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What do Serious Case Reviews achieve?

Peter Sidebotham

Warwick Medical School, University of Warwick, Coventry CV4 7AL

p.sidebotham@warwick.ac.uk

Tel: 024 7657 4878

Fax: 024 7652 8375

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INTRODUCTION

Although there had been some earlier public inquiries, the inquiry into the death of 7 year old Maria Colwell in 1973[1] was a critical episode in the history of child protection in the UK. It was this inquiry that led to the formalisation of inter-agency child protection procedures, the establishment of Area Child Protection Committees, and the creation of a child protection register. It also sparked off a long line of public inquiries into serious and fatal maltreatment, more recently superseded by statutory Serious Case Reviews (SCRs) carried out by Local Safeguarding Children Boards (LSCBs). The public outcries over the deaths of Victoria Climbié and Peter Connelly highlighted the fact that, in spite of all the time and resource spent on these reviews, the problems of severe child abuse have not gone away. This begs the question of whether we have truly learnt anything from the reviews and whether anything has changed as a result.

A SCR is mandated in England and Wales whenever a child dies and abuse or neglect are known or suspected to be a factor in the death.[2] LSCBs may also carry out a SCR into serious but non-fatal child maltreatment (Box 1). The prime purpose of a SCR is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children (Box 2). Given this primary purpose and the related aspects of identifying lessons to be learnt and acting on those lessons, evaluating the effectiveness of these reviews should be judged against those criteria:

- Are we better safeguarding and promoting the welfare of children?
- Are we identifying lessons about safeguarding children?
- Are we implementing actions to safeguard children?

Box 1: Criteria for holding a Serious Case Review
From *Working Together to Safeguard Children.*[2]
When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the LSCB should **always** conduct a SCR into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family. These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. In addition, a SCR should always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Young Offender Institution (YOI), a Secure Training Centre (STC) or secure children's home, or where the child was detained under the Mental Health Act 2005. (paragraph 8.9)

LSCBs should **consider** whether to conduct a SCR whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or
- a child has been seriously harmed as a result of being subjected to sexual abuse; or
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004146; or
- a child has been seriously harmed following a violent assault perpetrated by another child or an adult;

and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working. (paragraph 8.11)

Box 2: Purposes of Serious Case Reviews
From *Working Together to Safeguard Children.*[2]
The purposes of SCRs carried out under this guidance are to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

(paragraph 8.5)

WHAT HAVE WE LEARNT FROM SERIOUS CASE REVIEWS?

There seems little doubt that SCRs and the earlier public inquiries into child abuse deaths have had a substantial impact on the development of child protection policy and practice in England.[3, 4] However, both policy and practice are influenced by a wide variety of factors including public opinion, the media, and the political climate, as well as individual learning and behaviour. Demonstrating whether outcomes for children have actually changed is, however, immensely

difficult. Perhaps the most robust measure of the effectiveness of child protection is whether the rates of serious and fatal maltreatment are changing. Two studies of national death registration data have concluded that numbers and rates of violent deaths in infants and children have fallen over the past 30 years, suggesting that we are, at least to some extent, protecting the most vulnerable young children from abuse and neglect.[5, 6] Assessing whether there has been any impact on less severe forms of maltreatment is much more difficult, and a recent multi-country analysis suggests that in the UK, as with all other countries examined, there has been no significant overall trend in wider markers of maltreatment rates.[7] In contrast, a recent national study by the NSPCC showed that fewer 18-24 year olds in 2009 reported experiencing severe physical or verbal aggression from their parents or coerced sexual activity, compared to a similar sample in 1998.[8,9] In summary, there is some evidence that we are doing better at safeguarding and promoting the welfare of children, but this is not reflected in all measures. To attribute any fall in rates of maltreatment to the impact of SCRs however is a huge extrapolation. While it is acknowledged that SCRs have influenced the development of child protection policy and practice, there will be many other factors with equal or greater influence. In addition, while SCRs focus on improving inter-agency working to protect children, most child maltreatment affects children unknown to child protection services. It is likely that wider preventive measures will have a greater impact on maltreatment rates. Thus it is important to examine proxy measures which may provide some indication of whether we are identifying lessons and implementing actions to safeguard children.

A review of the national biennial analyses of Serious Case Reviews[10-14], and previous published studies of inquiry reports[15, 16] demonstrate a number of consistent themes in relation to professional practice (Box 3). The same biennial analyses also identify a number of new and emerging themes (Box 4). However, although these recent analyses have shed fresh light on aspects of professional working, many of the “new” concepts identified actually can be found in much earlier work. For example, concepts such as ‘static assessments’, the ‘rule of optimism’ and ‘fixed thinking’ were all identified in the 1980s and 1990s.[17] One less obvious measure is the extent to which issues identified in early reviews are no longer significant issues. For example, in a comparison of the Colwell and Climbié inquiries, Parton[3] pointed out that in the Maria Colwell case one of the key difficulties was in getting Maria examined by a doctor. Nowadays, while it may not always happen, or may not happen to the hoped for standard, no-one would question the relevance of a medical examination of a child with suspected physical abuse.

Box 3: Common themes in Serious Case Reviews

- Family characteristics – infants and young children have the highest risks of physical abuse and neglect; slight male preponderance; risks in large families; chaotic families with multiple problems ('toxic caregiving environment'); domestic violence, parental mental health problems and alcohol and drug abuse are all risk factors, though neither universally nor exclusively found in serious cases.
- Although a proportion of children and families have been previously known to child protection services, this is a minority; most serious and fatal maltreatment occurs without clear prior indicators of risk.
- The invisible child – children are not seen or their voices not heard in assessment processes. Professionals fail to take account of the child's perspective.
- Limited inter-agency co-operation and lack of service integration, especially between child and adult services
- Poor communication both between agencies and within agencies
- A failure to interpret information gathered.
- Poor recording of information and decision making.
- Decision making – lack of professional confidence; professional uncertainty in decision making; failure to challenge other professionals.
- Relations with families – hostile and non-cooperative families are difficult to work with and professionals may avoid engagement with them.
- Thresholds – different professionals and agencies may have different perceptions of the thresholds at which intervention is required; services may not be offered if a child or family is perceived not to reach a particular threshold.

Box 4: New themes emerging from recent biennial analyses of Serious Case Reviews

- Importance of an ecological framework for understanding the complexity of child abuse: 'child abuse is rarely related to a single cause but rather to the interplay of several factors in particular circumstances' (1999-2001)
- Maltreatment-related deaths and other serious incidents do not form one homogeneous group. Severe physical assaults are the commonest single group of deaths, however many more deaths are related to but not directly caused by maltreatment. (2005-7)
- Ecological niches - The specific vulnerabilities that the children bring to their physical and caregiving environments can be seen to occur in different age ranges which fit into age-linked ecological niches (2005-7)
- Mirroring of behaviour in the family and in the agency responses – chaotic families with multiple problems, parents who feel overwhelmed, the child's needs get lost; this context is mirrored in the responses of professionals who also feel overwhelmed and respond in a chaotic, disordered way in which the child's needs get lost. (2005-7)
- Exclusion of fathers – limited assessment of the role or status of fathers in considering risks to children; most social care involvement centres around the mothers (2005-7)
- "Fixed thinking" – previous assessments, or categorisation of cases influencing professionals' decision making about new findings; for example through neglect being perceived as low-level, long term risk and masking more acute risks to a child's immediate safety; or the concept of "rough handling" downplaying risks to young infants. (2005-7)
- "Start again syndrome" – the tendency, when confronted with a new issue, to forget or ignore previous concerns, so underestimating cumulative risks of harm (2003-5)
- The "rule of optimism" - Efforts not to be judgemental becoming failure to exercise professional judgement – professionals are typically reluctant to pass negative judgements on parents, but this can lead to a failure to then judge the situation and adequately appraise risk to the child (2005-7)
- Silo practice - Failure of professionals to look at aspects of the children's needs outside of their own specific brief (2005-7)
- Disguised compliance – parents who appear to engage and cooperate, but hide ongoing harmful behaviours (2005-7)
- The vulnerability of older children and adolescents – there has been an increasing emphasis in consecutive biennial analyses on the risks faced by older children and adolescents. The long-term impact of early emotional abuse and neglect; maltreatment outside the home; and risk-taking behaviour by adolescents all feature strongly. (2001-3; 2003-5; 2005-7; 2007-9)

These themes suggest that some aspects of learning keep recurring, but that other aspects are new, and still others cease to be so important. The fact that some issues come up repeatedly however does not necessarily mean that lessons have not been learnt or that nothing is changing. Some lessons are so important that they need to be re-emphasised and potentially relearnt as people, organisations and cultures change. We tend to learn best, both as individuals and as teams, when the material we are learning is contemporary and clearly relevant to our local context and

circumstances. SCRs provide an opportunity for that, bringing issues powerfully home in a local context and in a way that can directly influence front line workers.

Recognising that some lessons will continue to crop up in SCRs does not mean that we should simply sit back and accept that mistakes continue to be made and that children continue to suffer harm. Rather, we should seek to go deeper, to understand the systems, structures and cultures within our society and organisations which allow such mistakes to be made. Professor Eileen Munro has argued this powerfully in her recent review of child protection in England.[18-20] SCRs are designed as local in-depth reviews which can identify local issues. They can be used by LSCBs to influence local practice, but this needs to be done in the context of other influences, local issues and individual and organisational accountability. Where common issues come up repeatedly, it is important to look beyond the question of "what went wrong" to examine the deeper system issues of why such mistakes could be made.

LOOKING AHEAD

In keeping with the findings and recommendations of the Munro review, I would suggest that a number of changes in our approach to SCRs could improve their efficacy in influencing practice and helping to protect children. First, we need to distinguish between learning lessons and making recommendations. Recommendations can be helpful if they are limited, focused and lead to definitive action, but they should not be seen as implying that learning has taken place. Too great a focus on recommendations can lead to practice becoming increasingly procedure-driven with little room for professional judgement. Secondly, for learning to be effective, practitioners need to be more integrally involved throughout the process. The current approach, based primarily on a review of records with or without interviews of practitioners does not encourage learning. The Munro review calls for a much more interactive process whereby practitioners themselves engage directly with the review team to identify learning points. Thirdly, we need to support practitioners through the process. The SCR process is extremely stressful for practitioners. This is not helped by the current system of "securing" records, which tends to imply attribution of blame and leaves practitioners feeling vulnerable and unsupported. A supportive approach does not mean that issues of accountability are not addressed, rather, it allows for this to be done in a more effective and appropriate way, while still allowing learning to take place. Finally, as argued by Munro, learning needs to be taken to a deeper level. Rather than focusing on what went wrong, or whether mistakes were made, the focus of the review should be on why services failed to protect the child. This

requires a combination of understanding the characteristics of the case itself, and a robust analysis of the systems, structures and cultural factors underlying service provision.

As well as improving the approaches to carrying out reviews and analysing factors at a local level, there is an ongoing need to collate and disseminate the learning at a national level. This will not be achieved effectively simply by publishing and circulating all overview reports – with over 100 SCRs conducted each year, it is neither possible nor effective for individual practitioners to read and learn from each one. Rather, the system for national analyses needs to be continued and strengthened, and fresh ways of disseminating knowledge from these analyses need to be developed.[4]

Our system for Serious Case Reviews in England is one of the most comprehensive systems in the world. I have argued above that these reviews have led to considerable learning and have had an impact on our approaches to protecting children. In order for them to continue to be effective, they need to change with the times. With the publication of the Munro review, we have an opportunity to build on the successes of the past and rethink our approach, bringing in more effective and supportive approaches to learning.

Competing Interests

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References

1. Field-Fisher T, Davey M, Stevenson O. Report of the Committee of Inquiry into the Care and Supervision Provided in Relation to Maria Colwell. London: H.M.S.O. 1974.

2. HM Government. Working Together to Safeguard Children. Nottingham: Department for Children, Schools and Families 2010.
3. Parton N. From Maria Colwell to Victoria Climbie: Reflections on public inquiries into child abuse a generation apart. *Child Abuse Review* 2004;**13**:80-94.
4. Sidebotham P, Brandon M, Powell C, et al. Learning from Serious Case Reviews: Report of a research study on the methods of learning lessons nationally from Serious Case Reviews. London: Department for Education 2010.
5. Pritchard C, Sharples A. Violent deaths of children in England and Wales and the major developed countries 1974-2002: possible evidence of improving child protection? *Child Abuse Review* 2008;**17**:297-312.
6. Sidebotham P, Atkins B, Hutton JL. Changes in rates of violent child deaths in England and Wales between 1974 and 2008: an analysis of national mortality data. *Arch Dis Child* Published Online First 5 May 2011. doi:10.1136/adc.2010.207647
7. Gilbert R, Fluke J, O'Donnell M, et al. Child maltreatment: variation in trends and policies in six developed countries. *Lancet* In press.
8. Cawson P, Wattam C, Brooker S, Kelly G. *Child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect.* London: NSPCC 2000
9. NSPCC. *Child Cruelty in the uk 2011: An NSPCC study into childhood abuse and neglect over the past 30 years*. London: NSPCC 2011
10. Brandon M, Bailey S, Belderson P. Building on the Learning from Serious Case Reviews: A two-year analysis of child protection database notifications 2007-2009. London: Department for Education 2010.
11. Brandon M, Bailey S, Belderson P, et al. Understanding Serious Case Reviews and their Impact. A Biennial Analysis of Serious Case Reviews 2005-07. London: Department for Children, Schools and Families 2009.
12. Brandon M, Belderson P, Warren C, et al. Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we Learn? A Biennial Analysis of Serious Case Reviews 2003-2005. London: Department for Children Schools and Families 2008.
13. Rose W, Barnes J. Improving Safeguarding Practice: Study of Serious Case Reviews 2001-2003. London: Department for Children, Schools and Families 2008.
14. Sinclair R, Bullock R. Learning from past experience : a review of serious case reviews. London: Department of Health 2002.
15. Reder P, Duncan S. Lost innocents : a follow-up study of fatal child abuse. London: Routledge 1999.
16. Reder P, Duncan S, Gray M. Beyond Blame : Child Abuse Tragedies Revisited. London: Routledge 1993.
17. Hill M. The manifest and latent lessons of child abuse inquiries. *B J Soc Work* 1990;**20**:197-213.
18. Munro E. The Munro review of child protection: Final report - a child-centred system. London: Department for Education 2011.
19. Munro E. The Munro review of child protection interim report: The child's journey. London: Department for Education 2011.
20. Munro E. The Munro review of child protection part one: a systems analysis. London: Department for Education 2010.