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Articles

Findings from serious case reviews during the period 1987–2018: a personal and conceptual reflection. Part I

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Professor Holt has practised as a Social Worker and Children's Guardian for over 20 years, in the North West of England. Kim was appointed as Head of Department at the University of Bradford in 2004, before moving to Northumbria University in 2013, as Head of Department for Social Work, Education and Community Wellbeing. Kim was called to the Bar in 2005, and she continues a career in Child Protection and Family Law that spans over 35 years..

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Professor Kelly is an applied social psychologist with experience of undertaking research with organisations and groups in order to better understand judgement and decision making processes. Her work considers peoples lived experiences of policy initiatives. Professor Holt and Professor Kelly have published extensively in the area of Family Law and Professional Practice.

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Drawing upon personal reflections and analysis, interviews with professionals and existing literature, parts I and II of this article highlight key themes that emerge from an analysis of over 200 serious case reviews ('SCRs') during the period 1987–2018. The personal reflection and observations rely on professional involvement in SCRs during this period, as chair, author and committee member. Together with access to reports held in the repository (NSPCC National Case Review Repository 2017 https://learning.nspcc.org.uk/case-reviews/national-case-review-repository) and the most recent triennial analysis of SCRs (M Brandon, P Sidebotham, P Belderson, H Cleaver, J Dickens, J Garstang, J Harris, P Sorenson and R Wate *Complexity and challenge: a triennial analysis of SCRs 2014–2017 Final Report,* 2020), we explore different conceptual ideas that may elicit a greater

understanding, as to how and why the same themes continue to be rehearsed in the majority of reports involving serious injury or death of a child.

Involvement with SCRs began in 1987 as an early career social worker who, during a home visit expressed concerns regarding the risk to a young child who subsequently died, and where it became clear there were a number of lessons to be learned by professionals and agencies who were responsible for child protection. Since 1987, professional involvement in over 200 SCRs has included 30 years as a committee member, chair and author and following the submission of three reports to a local authority in 2017, it felt timely to reflect on SCRs from the perspective of a career as a social worker, barrister and academic.

This paper initially focuses on the origins of SCRs, before moving onto the political nature of certain reviews that have received significant public commentary (N Parton 'From Maria Colwell to Victoria Climbié: Reflections on Public Inquiries into Child Abuse a Generation Apart'. *Child Abuse Review*, 13, 80-94, 2004; N Parton *The politics of child protection: contemporary developments and future directions*, Palgrave, Basingstoke, 2014).

It considers issues in relation to the ways in which accountability and public and media interest might influence investigations into cases where children have died or suffered serious harm. Drawing on evidence from analysis and evaluations of SCRs we consider themes that seem to pervade reports consistently and outline some conceptual work that may help understand why SCRs seem to repeat the same conclusions and recommendations.

Public Inquiries and the origins of SCRs

The first public inquiry (at the request of Newport County Borough Council and Shropshire County Council to the Home Secretary) in the area of child abuse was in relation to the death of Dennis O'Neill, a child who died at the age of 13, at the hands of his foster carers as a result of physical abuse and neglect. The inquiry led by Sir Walter Monkton was concluded within 6 months, and in summary, he was concerned that local authorities were not compliant with the rules for accommodating children at the time; there was insufficient enquiry into the suitability of the foster carers; Dennis had not been visited early in the foster placement; medical examinations had not taken place; communications between different workers had been sporadic; and there was an overriding assumption that the placement was going well. Sir Walter Monkton was highly critical that administrative rules (as set out in the 1933 *Boarding Out Rules*) had not been followed, and that there had been significant delays in assessments in all areas of this case (Home Office *Report by Sir Walter Monkton on the circumstances which led to the boarding out of Dennis and Terence O'Neill and the steps taken to secure their welfare*, Stationery Office, 1945)

Almost 30 years later there were several high-profile inquiries into the deaths of children, notably, Maria Colwell (1973), Jasmine Beckford (1985), Tyra Henry (1985) and Kimberley Carlile (1987), all of which highlighted the failure of safeguarding agencies to work together to protect children, and the failure of local authorities to intervene particularly when parents were considered hard to reach.

The findings of these inquiries were not significantly different from the findings contained within the *Monkton Report*, focussing on poor assessments, poor inter-agency work, analysis of information that were inadequate, and a reliance upon over optimism. These reports were published before the *Cleveland Report* (1988), where local authorities and health professionals were criticised in respect of child sexual abuse where decisions to remove children from families had been hasty and over-zealous and overrode the rights of parents (Butler-Sloss, 1988).

As a result of these inquiries, together with increasing concern over the rights of children and their parents, and the need to consolidate legislation in respect of children, the Children Act 1989 was enacted; part 5 of the Act specifically related to Working Together under the Children Act 1989.

The principles of the Children Act 1989, promoted the upbringing of children in their families, wherever it was safe and possible to do so, and it gave a strong steer that agencies must engage in partnership working with children and their families, and the welfare of children must remain paramount.

In order to implement the Children Act 1989, *Working Together – A guide to arrangements for the inter-agency cooperation for the protection of children from abuse 1991*, provided prescriptive guidelines on assessment practices, timescales for practice and inter-agency responsibilities and working. Also, within this document was a requirement that where there were incidences of child death or significant harm, investigations must take place and recommendations for learning should be provided.

Despite several revisions to this Act culminating most recently in the Children and Social Work Act 2017, and several revisions to *Working Together* documents, now *Working Together to Safeguard Children – statutory guidance on inter-agency working to safeguard and promote the welfare of children, 2018*, it remains the case that the fundamental principles of the Children Act 1989, determine contemporary social work with children and their families.

The *Care Crisis Review*, 2018, acknowledged that 'The Children Act 1989 has stood the test of time, as has its underpinning principle of partnership with families to promote their children's well-being' (p 4), and it has been argued that the review found the child welfare legislative system to be basically sound (K Holt and N Kelly 'Care in Crisis – is there a solution: reflections on the care crisis review 2018', *Journal of Child and Family Social Work*, 25, 1 p1–7, 2020). Yet there continue to be investigations and inquiries into the deaths or serious injuries to children. The Children Act 2004 mandated that as from April 2006 local authorities would replace Area Child Protection Committees with Local Safeguarding Children Boards and LSCBs would be required under s 5 of the 2004 Act to undertake SCRs where a child had died or where there had been serious harm, and abuse and neglect were suspected. The remit of these local SCRs was to investigate: whether there were lessons to be learned from the case about the ways in which local professionals and organisations worked together to safeguard children; to identify the lessons to be learned, how they would be acted upon and what changes would be required as a result; and to thereby improve working.

Whilst SCRs took place at a local level there were several cases around this time where the government considered that there were issues that required further probing and that there may be lessons to be learned nationally, hence following local SCRs larger scale public inquiries were instigated. Examples include Baby P, Victoria Climbie and latterly Jay (2014) an Independent Inquiry into Child Sexual Exploitation in Rotherham 1997–2013, and the ongoing Independent Inquiry into Child Sexual Abuse ('The Westminster Inquiry').

In response to the concern that public inquiries and SCRs incur a high level of resources and costs, with no apparent improvement in terms of learning from successive reviews, some of which become national scandals (D Hirst '"A ticklish sort of affair": Charles Mott, Haydock Lodge and the economics of asylumdom', *History of Psychiatry*, 16, 311-332, 2005); in December 2015, the Department for Education ('DfE') approached Alan Wood CBE to lead a review of the role and functions of the then Local Safeguarding Children Boards ('LSCBs') in England. As part of the review he also looked at serious case reviews and Child Death Overview Panels.

The conclusion of the review was that for multi-agency working to be strong and effective it needs to be responsive and involve the right people. Wood proposed introducing a new system that would ensure accountability (DfE, 2016). In response, the government agreed to introduce a new statutory framework that would set out clear requirements and give local safeguarding partners the freedom to decide how they operate to improve outcomes for children. Subsequent to this the Children and Social Work Act 2017 and Working Together to Safeguard Children 2018 have replaced LSCBs with

three lead safeguarding partners; local authorities, the police and health (clinical commissioning groups). As such SCRs will no longer be commissioned by the local authority, but the three safeguarding leads must create transparent procedures and processes to be undertaken in cases of death or serious harm to children. However, the essential purpose of SCRs remains the same.

There are a number of sources for evaluations of both public inquires and SCRs (for example see Munro, 1999 and 2004; Parton, 2004; Burgess, 2011; Mackie, 2012; Brandon et al. 2002, 2005, 2008a, 2008b, 2009, 2014a, 2014b, 2014c). Munro (1999) undertook an analysis of all child abuse inquiry reports between 1973 and 1994, a total of 45 reports. Brandon et al, (2020) has been involved in the analysis of SCRs between 2003–2017, with the latest report considering instances of abuse during the period of 1 April 2014 and 31 March 2017, a total of 368 cases. *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014: Final Report, Department for Education: London 2016* (P Sidebotham, M Brandon, S Bailey, P Belderson, J Dodsworth, J Garstang, E Harrison, A Retzer and P Sorensen), and Brandon et al (2020), suggest that SCRs vary in the way they undertake reviews, report findings and recommendations, but ultimately SCRs, whether a finding was that death or harm could have been prevented or not, should be concerned with identifying and learning lessons and identifying and disseminating areas for improvement within safeguarding children practice. This is echoed by Munro (2019, p 123) where she argued that:

> 'We need a positive error culture in child protection. This does not mean feeling positive when errors occur but understanding that they are likely to occur and taking their occurrence as an opportunity to learn and improve' (E Munro 'Decision making under uncertainty in child protection: Creating a just and learning culture', *Child and Family Social Work* 24 p 123-130, 2019)

Brandon et al (2020), suggest that the increase in number of SCRs seen between 2011 and 2014 (63, 95, 135 respectively) has not followed through to 2014-2017 (134, 117, 117 respectively) yet the numbers remain high. The number of SCRs as a result of child deaths directly due to maltreatment remains steady at approximately 28 per year; the SCRs for children experiencing serious harm and deaths related to but not directly caused by maltreatment fluctuates between 30 per year between 2009–14 to 54 per year between 2014–17

Whilst only a small number of children subject to the SCR had a child protection plan at the time of their death or serious harm (54 out of a total of 191,930 on a child protection plan in the timeframe of the triennial review), the majority of children had been involved with children's social care at some level. These were children who had been stepped down from a child protection plan, or who were considered to be 'children in need', a lower level of intervention.

Whilst it is unrealistic to expect that the prevention of abuse can be wholly satisfactory these statistics suggest that the system seems to be working relatively well in protecting children on a child protection plan, but there are many children who remain in need of protection from serious harm who are known in the social care system.

Within the latest triennial review Brandon et al (2020) report on similarity of themes in SCRs including the 'pathways to harm' (p 14) experienced by children and families within the wider environment. These themes were concerned with child vulnerabilities and risk and parental and environmental vulnerabilities and risk. The complexity of interdependent issues such as poverty, substance misuse, mental health, criminal behaviour is highlighted, and the report outlines key points in relation to learning from the review. Importantly whilst there are some new issues in relation to practice with 'newer' forms of abuse, for example child sexual exploitation, criminal exploitation, many of the key points remain the same as previous analyses, for instance:

- While it is important to consider the needs of parents and the wider family, the voice and lived

experience of the child must not be lost in a focus on parental difficulties. (p 16)

- It is important for practitioners to consider the complex pathways through which vulnerability and risk may impact on parenting and outcomes for children, and not focus on single issues that do not address the underlying context. (p 16)
- Effective protective practice requires an ability to contextualise the lives of vulnerable children, understand the experience and perspectives of their parents or carers and engage with them through meaningful interactions and relationships with the professionals that are involved in their lives. This includes hearing the voice and understanding the lived experience of the child. (p 18)
- Questioning and assessments can often be perceived by parents as blame, creating a barrier to collaborative working; professionals need to be both robust and compassionate in responding to this. (p 18)
- Children in care or going through court processes have particular needs that require careful assessments, monitoring and support. (p 18)
- Assessments should not only look at what has happened to the child in the past and what that implies for their needs now, but also look to the future and what help will be needed as the child grows. (p 18)
- The language we use to talk about children's circumstances can both support and hinder effective safeguarding. (p 20)
- Fragmentation of services, with different front-line providers within the same agency, can lead to silo-working within as well as between agencies. (p 20)
- Clear multi-agency plans at both child in need and child protection levels are central to effective working. (p 20)
- Within a fragmented service landscape, co-location of services, joint protocols, robust IT systems, and ongoing support and guidance for front-line practitioners can be particularly important in enabling consistent work with families. (p 20)
- Demonstrating the impact of SCRs on practice or outcomes for children is challenging. (p 21)
- A preoccupation with process, tick-box responses, and organisational change can all present barriers to effective learning and impact. (p 21)
- Keeping learning contextual, local and embedded in reflective practice, helps to ensure the learning has an impact. (p 21)

Whilst there is recognition that it may be useful to continue to repeat findings, if the same themes emerge in the majority of cases, then it could be argued that learning lessons is failing to have sufficient impact on practice.

The politics of SCrs

The abuse of children is complex, with investigations far wider ranging than those reported in the 1970's and 1980's. They now encompass injury, neglect, sexual and emotional abuse, bullying, sexual and labour exploitation, familial, organisational, institutional, cultural and criminal issues (Working Together, 2018). Professionals tasked with protecting children operate within a practice landscape that is highly emotive – with competing discourses around the need to protect children from abuse, whilst avoiding the need for excessive state intervention in family life (M Butler and I Drakeford *Social work on trial: the Colwell inquiry and the state of welfare*, Policy Press, Bristol, 2011).

These competing discourses create an emotive response from both the public and politicians, with some cases attracting notoriety, leading to the further probing of professional involvement in the case in an attempt to identify learning to avoid further tragedies (H Laming *The Victoria Climbié inquiry: report of an inquiry by Lord Laming*. HMSO, London, 2003, www.victoria-climbie- inquiry.org.uk).

The decision as to whether a specific case receives public scrutiny, given the similar issues that arise in almost every single case, is a political one.

The plethora of recent cases of abuse of children by celebrities highlights a changing shift in culture and attitudes towards power within organisations and personal relationships. In a report prepared following the investigation into the allegations made in respect of the high-profile entertainer, the late Jimmy Savile, D Gray and P Watt (*Giving Victims a Voice: Joint report into sexual abuse allegations made against Jimmy Saville*, NSPCC, London, 2003) purport that:

> 'Savile's behaviour was that of a predatory sex offender who opportunely abused people. It's believed that he manipulated some of those around him to access potential victims and by real or implied threats used his status and position to prevent his activities being made public. His actions would today be categorised as "child sexual exploitation"' (2013: 9.5).

The realisation that an individual who held an iconic position within society, with the resulting trust, power and control that align with such privilege, prompted an emotive response of an unprecedented level.

In a more recent study it was highlighted that whilst there are many drivers to instigate public inquiries, two of those were the motivation of politicians needing to be seen to respond to events, and as a result of public outcry in response to media coverage of incidents (S Vincent, K Holt, N Kelly and E Smale 'What do Public Inquiries into the Care and Protection of Children Achieve?' *Child Abuse Review*, 2019).

It is argued here, alongside Rivett (2005), that the risk that any specific case could become a high-profile case limits the opportunity for openness and change, and that the potential for a 'positive error culture' where practice can be evaluated in an open and constructive manner (Munro, 2019) is inherently limited.

Whilst acknowledging that SCRs can use different methodologies (Sidebotham, 2016) the author's experience of the quality of SCRs suggests that they are extremely variable in respect of creating opportunities for learning. SCRs are only one mechanism for learning, yet the political context produces a tension between local learning which must be delivered in a timely and accessible manner and public and government scrutiny. The latter places a greater emphasis on inspection, audit and reporting. The author has demonstrable experience of navigating these tensions in order to manage the process that ensures the environment remains focused on learning rather than a culture of fear and blame.

Notwithstanding this highly contested area of practice where objectives such as professional learning and public and political scrutiny remain in juxtaposition, there are findings evident in almost every single case, which again are not significantly different from those in the case of Dennis O'Neill.

SCRs are subject to public scrutiny both in terms of accountability and of learning, to help us to avoid repeat tragedies. The executive summaries, interviews with professionals, and field notes from learning lessons events in 200 cases in various sites throughout the North of England over a 30-year period informed the primary data for this paper. Alongside this, documentation held in the repository of executive summaries published in 2016/17 (NSPCC, 2017) was drawn upon. In part II of this article, the authors identify five key themes rehearsed in this documentation comprising risk/uncertainty, value base, gender/parents, agency and communication.