BRIEFING

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# Significant Case Reviews: practice briefing

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In Scotland, Significant Case Reviews (SCRs) examine the circumstances and context of a child being harmed or killed, to evaluate the nature and quality of professional contact, if any, with the child, to identify any system failures which may impact on other children, and to learn from the incident, any specific lessons which will strengthen child protection systems, locally and nationally [1].

A Significant Case Review is not an enquiry into why any child or young person died, was harmed or to establish who may be culpable.

These are matters for criminal investigation and for employer disciplinary proceduresas appropriate [1].

## Key Messages

Reviews of cases that have resulted in death or significant harm for a child or young adult provide a valuable tool for learning and for improving child protection policy and practice [2].

- However, problems have been identified in the process of analysing Significant and Serious Case Reviews (SCRs) and it has been proposed that the review process and recommendations might not have sufficient impact on professional practice to protect children [3].
- Common characteristics of children and families whose circumstances formed the subject of SCRs have been highlighted across the UK. What stands out is the complexity of multiple concerns regarding family characteristics and the fact that neglect has consistently been found to be a background factor [4, 5].
- The first comprehensive study on SCRs in Scotland highlighted that most children and families at the centre of SCRs were known to social work services. However, some confusion in relation to responsibilities in individual cases and the need for a shared understanding of roles across agencies was noted [6].

# Introduction

In Scotland, Child Protection Committees on behalf of the Chief Officers Group, are responsible for deciding whether a Significant Case Review is warranted, and for agreeing how the review is conducted; however, any agency, including voluntary sector organisations, may initiate an SCR process [1]. In terms of the process to be followed when conducting an SCR, the Scottish Government proposes using evidence-based methodologies and makes specific reference to the Social Care Institute for Excellence (SCIE) Learning Together Model [7,8].

The central idea of this systems approach is that workers' performance is a result of their own skill and knowledge and the organisational setting in which they operate [9]. The SCIE model has three key principles: avoiding hindsight by understanding how the events in the case unfolded from the perspective of all those involved, providing adequate explanations by evaluating practice and explaining decisions, and actions taken and moving from individual instance to general significance [3].

## Analyses of Significant Case Reviews

The Scottish Government requested that the Care Inspectorate be charged with the responsibility of collating SCRs, reviewing and disseminating learning on a national level [10]. The Care Inspectorate aims to review and analyse all Significant Case Reviews and report nationally in order to shape, and improve where necessary, child safeguarding practices across Scotland. They will draw upon a previous audit and analysis of Significant Case Reviews [6], the first comprehensive study to look into SCRs in Scotland.

# Why is this issue important?

Reviews of cases that have resulted in death or significant harm for a child or young adult provide a valuable tool for learning and for improving child protection policy and practice [2]. Focusing on the circumstances of all those involved - children, families and professionals - provides the opportunity for reflection and may contribute to effective multiagency collaboration [4]. The review of cases that have resulted in significant harm for a child or young adult may therefore be a fruitful way of highlighting crucial aspects of practice that may otherwise be ignored [2]. In addition, SCRs can provide the opportunity for contemporary learning, relevant to the specific local context and circumstances [11]. Although Significant and Serious Case Reviews can play an important role in learning from the past and in shaping practice, their effectiveness in this respect has been questioned. [12] Identified barriers to learning from SCRs include the lack of accurate and comprehensive data on children and their families needed in order to fully understand the reasons behind the occurrence of harm [4, 6]. The complexities of matching national level data from different sources has also been noted [5].

More recently, it has been proposed that there are issues of accessibility in terms of length and common language [13]. In addition, questions have been posed as to the impact the review process and recommendations have on professional practices [3].

# What does the research tell us?

## Serious Case Reviews

Most of the research into analysing reviews of significant harm to a child or young person has been conducted in England. According to these studies, boys feature more prominently in SCRs and there is an over-representation of babies under one year of age [4,14,15]. An analysis of three biannual reviews of SCRs in England spanning the years 2003-2009, put forth a potentially 'toxic trio' in terms of family characteristics that may precipitate significant harm including parental substance misuse, violence and mental health problems often co-existing and confounded by poverty, frequent house moves and/or eviction [15]. Family 'volatility' which tended to erupt into violence has been found to be common in cases of young children while for older children, aged 13 and over, a history of rejection and loss and usually severe maltreatment over many years has been noted [16]. Neglect has been consistently found to be a background factor, for all age groups [4, 5], reported in 60% of all cases [17]. SCRs conducted in England reflect complex family histories, where there are multiple concerns which are overwhelming for practitioners [15, 16]. One common way of dealing with this complexity has been said to be putting aside knowledge of the past and focusing on the present, coined the 'start again syndrome', which prevents practitioners and managers from having a clear understanding of a case informed by past history [16]. In terms of agency involvement, findings from the analysis of six years of SCRs highlight that approximately half of the children at the centre of the review were not known to children's social care [15].

## Significant Case Reviews

The only comprehensive audit and analysis of SCRs reviews in Scotland focused on the years 2007-2012 [6]. Boys were slightly over-represented in the cases while one third of children were under a year old and one third were eleven or over. Common child characteristics included neonatal abstinence syndrome, low attendance/lateness at school/nursery, behavioural problems at school, risk taking behaviour, self harm, substance misuse and offending. The complex family histories found in English research resonate with Scottish findings; parental substance misuse and domestic abuse predominated while parental mental health problems were reported in 43% of SCRs. There was a high prevalence of housing problems including frequent moves, overcrowding and poor conditions. Physical neglect featured prominently in the cases of children who were on the child protection register at the time of the incident resulting in the SCR, with primary reason for registration, risk of harm due to parental substance use. However, long-term neglect and or/failure to thrive was also noted in cases where children were considered to be 'in need' as opposed to 'at risk', resulting in their cases drifting in spite of high levels of intervention and children sadly not protected from harm. The vast majority of families (93%) were known to social work services, with just 7% of families known only to universal services. However, the study also highlighted some confusion in relation to responsibilities in individual cases and the need for a shared understanding of roles across agencies [6].

An important point needs to be made; although research has highlighted common characteristics of children and families whose circumstances formed the subject of SCRs, causal connections cannot be made between these and the likelihood of significant harm or death for children.

*"The complex family histories found in English research resonate with Scottish findings; parental substance misuse and domestic abuse predominated while parental mental health problems were reported in 43% of SCRs."*

# Implications for practice

Learning from Significant Case Reviews can strengthen child protection systems, locally and nationally [1]. To support this process, the following section is devoted exclusively to the learning points for practice identified by the audit and analysis of 56 Significant Case Reviews and 43 Initial Case Reviews conducted in Scotland between 2007 and March 2012 [16, 18].

Professionals should always consider the family's financial circumstances and the impact of poverty. It should be noted that financial hardship did not feature prominently in the cases analysed; however, as the authors note, this is likely to be an underestimate due to insufficient recorded information. Housing agencies and police hold important information in relation to anti-social behaviour and neighbourhood problems which should be shared across agencies. The potentially protective role of members of the extended family should always be considered. However, as evidenced by the family members whose circumstances informed the analysed reviews, the role of extended family members is not always protective or positive. Social isolation should always be considered as a risk factor. It may be a particular risk in families that have moved to Scotland from other countries. Children's stories should always be reflected upon critically, taking into consideration their experiences and feelings. The Scottish findings postulate that children's views were not always consistently gathered [6]. This resonates with findings from England which highlight that children were frequently not asked about their views and feelings [14]. Parents' explanations for injuries and non attendance at school should always be looked into and considered in the context of other risk factors such as missed appointments. Relatedly, missed appointment protocols should be in place; the number of missed appointments should be collated and considered within the context of risk. The reasons for challenging behaviour at school and/or absconding from foster or residential care should be explored.

Lack of cooperation with agencies and problems with school attendance have been identified as risk factors; therefore, patterns of both should be monitored as changes may be indicative of increased

level of risk. In cases which do not meet the threshold for statutory intervention, child protection concerns should always be considered and risk identified. The interaction between different risk factors - whether these relate to child and family characteristics or interaction with agencies - should be given careful consideration in order to identify the level of risks to the child and assess whether the provided support is appropriate in terms of managing risk. Intervention for young people should not automatically be withdrawn when they refuse to engage; instead a flexible and individually tailored approach should be adopted. Substance misuse has been highlighted as a significant family risk factor across the UK, especially in cases of infants and school aged children [6, 15]. Related learning points for practice in Scotland indicate that health and social care staff should be familiar with guidance in relation to breastfeeding for mothers taking methadone and be able to offer safe advice. Finally, it should be acknowledged that children and young people affected by parental drug use may themselves be engaged in drug use. Therefore, it has been advised that protocols for children who are withdrawing from opiates should be in place.

As Vincent and Petch suggest, the *"SCRs provided evidence of some excellent multi-agency working with agencies effectively sharing information and coming together to meet children's needs. However, the fact that children died or were harmed despite such levels of multi-agency communication and provision of intensive support suggest that good multi-agency working may not always be sufficient to protect children"* [18].

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