Triennial Analysis of Serious Case Reviews (2011-2014):
Practice briefing for Local Safeguarding Children Boards

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). The full report and a short PowerPoint presentation on the methodology for analysis are available at:
http://seriouscasereviews.rip.org.uk/resources

Analysis of recent SCRs provides important pointers for LSCB Chairs and Board members when fulfilling their statutory duties (set out in *Working Together to Safeguard Children* 2015). This briefing summarises key messages for Local Safeguarding Children Boards (LSCBs), LSCB Chairs, Board members and Business Managers and provides recommendations for action by LSCBs in overseeing the following areas of practice:

> Setting thresholds for intervention

> Developing policies and procedures

> Monitoring and evaluating the effectiveness of services

> Multi-agency training

> Raising awareness of safeguarding

> Supporting information sharing

> Conducting serious case reviews.

This briefing focuses on the strategic changes LSCBs can make in response to the findings of SCRs. Four other briefings in the series set out in more detail learning for practice in individual agencies:

> Education practitioners

> Health practitioners

> The police and criminal justice agency practitioners

> Social workers and family support workers.

Page references attached to quotations and specific cases in the briefing are to the full report (Sidebotham et al, 2016).

The role of Local Safeguarding Children Boards in implementing learning from serious case reviews

The report highlights the important role played by LSCBs in improving systems in response to SCR findings. The authors recommend that the majority of recommendations or learning points in good quality SCRs should be aimed at the LSCB and the strategic leaders from different agencies who sit on that Board.

SCRs should not simply identify weaknesses in practice, but should identify the systems and support that organisations offer to practitioners to enable and realise changes in practice. This includes:

> Building effective structures (p185)

> Coping with limited resources (p193)

> Establishing workable processes (p196)

> Embedding responsive cultures (p200).

Setting thresholds for intervention

Setting thresholds is a crucial responsibility for LSCBs, but this cannot be only about the process of writing a document and expecting it to solve all problems. There are potential pitfalls in how practitioners interpret thresholds:

> Different practitioners can perceive thresholds differently due to variations in professional culture.

> Perceptions of thresholds are not static and can fluctuate over time due to *workloads, professional backgrounds, new or emerging understanding, or political or cultural expectations* (p173).

Agreeing when thresholds have been met for young people to access specialist services appears to be particularly problematic. As in previous national analyses of SCRs, the report highlights differences in perceived thresholds between referring practitioners and children's social care. The authors emphasise that where a practitioner feels their concerns have not been understood or acted upon, they have a duty to escalate those concerns through their agency or LSCB channels (p248).

Thresholds for closing a case to children's social care can be as risky as thresholds for accessing support in the first place.

> Some risk factors for significant harm, such as neglect or domestic violence, are long-term issues but an incident-led approach to assessment of risk can lead to these cases being closed without ongoing monitoring or support being put in place.

> Case closure due to parent or carer non-engagement with 'child in need' services should be accompanied by an assessment of ongoing risks of harm to children.

LSCBs should manage the risks associated with the application of thresholds by:

> **keeping threshold decisions under review, as circumstances change or new information presents new risks, or where low-level concerns persist over time**

> **providing practitioners with mechanisms through the LSCB to challenge threshold decisions with which they disagree.**

Developing policies and procedures

Building effective structures
Setting thresholds is only the beginning of designing a system of proportionate and effective services for children and families.

The number and range of bodies and providers of services for children and families, from universal through to more specialist services, can make it particularly challenging for families to access the right services at the right time. So ensuring good relationships and communication between services is vital to prevent families falling through the gaps.

Care pathways need to be coordinated and clear, and need to have built in systems for review and updating, particularly when underlying structures change. (p189)

Gaps can occur between:

> **primary care (universal) services for different age groups,** for example, in the transition between midwifery services and health visitor services, and between health visitor services and school nurses

> **primary and secondary care services,** here issues about eligibility and availability of secondary services, and reliance on voluntary self-referral to more intensive services, can contribute to families not getting the help they need

> **emergency responses to individual incidents and referral for more thorough assessments of longer-term safety and welfare,** for example, when police respond to domestic violence incidents or when infants are presented with injuries at accident and emergency departments.

LSCBs should:

> **keep the changing service delivery landscape under review**

> **ensure that transition procedures support timely information sharing.**

Establishing workable processes

Bureaucratic processes are implemented with the intention of forming a robust and replicable mechanism around professionals and families to ensure best practices are upheld... However, the rigidity of these processes may at times be incompatible with the realities of how services operate and are accessed. (p196)

Processes and procedures are often the subject of recommendations in SCRs. However, the authors provide a note of caution about too rigid a focus on procedures. Procedures need to be carefully designed and supported by a culture in which *doing the right thing* is more important that doing things the right way. Following procedure can become a task in its own right, rather than a tool for guiding work with families.

Too rigid a compliance with procedures can:

> lead to missed opportunities for identifying vulnerability

> create a disincentive for acting outside of the usual processes (eg, in one case a GP practice removed a mother and her children from their list because of a persistent lack of response to routine appointments, when seeing the child before removal would have provided evidence of the child's malnourishment: p197)

> when combined with human error (eg, failure to send a specific form) lead to families' needs not being met.

In relation to assessment, an over-reliance on procedures can be particularly damaging due to:

> *variation in the effectiveness, value, and types of assessment tools available* (p197)

> practitioners focusing on 'filling in the boxes' rather than taking a holistic view of the child or family

> failure to scrutinise the validity of information put into the assessment, leading to biased judgements.

When assessing risk and vulnerability, practitioners need to 'think outside the box', take a holistic approach to the child and family and maintain an alert sense of professional curiosity.

Good practice example

The core assessment completed by children's social care was a key document that defined and guided the work of children's services. As a tool it provides a structured framework for children's social care to record information gathered from a variety of sources to provide evidence for their professional judgements, facilitate analysis, decision making and planning. (p174)

Effective early help assessments and planning processes support referrals to children's social care by providing clear reasoning for the referral and sufficient background information for social workers to assess the level of risk. (For more on effective early help, see *Monitoring and evaluating effectiveness of services* below).

Procedures are only as good as the systems in which they are applied:

> Staff need to be familiar with procedures and comfortable using them.

> Procedures should be reviewed regularly to ensure 'fit' with the wider system and that they are aligned across agencies.

> Where IT systems support the implementation of procedures, for example by highlighting missed appointments, these should be reviewed to ensure they operate effectively across agencies.

> There should be a clear escalation process for staff concerned about the impact of procedures on specific cases.

LSCBs should:

> **consider how procedures and guidelines are communicated to staff**

> **regularly review procedures in light of experience and changing structures**

> **ensure staff know how to comment on, and contribute to changing, procedures that present barriers to working effectively with children and families and with other agencies.**

Monitoring and evaluating the effectiveness of services

Coping with limited resources

Resource constraints are frequently mentioned in SCRs, although it is unclear whether this is a new issue resulting from funding cuts and increasing demand, or simply a new focus on systemic issues when examining the causes of failings.

What is clear is that high caseloads are one of the most common consequences of a lack of resources.

High and unmanageable workloads can result in delays in provision of services, higher thresholds for accepting referrals, or a lower level of service being provided. In particular, agencies often adopt short-term pragmatic solutions, rather than consider the ongoing needs of families... This can also lead to a lower quality of working, with practitioners not having sufficient time to complete tasks appropriately, or taking short-cuts in order to manage their workload. (p194)

Building relationships with families and listening to children can be challenging when caseloads are high or staffing is unstable. This is particularly apparent when working with young people, who value help that is *consistent, holistic and available over a long period of time on their own terms if possible* (p119).

System design can mitigate some of the effects of higher caseloads. **LSCBs should monitor the use of resources across agencies. This should include:**

> **monitoring caseloads and their impact on practice**

> **ensuring opportunities for critical reflection through supervision**

> **examining levels of administrative support available to practitioner teams**

> **scrutinising the allocation of cases to trainees or junior members of staff and the additional support put in place.**

Overseeing effective early help services

The report highlights the need to provide preventative services to prevent risk factors and vulnerabilities from escalating into harmful acts or omissions that cause serious harm.

It is clear that significant opportunities for protecting children lie in preventive interventions within the community and by universal services. Such opportunities arise through recognising and managing risk and vulnerability, and through promoting resilience in children and families. (p133)

Practitioners in universal and targeted services can play an important role in identifying and acting on risks and vulnerabilities. The authors point to the following risk factors and early indicators of abuse and neglect identified in research literature:

> poor engagement with services

> repeated 999 calls

> adults with learning disabilities, which may impair their capacity to parent appropriately

> parental mental health difficulties

> criminal behaviour, particularly violent crime

> domestic abuse

> housing issues, including overcrowding

> parental beliefs and practices, including home education.

Practitioners in universal and targeted services will need to hold cases where there are *potential* risks, rather than actual current risks. In order to do so safely, they will need to:

> offer support for low-level needs

> be aware of changing circumstances that may increase risk

> listen to children and provide opportunities for disclosure

> be aware of the parenting or carer responsibilities of adult clients and the potential risks those adults may pose to children

> be confident in discussing personal relationships with parents (eg, the possibility of domestic abuse) and assessing their impact on children

> listen to and engage with wider family members and recognise the impact of isolation from wider family networks

> make referrals for specialist services where needed, rather than rely on adults or young people to self-refer, and monitor actions taken by individuals to seek out further support.

Processes for assessing need and offering help below the threshold for social care can be unclear, however. Failure to meet a threshold for specialist services should not result in a less rigorous process of assessment and service provision.

The report recommends that procedures for multi-agency meetings and assessments below the threshold for social care should have:

> a clear structure and format

> an assigned chair

> opportunities for full and frank information sharing

> an appraisal of risk and vulnerability

> recorded minutes that are shared with the group

> result in a clear plan with assigned accountability and measurable outcomes.

Engaging specific groups of practitioners and services

LSCBs have a critical role in engaging specific groups of practitioners with safeguarding activity, particularly those agencies where safeguarding and promoting welfare is not their core activity.

General practitioners (GPs)

The engagement of GPs in both reporting safeguarding concerns and in offering early help is highlighted as an opportunity, but also as a challenge. There need to be clear shared expectations about what GPs are expected to do as coordinators of care and as the link with secondary care services. (For more discussion see the briefing for health practitioners).

Housing

For adolescents, including those over the age of 16, rules and decisions about housing and accommodation appear regularly as a factor contributing to the vulnerability of young people (e.g. an SCR involving a young person's suicide p112). In particular:

> Housing decisions are often made at a moment of crisis and then not reviewed until another crisis arises.

> Eligibility for housing can be dependent on parents not being willing to accommodate the young person, regardless of the young person's wishes or feelings.

> A lack of housing options for young people over 16 can lead to them being housed with adults, which can put them at increased risk.

Secure settings

In a number of SCRs concerning adolescents, the young person had spent time in custody. A lack of information sharing about what had happened during the custodial sentence led to missed opportunities to identify risks and potential protective factors on release.

In one case, a young person had disclosed past abuse (p116) and in another the young person had formed an interest in religion, a potentially protective factor (p109-110). However, in neither case did these relevant issues form part of the plan for the young person on release.

Probation services

Probation services hold significant information about adults who may pose a risk to children. They conduct assessments focused on the risk offenders pose and these should take into account the access offenders will have to children. These assessments will be updated and may be the first to identify changes in circumstances that affect the level of risk, such as a change of address to a household that includes children.

Probation officers often also have access to assessments conducted during the court process or while an offender is in custody, which can support assessments of parenting capacity and risk, such as mental health assessments or information about substance misuse. This information is not always shared appropriately. (See also the briefing for practitioners working in the police and criminal justice agencies).

> **LSCBs are well placed to engage services that may not understand their role in safeguarding children. They should help those services consider how they can contribute to the shared goal of keeping children safe.**

Multi-agency training

Training programmes can help to raise awareness of specific risks and vulnerabilities and the report finds that most recent SCRs suggest a good awareness of risk factors, particularly in universal services. However, applying this knowledge to assess vulnerability, rather than simply making a referral to social care for further assessment, may require more in-depth training and supervision. Practitioners in universal and targeted services need to be aware of the underlying potential risks in cases where current risk does not justify social care involvement.

Assessment and analysis training should highlight parental characteristics and behaviours that increase the vulnerability of children. The role of the potentially high-risk combination of substance misuse, poor mental health and domestic violence continues to be highly relevant. However, the analysis also highlights the risks associated with:

> young parents

> maternal ambivalence, and the possible significance of a failure to engage with universal services

> parents' adverse childhood experiences

> relationship difficulties, including acrimonious separation and patterns of multiple consecutive partners

> bereavement and loss and the effect of these experiences on parents

> a history of criminality, particularly violent crime.

Wider environmental factors should also be considered in assessment, including:

> social isolation

> social deprivation

> transient lifestyles

> overcrowded housing or unsuitable housing.

Safeguarding training should raise awareness of different needs and risks associated with adolescence, the increased risk for young people who are exposed to multiple risk factors and understanding risky or challenging behaviour as a sign that a young person may need help.

Domestic violence training should ensure that practitioners understand coercive behaviour and its influence on the victim's ability to disclose and to keep their children safe after separating from the abusive partner.

Training for all teams, including disabled children teams, should ensure practitioners are alert to:

> the emotional stress placed on children, young people and their parents when coping with disability

> the possibility of maltreatment and being wary of attributing potential indicators of maltreatment to the child's disability

> the difficulties in communicating with disabled children and the behavioural cues that might communicate distress.

The LSCB should review all current training programmes to make sure the content reflects up-to-date lessons from this triennial analysis of SCRs.

Awareness raising about safeguarding

The report's analysis of child sexual exploitation (CSE) cases subject to the SCR process highlights the role of potential agency and community preconceptions about 'normal' sexual behaviour in failures to respond to concerns. This includes misunderstanding the extent of young people's agency, leading to victim blaming rather than offering help.

If this sense of helplessness in the face of young people living with brutal and traumatising experiences is to change it will need an absolutely clear and consistent message from the highest level of the agencies that if this experience is not acceptable for our own children, it will not be acceptable for any children. (Quoted from an SCR, p132)

Social media increases vulnerability by providing opportunities for *grooming, for bullying, and the exchange of inappropriate photographs, and for access to information and items to purchase* (p91). The rapid development of online activity and social media platforms can be confusing for parents, practitioners and organisations. LSCBs should play a role in raising awareness of online risks to children and young people.

The report also highlights the crucial role that wider family members and members of the public can play in raising concerns and providing information to inform assessments of risk. Clear communication of safeguarding work, including how to make a referral, the nature and consequences of child maltreatment and the support available to families will encourage family members and others to come forward with information.

The LSCB should develop a communication strategy aimed at practitioners, parents and the wider public that addresses safeguarding concerns in the community and offers advice on managing online activity to keep children safe online.

Supporting information sharing

Good communication is essential for collaboration... Such communication requires a combination of practitioner skills, effective facilitative systems and a culture that promotes information sharing for the protection of children. (p165)

A lack of information sharing was identified as an issue in 65 of the 66 SCR reports that were studied in depth. The prevalence of problems around sharing information suggests that a lack of information sharing is a systemic issue of *deep cultural barriers* (p167), rather than a lack of awareness about the need to share information: *... our professional, legal and political cultures continue to emphasise the right to privacy* over the safety of children (p168).

This *'default position'* of not sharing information runs the risk that no practitioner has *a comprehensive overview that would enable appropriate risk assessment* (p167) and hinders efforts to triangulate and corroborate information gathered from other sources, particularly parental accounts.

An alternative position... would be to presume that any information that has a bearing on child welfare should be shared with other professionals unless there is reason not to. As such, the onus would be on the professional to make an active decision not to share information and to document their reasoning (p167).

The report identifies several systemic issues that are barriers to good information sharing and proposes some solutions (p169-170):

Constraint or barrier	Opportunities for improvement
Fragmentation of services	Where services operate from different settings or under separate management structures, clear internal information sharing pathways and agreements can enable effective intelligence flows.
Lengthy processes for sending information	Permitting direct information sharing in safeguarding cases instead of relying on slower routine methods (perhaps through third parties) can ensure the information gets to the right people quickly, allowing them to act.
Reliance on paper records for information sharing	To support the previous point, in sharing safeguarding concerns, best practice should be to combine direct verbal or face-to-face communication with clear and comprehensive follow-up documentation.
Lack of clarity of the nature and purpose of information sharing	Establishing clear procedures or using pro-formas can help ensure that requests specify *what* information is being sought and *why*. This can avoid unnecessary delays in the receiver being forced to seek clarification.

Other considerations for monitoring and developing information sharing practice include:

> Sharing the most basic information, for example that a child is on a Child in Need Plan, can help to ensure that other agencies keep an eye on the child and report any further concerns.

> Even when information is shared, delays can leave children in risky situations for too long and can disrupt the safeguarding pathway.

> Information sharing is not a one-off process, but should be part of a continuous dialogue among practitioners to allow for reassessment of risk, taking into account new information as it arises.

> Sharing information is only the first step in safeguarding and promoting the welfare of children. Appropriate appraisal of the information shared, and using it to guide decision-making and planning, are also required.

> Information sharing should be a two-way process, with practitioners who make referrals receiving feedback and ongoing information about action taken.

> Routine sharing of information, such as domestic violence reports, can lead to an overwhelming amount of notifications. Sending notifications to those who are in the best position to monitor ongoing risk or offer support helps ensure that the notification has the desired effect.

Good practice example

... DV1s [the police notification of domestic violence form] were sent by police to the normal partner agencies but also to secondary schools via [the] County Council. This appears to be sensible in as much as teachers are in an excellent position to help children and young people discuss their situation as well as giving the teachers background knowledge that may help to explain a child's absence, poor attainment or bad behaviour (Quoted from an SCR, p169).

LSCBs should:

> review information sharing protocols, particularly below the child protection threshold, to ensure practitioners are supported in sharing their concerns appropriately

> review procedures for sharing information, including how records are completed (IT, admin support) and how requests are made for information to be shared.

Conducting Serious Case Reviews

The report highlights a number of considerations for LSCB chairs when commissioning and managing the SCR process:

> **The knowledge base of the report writer:** their background and knowledge of relevant areas of practice and whether additional external expertise could contribute to the analysis.

> **The need to balance the independence of the report writer with LSCB involvement:** LSCBs are inevitably involved in setting the terms of reference, scrutinising the findings and recommendations, and overseeing the actions that result from the SCR.

> **The potential for delay at each stage of the review process:** the report identifies common delay points in the SCR process (p225) – for example, debates about whether to initiate an SCR or what kind of SCR to hold, or whether to conduct a parallel review (eg, a domestic homicide review); waiting for results (eg, post mortem, parental toxicology); and delays in publishing after completion.

> **Proportionality:** this will include decisions about the methodology used, the scope of the inquiry and how far the lines of enquiry are pre-determined or develop as the review progresses, and the timeframe set for completion.

The LSCB needs to decide on the methodology and process to be used when commissioning an SCR. A range of different methodologies were used in SCRs conducted between 2011 and 2014 (*at least nine different review types not including blended approaches and hybrid reviews* p217); however, the majority of SCR reports are not explicit about the methodology used and only a few highlight how the process influenced the learning (p227).

When choosing what approach to use in conducting the SCR, LSCBs should consider:

> **How far the LSCB should pre-determine the questions to be asked or the key lines of enquiry to be pursued:** Pre-set questions *could in some cases dictate the shape of the review and structure of the final report,* while at least one methodology suggests routes of enquiry should *emerge as part of the independent review process and should not be pre-determined* (p226).

> **The kinds of questions that the methodology considers:** Some methodologies encourage questions that can *encourage analytical thinking and a learning culture* (p228), but in some cases the final report does not live up to the promise of the methodology used.

> **How far the methodology encourages the author to compare findings with other SCRs:** This could include comparison of findings with similar SCR themes locally, regionally and nationally – and, if local, identify what has changed or not changed since previous reviews and why.

> **Whether the methodology results in recommendations, key questions or learning points:** Different methodologies present conclusions differently, depending whether the review focuses on practice issues, system issues or both. In some methodologies, the LSCB is left to write the action plan based on learning points, while others present specific recommendations for action.

In order to maximise learning from the SCR, thought must be given to how the findings are communicated through the final report. LSCBs should consider:

> **the length of the report and its readability,** including judicious use of appendices and references, the presentation of a concise chronology of events and the use of cross-referencing between the narrative and analytical sections

> **the structure of the report,** including a clear summary of key learning points at the beginning, a contents page to help practitioners quickly find relevant sections, and a dedicated section on the child, their experiences and voice

> **the ease with which others can find the final report** on the LSCB webpage, through a dedicated SCR tab or hyperlink

> **the accessibility of the report's findings to others,** including a glossary and careful use of any locally defined acronyms that may not be easy to interpret for those from outside the area

> **the impact of post-hoc redaction and efforts to preserve anonymity** on the clarity of the analysis and findings – for example, how far redacting details about the child's cultural background or medical issues hinders understanding of what happened and why.

The LSCB serious case review panel *should have a role in carrying out a rigorous check of the final report* (p222). The panel should consider the following when judging the quality of an SCR:

> **their own knowledge** of policy, practice and the local context and whether this is sufficient to provide challenge of the findings

> **the quality of individual management reviews** (IMR)(where used) on which the final report is based

> **the tone,** particularly the balance of defensiveness and criticism within the report

> **the quality of analysis** and whether the report's recommendations follow logically and methodically from the narrative and analysis

> **the conclusions**, including whether there is a clear distinction between specific recommendations (see below) and broad learning points that repeat lessons from previous reviews and national policy or research

> **the content of the accompanying action plan,** whether written by the report author or the LSCB in response to the author's questions or learning points

> **whether the report reflects learning and actions taken during the review** process itself and identifies how these improvements will be checked and monitored.

SCR recommendations should be:

> **specific** about who should take action and focused on the work of individual or groups of practitioners or on managerial and organisational issues (the role of managers or the LSCB in monitoring compliance should be clearly stated)

> **realistic** and based on a good knowledge of existing structures and agency cultures and not simply state that practitioners should follow existing procedures, without exploring why they do not currently do so

> **actionable** and provide a timescale for action and set out how progress should be checked or measured.

References

HM Government (2015) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children.* London: Department for Education.

Sidebotham P, Brandon M, Bailey S, Belderson P, Dodsworth J, Garstang J, Harrison E, Retzer A, Sorensen P, (2016) *Pathways to Harm, Pathways to Protection: A Triennial Review Of Serious Case Reviews 2011-2014.* London: Department for Education.

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UEA University of East Anglia

crcf Centre for Research on Children & Families

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