

Serious Case Reviews in London

Briefing Note for the Safeguarding Children Board

Introduction

The London Safeguarding Children Board has recently produced its first annual report of Serious Case Reviews (SCRs) in London based on a sample of 27 SCRs over a 2 year period from 2004-6.

Aims

This project aims to identify and analyse the common findings and recommendations for service improvement in as short a timescale as possible with the following objectives:

- To add value and support learning for London
- To propose action to improve practice and procedures
- To develop an approved list of SCR consultants and a toolkit for best practice

London Context

It is important to recognise some of the unique challenges that face professionals working to safeguard children in London, as follows:

Cultural Diversity

London is characterised by high levels of cultural diversity and some 40% of the population are from a minority ethnic group. 32% of children in secondary schools have English as a second or other language and in primary schools, the figure overall is 37% and 51% for inner London.

Language is one of a number of critical factors that contributes to a failure to engage effectively with minority groups that is evident from this project.

Deprivation

There are more children and families living in poverty than anywhere else in the UK, 51% compared with 28% nationally. Research has shown that children in the lowest social class are more likely to die in the first year of life and twice as likely to die before the age of 15 compared to children in the highest social class (Botting, Roberts).

A quarter of children in London live in families where unemployment is a feature, the highest proportion in the country.

Mobility

60% of London boroughs have high numbers of mobile families with the associated risks of failure to access services and social exclusion. Large numbers of families are resident in temporary accommodation and over one fifth of mobile families are not registered with a GP.

Mental Health

Known to be on the increase for young people and linked with other factors such as homelessness. Children of refugees are particularly vulnerable and the large refugee population presents challenges in terms of access to services. There are large numbers of adults with mental health problems in London, with additional complexities for BMER communities.

Children living with parental mental illness may be in need of support and protection from a range of risks, including the strain of caring for a mentally ill relative.

Serious Case Review Reports

The purpose of Serious Case Reviews, as set out in Working Together 2006 is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what these lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence.
- To improve inter-agency working and better safeguard and promote the welfare of children.

The reports need to ensure clear information is produced that enables practice to change. However, analysis of the reports showed the following:

- Variable quality
- Varying number of recommendations (from 2 to 48)
- Difficult to identify lessons
- Lack of sense of urgency for implementation of recommendations
- Not clearly distinguished as needing single-agency or multi-agency response

There are therefore implications about the quality and consistency of reports and the commissioning framework and resources.

Profile of Cases

Age

43% 6 months and under
50% one year and under
16% age 2 and 3
20% age 4 to 10
13% age 13 to 18

Types of Injury

A wide spectrum including shaking, (highest number), suffocation, drowning, neglect, stabbing, poisoning, hanging and others. This included a child who died through ritualistic abuse.

Perpetrator

Father 54%
Mother 50%
Grandmother 4%
Brother 4%
Subject 8%

Ethnicity

65% of SCRs featured BMER families, 42% of whom were immigrants arrived in last 5 years

Selected Case Features

- Children on the child protection register 19% (five cases)
- Neglect as central feature 19% (five cases)
- Presence of fabricated and induced illness 8% (two cases)
- Existence of child sexual abuse 8% (two cases)
- No LA children's social care involvement prior to the incident 27% (six cases) however, in all six cases evidence of prior neglect and abuse that had not been notified to LA.
- Mother and child died together 8 % (two cases) one in which mother killed herself and child and in the other mother's partner killed both.

What's Significant About London Data Compared With The National Picture?

Higher number of cases open to Children's Social Care (London 73%, nationally 30%)

Younger age profile (London 55% under 1, nationally 15%, London, 16% over 10, nationally 60%)

High mobility (high both London and nationally)

Immigrants (data not known nationally but 42% in London)

Parental mental health (48% in London, 35% nationally)

Domestic Violence (56% in London (data not recorded nationally))

Key lessons: Emerging Themes

Managing Information

Serious failures in recording, reviewing and analysing information. Poor quality of recording of historical information and chronologies as well as current events. Errors in recording practice and file storage.

Listening to Other's Concerns

In many cases, professionals did not give enough consideration to concerns of other professionals or family members and in some cases this was due to lack of respect and poor professional attitude.

A critical factor was the need to recognise that third party information, including that provided by the general public must be given the same status and same duties to refer arise.

Multi-agency Assessments

75% demonstrated need for improved assessment, for example, family where on at least 8 occasions, mother had experienced DV and yet this was not addressed by any agency as a concern in its own right. Need for assessments to be 'live' and involve direct contact with family and other professionals.

Risk of Harm

In 58% cases reference made to need for and absence of assessment of risk of harm to child, for example adult mental health assessment did not include any consideration of risk to child. Need for a sharper risk led focus using history and patterns of behaviour. Evidence of false optimism and 'fresh start syndrome' with fatal consequences.

Care Planning

55% cases had no plan and tendency to be reactive rather than strategic. There was a gap in contingency planning and following up to ensure interventions had been delivered (e.g. money given for cot but no-one checked if it had been bought and was being used).

Lead Professional

A number of cases lacked a lead professional and consequently co-ordination.

CP Knowledge and Compliance

In 63% of cases, professionals lacked knowledge and/or failed to comply with CP procedures, resulting in failures to protect and missed opportunities.

Multi-agency Working

Poor co-operation, failures in information sharing and poor multi-agency involvement in assessment, planning and monitoring.

Challenge

A number of cases featured professional disagreement that remained unresolved to the detriment of children. There was a tendency to defer to medical opinion and professional hierarchy affected judgement. Many challenges resulted from thresholding differences.

Child Focus

56% SCRs identified that intervention was focused on the adult's needs at the expense of the child. There were still too many cases where the child was not spoken to and the impact of the parental behaviour on the child not given sufficient consideration.

Working with DV

Services frequently failed both the children and mothers and there was a need for a more holistic approach based on sound information sharing practice. Barriers in accessing interpreting services were noted in some cases and overall a clear framework for assessing and managing risk is lacking, hence the development of new procedures.

Working with Violent and Aggressive Families

Staff needed more help and support in dealing with difficult families and challenging non-compliance. There is a need for a multi-agency response to be developed and for practitioners to develop more 'professional scepticism' in dealing with un-cooperative families.

Responding to New Concerns

The report identified a need for a more dynamic approach that was responsive to new information and risk indicators such as parental mental illness. In change of circumstances, there should be a multi-agency review and more authoritative intervention to deal with drift and cases seen as 'stuck'.

Other Issues

- **Neglect**, all cases were concurrent with other forms of abuse. Tolerance of lack of progress was a feature and managers and conference chairs need to provide direction and oversight.
- **FII** In neither case was FII addressed as an issue and this needed to be fully explored.
- **Sexual Abuse**, professionals failed to recognise signs of sexual abuse and this was not covered in the SCR as not a recognised feature of the case. There was also a failure to share information in a case where a sibling was at risk. In the case where the child was a perpetrator, the possibility of him being a victim was not given consideration.

London Themes

Diversity

- 65% BMER
- Need to address diversity issues as part of assessment
- Poor response to statutory services, especially where DV and MH issues
- Lack of training and confidence
- Poor practice, failure to address cultural and racial issues
- Access to interpreters

Mobility

- Challenge of families in Temp Accommodation
- Boundary issues
- Problems in tracking and transferring information and records

Mental Health

- Current systems are failing children and parents
- Failure to recognise impact of mental illness on children
- Eligibility criteria for services did not include having children
- Discharge did not consider parenting capacity

Recommendations

These are organised into thematic recommendations, recommendations that are general and those that are specific to services or circumstances. There are over 30 pages of detailed recommendations that include all services.

The report concludes with the following recommendations:

- Standard format for Serious Case Reviews using standardised headings.
- London Board to embark on scoping exercise re SCRs.
- London Board and LSCBs to consider thresholds for different reviews to maximise learning, including NHS serious untoward incidents.
- Adoption of standard chronology software package across London.
- Training for staff in undertaking internal management reviews.
- Training in compiling overview reports.
- Independence of overview author.
- Consideration of approved list of consultants and commissioning arrangements.
- LSCB review of training programme to incorporate:
 - Professional curiosity
 - Responsibility/accountability
 - Understanding of own and other's roles
 - Confidence in recognising harm
 - Confidence in sharing information
- Development of and commitment to a robust London wide conflict resolution model (new procedures) and training to raise confidence in challenging other professionals.

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