



Learning the lessons from Serious Case Reviews



SCRs - The Statutory Context

- Serious Case Reviews are carried out when abuse and neglect are known or suspected factors when a child dies or is seriously injured – and when there are lessons to be learned about inter-agency working
(Working Together to Safeguard Children, 2006)



What's the point?

- **TO LEARN** – we must identify what went wrong and work to put it right
- More broadly, to inform national research so that more can be understood about patterns of behaviour – children, families, professionals and organisations



Safeguarding is Everyone's Business

- Lessons from SCRs do not just relate to agencies whose work involves responsibility for child protection
- Everyone that has direct or indirect contact with families where there are children has a responsibility to those children and should raise concerns if they have them

“It is simpler to lift the telephone than live with the regret of not doing so” SCR Baby Peter



Key Lessons

- Core learning points are common to **all** serious case reviews – the national picture



It is not easy

- Child Protection work is hugely complex
- We all work most of the time with shades of grey and need help from each other to give these definition
- In the context of a child protection investigation there is no reason not to share what you know or what makes you concerned
It's called 'Working Together to Safeguard Children' for a reason

Lesson: Authoritative Practice

- To be effective, professionals working in the field of child protection have to be authoritative
- Authoritative practice does not mean you have to shout louder and is not without compassion and support
- Authoritative practitioners understand the need for challenge and are confident in the face of the facts
- Authoritative practitioners share information appropriately

Authoritative Practice

- Authoritative practitioners contribute effectively to assessments, conferences and core groups
- An authoritative child protection plan is not a list of concerns; it clearly identifies risk, response and desired outcome
- Authoritative practice follows through when response/outcome does not happen

EXAMPLE: BABY PETER

- It was known from the outset that there were indicators of risk - indicators that individually and together warranted further investigation
- Every agency had opportunities later to review their assessment of what was going on – and didn't
- Facts reduced in significance in the face of an adult's apparent willingness to comply and professionals' willingness to believe

Think the Unthinkable

- LOOK AT THE FACTS, ask questions, explore your hunches
 - WHERE IS THE EVIDENCE of change?
- Research
75% parents do not co-operate with services (includes disguised compliance & "telling workers what they want to hear") Brandon et al, 2009

Lesson: Past history – an indicator of present risk

- Understanding the impact of an adult's past history is crucial to any assessment of risk to their children in the present
- The effects of child abuse can be severe and last into adulthood
- Past history is an indicator of capacity for good attachment

Research

"Any assessment should take account of past or potential patterns of behaviour or concerns" Brandon et al, 2009

Lesson: Attachment is not the same as Interaction

- Do not confuse a strong attachment with a good adult/child interaction
- Abusive parents can appear to have good interactions with their children – they may overcompensate or put on a display for strangers
- A proper assessment of the quality of attachment takes time and expertise

Lesson: A 'Seen' child is not a Safe child



- How many case files record 'child seen'? What does that really tell you?
- Almost every child that has died in the last 40 years was 'seen' by professionals within days (or hours) of their death
- Seeing a child is only effective if it helps you understand what it is like to be that child - ask yourself – what is it like to be that child, or better still, ASK THEM
- Older children often ignored

Lesson: Domestic Violence is a serious risk to children



- The presence of a child in a household where domestic violence is an issue should immediately alert you to risk. To see them and do nothing is unacceptable
- "Where there is DV in families with a child under 12 months old (including an unborn child), even if the child was not present, any single incident of DV should trigger a CP investigation"
London Child Protection Procedures 2007, 5.11.35
- The "hidden" men

Lesson: Involvement is not the same as Engagement



- NEVER ASSUME
- At times in the Baby Peter case professionals failed to act because they thought other involved professionals would
- Child protection is like a relay race – make sure the information you hand over has been received and understood
- CP Plans must be clear about who is responsible for what

Lesson: Participation is not the same as Co-operation



- Don't confuse an **apparent** willingness to turn up for meetings/appointments with an **actual** willingness to co-operate with a child protection investigation or plan
- Rule of optimism rationalises evidence that contradicts progress
- Rule of optimism more likely to prevail when staff feel under duress

Lesson: Neglect is a Relationship Issue



Neglect is not just about nits

- It could be an indicator of a flawed adult/child relationship, about which you need to do something
- All neglect indicators stem from a parental choice to prioritise something else above their child's basic needs
- Use the indicators (head lice, weight loss, appetite etc) to question the relationship

Lesson: No two families are the same



- **There is no such thing as a typical family for your area and it is dangerous to think that way**
- Many families you work with are vulnerable; it's easy to be too tolerant of levels of neglect and miss the individual risk indicators

Recommended actions



- Establish a Safeguarding Service Development Group by a senior manager
- Undertake a QA case file audit of safeguarding cases against national standards
- Embed a system of monthly/quarterly monitoring of safeguarding case activity
- Undertake an audit and review of practice, policies and procedures
- Implement as required robust policies and procedures supported by a set of minimum practice standards from contact to closure including Assessment of Risk
- Establish a permanent post of Safeguarding Manager

Recommended actions



- Conduct regular themed audits eg neglect
- Review and upgrade Safeguarding training at Foundation , Intermediate and Advanced levels(including head office staff and Trustees)
- Review and strengthen Social Car Induction process with regard to Safeguarding
- Review and strengthen supervision arrangements – reflective practice
- Hold staff conferences/seminars to share learning and promote good practice

How can we help others learn?



- Take the key messages to team meetings /staff conferences and discuss
- Have them in mind whenever you do and receive supervision
- Make an understanding of them a demonstrable objective in your performance appraisals
- Want more for children and families than they want for themselves

How can we help others learn?



- Identify which staff need help in which areas and provide the training that meets their needs
- Ensure that you protect their time so that they can attend training
- Talk to them afterwards – did they learn anything? Test it in supervision

It is essential that Family Support staff and managers :



- Have the necessary skills and knowledge to assess and work authoritatively with risk ,complexity of need and neglect
- Are able to work in partnership with social workers as part of an agreed child protection plan wherein the role and purpose of family support is made explicit
- Are able, supported by managers, to use their professional authority to challenge bad practice (including poor communication) and, if necessary, to escalate their concerns
- Are able to challenge the appropriateness of a family support intervention where this does not seem to be appropriate to the assessed level of need and risk
- Receive the supervision and management support necessary to ensure high quality safeguarding practice

Two final thoughts



- Tendency to optimism and unwillingness to be judgemental
- Fixed thinking – assessments an event rather than a process

And finally...make time for the research



- Biannual reviews of SCRs
www.dcsf.gov.uk/research
- Children under 1 consistently highest % subjects (46% 07; 47% 05)
- Despite copious guidance professionals are still unsure about what information to share

Other useful sites



- www.C4EO.org.uk (Centre for Excellence Outcomes in Children & Young People's Services)
- www.rip.org.uk (Research in Practice)
- www.scie.org.uk (Social Care Institute for Excellence)
- www.nice.org.uk (National Institute for Health & Clinical Excellence)
- www.ofsted.gov.uk