

Practice Notes



Welcome

Welcome to the first **Practice Notes** newsletter which has been drawn up by the Local Safeguarding Children's Board (LSCB) in conjunction with the Children and Young People's Trust (CYPT). It aims to support practitioners in statutory and third sector children's services to keep up to date with findings from Serious Case Reviews (SCRs); Individual Management Reports (IMRs) and Serious Untoward Incidents (SUIs).

In the future, **Practice notes** will also have a section on findings from our Standards and Complaints manager and from other audits which inform us of good practice as well as where services could be strengthened. The newsletter will be issued two or three times a year when we have sufficient information to share with you.

You may like to keep a folder of these newsletters in



your team or practice so it is available to you and your staff as and when required.

This first section reports on the national findings from the "Study of Serious Case Reviews" by Wendy Rose and Julie Barnes (the Open University) (2001-2003) and from "Analysing Child Deaths and Serious Injury through abuse and neglect (2003-2005)" by the Marion Brandon et al (University of East Anglia).

Places to go to for more information

The Children and Young People's Trust is also a member of Research in Practice (RIP) a national organisation that promotes evidence based practice for social care and related issues in Health and Education go to www.rip.org for more information (our user name is **brighton-hove** and our password is **welcome**). All member agencies of the LSCB are welcome to access this site.



The CYPT and Adult Services are also members of 'Making Research Count (MRC)' based at the University of Brighton go to:

www.brighton.ac.uk/sass/research/mrc/

for more information.

Key messages for the study of serious case reviews from 2001- 2005

A serious case review takes place when a child dies or is seriously injured and abuse or neglect is a known or suspected factor. Figure 1 shows the ages of children subject to national serious case reviews (2001-3 and 2003-5).

This suggests that there are two cohorts of children most at risk (a) young children, under 5 years old – specifically children under one year and (b) adolescents.

In the 2003-5 study just 55% of the children were known to social care and as you will see above most of the children who died or were seriously harmed were not subject to child protection procedures so did not have a child protection plan. Marion Brandon et al notes that the families of very young children who were physically assaulted tended to be in contact with universal services or adult services rather than children’s social care.

Practice note

Staff working with young babies and their families, particularly midwives, health visitors and GPs have a key role in safeguarding children. Brighton and Hove CYPT practice would endorse the view that children under 5 who are identified as at risk of abuse should be encouraged to engage with formal child care so that there is additional professional oversight of their welfare.

In the 2001-3 study		In the 2003-5 study	
29%	under 1 year	47%	under 1 year
18%	1-2 years	20%	1-2 years
9%	3-4 years	7%	3-4 years
24%	5-10 years	16%	5-10 years
20%	11-16 years	9%	11-16 years
Only 18% of children had a child protection plan		Only 12% of children had a child protection plan	

Fig 1 - Ages of children subject to a serious case review

In the majority of cases that went to serious case review there was an apparent lack of co-operation, or an apparent lack of compliance or hostility by the parents towards professionals. This was typical in cases of neglect. Parents with something to hide tended to avoid agencies (e.g. failed appointments / always out etc). In situations of domestic violence staff were fearful of violent and hostile men.

In these cases there was also a tendency for the case to be closed or passed around to a succession of workers whereupon key information is lost or a new assessment started. The reports warn against a ‘start again’ syndrome where (a) a new professional starts the assessment process again (b) there is an over optimism that things will get better with a new worker and where (c) professionals put aside knowledge of the past history and focus on the present.

Practice note

The ‘start again’ approach prevents practitioners thinking and acting systematically, particularly in cases of long standing neglect. It is essential to refer to the family’s past history and analyse the parent’s capacity to change in the light of previous events. Since there is considerable emphasis on electronic information sharing and recording it is important to remember both the power of personal contact (talk to other professionals involved) and the reading of back files and reports.

In both research reports the impact of domestic violence, parental ill health and substance misuse were significant and in a third of case there was co-morbidity of all three. A combination of these elements present as a critical risk factor which should inform both assessment and intervention. The reports note that in cases of domestic violence, there is a risk professionals focus on the adults’ needs and behaviour and do not

recognise the impact this abuse has on children. The volatility and aggression shown by some families present workers with the most challenging of tasks, not least to get access to the children to assess risk. This should not be underestimated.

Children who have witnessed or experienced domestic abuse are more likely to have poor school attendance, and be subject to or perpetuate bullying, aggression and offending behaviour.

Practice note

Family violence and a history of previous injury or visits to A&E present warning signs of abuse. Moreover community and hospital based practitioners need to recognise the dangers of domestic violence to children's safety.

Whilst a number of children identified in these reports did not have a child protection plan it is noted that in cases of severe neglect, the families of the child were known to children's social care over many years. Intergenerational patterns of abuse and neglect were evident; with family histories being complex, confusing and often overwhelming for practitioners.

The neglect cases studied by the authors of the reports included 'overlying' (co-sleeping), physical illness, accidents and house fires as well as other more common indicators of neglect

and emotional harm. Factors which were common included a history of emotional abuse / neglect experienced by the parents, frequent moves at key times, multiple pregnancies with many losses due to terminations / miscarriages, poor accommodation, social isolation, concerns about sexual abuse and the caregivers who were mentally or physically ill.

The risks of recurring maltreatment are higher with neglect than other types of abuse.

Risk to 'hard to help' adolescents

Many of the older children subject to a serious case review were described as 'hard to help' and failed by agencies.

Most had a history of loss and rejection and of neglect and abuse. These young people were known to Children & Adolescent Mental Health Services, Youth Offending Teams, Educational Welfare services and the Police and some had a history of being in care, with numerous placement breakdowns. By the time they reached adolescence the young people were harming themselves and misusing substances. They were frequently missing or excluded from school and at risk of exploitation. The 2003-5 study termed the phrase 'agency neglect' to describe how professionals gave up on these young people and returned them home because of anti-social behaviour or persistent running way

and as a consequence they were receiving low levels of professional support at the time of their death.

Practice note

Some older adolescents are beyond the reach of existing services and their vulnerability is not being recognised or taken sufficiently seriously by professionals. All agencies working with adolescents must be helped to recognise the risk of suicide in vulnerable young people.

Whilst all this is necessary, if depressing, reading, the authors have offered some additional key messages to assist professionals:

Keep your focus on the children in the family; even if you are not a trained social worker, you have a responsibility to check on the child's welfare and to have a curious mind.

When undertaking an assessment of a child's needs be sure to focus on the analysis of your assessment; what are you going to do as a consequence of gathering information and what is the desired outcome? Act on information rather than accumulating it.

The case may require a risk assessment; can you identify warning signs such as previous admissions to hospital, an escalation in domestic abuse;

Key messages for the study of serious case reviews from 2001- 2005 continued

hostility; avoidance; illness or substance misuse?

In every serious case review the issue of sharing information is raised. If in doubt seek guidance, but remember no child has died because professionals shared too much information but many have died because they did not share information appropriately.

If you are in the CYPT, use supervision well and take time to reflect on complex cases with your manager to gain an overview of the case and its progress. Effective and accessible supervision is essential to support staff and help them think critically.

We are at risk of seeing incidents in isolation; of responding to crisis and not seeing the bigger picture. All the reports emphasise the value of looking at events and patterns of behaviour cumulatively to gain a measure of the family's capacity to parent safely.

It goes without saying that these messages are no substitute for reading the original reports and other recognised research. Practitioners across the CYPT will recognise that they have a responsibility to maintain their knowledge and skills in accordance with their professional practice – in other words, find time to read and keep up to date with the research!

Messages from the Brighton & Hove Serious Case Review (Case G) that affect current practice

Case G concerned a child who remained in the care of her father for 6 weeks after the mother was murdered in the family home. The body of the mother had remained hidden in and around the house until its discovery. The father was subsequently found guilty of the murder.

Following the discovery of the body it was established that the family had a history of domestic violence going back a number of years.

Professionals who observe or wish to report a child protection concern should keep accurate and contemporaneous notes of the events which concern them.

Referrals to social care must contain all relevant information including previous addresses and telephone contacts where this is known. All telephone referrals by professionals should be followed up in writing within 24 hours. For further guidance see the Pan Sussex Child



[The following are messages taken from the SCR action plan and are common to all practitioners; each partner agency will be required to address other action points in the full report that are not detailed here.]

GPs and other workers are reminded that where incidents of domestic violence are reported and there are children present in the family, consideration should be given to reporting the matter to children's social care teams.

Protection and Safeguarding Procedures – now online on www.proceduresonline.com/brighton

Assessments on families who are new to the area should involve contact with the previous school / social services to see if there were any previous concerns or involvement.

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