

Serious Case Reviews (SCR)

Barriers to Learning from SCRs

Extracted from Department for Education Report on Barriers to Learning from SCRs

Kingston University's Institute for Child-Centred Interprofessional Practice (ICCIP) was awarded a contract from the Department for Education (DfE) to undertake a small study investigating barriers to learning from Serious Case Reviews (SCRs) in order to identify ways of overcoming these barriers and ensure that any learning is embedded in policy and practice. The ICCIP Serious Case Review (SCR) multi-disciplinary team are working at national, regional and local levels towards developing an action plan for England on how to enhance and embed learning from serious case reviews more effectively.

Key Findings of Emerging Themes

Major themes that emerged throughout this research relating to barriers to learning from SCRs demonstrated that there is considerable consistency of views across all four geographical areas of England, across frontline practitioners, frontline managers and senior and strategic managers, and across all agencies working in safeguarding.

Data analysis illuminated key emerging themes which have been organised under three main categories:

- SCR Processes and Publications;
- Learning Culture and Training;
- Systems Approach to Policy and Procedures.

Barriers to Learning from SCRs

SCR Processes and Publications

- The length, time and content of SCR publications create an ethos of 'blame,' avoidance, apathy, defensiveness and increased workload. This is exacerbated by media coverage. The number and dispersal of SCRs nationally means it is difficult to give them all local attention, and what gets attention is then skewed and determined by national media selectivity and coverage.
- The numbers of recommendations that generate new policies and procedures is overwhelming.
- The SCR reports are not accessible in terms of length and common language to make them meaningful and manageable to all users across different sectors, professions and agencies. Key themes and learning are not adequately identified nationally.
- The SCR process is itself costly in terms of finance and capacity and may not generate the most useable or interpretable learning for local practice.
- There is concern about publication in full and how this relates to transparency and confidentiality.

Learning Culture and Training

- There is insufficient regular, appropriate and purposeful training across and within disciplines.
- Not all training is appropriate for different roles and responsibilities of staff within and across different disciplines and agencies including the Private, Voluntary, Independent sector of private, community and voluntary organisations.
- The learning from SCRs is repetitive and can lead to lack of attention and engagement.
- Front-line staff have limited involvement in the generation of learning and ensuring its relevance and applicability.

Policy and Procedures

- Policy and procedures development and implementation are not proportionate or sensitive to the scale, locality and context of the case.
- Rapid policy and procedural change and implementation impacts significantly on frontline staff creating confusion and tensions relating to workload, roles and responsibilities and accountability.
- Change takes time to embed and too much change nationally and locally is destabilising and undermining.
- Policies and procedures do not always recognise the human and emotional aspects in terms of interpretation, judgement and decision making.
- Policies and procedures may not be sensitive to what is able to be actioned by practitioners with large workloads and who are already very busy.
- Communication systems are currently ineffectual in ensuring that learning from SCRs informs practitioners within and across disciplines, agencies and sectors.

Enablers to Learning from SCRs

SCR Processes and Publications

- The SCR processes should be less resource demanding, more timely, and more engaging of frontline practitioners.
- SCR reports should be more succinct and shorter.
- Reset the process to promote learning rather than blame.
- Reset the process to promote reflection and analysis rather than primarily description and hind-sight judgments.
- Key themes and learning should be identified within the reports and highlighted locally and nationally.
- There should be national, themed repository of reports, with some targeting at different professions, practitioners and management roles, agencies and sectors. (Since the initial first draft of this report the DfE have initiated a national and themed repository of all SCRs.)

Learning Culture and Training

- There needs to be a continuing programme of training at strategic and operational levels to reinforce and embed learning and practice change.
- Training should develop knowledge and skills for practitioners to understand thresholds, supervision requirements, effective record keeping, risk, referral systems and to develop effective communication skills with all stakeholders and partners.
- Interagency relationships need to be built in order to support the emotional impact of learning and decision making from SCRs (threshold decision making under pressure).
- The value of the 'child's voice' needs to be understood within the context of the family (background, culture and history).
- A new reporting system needs to be developed that captures learning from smaller incidents as well as major emergencies to better reflect the typical context of working practice (incremental and regular learning).
- There needs to be more regular and focussed training appropriate to different levels and engagement in SCRs (including scenario and case study approaches).
- The importance of learning should be recognised by senior leadership and champions to ensure engagement with and relevance for practice and practitioners.
- A stock of lessons learned for on-going incremental learning needs to be developed.
- A new evidence-based process of learning is needed that will directly begin to positively shape and transform services in order to promote an effective safety culture.
- There is a need to create an organisational and cyclical 'learning culture' within and across the services.
- The integration of an interprofessional learning 'tool' into the culture needs to be developed to ensure sustainability of a positive organisational transformation.

Policy and Procedures

- Changes in policy and procedures should be discussed and tested with frontline practitioners before roll-out and implementation.
- There should be awareness that over-proceduralisation squeezes out professional practice, judgement and accountability and ownership of actions.
- Frontline managers - and supervision- are crucial in changing, supporting and quality assuring practice and should be a particular focus of changing, enhancing and sustaining good practice.
- Strategic and senior leadership within and across organisations and disciplines is crucial in ensuring attention is given to the learning and changes generated by SCRs.
- Auditing the impact of, and embedding changes, needs to be given more attention.
- Clear lines of communication structures within and across all the services are required.
- An analysis from previous experiences and drawing conclusions for future directions can develop a stock of lessons learned for on-going incremental learning.
- There is a need for follow up learning and procedures to ensure corrective actions are implemented so that underlying root causes can be monitored system wide.

Case reviews published in 2015

A chronological list of the executive summaries or full overview reports of serious case reviews, significant case reviews or multi-agency child practice reviews published in 2015.

April 2015 – Croydon – Josh

Death of a 3-year-old boy in March 2013. Mother carried Josh into the path of an oncoming train, killing them both.

Background: Mother had a history of severe anxiety disorder and had been receiving treatment from her GP and various mental health services in the months preceding Josh's death.

Key issues: procedural failure responding to a children's social care referral made by Mother's psychiatrist; a culture of overreliance on children's social care for actions regarding a child; and perceived inconsistent and misleading advice from mental health services leading Mother and Family to continue accessing private mental health providers as they lost trust in NHS providers.

Model: review was undertaken using the Significant Incident Learning Process (SILP).

Keywords: adult mental health services, suicide, referral procedures

April 2015 - Lambeth – Child I

Death by drowning of a 20-month-old boy in July 2013.

Background: Child I and his two older siblings were subject to child protection plans under the category of neglect at the time of the incident. Parents both had learning difficulties and at times reacted with anger and hostility to professional interventions. Child I was found face down in the bath; mother reported she had left Child I in the bath, informing father she had done so, before leaving the house. Parents were subject to police investigation as alleged perpetrator and witness throughout the case review process.

Key issues: professional emphasis on investigating physical injuries at the expense of considering indicators of neglect; and overreliance on written agreements with parents to support child protection arrangements.

Model: Social Care Institute for Excellence (SCIE) Learning Together model

Keywords: adults with learning difficulties, neglect and interagency cooperation

March 2015 – Blackpool – Baby Q

Serious unexplained head injury of an infant, under 4-weeks-old.

Background: Mother found guilty of causing or allowing her baby to suffer serious physical harm. Baby Q was removed to permanent care of an approved family member.

Key issues: family's transient living arrangements, lack of engagement with antenatal care, substance misuse, domestic abuse, maternal depression and high levels of parental anxiety.

Learning: importance of midwives and health visitors co-planning and coordinating responses and need to routinely and confidentially ask parents about domestic abuse, mental health and substance misuse.

Recommendations: put in place a mechanism to reduce the risk of confusion caused by recording the same case under multiple surnames and ensure there is full consultation with other agencies before a diagnosis is changed from non-accidental injury to medical cause.

Keywords: head injuries, infants, non attendance.

March 2015 - Coventry – Child T

Death of a 3-week-old girl in June 2013; coroner classified cause of death as 'unascertained'.

Background: Following Child T's death, a home visit found that the family were living in dirty and unhygienic conditions. There had been no previous concerns about the mother's care of her children and they were not known to children's social care.

Key issues: issues identified include confusion across partner agencies about when the Common Assessment Framework was open and when it had been closed and a failure to check the room in which the child was to sleep during the community midwife's home visit.

Recommendations: simplify the Common Assessment Frameworks' management system and always check the room in which the child sleeps in the day and night.

Keywords: infant death, neglect, home environment

March 2015 - Dorset – Family S15

Sexual abuse of a 14-year-old girl by her mother's partner.

Background: Perpetrator moved into the family home when Felicity was 13-years-old. Felicity became pregnant as the result of the abuse. Perpetrator was known to police having been served with a Child Abduction Warning Notice in connection with another adolescent girl. Felicity was the subject of a child protection plan under the category of sexual abuse. Perpetrator pleaded guilty to sexual assault and was sentenced to 3-years in custody.

Key issues: an over-reliance on the child making a disclosure; lack of direct involvement from police leading to a lack of focus on the possibility that a crime was being committed; misplaced confidence in the effectiveness of a Contract of Expectations as a tool to disrupt the relationship between Felicity and the perpetrator.

Learning: consideration should be given to the provision of child sexual abuse training for GPs who prescribe contraception; and the need for children to be safe physically and emotionally, before therapeutic work can be effective.

Model: Partnership Learning Review model.

Keywords: Child sexual abuse, grooming, information sharing.

March 2015 - Haringey – Child D

Serious injury of an 11-week-old baby.

Background: Mother took Child D to hospital with a fractured arm. X-rays identified a number of old fractures sustained when Child D was about 1-month-old. Child D was taken into foster care; mother and father were arrested and charged with neglect and causing or allowing Grievous Bodily Harm (GBH). The case was later dismissed due to the non-availability of a key witness.

Key issues: mother was physically abused and neglected as a child and had spent time in care.

Family history of violence and criminal activity.

Learning: focus on targets led to lack of critical assessment and professional desensitisation of the environment of violence and criminal activity the baby was growing up in.

Model: Social Care Institute for Excellence (SCIE) Learning Together model

Keywords: infant; injuries; adults abused as children.

March 2015 – Isle of Wight – Q Family

Long term physical, emotional and sexual abuse and neglect of several children within a family.

Background: Family had complex needs, requiring the involvement of multiple agencies over a period of nearly 20 years. Children were exposed to a highly sexualised environment and had unsupervised contact with an individual believed to be a risk to children. For 2 brief periods some or all of the children were placed on the child protection register. Care proceedings were initiated in 2013.

Key issues: domestic abuse; inter-sibling violence; parental alcohol misuse; and an aggressive, manipulative and litigious paternal response to professional interventions.

Learning: need for supervision and use of discretion in excluding hostile parents from child protection conferences.

Recommendations: multi-agency meetings should be convened if any agency has major concerns; records should be easily accessible and processes should allow multi-agency discussion of chronic cases without a single trigger event.

Keywords: repeated abuse, disclosure, hostile behaviour.

March 2015 - Kirklees – A young person

Attempted suicide of an adolescent boy in September 2013.

Background: The young person's attempt on his life has been linked to a drug influenced psychotic episode. Family were well known to agencies and there had been professional concerns around neglect of the young person and his siblings since 2005. Between 2009 and 2011 the young person was the subject of a child in need plan, a child protection plan, care proceedings and a supervision order.

Key issues: poor school attendance; offending; substance misuse; mother and young person's lack of engagement with professionals; mother's non-compliance with parenting orders and school attendance; and challenges associated with the significant number of professionals and agencies involved with the family.

Learning: need for professional awareness about the link between substance misuse and mental health problems and the link between long term neglect and suicide ideation; and need to maintain focus on older children when there are younger children in the family.

Recommendations: the development and implementation of a toolkit to help professionals engage with 'hard to engage' young people.

Keywords: suicide, adolescent boys, substance misuse.

March 2015 - Leeds – Child V

Death of a 17-year-old boy, as a result of hanging. Ryan was found with a ligature around his neck in a cell in a Young Offender Institute (YOI); Coroner's inquest concluded accidental death.

Background: Ryan had been in the care of Leeds City Council since he was 16-months-old; when he was 13-years-old his long-term foster placement broke down and he did not have another stable placement.

Key issues: history of extensive record of offending; chaotic lifestyle and risk-taking; aggressive behaviour; and frequent movement between accommodation.

Recommendations: corporate parenting responsibilities for promoting education, training and employment; and provision of suitable, specialised accommodation for young people with high

support needs

Keywords: adolescent boys, young offenders, suicide

March 2015 – Nottingham City – Child G

Death by drowning of a 10-month-old baby girl in May 2012.

Background: Mother stated she briefly left her infant unsupervised in the bath and pleaded guilty to involuntary manslaughter. Family were known to a number of services, including: police, health visitors, social care, probation services and Cafcass.

Key issues: professionals didn't consider the impact of parents' mental health, domestic abuse and substance misuse on children and some decisions were based on self-reported information from the parents as opposed to thorough assessments.

Recommendations: incidents of children being left home alone must be treated as a child protection issue and all appropriate family members should be included within risk assessments.

Model: systems methodology.

Keywords: infant deaths, family violence, optimistic behaviour.

March 2015 – Oxfordshire - Children A, B, C, D, E and F

Sexual exploitation of 6 girls aged 12-16 who were the victims of offences between May 2004 and June 2012.

Background: 9 men were charged with offences, of which 7 were convicted on 14 May 2013. Girls targeted had complex needs, and many were known to children's services or in care. They were groomed by older men who supplied them with drugs and alcohol.

Key issues: lack of understanding of child sexual exploitation, insufficient use of child protection processes, lack of organisational overview, difficulty managing missing children and a focus on young people's behaviour rather than their risk of being harmed.

Recommendations: review escalation procedures, clarify agencies' child protection roles and review national guidance on the use of disruption techniques in safeguarding children.

Keywords: child sexual exploitation, grooming, professional attitudes.

February 2015 - Hertfordshire – Young Person B

Suicide of a 17-year-old girl in April 2013. Child B was an inpatient in a specialist adolescent mental health clinic under Section 3 of the Mental Health Act 1983 at the time of her death.

Background: B was admitted to the clinic due to concerns that she had an eating disorder and because she had been self-harming. B lived with mother and step-father until January 2012 when she moved in with her boyfriend and then later her father. Although B's living arrangements were initially agreed by mother, she soon afterwards wanted B to return home. Family were known to services including Targeted Youth Support Service (TYSS) who worked with B, her mother and step-father to try to rebuild their relationship.

Learning: contact with children's services should be considered when a young person presents with significant mental ill-health and where there are concerns about the impact of family dynamics on protective factors; and formal consideration should be given to sharing the details of Community Treatment Orders (CTOs) with agencies providing services to young people placed on CTOs, including schools.

Model: Partnership Learning Review model

Keywords: suicide, self-harm, anorexia, Mental Health Act 1983

February 2015 – Southampton – Child K

Death of a 7-year-old boy in December 2011, as the result of a serious head injury.

Background: Mother's partner, Mr X, and Mr X's brother, Mr Y, were arrested following Child K's death however no prosecutions were made. This decision was reviewed in April 2014 and mother,

Mr X and Mr Y were arrested; in December 2014, the Crown Prosecution Service decided that no further action would be taken in relation to Child K's death. Family were well known to agencies and Child K and his siblings had been the subjects of Child Protection plans for a period in 2011. History of: significant and sustained domestic abuse; repeated witnessing of injuries to Child K; concerns from school over Child K's sexualised behaviour, poor attendance, attention-seeking behaviour and temper outbursts; and inadequate response to repeated referrals from maternal grandmother to children's social care.

Key issues: possible low expectations of professionals in relation to the quality of life Child K and his siblings could expect; and failure of practitioners to make connections between being intimidated by Mr X and the probability that Child K would feel similarly threatened.

Recommendations: raising public awareness locally of the links between domestic abuse and safeguarding of children.

Keywords: domestic abuse, physical abuse, scapegoating

January 2015 - Leeds – Child Y

Death of a 14-week-old girl in March 2012. Post-mortem examination jointly conducted by two pathologists resulted in the recording of two different probable causes of death:

Sudden Infant Death Syndrome and unascertainable.

Background: Child Y lived with mother, father and five older siblings in a three bedroom property at the time of the incident. Family had been known to children's services since 2003 and children were subject to Child in Need and Child Protection plans at different times before and after Child Y's death. Professionals' concerns primarily related to home conditions, children's personal hygiene and school attendance.

Key issues: poor assessments, not carried out in a timely manner contributing to 'drift'; and lack of appreciation of the long-term impact of neglect and belief that better outcomes would be achieved by maintaining parents' cooperation

Recommendations: various, focusing on conflict resolution, multi-agency working and training.

Model: systems model.

Keywords: child neglect, drift, co sleeping

January 2015 – Liverpool - Maisie

Death of a female infant in December 2013 as a result of Sudden Infant Death Syndrome

Background: Family were known to children's services in a neighbouring local authority where one of Maisie's siblings, Sibling 4, had been subject to a Child Protection plan.

Key issues: maternal alcohol misuse; domestic abuse; volatile relationship between mother and older sibling, Sibling 1; and deaths of two of mother's previous children from natural causes, the second of these deaths having been the subject of a serious case review (SCR).

Learning: need for clarity in relation to specialist roles such as the Enhanced Midwife, including clear expectations in relation to safeguarding; and changes in legislation, whereby previous contacts with children's services will be a contributory factor in granting Legal Aid, acting as a possible incentive towards making anonymous referrals.

Model: Uses a systems approach to present findings and questions for Liverpool Safeguarding Children Board.

Keywords: Sudden Infant Death Syndrome (SIDS), alcohol misuse, Common Assessment Framework (CAF)

January 2015 – Liverpool - Mary

Death of a 6-month-old girl in July 2013, cause of death unascertained. Post-mortem recorded that Mary was a well-nourished child and found no past or current injuries; a number of risk factors for sudden infant death syndrome were identified, including prematurity and parental smoking.

Background: History of family violence; parental substance misuse; and professional concerns

about school attendance levels and the health of Mary's two older siblings who were significantly overweight.

Findings: lack of a common language and understanding between agencies; insufficient professional recognition of parental failure to meet a child's education or health needs, as significant indicators of neglect; and ineffective follow-up from health services for a baby with on-going health needs in the care of parents with a poor history of engagement.

Recommendations: raises issues of consideration for Liverpool Safeguarding Children Board based on the review findings.

Model: uses a systems approach.

Keywords: Sudden Infant Death Syndrome (SIDS), child neglect, professional challenge

January 2015 - Oldham – Child D

Death of a 7-week-old English/Polish child in January 2014, as the result of a severe head injury and multiple other injuries.

Background: Mother, mother's boyfriend and another adult male were arrested on suspicion of murder. All adults were sentenced for Perverting the Cause of Justice; sentencing Judge commented that at least one of the adults must have been responsible for the injuries.

Key issues: mother emigrated to the UK from Poland in 2010. Mother reported not knowing she was pregnant until 2-weeks before Child D's birth and did not engage with community-based ante-natal services. Mother was known to police following a number of allegations of assault and domestic harassment.

Learning: insufficient professional curiosity given the concealment or denial of mother's pregnancy; and the use of two different formats for inputting dates of birth onto electronic systems contributing to an error that prevented sufficient sharing of information

Recommendations: the use of genograms by community-based practitioners as a tool to gather information and to prompt practitioners to be inquisitive; and simplification and consistency in data inputting formats and processes.

Keywords: professional curiosity, concealed pregnancy, domestic abuse

January 2015 - Tameside – Child F

Death of a child as the result of non-accidental head injury.

Background: Mother was on holiday and the time of the incident and Child F had been left in the care of mother's partner, MP1. MP1 was arrested on suspicion of murder.

Key issues: MP1 had a history of threatening and controlling behaviour.

Learning: strengthen safeguarding in the private housing sector and consider the risks posed by mothers' intimate partner relationships.

Recommendations: change police policy to ensure that any threats made indirectly or directly to children get a high risk rating and result in immediate action and ensure that child health checks and follow-ups are conducted in an effective and timely manner.

Keywords: child deaths, non-accidental head injuries, family violence.

January 2015 - Walsall – W4

Death of an adolescent girl in December 2012, caused by inhalation of the products of combustion.

Background: The Young Person had barricaded herself into her bedroom and set fire to a mattress following a dispute with her carers. At the time of her death, the Young Person was living in a care home where she was the only resident with two adult carers. When the Young Person was 3-years-old, she and her three siblings were removed from the care of their parents due to neglect and placed with their paternal uncle and aunt. The Young Person became a Looked After Child in the care of Walsall Children's Social Care when 15-years-old, during which time she experienced five placements, some of which were out of borough. Significant history of: aggressive and violent behaviour; offending; frequent absconding from placements to return to

family; risk-taking; and fire-setting

Recommendations: the option of secure accommodation must be regularly and robustly considered when the frequency and intensity of violent behaviour and absconding increases.

Keywords: adolescents, risk assessment, allegations of abuse