INTRODUCTION

Serious case reviews are carried out when abuse and neglect are known or suspected factors when a child dies (or is seriously injured or harmed), and there are lessons to be learnt about inter-agency working to protect children. At least every two years, an overview analysis of serious case reviews in England is conducted to draw out themes and trends, so that lessons learnt from these cases as a whole can inform both policy and practice. This is the third such overview analysis and involved a near-total sample of 161 cases.

Key Findings and Learning Points:

• Two thirds of the 161 children died and a third were seriously injured.

• A total of 47% of the children were aged under one, but 25% were over 11 years, including 9% who were over 16. Many older children were ‘hard to help’ and failed by agencies.

• A total of 12% of children were named on the child protection register, and 55% of children were known to children’s social care at the time of the incident.

• The families of very young children who were physically assaulted (including those with head injuries) tended to be in contact with universal services or adult services rather than children’s social care.

• In families where children suffered long term neglect, children’s social care often failed to take account of past history and adopted the ‘start again syndrome’

• In the cases where the information was available, well over half of the children had been living with domestic violence, or parental mental ill health, or parental substance misuse. These three problems often co-existed
The Study

The study analysed, for the first time, a near total sample of 161 serious case reviews undertaken during the two year period from April 2003 to March 2005.

The ‘full sample’ of 161 cases included all of the available incidents of child fatality or serious injury through abuse or neglect, notified to CSCI (Commission for Social Care Inspection), which were the subject of a serious case review. Only basic information recorded at the time the incident was notified to CSCI, was available which means that some of this information is sparse or proved to be incorrect.

The ‘intensive sample’ is a sub-sample of 47 reviews drawn from the 161 cases where fuller, more detailed information is available from the serious case reviews’ overview reports and chronologies.

The overall aim of the study was to use the learning from serious case reviews to improve multi-agency practice at all levels of intervention including universal services and early intervention. It also aimed to analyse the ecological-transactional factors (also referred to as inter-acting risk factors) for children who became the subject of serious case reviews.

The findings about the children and their circumstances make powerful and painful reading. Prevention of child death or injury through abuse or neglect is uppermost in the minds of practitioners and managers working with children and families. However, the complexity of family circumstances means that even if the ‘whole picture’ of family circumstances had been known, it would not always have been possible to predict an outcome for most of the children. Although the majority of these cases may be essentially unpredictable, and working with uncertainty and risk is at the core of work with children and families, in most reviews there were numerous childhood adversities that were not known to practitioners. Awareness of these difficulties and the way in which they had an impact on family life would have aided professionals’ understanding of the children’s circumstances.

To have a better chance of understanding the risks of harm that children face, practitioners should be encouraged to be curious and to think critically and systematically. Being aware of the way in which separate factors can interact to protect from harm or cause increased risks of harm to the child is a vital step in this process. Since in many of the cases families were known to adult services and not just to children’s services, the well being of children and whole families must also be a priority for those working in services for adults.

The reviews identified not only confusion and misunderstanding of thresholds, but also a preoccupation among agencies with eligibility criteria for services rather than a primary concern about the child or children with whom they were working. A key test of the effectiveness of Local Safeguarding Children Boards will be the extent to which they are able to rectify the long standing problems with thresholds.

Attempts to learn from these cases and a determination to prevent or avoid their reoccurrence can lead individuals to misinterpret and misapply information. Although domestic violence, parental mental ill health and substance misuse were common, it is important to stress that, in this study, there are no clear causal relationships between these potentially problematic parental behaviours and child death or serious injury.

In Working Together to Safeguard Children 2006 there is a government commitment to serious case reviews being analysed periodically. To optimise the learning from the deaths and serious injury of these children, there is a need for consistently reported minimum information. This will help build a more rigorous knowledge base to provide better pointers to prevention of injury or death where abuse or neglect is a factor.

Detailed Findings

The children

In two thirds of the reviews the children died and in a third the children were seriously injured. As in other studies of serious case reviews, almost half of the children were under the age of one year. Many of these babies had non fatal injuries (often head injuries). A quarter of the children were aged between one and five years, and a further quarter were over eleven years old, including a significant minority who were aged over sixteen. This shows that older adolescents are being significantly harmed or dying (many committed suicide).
Practice notes:

• Staff working with young babies and their families, particularly midwives, health visitors and GPs, have a key role in safeguarding children.

• Some older adolescents are beyond the reach of existing services and their vulnerability is not being recognised or taken sufficiently seriously by professionals.

The parents and carers
Using information from the detailed sub-sample of 47 cases, there was evidence of house moves for about one third of parents and carers and a similar proportion were living in poor conditions. Only a small minority had supportive family links. There was evidence of domestic violence in two thirds of families, and mental health problems or substance misuse among well over half of the parents or carers. The coexistence of all three potentially problematic parental behaviours was evident in a third of these families.

Practice note:

• The added impact of parental mental ill health, to the known risks of harm to children when domestic violence and parental drug or alcohol misuse coexist, is a potential risk factor which should inform both assessment and intervention.

Which agencies were working with these families?
Although 83% of the families had been previously known to children’s social care, little more than half of the children were recorded as receiving services from children’s social care at the time of the incident which resulted in the serious case review. A number of cases, however, had been ‘closed’ by specialist services days or weeks before the incident. As in other studies of serious case reviews, few of the children’s names were listed on the child protection register (12%). This is a reminder that children living with the serious risks of harm reflected in these case reviews are rarely within the ambit of formal safeguarding procedures.

All practitioners, and particularly those working with the Common Assessment Framework and adopting lead professional roles, need a holistic understanding of children and families. They should be alert to the way in which separate factors can interact to cause increased risks of harm to the child. Practitioners identifying additional needs for children should be supported in understanding when it is safe to work with early, low level safeguarding concerns, and when to adopt Local Safeguarding Children procedures without delay.

Practice notes:

• All practitioners working with children and in services for adults need to be aware of the risks of significant harm across all levels of need and intervention.

• Working with early needs means working within, not outside of, the safeguarding continuum.

How did families and practitioners work together?
In many cases parents were hostile to helping agencies and workers were often frightened to visit family homes. These circumstances could have a paralysing effect on practitioners, hampering their ability to reflect, make judgments, act clearly, and to follow through with referrals, assessments or plans. Apparent or disguised cooperation from parents often prevented or delayed understanding of the severity of harm to the child and cases drifted. Where parents made it difficult for professionals to see children or engineered the focus away from allegations of harm, children went unseen and unheard.

When reluctant family engagement was coupled with frequent moves of home, records were often sketchy or inaccurate and practitioners would not be aware of the sequences of events or behaviours which might be indicative of serious risks of harm to the child or children.

How did agencies work together, share information and challenge each other?
As in all other studies of serious case reviews, communication problems among agencies and professionals were common. However, there was some evidence that direct verbal communication provided a more immediate and effective way to share concerns.

There was hesitancy in challenging the opinion of other professionals which appeared to stem from a lack of confidence, knowledge, experience or status. Although there were some good examples of incidents of confident professional challenge, sustained challenge was difficult, and differences of opinion or judgment were rarely pursued to a satisfactory conclusion.
Practice note:
- Since there is considerable emphasis currently on electronic information sharing, it is very important to remember the power of personal contact.

Typology of cases

In-depth analysis of the intensive sample of 47 cases revealed an even clustering into the following broad but overlapping themes:

- Neglect
- Physical assault
- ‘Hard to help’ older children (aged over 13 years) who experienced ‘agency neglect’.

Neglect:
Many families where children were severely neglected were well known to children’s social care over many years, often over generations. Family histories were complex, confusing, and often overwhelming for practitioners. One common way of dealing with the overwhelming information and the feelings of helplessness generated in workers by the families, was to put aside knowledge of the past and focus on the present, adopting what we refer to as the ‘start again syndrome’. In cases where children had already been removed because of neglect, parental history was not fully analysed to consider their current capacity to care for this child. Instead agencies supported the mother and family to ‘start again’. The ‘start again syndrome’ prevents practitioners and managers having a clear and systematic understanding of a case informed by past history.

Engagement with agencies
Families tended to be ambivalent or hostile towards helping agencies, and staff were often fearful of violent and hostile men. Although parents tended to avoid agencies, agencies also avoided or rebuffed parents by offering a succession of workers, closing the case, losing files or key information, by re-assessing, referring on, or through initiating and then dropping court proceedings. There was systemic failure to engage with the parents’ fundamental problems in parenting and the child’s experience of direct or indirect harm. These problems were exacerbated by the lack of a shared understanding of definitions and thresholds for neglect, leading to confusion and delay of key decisions (see also Gardner forthcoming).

Practice note:
- The ‘start again syndrome’ prevents practitioners thinking and acting systematically in cases of long standing neglect.

Physical assault in young children
Although there were some similarities to the family profiles in the ‘neglect’ cases the key difference was the presence of ‘volatility’, which tended to erupt into violence. In addition there was often a history of previous injury, illness or admission to Accident and Emergency for the baby or child. In these cases, there was less contact with children’s social care, or involvement for briefer periods of time and greater involvement with services for early needs or universal services in these cases. Domestic violence was present in almost all these families.

Engagement with agencies
The police tended to be the agency most involved with these families, often containing domestic or community conflict or violence. Some parents had mental health difficulties and past, but rarely current, involvement with children’s social care. Links with probation and mental health agencies were more frequent than links with children’s social care. Many, but not all, families were ‘difficult to engage’ with many missed appointments. There was sometimes a lack of awareness on the part of health staff and some branches of the police force to the link between domestic violence and the risk of harm to the child.

Practice note:
- Family ‘volatility’ and a history of previous injury or admission to A&E for the child present warning signs of abuse. Moreover, community and hospital based practitioners need a greater awareness of the dangers of domestic violence to children’s safety.

‘Hard to help’ older children
The theme of older adolescent children who were very difficult to help emerged powerfully. Almost all of these ‘hard to help’ older young people (over the age of 13) had a long history of high level involvement from children’s social care and other specialist agencies, including periods of state care. Latterly, agencies had ‘neglected’ these young people’s needs.
**Profile**

Most children who had experienced extensive contact with agencies shared elements of the following profile:

- A history of rejection and loss and usually severe maltreatment over many years.
- Parents or carers with their own history of abuse and rejection, most of whom misused substances and had mental health difficulties.
- By adolescence most were typically harming themselves, neglecting themselves, and misusing substances.
- It was difficult to contain these young people in school and in placement. There were numerous placement breakdowns featuring running away. Going missing increased the risk of sexual exploitation and risky sexual activity. The causes of running away were not properly addressed.
- Persistent running away sometimes led to discharge home, so that at the time of the incident which prompted the serious case review, the young person may have been receiving low level services only.

This catalogue of risk factors reinforces the view that it is the cumulative interaction between these difficulties that produces the most harmful effects (Rutter 1979). The reviews showed that state care did not always support these young people fully.

**Engagement with agencies**

Agencies appeared to have run out of helping strategies and were sometimes reluctant to assess these young people as mentally ill and/or with suicidal intent. Time was wasted arguing about which agency was responsible for which service and whether thresholds were met, thereby delaying the provision of services that the young people needed. There was a lack of coordination of services for these young people 'in transition' and failures to respond in a sustained way to their extreme distress which occurred in parallel to their very risky behaviour.

**Practice note:**

- ‘Agency neglect’ of these ‘hard to reach’ young people should be acknowledged. More creative, more responsive services are needed that address the young people’s trauma and the root causes of their problems. Better join up with adult services is essential.

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**Additional Information**

*The full report (DCSF-RB023) can be accessed at [www.dcsf.gov.uk/research/](http://www.dcsf.gov.uk/research/)*

*Further information about this research can be obtained from Nigel Gee, 6S22, DCSF, Sanctuary Buildings, Great Smith Street, London SW1P 3BT.*

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*The views expressed in this report are the authors’ and do not necessarily reflect those of the Department for Children, Schools and Families.*