious case reviews where children die.

## IMPLICATIONS FOR POLICY AND PRACTICE

Implications for policy and practice were drawn from all three consecutive analyses of serious case reviews (Brandon et al, 2008 and 2009) drawing on over 600 cases.

### Recurring findings with policy implications include:

- Just under half of the children at the centre of the review are not known to children's social care at the time of the child's death or injury, so safeguarding children really is 'everyone's responsibility'.
- It is particularly important that the responsibility for protecting babies and pre-school aged children is shared since two thirds of all serious case reviews concern children under the age of five (and half are for infants).
- Many of the cases over the six years clustered just below the threshold for services from children's social care and also at the boundary between 'children in need' and 'child protection' routes. There was often a hesitancy about whether or not this was a 'child protection case' and a preoccupation with thresholds and which professional group was 'responsible' for the child.
- More than half of the children were known to children's social care at the time the death or harm occurred. A sizeable minority of almost a third of the children had known child protection risks, with either a child protection plan at the time of the incident or in the past.
- The apparent uncertainty, on occasions, about which serious harm cases to bring to review, coupled with the increasing number of serious harm SCRs undertaken, prompts a consideration of taking serious harm cases out of the serious case review process. This would be in line with most other countries' enquiry processes into child death through abuse. This would not preclude the possibility of other kinds of reviews taking place for serious harm cases.

### Learning about the serious case review process

The 2005-07 study examined the serious case review process through 24 interviews with those closely involved with either the child, and his or her family, or the SCR process (Brandon et al, 2009, Chapter 4). In summary,

- **Scoping** of reviews needs to be managed carefully so that it is possible to make sense of the child and his or her circumstances and services offered within a current and a historical family context. Some areas kept the scoping timescale brief and manageable, but captured good information about the child and family through a succinct summary of early family history.
- **Family involvement** was becoming common practice and learning from the child death overview processes was helpful in normalising this. Reasons for not involving family members mostly revolved around delay prompted by ongoing court proceedings and family sensitivities.
- **Practitioner involvement:** None of the practitioners interviewed felt adequately involved in the SCR process or its subsequent learning. This did not help the lasting distress practitioners experience when involved with families where children die through abuse.
- **Embedding the learning** in practice was taken seriously. Examples of positive practice in monitoring recommendations and making them achievable were given. Dissemination of learning included briefing seminars, training events, newsletters and bulletins or brief reports outlining key issues.

## **Ways of thinking about safeguarding practice**

Some new ways of thinking about safeguarding practice emerged from the analysis over the six years. Other recurring messages are reminders about what is known about good practice.

**The ecological transactional approach** to the analysis provides a theoretical framework for thinking about the dynamics of interactions between children, carers and agencies and the way that different risk factors for harm combine and interact to influence children's development and safety. It helps us to understand parenting capacity primarily in terms of the caregiver's psychological sensitivity and availability to their child. A major predictor of poor parenting is a lack of understanding of the psychological complexity of children, especially babies. Parents' current resources and ability to keep their children safe are challenged by social and economic factors like poverty and community violence and other hardships which affect their capacity to be attuned and sensitive to their developing children. A dynamic ecological explanatory view of parent-child interaction should allow practitioners to spot warning signs of abuse at an earlier stage, based on less information.

**Building strong relationships** with children and families and compassion is crucial to reducing maltreatment, but trust needs to be placed with care, and 'respectful uncertainty' towards families, and interest and curiosity in their narratives, needs to be part of the practice mindset. To work with families with compassion but retain an open and questioning mindset requires regular, challenging supervision. Supervision also supports **sustained and dogged professional challenge** – the ability to question, with confidence and authority, professional colleagues both within one's own agency and in other sectors.

**Patterns of cooperation** for example hostility, non-compliance and deception by families were recurring themes. Persistent non attendance at appointments can be part of a pattern of non-cooperation and signal risks of harm. Non-attendance should not be an 'excuse' for professionals to close a difficult case. Hostility is not necessarily unchangeable and can be modified by practitioners' positive engagement and relationship skills.

**The 'start again syndrome'**, has proved a helpful way of conceptualising practice and decision making especially in cases of neglect. In these circumstances knowledge of the past is put aside with a focus on the present and on short term thinking. There may, for example, be an unfounded assumption that a new baby, or a different partner, presents an opportunity for the family to embark on a more successful period of parenting, without adequate professional reflection about whether the parental capacity to care for the child has in reality changed. This way of thinking and behaving tends to happen when workers are overwhelmed. 'Starting again' is a way of dealing not only with overwhelming amounts of information but also the feelings of helplessness generated by families, especially in long term neglect cases. This strategy prevents workers from having a clear and systematic understanding of a case. Starting with a clean slate can be prompted by a worker leaving (or being away on sick leave) or a new practitioner starting afresh to form an 'unprejudiced' view of the case. It can also be prompted by the courts rejecting applications for care orders and instructing workers to give families another chance to demonstrate successful parenting.

**Overwhelmed practitioners** formed a theme in the 2005-07 study (Brandon et al 2009, Chapters 3 and 4). The chaos, confusion and low expectations encountered in many families were frequently mirrored in the organisational response and in professionals' thinking and actions so that both families and workers were overwhelmed and failed to see or take account of the needs of the child. This also occurred in some serious case reviews where the child was also 'lost'. Practitioners who are overwhelmed not only with the *volume* of work but also by the *nature* of the work will struggle to think, understand, make good decisions and do even the simple things well.

**Efforts to think the best of families** were found where there was a reluctance to make negative professional judgements about a parent. Workers were keen to acknowledge the successes of the often disadvantaged, socially excluded parents who were using their services, and reluctant to see them as parents and judge their behaviour as harmful to the child. In cases where adult-focused workers perceived their primary role as working within their own sector, failure to take account of children in the household could follow.

**Flexible thinking** is needed about families and about the source of harm to children. There were examples of flawed professional judgement and rigid or fixed thinking in a number of cases from 2005-07 (Brandon et al 2009, Chapter 3). Once a view had been formed there is often a reluctance to revise a judgement about the family, or about individual family members. Thus a 'neglect' mindset could preclude the thought that the child might also be physically or sexually harmed; 'rough handling' injuries seen as less serious acts of careless parenting rather than as an indicator of much more grave underlying concern about physical injury; and father figures could be seen as 'all good' or 'all bad'.

## CONCLUSION

Throughout the three biennial studies we have emphasised the complexity of each child's circumstances and the consequent difficulties professionals face in making sound professional judgements. It is the individual *differences* in each child's case that pose the most challenges for understanding and hence for practice and decision making. The demands and the complexity of the task of protecting children and the importance of supporting professionals, especially social workers, to make sound professional judgments has been accepted by policy makers and, increasingly, the public.

Serious case reviews present a lasting testimony and memorial to children who die in horrific circumstances. This must be remembered in the deliberations about learning from these reviews.

## References

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### **Additional Information**

Copies of all of the reports can be downloaded free of charge at  
<http://www.education.gov.uk/research/>

Further information about this research can be obtained from Julie Wilkinson,  
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This research report was written before the new UK Government took office on 11 May 2010. As a result the content may not reflect current Government policy and may make reference to the Department for Children, Schools and Families (DCSF) which has now been replaced by the Department for Education (DFE).

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.