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Research Brief

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New learning from serious case reviews: a two year report for 2009-2011

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INTRODUCTION

Learning from serious case reviews (local enquiries into the death or serious injury of a child where abuse or neglect are known or suspected) is acknowledged to be important. This is the sixth two yearly national analysis of such reviews (from 1 April 2009 - 31 March 2011) and the fourth undertaken by this research team. It produces a number of new insights alongside the recurring messages for practice. It also adds to our cumulative research knowledge of these cases helping to identify patterns and deviations from patterns over time.

KEY FINDINGS AND LEARNING POINTS

- Drawing on the serious case review notifications from the single year 1 April 2009 to 31 March 2010 and comparator data from other sources, we estimate that the total number of violent and maltreatment-related deaths of children (0-17 years) in England is around 85 (0.77 per 100,000 children aged 0-17) per year. Of these, around 50-55 are directly caused by violence, abuse or neglect, and there are a further 30-35 in which maltreatment was considered a contributory factor, though not the primary cause of death.

- The complexities of matching national level data from different sources underlines the difficulty of interpretation and prediction so that tracking the extent to which this estimate rises or falls will never be exact. It is important to recognise that there are a wide variety of ways and contexts in which children may die as a result of violence or maltreatment. Different data sources are required to capture the breadth of these perspectives. It should be possible to establish an observatory function to report regularly on numbers and rates of violent and maltreatment-related deaths, and to set these findings in the context of other measures of childhood vulnerability. This however would require collaborative arrangements between the Department for Education, the Home Office, and the Office of National Statistics, to ensure timely sharing of data and agreed parameters for reporting.

- In carrying out this biennial analysis, the research team has built on previous work to develop and design a framework for the qualitative analysis of individual serious case reviews. This involves a process of layered reading of the individual reviews, and coding of data using a theoretical framework built on three core domains: the child; the family and environment, including parenting capacity; and systemic and service issues. There is now a draft framework which can be used for analysing serious case reviews and child deaths at a regional or national level.
- Serious and fatal maltreatment represents the tip of an iceberg; while overall numbers of children dying as a direct consequence of maltreatment may be small, many more children and young people suffer from lower levels of abuse or neglect. We need to learn from the experiences of all these children; every serious case review can provide a potential window on the system (Vincent

2004), allowing us to identify lessons to be learnt for safeguarding and promoting the welfare of children.

- A particular focus of this biennial review was an examination of serious case reviews for children aged 5-10. This highlighted particular issues of hidden adversity in this age group, the risks of harm to children associated with parental suicide or parental self-harming behaviour, and the potential adverse effects on children linked with parental separation.

- Neglect is a background factor in the majority of serious case reviews (60%), and for children of all ages not just the younger children. Although neglect is uncommon as a primary cause of death in children, it is a notable feature in the majority of deaths related to but not directly caused by maltreatment, including sudden unexpected death in infancy (SUDI) and suicide, and in over a quarter of homicides and fatal physical assaults. Neglect was the primary reason for undertaking a serious case review in 11% of the non-fatal cases, but also featured in 58% of other non fatal cases, including physical abuse and sexual abuse.

- A possible sign of improvement in protecting children is the fall in the number of children at the centre of a review with a child protection plan in place - declining from 16% in 2007-2009 to 10% for the latest two year period, at a time when overall numbers of children with a child protection plan are rising. A possible sign of improvement in protecting babies is the decreasing proportion of reviews undertaken concerning infants – dropping from 46% to 36% of all reviews.

- An understanding of normal development in childhood is an essential component of child protection practice. Overall, there is a dearth of child development teaching on professional courses for those who will be working with children. Where children have communication impairments the onus is on the professional not the child to find ways of communicating.

- SCR recommendations are still very numerous and the endeavour to make them specific, achievable and measurable has resulted in a further proliferation of concrete or procedural tasks to be followed through. Part of the issue may lie with the skills and knowledge of those conducting the reviews but also with the need to distinguish between learning lessons and making recommendations. The best learning from serious case reviews may come from the process of carrying out the review.

BACKGROUND

The new approach adopted for this national analysis of serious case reviews, has been to publish findings as they become available, and to combine the regular relaying of messages to policy makers and practitioners, with final reporting and taking stock of what has been learnt from the totality of serious case reviews over the past two years. Hence three of the five studies brought together in this report have already been published.

Overall, access to a greater number of SCR overview reports for this two year period has allowed us to explore themes in a way not previously possible.

AIMS

As in previous two yearly studies of serious case reviews, the overarching aim was to identify common themes and trends across the 2009-2011 review reports drawing out the implications for policy and practice. There were also new aims which were followed through in separate but interlinked studies:

- To explore the feasibility for a combined interface between serious case review and child death review data and explore the utility of other available datasets to provide comparator data;
- To develop and design a framework for the qualitative analysis of individual SCRs; to test this on reviews concerning children in middle childhood (aged 5-10) – a group hitherto unexamined in any detail;
- To examine the evidence from a small sample of serious case reviews where there is evidence to suggest a lack of child development knowledge or training for practitioners;
- To provide a thematic and critical analysis of recommendations and action plans from 30 serious case reviews.

METHODOLOGY

The overall two year analysis includes five inter-linking studies, drawing primarily on either the 115 serious case reviews notified to the Department for Education during the single year 2009 – 2010, or the full sample of 184 serious case reviews from the two year period 1 April 2009 - 31 March 2011. The five studies have their own separate research questions and most employ a mixed methods approach providing quantitative, background characteristics of a larger sample of serious case reviews and a qualitative, thematic analysis of a smaller sample of reviews studied in depth. Two are wholly qualitative thematic analyses and one study uses quantitative descriptive analysis to set serious case review data in context with other national level comparator data (for example from the Office for National Statistics and the Home Office). All of the studies are informed by the same approach to the exploration of interacting risks which seeks to understand inter-agency working within the dynamic context of the developing child's world.

FINDINGS

How many children die as a result of maltreatment?

Drawing on the serious case review notifications from the single year 1 April 2009 to 31 March 2010 and comparator data from other sources[1], we estimate that the total number of violent and maltreatment-related deaths of children (0-17 years) in England is around 85 (0.77 per 100,000 children aged 0-17) per year. Of these, around 50-55 are directly caused by violence, abuse or neglect, and there are a further 30-35 in which maltreatment was considered a contributory factor, though not the primary cause of death.

The overall rates of SCRs relating to fatal cases have remained relatively stable over the past 5 years. The highest risks remain in infancy, although a second peak is seen in adolescence. The patterns and nature of these deaths are likely to vary and any further efforts to reduce these rates should be based on a good understanding of the different patterns.

How have patterns of serious case reviews changed?

There is a considerable drop in the number of serious case reviews over the latest two year period – a total of 184 in comparison with 280 cases from 2007-09 (when almost half were serious injury cases). This represents a return to the earlier pattern of fewer reviews (189 reviews during 2005-07 and 161 during 2003-05) and to the previous proportion of two thirds fatality cases and a third relating to non fatal serious

[1] Office for National Statistics, Mortality data from death registrations; Home Office, Crime Statistics; Department for Education, child death overview panel data.

injury, although there is a drop in non fatal cases in 2010-11 which may suggest a new pattern of undertaking serious case reviews emerging.

Just over a third (36%) of all serious case reviews concerned a baby under one year of age – a drop of more than 10% from the consistent pattern of earlier years. This difference may reflect a change over time in local decision-making about when to undertake a SCR for non fatal cases, perhaps linked to the establishment of statutory child death overview processes since 2008. It might also be attributable to the success in spreading awareness among practitioners and community groups of the vulnerability of babies and the risks of harm they face.

The only category of fatality or harm showing much change was deliberate homicide where there was a 10% rise, explained largely by an increase in the number of filicide suicides and perhaps by the Home Office's introduction of Homicide Reviews.

What new learning is there about patterns and behaviour in families?

For the first time we have a clear understanding of the extent to which neglect features in serious case reviews. This sets a good foundation for further exploration of the learning about neglect in these cases. We know that neglect was an underlying feature in at least 60% of the serious case reviews. Although neglect is uncommon as a primary cause of death in children, it is a notable feature in the majority of deaths related to but not directly caused by maltreatment, including SUDI and suicide (present or past neglect was a factor in eleven out of fourteen suicide cases), and in over a quarter of homicides and fatal physical assaults. Neglect was the primary reason for undertaking a serious case review in 11% of the non-fatal cases, but also featured in 58% of other non fatal cases, including physical abuse and sexual abuse.

Almost 60% of the mothers were under 21 years of age when they had their first child. Although the vulnerability of many of these young mothers, who were children themselves when they had their first baby, has been recognised, we need to acknowledge that this vulnerability can be lasting and that there may be cumulative stresses and risks of harm when these young first time mothers go on to have more children.

The enhanced vulnerability of disabled children is becoming well recognised and was a feature in 12% of these serious case reviews. The risk of harm went unrecognised in these cases, sometimes where the family presented as loving and cooperative.

What are the changes in agency responses?

At the time of the incident, 18 (10%) of the children had a child protection plan - a marked drop since the previous two biennial reviews, in a period when the number of children with a child protection plan has been steadily rising.

Less than half of the children and families were receiving a service from children's social care (42%). A further 23% of cases had been closed, sometimes because of non-cooperation. In 14% of cases a referral had been made but not accepted, implying perhaps that thresholds to children's social care were set too high, particularly in light of the severity of the difficulties presented at the time of the referrals. Just over a fifth (21%) of the children had never been referred to children's social care.

What have we learnt about children aged 5-10?

Analysis of 21 overview reports from serious case reviews concerning children aged between 5 and 10 years revealed few distinct features that could be linked to children in this particular age group. There were instead many similarities with other age groups, and a significant diversity in the type of cases for these children. Such heterogeneity has particular challenges for understanding and practice.

The primary school years are generally perceived to be a positive time for children and rates of serious harm are low. Nevertheless substantial numbers of children do suffer significant harm and there may be particular issues in this age group around hidden adversity. Most of these children will be seen regularly in school, and when they present well, professionals may be unaware of underlying concerns. In contrast to the pre-school years, there tends to be little direct professional engagement with the parents or the home environment. School staff may be unaware of the circumstances of these children outside of the school environment. Indicators of physical and emotional harm may be harder to detect in this age group. Children who are experiencing neglectful or abusive home environments may not stand out at school as being any different from their peers, or may present with otherwise non-specific emotional or behavioural indicators. Staff in universal services need to be alert to this, and aware of the limitations of seeing children only in the safe environment of the school. When young children display worrying behaviour such as truanting, running away or stealing food, attempts should be made to understand the child's context and to listen to them, not merely to return them home.

Parental mental health problems featured in a majority of cases, and suicidal or self-harming behaviour was particularly prominent. This may be linked to subsequent harm to children, including through extended suicides. Parental suicidal or self-harming behaviour needs to be taken very seriously, and the potential risks to the children thoroughly assessed. Being a parent is generally perceived to be a protective factor in relation to adult suicide or self-harm:- thus when a parent is threatening or actually carrying out suicidal or self-harming behaviour, this protective element may have been lost.

Many children in this age group are affected by parental separation. This may be a context within which children are at risk of significant harm, particularly where the separation is coupled with ongoing domestic violence or controlling behaviour, where there are conflicts around contact arrangements, or where children are caught in the midst of acrimonious separations. Domestic violence featured prominently in these cases, and it was clear in several cases that the impact on children did not stop when the parents separated, often with ongoing threats or controlling behaviour affecting both the mother and her children. Some of these cases highlighted that acrimonious separations can present direct risks to children's safety and welfare, including risks of homicide. Even where the cases do not progress to such extremes however, there is evidence that children suffer emotional harm, potentially being used by parents to get at each other, or being caught in the middle of ongoing conflict.

How might better practitioner knowledge of child development help to protect children?

A good working knowledge of child development is essential for all workers who come into contact with children. However access to good child development training is patchy. Child development is not covered thoroughly in all social work qualifying courses where it is subsumed within the broader curriculum of lifespan development. In health, training in paediatrics generally and child development specifically is desirable but not mandatory for General Practitioners, and there is also a lack consistency in child development training for health visitors and paediatricians. Higher Education Institutions providing qualifying teacher training report that primary school teachers receive very limited child development input and secondary school teachers will typically get none. There is scope for improvement in child development training for all professionals working with children.

An understanding of normal motor development in childhood is an essential basis for evaluating the significance of bruising, and for distinguishing potentially abusive from non-abusive injuries. The need for heightened concern about any bruising in a pre-mobile baby is emphasised by their limited physical self control and independent movement. For toddlers and pre-school aged children, an unusual pattern or site of bruising should provoke curiosity about how and why the bruising is occurring, and how well the child is being kept safe and supervised. This is true for all children including those with disabilities and/ or complex health needs.

For disabled children of all ages there was a tendency to see the disability more clearly than the child. This could mean accepting a different and lower standard of parenting for a disabled child than would be tolerated for a non-disabled child – for example keeping a child shut in a bedroom for long periods for 'safety'. The onus on communicating with children who have communication impairments should be on the practitioner not the child.

It is not helpful to consider poor or faltering weight gain for babies and toddlers as a purely mechanical feeding problem. A contextual understanding of the differing reasons why parents appear not to be nurturing their child is very important. Questions about emotional development, attachment and the parent-child relationship need to be raised.

To get a sense of older children's developmental state, professionals need to understand their developmental pathway over time. Practitioners who did not get to know the young person or make a relationship with them, tended to pay insufficient attention to the impact of maltreatment on their development. Pockets of good development in maltreated young people do not necessarily signal resilience.

What have we learnt about recommendations?

The most startling findings to emerge from the Recommendations Study have been not only the sheer volume of recommendations to emerge from reviews (an average of 47 per review), but also that the largely successful endeavour to make them specific, achievable and measurable has resulted in a further proliferation of tasks to be followed through. Carrying through these, often repetitive, recommendations consumes considerable time, effort and resources – but the type of recommendations which are the easiest to translate into actions and implement may not be the ones which are most likely to foster safer, reflective practice. The typical route to grappling with practice complexities like engaging hard to reach families, was to recommend more training and the compliance with or creation of new or duplicate procedures. Fewer recommendations considered strengthening supervision and better staff support as ways of promoting professional judgement or supporting reflective practice.

Action plans which are easy to implement tend to be ones that address superficial aspects of procedures and concrete tasks. This focus on creating or adapting local procedures, or arranging training for which the LSCB has the responsibility and capability to monitor and implement via the action plan, can mean that the deeper and wider issues get sidelined or diluted.

The interface between societal issues like deprivation and maltreatment are rarely reflected in recommendations or action plans. These big issues, such as poor environment and bad housing, tend to be thought of as beyond the scope of the review despite *Working Together to Safeguard Children* (HM Government 2010:248) inviting consideration of national policy and practice issues. LSCBs may consider that these are issues over which they have little influence even though the potential for a single serious case review to prompt wide ranging change should by now be understood.

Rarely was a research evidence base cited for the recommendations made. This begs the question of the extent to which recommendations were thought to be likely to deliver change, and whether there were clear rationales for making, or not making, recommendations. Part of the issue may lie with the skills and knowledge of those conducting the reviews but also perhaps with need to distinguish between learning lessons and making recommendations. Recommendations can be helpful if they lead to definitive action but implementing them should not be seen to imply that learning has taken place. The best learning from serious case reviews may come from the process of carrying out the review.

IMPLICATIONS FOR POLICY AND PRACTICE

There were a number of insights into the traps that professionals can find themselves in. Practitioners found reasons to believe that unrealistic explanations (for bruises for example) were plausible and didn't question themselves or others or act with sufficient curiosity. Throughout the studies there was a sense of disconnection from the children themselves:- not paying attention to children's emotional development and not thinking about what it's like to be a child living in that family or beyond the school setting; seeing the disability not the child; and most powerfully holding back from knowing the child as a person. Acting on these issues and having the confidence to get to know and work with the child requires a sound knowledge of child development, and especially emotional development. All of these factors and the anxiety that surrounds working with children and families, point up the emotional toll that working with children, from any discipline and especially social work, takes on the practitioner.

This national analysis again highlights the importance of challenging and reflective supervision which pays attention to the impact of the case and the work on the practitioner and goes beyond procedures and processes. Supervision should foster professional development, encourage practitioners to keep their knowledge up to date and prioritise the time needed to get to know children and families. Strong support and constructive challenge of front line practitioners will not be possible if the agency context is one of overwhelming workloads with a limited capacity, or lack of permission to invest in relationship building or critical reflection.

Implications for Policy

The Munro Review has recommended that serious case reviews be undertaken using a systems methodology that moves away from a focus on the specifics of the particular case to identify underlying local issues that influence practice more generally. The shared learning from this practitioner inclusive approach could offer a sense of catharsis and help to restore workers' confidence.

There are perhaps distinctions, however, to be drawn between doing the review and the recording that will result from the serious case review. There are some potential problems if the proposed typology for carrying out a review is also intended as a format for providing data in individual cases which can be aggregated at a national level. If only agency level data are available and characteristics of the child or family are missing it will not, for example, be possible to continue to build the current research database (which dates back to 2003). Being able to understand differences and similarities between individual cases and the whole cohort of serious case reviews has provided learning with policy implications. Most importantly, having a national sense of the profile of the children and their families puts the children as real people back at the centre of the review.

Future research could now usefully combine learning from serious case reviews and child death overview panels (CDOP). Bringing together data from these and other national sources has been complex but has produced useful results, not least the possibility of establishing a cautious estimate of any rise or fall in child deaths through maltreatment. A similar exercise can be refined and replicated on a regular basis. A framework for national analysis of serious case reviews which was developed by the researchers could also be used for regional or national analysis of CDOP data.

Conclusion

A measure of success of serious case reviews may be finding in these research studies a large number of what the Munro review has termed 'low probability' cases - those not known to children's social care or other specialist agencies. By definition it will be harder to predict and prevent death or catastrophic harm to these children because there are lower levels of known risks. Paradoxically, the better we get at this work the more we reveal hitherto unrecognised maltreatment. These finer points of prevention or

predictability do not lessen the pain that surrounds the death or harm of each child. In whatever way the new serious case review system is configured, it is essential to remember that each review is about an individual child and not just a system.

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Additional Information

The full report can be accessed at http://www.education.gov.uk/publications/
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