Findings from Local and National Serious Case Reviews
GSCB Roadshows 2014

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Plan

- General facts – National and Local
- National examples and learning
- Local example and learning
- NSPCC – learning from SCRs (Thematic briefings)
- Summary of key themes
Serious Case Reviews are taking place regularly across the country. These are all published on the LSCB websites and NSPCC. There is a lot of ‘learning’ out there!

In July 2014 the DfE published a study “Barriers to Learning: SCRs”. Key themes were identified relating to culture and training, SCR process and publications and impact of Policy and procedures.

Systems reviews are becoming more embedded in practice – although many SCRs from traditional style still being published.
General facts about SCR – Local

- We have completed two SCIE ‘Learning Together’ reviews (2011 and 2012).
- Gloucestershire published a SCR in the summer 2014.
- We have recently started a new SCR relating to the 16 yr old pregnant girl who was killed by her boyfriend.
- We are due to start another SCR in relation to a baby that died last summer. The criminal trial has not yet concluded.
Key learning – National

- The learning from key SCRs (Daniel Pelka, Keanu Williams, Hamzah Khan, Rochdale – Child Sexual Exploitation) was shared through workshops last year.
  (presentation available if wanted)

- Number of new SCRs (Plymouth, Lincoln and Devon) have recently been published the learning is very similar
Child E – Plymouth

- Traditional IMR methodology
- 4 week baby died due to significant head injury
- Mum had history of universal services
- Dad had significant history of statutory services (Police, probation, Youth Offending and Connexions)
LEARNING – Child E

- Dad’s history was not known by new professionals and therefore was not considered in the pre birth assessments
- Dad asked the GP for help with his drinking as new baby on the way
- The impact of this information was not considered from the child’s perspective
- Midwife did not ask mother about Domestic Abuse
- Assumption made that extended family were supportive
SCIE ‘Learning Together’ model used

3 month old baby received a significant head injury through Non Accidental Injury (NAI)

Mother and father had significant history with statutory services.

Mother was 18yrs and had previous children

Father was 34yrs and had had previous children removed, but then acquired a residence order for subsequent children
LEARNING – baby H

- Information was lost between professionals
- Response from professionals was incident focused and dealt with the presenting issue rather than looking at the wider / holistic view e.g. when baby was removed against medical advice
- Impact on professionals working with challenging parents was under estimated which affected decisions made by staff and ability to reflect on events was not prioritised.
Child V died at 14 months old due to significant head injury (shaken)

Child had had a previous admission to hospital for head injury and questionable bite mark seen on child’s leg at the time

Family moved house between the two incidents

Mother heavily pregnant and gave birth a week after child V died

Step father had raised previous concern that child ‘bruised easily’
LEARNING – Child V

- Change in management oversight impacted on continuity of challenge

- The change of status from Child Protection to Child in Need was quick and holistic risk assessment not completed

- EDT were central to both incidents – OOH response needs to be tight and ensure information / time / evidence is not lost

- Lack of professional curiosity

- Discrepancies in information not challenged
Child Abigail – Gloucestershire

- Abigail was 5 yrs and suffered significant neglect
- Large family who were known to statutory services for many years
- History of neglect, domestic and sexual abuse
- Partial and non engagement of the family with services for many years
Impact of neglect on children underestimated and a need for a shared understanding across partnership

Child’s experience needs to be central to all interventions

When parents engage / disengage with services what impact is this having on the child?

Plans for children need to be outcome focused to prevent delay

Professionals need confidence to challenge and question other professionals
Disguised compliance
“..involves parents giving the appearance of co–operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and to delay or avoid professional intervention.”

- Very young children are at particular risk from a lack of timely intervention due to disguised compliance
Learning for improved practice

- **Establish facts** – gather evidence what has been achieved
- **Chronologies** – evidence past parenting behaviour
- **Recording** – child’s perspective
- **Outcome focussed** – rather than process
- **Supervision** – reflection and challenge

NEED TO GET THE BASICS RIGHT!!
NSPCC briefings – Housing sector

- Housing have a unique insight into family lifestyle and behaviour
- Many housing issues are emerging child protection issues
- Housing often are the first agency to see child protection issues

Learning for Improved practice

- Housing assessments need to include focus on child protection
- Professional challenge required
Learning for improved practice

- See Parents – Think Child
- Share information and make referrals (many SCRs show good practice in VCS – need to put referrals in writing)
- Receiving referrals – need to let referrer know if appointments missed / non engagement
- Clarify role and expectations – frequently assumptions made, continue to report concerns

http://www.nspcc.org.uk/preventing-abuse/research-and-resources/at-a-glance-thematic-briefings/
Summary of key learning (National and Local)

- Think Family – what is the impact on the child of the parents behaviour?
- Professional curiosity
- History needs to inform assessment and be shared
- Childs experience needs to be highlighted and remain central to planning and decisions
- Processes are there to support practice not to take away professional judgement / thinking

Child deaths are not always preventable but we need to ensure our safeguarding system’s are robust