Summary of 'Pathways to Harm, Pathways to Protection: A Triennial Analysis of Serious Case Reviews 2011- 2014' published May 2016

This study is the fifth consecutive analysis of SCRs undertaken by the same research team from the University of Warwick and the University of East Anglia and commissioned by the Department for Education. The study considers 293 SCRs relating to incidents which occurred in the period 1st Aril 2011 to 31st March 2014. They are also analysed in the context of the learning from the previous reviews. A systems methodology has been adopted to inform the analysis.

Key Findings

- Once a child is known to be in need of protection and a plan is in place, the system generally works well.
- Overall increase in SCRs and a steady increase in activity across the system.
- No change in the number of child deaths linked to maltreatment and if anything a reduction in all except the older adolescent group.
- Only 12% had a CP plan in place at the time of their death or serious harm.
- Pressure points identified at 'step up' or 'step down'.
- Fewer than half had current involvement with CSC and almost two thirds had at some point been involved with CSC.
- Cases are closed too soon or lack ongoing support services/monitoring – long term planning needed where children have already suffered maltreatment.
- Good awareness of risk across workforce but not always rigorous enough in assessing and following through on identified risks.
- Where threshold to CSC is not met there may be little analysis of risk of harm and support plans may be unclear and can drift.
- For many of the children the harm they suffered occurred despite the effective and creative child safeguarding work by professionals.

Pathways to harm

- The most serious and fatal maltreatment takes place within the family.
- The youngest infants and older children (adolescents) stand out as being particularly at risk for different reasons.
- For adolescents, high correlation with mental health issues and risk taking behaviours; disabled children are particularly vulnerable where signs of abuse and neglect may be masked by, or misinterpreted as due to, underlying impairments.
- Parental and environmental risk factors in relation to domestic abuse, substance misuse and mental ill health have already been noted, but also include adversity in parents' own childhoods, history of violent crime, multiple consecutive partners, acrimonious separation and social isolation. Practitioners should consider cumulative risks with any of these risk factors.
- Step change required with how we understand and respond to domestic abuse – the impact of all DA is harmful to children – move from incident based models to understanding the nature and impact of coercive control.
- Impact of transient lifestyles and inappropriate housing.
- Be alert to the fact that not all family networks will be supportive.
- Vulnerability if not in school due to 'invisibility' and social isolation and impact of managed moves across schools on established relationships.

Pathways to Prevention and Protection

- *Hearing the voices of the children and families* – voices of adolescents of equal importance to younger children; attend to 'silent' ways of communicating; particular issues for families talking about CSE; need to hear father's voice if families are separated/separating; maintain attitude of respectful uncertainty and professional curiosity.
- *Assessment and thresholds* – need for clear thresholds and pathways for escalation and de-escalation and more robust approach to CAF. CSC assessments need to be planned, comprehensive and timely and involve all professionals; view assessment as an ongoing process and not a one-off event; closure to CSC does not necessarily mean risks have ceased.
- *Reluctance to take responsibility* – do not hang back and expect others to act or pass on information and then think responsibility has ended; do not make assumptions and check out facts; do not have a narrow view of responsibility bound by own discipline.

Agency Structures, Processes and Cultures

- *Building effective structures* – concerns are identified about impact of reconfiguration of services particularly in social care and health; need to ensure staffing structures reflect appropriate knowledge, skills and experience. Risks highlighted through complexity and fragmentation of primary health services through mix of providers and relative isolation of practitioners. Importance of recording and passing on information stressed, particularly in periods of transition. Complexity is compounded in secondary health care and interplay between primary and secondary. Clear co-ordinated pathways across health services for families with particular vulnerabilities are needed with clear signposting and reasons for accepting/rejecting cases.
- *Coping with limited resources* – steady increase in activity alongside budget cuts leading to higher workloads. This can affect effective joint working, delays, quality of assessments. Consider admin support, scheduling of work, strengthen staff support and management. This is an imperative area for leaders and managers to address.
- *Embedding responsive cultures* – need shift from incident/episodic service provision to culture of long-term and continuous support and need managerial permission for this shift in tackling neglect/emotional abuse. Complexity and dynamics in family can be mirrored in involvement and responses of professionals. Principles of authoritative practice recommended i.e. professionals exercise judgement, encourage professional curiosity, take responsibility, respect and value role of others alongside relationships of trust with children and families. Combination of authority, empathy and humility.

Quality of SCRs

- Concerns about detail at expense of clarity and analysis and need for briefer more proportionate SCRs to reduce delay and speed up learning.
- Overall reports were shorter with fewer recommendations but variations in quality of recommendations.
- Reasons for delays in publishing include complex negotiations re decision making to initiate the review; hold ups during the process; delays in releasing report for publication, often because of concerns on impact on family.

- Greater adoption of systems methodologies leading to more learning points and fewer recommendations and deeper analysis. Some findings lack recommendations.
- Good quality SCRs should incorporate lessons learnt linking to findings of the review; findings and questions for the LSCB to promote deeper reflection and response and action plan to address the learning; include recommendations for case for change; strategy for dissemination and learning to reach practitioners and managers.
- Recommend moving away from pronouncing whether a death or serious harm could have been prevented because there are always lessons to be learnt. This embraces model of pathways to harm and protection. Move from blame and failure to narrative of 'progress and hope', affirming achievement and talking hold of opportunities to learn and improve.

Issues for Oxfordshire

All findings are noteworthy and should be reinforced for managers and practitioners, many are consistent with our own findings in our quality assurance work and some have already been taken on board locally, specifically following the SCR into Children A-F. The following points are worth highlighting in particular.

For senior managers

- Coping with limited resources and increased activity and need for senior leaders to identify strategies to manage workloads and sustain acceptable levels through ongoing vigilance.
- Alongside this is the recommendation that there should be long term continuous approaches where maltreatment has been identified and a move away for single or episodic responses.
- Effective structures to be maintained through service change particularly in health and social care. Complexity of health structures noted and need for clear pathways and information sharing across transition points - locally had a potential impact on Baby L.

For practitioners and front line managers

- Step change required with how we understand and respond to domestic abuse and the need to move from incident based models to understanding the nature and impact of coercive control – Child J.
- Disabled children are particularly vulnerable where signs of abuse and neglect may be masked by, or misinterpreted as due to, underlying impairments.

The full report is available here *Link*

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