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Triennial Analysis of Serious Case Reviews (2011-2014):

Practice briefing for social workers and family support workers

June 2016

Introduction

This briefing is based on the findings of the *Triennial Analysis of Serious Case Reviews 2011-2014* (hereafter, 'the report') (Sidebotham et al, 2016), the fifth national analysis of serious case reviews (SCRs).

It highlights the key safeguarding issues, challenges and implications for practice that have emerged from analysis of the SCRs for those working in social work.

The briefing aims to support personal and team development, including in team meetings and training events and in supervision. It can also be used more broadly to strengthen reflection on organisational practice and service development.

The briefing is intended for social workers, family support workers and other practitioners who work in early help, with children in need and children at risk of child maltreatment or experiencing domestic violence and parental separation. It will also be relevant for child protection conference chairs, team leaders and family court advisors working in both public and private law.

This is one in a series of five briefings based on the findings of the report, each providing a summary of learning and key messages for different groups. The other briefings are written for:

- Local Safeguarding Children Boards
- Education practitioners
- Health practitioners
- The police and criminal justice agency practitioners.

Page references throughout the briefing are to the full report (Sidebotham et al, 2016).

What is a serious case review (SCR)?

- A Local Safeguarding Children Board (LSCB) commissions an SCR when a child has died in circumstances where abuse or neglect were known or suspected *or* when a child has suffered serious harm and there are concerns about the way agencies have worked together to protect the child.
- The purpose is to identify what happened and why so that systems to prevent harm to children and to protect them when serious harm has been done can be improved.
- SCRs highlight good practice as well as poor practice.

The report is based on a quantitative analysis of 293 SCRs relating to incidents that occurred between 1 April 2011 and 31 March 2014, and analysis of a sub-set of 175 SCRs (providing quantitative and qualitative data) for which SCR final reports were available (66 representative SCR final reports were also selected for further detailed qualitative analysis). The methodology is explained in a short PowerPoint presentation that accompanies the five briefings and is available at:
http://seriouscasereviews.rip.org.uk/resources

Working together

Working together is inherently complex. The highest risk cases are rarely obvious and may be known only to universal services or early help. Keeping children safe means working with the practitioners and services who see them most – nursery workers, teachers, the health visitor, as well as members of the family – and those who know the parents, such as the police, probation, adult mental health services, and drug and alcohol agencies.

National guidance emphasises that safeguarding is everyone's business, but the report identifies evidence of 'subtle hierarchies' within existing systems: information provided by social workers and health workers was often weighted differently to that from family support workers or nursery workers (p208); undue weight was sometimes accorded to medical opinion; and information from senior practitioners was not always challenged. Practitioners across professions tend to defer safeguarding responsibility to social workers: *Decision making in conferences was seen as within social workers' remit or that of the conference chair and non-social work professionals viewed social workers as ultimately responsible for child protection* (p208).

Multi-agency working could be particularly difficult as cases moved between primary and secondary services; opinions varied, eligibility was disputed and voluntary self-referrals were not pursued. Fluctuating thresholds within and between agencies also caused problems. Some parents and children felt they were left without the opportunity to build a relationship of trust with a practitioner over time.

- Work with vulnerable children outside the child protection system requires a rigorous focus on risk and vulnerability, clear plans with measurable outcomes, accountability, regular reviews and well-chaired meetings with circulated minutes.
- When making a plan, it is important to establish who is going to be working with the family and explaining what is happening; a team is important, but a trusted individual is vital.
- Despite their significance in statutory guidance, strategy discussions 'do not feature highly' in SCRs (p172). Children's social care should reflect on whether they are making best use of strategy meetings to plan investigations and share information: is their purpose clear, are the right people are invited, are minutes sent out quickly?

Referrals and information sharing

Lack of information sharing was an issue in 65 of the 66 SCR reports studied in depth; by contrast, the authors emphasise that in over ten years of analysing SCRs, they have not come across a single case where too much information sharing caused harm to a child (p166).

The report identifies some misunderstanding of legislation around data protection intended to facilitate information sharing (p168). When asked for information, practitioners were sometimes uncertain about what was relevant or were not given a clear explanation as to why inquiries were being made (p169). In some cases, family and criminal courts, the police, prison and probation services held crucial information about perpetrators' mental health, substance misuse or criminal history that was not shared either with children's social care or with health practitioners working with adults in the community.

In many SCRs, important information received by children's services from other agencies was treated as 'for information only' no action taken (p172) because it had not been formulated as a formal referral.

- Information sharing should be the default position for any information that has a bearing on child welfare (p167): *As such, the onus would be on the professional to make an active decision not to share information and to document their reasoning with reasons for any decision to withhold information clearly recorded.*
- Action should be taken in response to any information received relating to potential harm to a child, even if this is not presented as a referral.
- Communication is a two-way process: Where frontline workers express concerns or share information with child protection agencies but receive no feedback, their confidence in the process may be undermined. Child protection agencies must feedback promptly to referrers and others participating in safeguarding (p171).

Assessments

Thorough and comprehensive assessments contribute to effective decision-making and action to protect children. But while there was good practice in these cases, assessment was sometimes seen as a one-off event rather than an ongoing process, information was not always sought from key agencies and inter-agency tensions could affect the quality of the work (p175).

Practitioners *must actively strive to keep an open mind to different explanations for any presenting feature* and avoid the fixed thinking *whereby other possibilities are eschewed once one opinion has been formed* (p175). Even when a possible non-abusive explanation is found, this should not be assumed to confirm a child *has not suffered or will not suffer significant harm.*

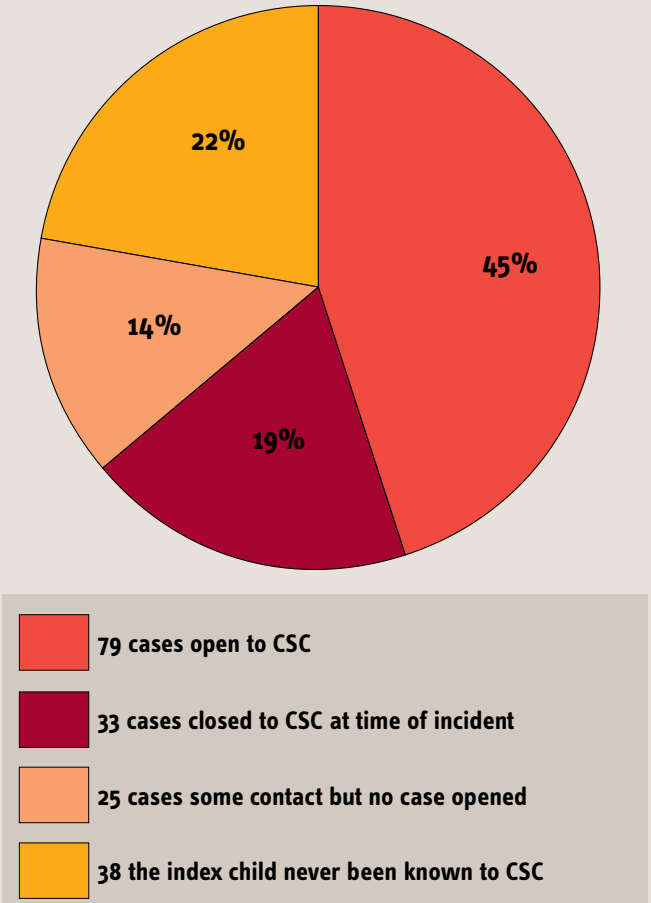
Early help assessments

When done well, the Common Assessment Framework (CAF) or other early help assessment processes can help explore risks and embed a holistic approach, but there must be clear thresholds and pathways for escalation and de-escalation. However, reliance on parental consent meant the CAF was not always used when it was needed (p14) and at times it was used inappropriately for problems like neglect and sexual abuse, which needed assessment from children's social care (p111).

- Practitioners 'must remain mindful of the ongoing nature of assessment' (p175): assessments must be updated regularly and the need for new assessments identified, and must include information from key agencies and family members.
- Supervision should be used to plan and review assessments, address confirmation bias and explore optimism about parental change.
- Assessment needs to look at the big picture, not just specific incidents. What are the underlying difficulties? What is the family history? What is it like to be this child?
- A child's behaviour, health or disability must be understood in the context of the parenting they are experiencing.
- Information from family and professionals needs to be carefully evaluated and analysed rather than repeated uncritically.
- Effective plans are those informed by needs rather than service availability.
- Decision-making needs to be explicitly recorded.
- A decision to take no further action, close or downgrade a case or defer a decision is as significant as an escalation.

Understanding vulnerability and risk

Children's Social Care (CSC) involvement with the families in the sub-set of 175 final reports



Most (55%) of the children and young people who were the subjects of these SCRs were not involved with the child protection system at the time of their death or serious harm. Almost two-thirds (64%) were or had previously been known to children's services; *and as such should be considered by agencies as having recognised and potentially long-lasting vulnerability or risk* (p13). 12% were subject to a child protection plan and a further 12% had been in the past (p45). A further 14% of children were below the threshold for a service; their referral had not been accepted, or an assessment had not led to a service, but they were 'on the radar'. Thus in 78% of the cases children's services were or had been aware of the child. In the remaining 22% of the cases children's services had never been alerted or involved (p53).

Most abuse is chronic and ongoing, causing cumulative harm and requiring lengthy intervention. A key challenge for practitioners is *the apparent normality of most abused children': they 'rarely stand out* (p68).

For those who were known to social care, risk assessments could be impeded by mistaking parental co-operation with services for evidence of change, accepting parental assurances uncritically, a focus on parental problems that obscured the child, a mindset that prioritised keeping families together at all costs, or dealing with each new incident separately without recognising cumulative harm or addressing the underlying issues.

- Practitioners must be persistent and vigilant to the child's needs, maintain ongoing support and pursue issues around non-engagement.
- Assessing risk requires an understanding of underlying issues and chronology, not just the current incident.
- Risk and protective factors in the parent and the wider environment need to be understood, with a focus on the impact on the child.
- Risk factors interact to escalate risk and may change unpredictably. Children suffer cumulative harm as risks persist over time.
- Significant change (such as a new partner or non-attendance at appointments) is a cue for reappraisal of risk assessment.

Vulnerability in children

Two age groups stand out as being particularly vulnerable to suffering serious harm as a result of maltreatment (p69): **babies** and infants; and **adolescents**.

Very young children are inherently vulnerable and some factors place them at higher risk of abuse and neglect – for example, premature and low birth weight babies and those requiring special care because of illness, and babies born with neonatal abstinence syndrome as a result of maternal drug misuse in pregnancy (p69). Of the 293 children who were subject to SCRs in the 2011-14 sample, 120 (41%) were less than 12 months at the time of their death, or incident of serious harm; and nearly half of these (43%) were under three months old.

By **adolescence**, the impact of long-standing abuse or neglect may present in behaviours that place the young person at extra risk of harm. Almost two-thirds of the young people aged 11-15, and 88% of the older adolescents, had experienced mental health problems. Self-harm and risk-taking behaviours such as substance misuse, risky sexual behaviour, gang membership and offending were common themes. Suicide and child sexual exploitation, two 'growing areas of concern' in relation to adolescents, are discussed later in the briefing.

Children and young people not in school, due to poor attendance or exclusion, can be especially vulnerable due to their 'invisibility' and social isolation. The report looks in detail at four SCRs where the child (or children) was **home educated**. For most families, home education will be 'effective and nurturing', but for some the choice *is in fact a guise to remove a child from public scrutiny, or a further component of neglect or emotional abuse* (p93). In all four cases there had been referrals to children's social care due to concerns about abuse and neglect, but they did not always reach the level of child in need and none reached the level of child protection (p94). Abuse included longstanding sexual and physical abuse, which might have been noticed within a school setting.

Children with a disability or additional health needs are a particularly vulnerable group as signs of abuse and neglect may be masked by, or misinterpreted as due to, underlying impairments (p71-72).

The report also identifies **social media and virtual relationships** as areas of risk for young people in these SCRs review which did not feature in earlier national analyses (p91). The internet and social media provided opportunities for grooming and bullying and for adults to communicate inappropriately with children.

Risk factors in adults and families

A wide range of risk factors in the parents' backgrounds may raise potential risks to the child, including:

- domestic abuse
- mental health problems
- drug and alcohol misuse
- adverse childhood experiences
- a history of criminality, particularly violent crime
- patterns of multiple, consecutive partners
- acrimonious separation.

These factors appear to interact with each other, creating cumulative levels of risk the more are present (p77). Other potential risk factors include young parenthood (p73), maternal ambivalence about pregnancy and poor ante-natal engagement (p74) and large family size (p75). Additional factors include poor housing (p87), transient lifestyles (p88) and social isolation (p88), which can be a particular issue for immigrant families.

Dealing with uncertainty

Contested accounts, vague or retracted disclosures, deception and inconclusive medical evidence are common in child protection and practitioners are often presented with concerns *which are impossible to substantiate* (p176). In such situations, 'there is a temptation to discount concerns that cannot be proved'. A child-focused approach means it is important to remain mindful of the original concern.

> *Local teams need clear procedures that respond to the needs of children and families when the threshold for child protection is not met or concerns are not substantiated. In situations where concerns have been raised it is likely that the family will have ongoing needs.* (p177)

The last few years have seen an increasing emphasis on the use of standardised tools as a means to reduce uncertainty. However, tools 'vary in their effectiveness, value and type', and in some cases professional practice became focused on completing the task as an end in itself (p197), rather than using the tool to inform work with the child and family.

- 'Unsubstantiated' concerns and inconclusive medical evidence should not lead to case closure without further assessment.
- Retracted allegations still need to be investigated.
- The use of standardised tools can reduce uncertainty, but they are not a substitute for professional judgement; results need to be collated with observations and other sources of information
- Social workers are responsible for triangulating information (p170) – seeking independent confirmation of parents' accounts and weighing up information from a range of practitioners, particularly when there are discrepant accounts. The weight given to different sources should be made explicit in investigation and assessment.

Responding to poor engagement

Many of the families in these cases had a history of poor engagement with social work and other services. Failure to attend medical or other appointments or a lack of take-up of supportive services sometimes prompted case closure when families were known only to universal services or classed as child in need cases (p249). Parental non-engagement was sometimes regarded as a legitimate 'choice' and repeated excuses for non-attendance were accepted without challenge.

The authors suggests services consider a shift in terminology from DNA ('did not attend') to WNB ('was not brought'); this will maintain focus 'on the child's ongoing vulnerability and dependence, and the carers' responsibilities to prioritise the child's needs' (p147).

Child protection involves mainly involuntary clients who may be reluctant to work with practitioners for a range of reasons. Some children were left at risk because of an over-reliance on family members to follow up recommendations, such as seeking help from other agencies. In some cases, such plans are appropriate and respect parental autonomy, but there can also be risks inherent in this approach. Individuals may not recognise the risk to their child, be unwilling to act, perceive the recommended service as unhelpful, lack the time or money to attend, be restricted by coercive control from a partner or not understand why an intervention is needed.

The report identifies some over-reliance on working agreements, which sometimes lacked 'rigour and clarity' leaving parents *uncertain of expectations and plans* (p154). The extent to which parents genuinely consented to such agreements was sometimes questionable, given that they were often fearful their child would be removed if they did not co-operate. Barriers to clear expectation identified in some SCRs were parents not speaking English or not being able to read well (p251).

- Cases should not be closed or stepped down on an untested assumption that effective help is in place.
- Cases may need to be stepped up to child protection if help is not accepted or doesn't work.
- Non-attendance should not lead to case closure without reviewing risk and sharing this information.
- Repeated excuses or a pattern of cancelling and re-scheduling appointments need to be challenged and concerns about this made explicit in assessments.
- Written agreements need to be in plain English and not used as a substitute for legal action or calling a child protection meeting. Parents need time to think about the situation and take legal advice before they sign an agreement.

Listening to children

Many of the children were either too young or not able to tell anybody in words about what was happening to them at home. Assuming that non-verbal children cannot communicate increases their vulnerability. Many adolescents find it difficult to talk to adults and will struggle to express their needs or feelings (p135).

Disabled children were more vulnerable when practitioners lacked the skills to communicate with them, or indicators of abuse (eg, physical injury, developmental delay, challenging behaviour, poor growth) were attributed to their disability (p71). Some parents actively deflected attention from safeguarding concerns by focusing on health matters (p72). In some cases, practitioners under-estimated the practical, emotional and financial demands on parents of disabled children and there was *a lack of consideration given to the impact of the disability on how the family functions* (p72).

Social work and family support practitioners should:

- Reflect on *how best to enable children to express their views while taking account of the child's age, development, and language* (p133).
- Expect children to find it hard to talk and so take responsibility for communication.
- Be careful about where they talk to children (who else is around?).
- Be alert to non-verbal communication, particularly with disabled and very young children.
- Make time to play with children in order to understand their worlds – observation and play are central to child protection work (play is particularly useful if children do not speak English).
- Observe children within the home: *An active effort must be made to actually see children in their families* (p134).
- Understand 'difficult' or 'demanding' behaviour in the context of the child's experiences over time and in the context of their current parenting.
- When dealing with reports of frightening adult behaviour (eg, drug use, self-harm or violence), ask themselves: 'What is it like to be this child in this house?'.

Working with the extended family

Extended family can members play a crucial part in protecting children by supporting the child, sharing information, contributing to assessments and helping to make plans. Building trust with extended families can help to protect the child. However, the reality of support from family needs to be tested – it may be absent or risky:

> *What is essential in working with any extended family is not to make assumptions about their presence or how supportive they may or may not be, but to test those assumptions through appropriate evidence gathering and assessment* (p89).

Extended family members had sometimes known about maltreatment for a long time before they raised concerns. This was for a number of reasons (p156): not knowing who to talk to; fear of damaging their relationship with the parents; fear of the perpetrators; fear that the child would be removed or distrust of child protection services. In some cases, extended family members were covering up abuse.

In some cases, social workers missed opportunities to seek the views of extended family members when carrying out investigations and assessments or failed to take their concerns seriously. Responsibility for protecting the child was sometimes inappropriately deflected back to the family in situations requiring professional intervention (p157).

- Extended family members need reassurance and information about what will happen next and feedback about the outcome.

Domestic abuse and parental separation

The report found improved practice in response to domestic abuse, with better systems in place to enable women to disclose and more awareness of the risks to children. However, it also notes:

> *The impact of all domestic abuse is harmful to children and 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 of coercive control and its impact on women and children.* (p12)

Domestic abuse was a factor in more than half of the SCRs, and in the lives of nearly all the children who died as a result of overt filicide (p78). Many children experienced domestic violence towards their mother from a succession of partners (p77). Mothers often lived with men who exercised coercive control over many aspects of their lives; in some cases, an incident-focused response failed to take into account how this affected them and their children (p80). Controlling or coercive behaviour in intimate or familial relationships is now a criminal offence (Serious Crime Act 2015); use of that legislation needs to become embedded in responses to domestic abuse.

Many mothers suffered cumulative harm that made it difficult for them to disclose the abuse, access services, leave a violent man or protect their children. Assurances that a violent man has changed or does not present a risk to the children should be treated with scepticism (p81); violence does not usually stop without intervention.

Separation from a violent partner is a time of increased risk but services were sometimes withdrawn. Abuse regularly continued after separation (which was often acrimonious) and focused on contact issues. In some cases, restrictions on paternal contact appear to have triggered the fatal assault on a child (p79). Domestic violence may also have been a factor in two cases in which a mother took her own life and those of her children, apparently in an attempt to escape an impossible situation (p79). Parental threats or reported fears about suicide or harm to the child in the context of acrimonious separation need to be taken seriously.

Some children were involved in private law proceedings and it was difficult for social workers to find out what was going on in children's lives when their parents were embroiled in conflict over contact (p157). It could be particularly difficult for non-resident fathers to get their voice heard when they tried to raise legitimate concerns, which could be dismissed as malicious.

- Most serious and sustained violence is perpetrated by men. However, social workers need to keep an open mind – both men and women perpetrate domestic violence and mutual violence is relatively common (p79).
- Couples need to be seen separately and together; this requires safe, accessible interview rooms.
- Work with violent men is essential to keep children safe at every stage.
- Parental insight into the harm caused by domestic violence does not guarantee safety for their child.
- Separation is a period of increased risk for women and children. Services should not be withdrawn at this point and adult victims need access to supportive services.
- The needs of children involved in private law proceedings as a result of acrimonious separation must be prioritised over those of either parent.
- Reports of child maltreatment by either parent in the context of private law proceedings should be investigated; post-separation allegations can be malicious *and* true.

Adolescents

The report looks in detail at SCRs relating to adolescent suicides and child sexual exploitation (CSE), *two growing areas of concern* (p99).

Suicide

The report looks in detail at 17 SCRs for which final reports were available relating to suicide among 11 to 18-year-olds, as this was the largest single cause of death in that age group. Loss and rejection were common threads in lives characterised by parental conflict and separation, domestic abuse and parental substance misuse. In one in three cases, the young person had spent time in care, a young offender institution or a Tier 4 mental health unit. Almost half the SCRs recounted instances of the young person going missing, which often indicated *a sense of hopelessness and a lack of control* (p107). Feelings of hopelessness and isolation were often compounded by school absence and exclusion.

Many had either chosen or been forced to move out of home, which led to transient lifestyles, short-term 'sofa surfing' and periods staying with friends (p112). Some who had been looked after moved into independent accommodation, but this often increased their sense of isolation and loneliness *after a life of changing placements and instability* (p113). Other young people had taken on the role of being a young carer, but the strain of the role was not always adequately recognised. One young carer was discharged from CAMHS *in spite of clear vulnerabilities … and with no resolution of the problems* he was facing (p107).

At the time of their suicide, just over half of these cases were open to children's social care; in all but two of the 17 cases, the young person was involved with CAMHS. For some young people, mental health problems had developed relatively quickly (over months); however, most had displayed behaviour indicative of underlying mental health issues over a long period of time.

While it may not always have been possible to foresee that a young person's life would end in suicide, there were *many indicators of the high risk of serious harm to themselves and therefore a clear need for more sustained support* (p110). Opportunities for prevention did arise at different times, but in order to adequately protect against and prevent suicides, multi-agency work is required, with an emphasis on relationship based practice. This should be *consistent, holistic and available over a long period of time*, preferably on the young person's own terms (p119). Self-harm and/or suicide attempts preceded all but one of the suicides *and should be taken seriously whenever they occur* (p119).

- Expressions of suicidal ideation and self-harm should always be taken seriously.
- When there is family conflict, it is important to support the young person as well as the parents.
- A young person's current behaviour needs to be understood in the context of family history.
- Education is key for vulnerable young people – exclusion from school can represent a crisis.
- Homelessness significantly increases the risk of suicide for young people who are feeling lonely and hopeless.
- Vulnerable young people need a high level of support when leaving home or care and moving into independent living.
- Arranging housing for looked after young people is a vital child protection task.
- Young people appreciate ongoing support from one key person, but agencies need to work together to support vulnerable young people and review plans regularly.

Child sexual exploitation (CSE)

There has been significant progress in the recognition and response to CSE by child protection and other practitioners during and since the period covered by the report. There were seven cases involving CSE in the report. Two of these focus on a small number of children who were considered representative of a much larger group of young people exploited in the same area.

These young people's histories had much in common with those who took their own lives. They had often experienced a lack of parental protection, abandonment and rejection, low self-esteem and a pattern of seeking affection and approval in risky situations (p121). Some young people grew up in areas in which CSE had 'become the norm' (p122).

The impact of these histories was often lost as the focus shifted to the young person's behaviour. Agencies losing sight of young people's vulnerability and making assumptions about their ability to remove themselves from harm was a common feature of SCRs involving CSE. The impact of CSE was often 'missed or misunderstood' by practitioners and overall there was *a lack of understanding by professionals of the dynamics and prevalence of CSE* (p123).

Young people's *disruptive, sometimes sexualised, often challenging and occasionally intimidating behaviour* (p124) was misinterpreted by practitioners. In one case, sexual health workers were the first practitioners to 'name' what was happening, but children's social care *concluded that no strategy meeting or assessment was necessary nor was any action required other than offering support* (p124).

The serious case reviews relating to CSE highlighted the critical importance of relationship-based practice with young people. Developing a relationship may dissipate resistance to engagement and begin the process of enabling a young person to recognise the dangers they may think they are 'making choices' about. Self-worth is built from a sense of being loved and lovable; this may begin the upward spiral of building resilience and a sense that they deserve better.

- CSE can happen anywhere, to anyone.
- Language matters in CSE and inappropriate language must be challenged: naming what is happening as child sexual exploitation is important.
- Power is a key issue in CSE. When young people appear to put themselves at risk willingly, this needs to be understood in terms of coercion, grooming and fear of the consequences of refusal, as well as the urgency of unmet emotional needs.
- Consistent support from specialist workers is key to protection.
- Concerns raised by parents or workers from other agencies must be taken seriously.

References

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