The publication of this report is the latest in a decade-long regular analysis of serious case reviews undertaken by the same research team based at the University of Warwick and the University of East Anglia. Attempts at accumulating the learning from serious case reviews of course extends much further back than this, but the continuity of this research is important as the studies undertaken by universities of Warwick and East Anglia have developed a systems based analysis of serious case reviews, and more recently, the majority of serious case reviews themselves have been undertaken using approaches which draw heavily from systems theory.

The title of the report - “Pathways to Harm, Pathways to Protection” ([https://www.gov.uk/government/publications/analysis-of-serious-case-reviews-2011-to-2014](https://www.gov.uk/government/publications/analysis-of-serious-case-reviews-2011-to-2014)) is itself illustrative of a model for understanding how serious child abuse occurs. The report maintains that it is only by acknowledging that abuse is the result of harmful actions or omissions by perpetrators of abuse or carers, can we then place in the correct context the actions of professionals, family members and other organisations and subsequently have a better understanding of what actions would reduce the risk of similar incidents occurring in the future. It could be argued that in the past there has been a failure to include the actions of the perpetrator or carer, and focus on the actions of the professionals in an attempt to “learn the lessons”, and unless we understand the context correctly the subsequent analysis is incomplete.

**Pathways to Harm Prevention and Protection**

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1 Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014
The model is helpful in understanding what comes later in the report, although perversely, on first encountering it, it tends to help to work backwards from right to left and begin with an incident where a child has been harmed, and consider the various factors in their turn. It should also be remembered that diagram attempts to capture a dynamic process, and those who harm children may also be capable of providing positive and protective safeguards. Above all, it seeks to place the abuse of the child in the context of the home environment.

Some professionals who have been actively involved in serious case reviews over recent years may feel they have more than enough recommendations without seeking learning from an additional 175 cases. Conversely the triennial review will be the only contact with serious case reviews for many professionals, and the lessons drawn from the quantitative analysis of 10 years’ worth of reviews will be of particular interest to them.

The review also underlines an important tenet of our system of reviews; the purpose of serious case reviews is to identify learning which can potentially help reduce the likelihood of further serious incidents or improve the quality of the services offered. The nature of working with vulnerable children and their families is that there are invariably different courses of action that could have been taken or choices that could have been made. In the aftermath of a tragic event there is also a responsibility towards the children and their families, to identify the lessons, disseminate learning and improve services.

**What do SCRs tell us about the child protection system?**

Between 2011 and 2014 the number of children subject of a child protection plan has increased dramatically; with an additional 5,600 children on plans, reaching a total of 48,300 by the end of March 2014². The evidence from the analysis of serious case reviews is that when a child protection plan is in place, the system is effective in safeguarding children; and there has been no corresponding increase in the number of child deaths linked directly to maltreatment or abuse. In the latest study, only 12% of the subjects the serious case review were also on a child protection plan at the time of their death or serious harm.

The triennial review suggests that children on the threshold of services or whose cases are in the process of being “stepped up” to social care, or “stepped down” to universal services are more likely to be the subject of serious case reviews. Two thirds of these children had at some point been involved with children’s social care, and with the benefit of hindsight, it may be true that in some cases involvement may have ended prematurely. This highlights the need for services to be able to provide long term support for vulnerable children and families. Although the review recognises the current context of this is at a time when many services have been cut, leading to increased workloads. In this situation agencies inevitably adopt short-term solutions as a way of managing work-loads.

² This upward trend continues, see [Child Protection Register Statistics England: 2011 - 2015](https://www.nspcc.org.uk) (NSPCC)
In contrast to previous biennial reviews, resource issues were regularly flagged up in the latest sample of serious case reviews. This may reflect the ongoing impact of reduced resources, but may also be a feature of adopting a systems methodology when carrying out a Serious Case Review which considers the organisational issues at the time underlying individual practice decisions.

Complexity and fragmentation of services is a common finding of many reviews; with coordination of services and communication between professionals being particularly highlighted as key areas of practice which are time consuming and requiring skill and tenacity. The interplay of these services can also be extremely confusing for families. This highlights the need to improve the clarity of information about what services provide and how they may be accessed. Having recognised that families on the threshold or between services are over represented in the cases which become serious case reviews, care needs to be taken that the complexity of service delivery does not in itself become a further risk.

**Practice Messages**

The children and young people subject to serious case reviews are not evenly spread across the age range; there are two definite spikes - very young babies and older adolescents.

The natural vulnerabilities of babies and young children are exacerbated when combined with prematurity or other health problems and parental issues such as drug abuse or domestic violence.

For many adolescents with a history of abuse and neglect, it is because they may have developed their own mental health problems or are engaged in risky behaviours involving drink, drugs and criminal offending.

The particular vulnerabilities of disabled children should not be overlooked; as their abuse or neglect may go undiscovered because of their pre-existing conditions or communication problems.

**Cumulative Risks**

Having publicised the concept of the “toxic trio” in an earlier biennial review this review makes an important distinction between the 3 inter-related issues of domestic violence, parental mental health and substance misuse. Domestic violence is always harmful to children (domestic violence should not be seen solely in terms of violent incidents, but also in context of coercive control), parental mental health problems are not in themselves a risk to children (however, they should be considered a risk when they exist alongside other parental risk factors) and all 3 issues should be seen and assessed as part of a pattern of cumulative risk.

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3 New learning from serious case reviews: a two year report for 2009-2011, DfE 2012. The term “Toxic Trio” is sometimes used to describe inter-play of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to children has occurred.
Cumulative risks should also include the impact of lifestyles, the quality of the environment, including accommodation issues, school attendance and the impact of the wider family network.

**Hearing the Voices of Children and Families**

In the context of earlier comments about the fragmentation of services and short-term intervention. It is unsurprising that services sometimes have difficulty in “hearing the voice of the child”. However, it is of course essential that services allow children to be heard. This requires safe and trusting environments and practitioners who have the skills to facilitate children expressing their views and understand how they may express themselves through behaviour as much as verbally.

**Communication and Information Sharing**

It is axiomatic that this is an area of practice which can always be improved; along with identifying needs for further training, the need to improve communication and information sharing is almost certainly the most common and most long-standing issue identified by serious case reviews.

However, having accepted that this is an area of practice which can always be done differently, and probably better, poor communication should not be accepted as a fact of life. There is evidence from the review that practitioners are uncertain about how and when to share information despite national guidance. Communication is the cornerstone of shared case responsibility and collaborative working. It is apparent that some organisations are still reluctant to share information for fear of breaching data protection or patient confidentiality guidance. There is a need for clear safeguarding systems which challenged this thinking and support effective communication.

**Assessments and Thresholds**

The gatekeeping services will always have inherent risks; there are situations where families don’t meet the threshold for a service and there is no fall back or ongoing provision meaning these cases are closed until the next crisis.

Assessments play their part in identifying risks and vulnerability and involve all the professionals working with the family as well, as all of the family members. The review found there was still a tendency for assessments to be seen as one off events, rather than an ongoing process. There is a need for workers to adopt an attitude of “respectful uncertainty” and be prepared to challenge and seek corroboration for self-reported events. While this is undoubtedly true, phrases such as “respectful uncertainty” and “professional curiosity” begin to lose their value when they are overused and applied to too many different situations. In practical terms, effective and challenging supervision and peer support are necessary and powerful adjuncts to effective practice.

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4 Information Sharing: Advice for Practitioners Providing Safeguarding Services to Children, Young People, Parents and Carers, DfE 2015
Reluctance to Take Responsibility

Another finding consistent with earlier reviews was that some professionals delay taking action on the assumption that, having passed on information their responsibility ended at that point. These professionals had a narrow view of their responsibility in a case; a view derived from the restrictions of their own professional background or discipline.

While this is not the most significant finding, the fact that this tendency has been noticed in previous biennial reviews illustrates the need to reiterate practice messages and embed this learning in multiagency training.

The Quality of Serious Case Reviews

It is important to remember that reviews are not ends in themselves - but the vehicle for analysing events and processes, and disseminating learning with the clear aim of improving services in future, and reducing the incidence of abuse and neglect.

The qualitative analysis of the serious case reviews in the study should also be of interest to a wider audience and not only those with a professional interest in the conduct of SCR’s. It is now much more common for practitioners to participate in reviews at first hand as an essential part of the review. Such first-hand experience is an important development in how learning is disseminated and embedded in team cultures. It is now also the norm, for family views to be sought and incorporated in the review process.

The review identified 9 different types of review, most of which adopted a systems based approach. In broad terms, SCR’s tend to be shorter with fewer recommendations. SCR overview reports are more likely to be structured in a way where there is less emphasis on a narrative but the learning from a case is highlighted and linked to specific recommendations.

The review suggests that a good quality SCR incorporates particular characteristics:

“These include lessons learned which are clearly linked to the findings of the review; findings and questions for the LSCB, to promote deeper reflection on the lessons of the review, and leading to a response and action plan developed by the Board to address that learning; specific recommendations where there is a clear case for change, again with a response and action plan developed by the Board; and a strategy for dissemination and learning of the lessons that will reach relevant practitioners and managers within the Board’s constituent agencies”

The findings of this review, set alongside the Quality Markers developed earlier in the year by SCIE/NSPCC provide a comprehensive framework for basing future reviews on the experience and analysis of previous experience.

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5 *Pathways to Harm, Pathways to Protection: A Triennial Analysis of Serious Case Reviews 2011 to 2014*

6 *Serious Case Review Quality Markers* see also tri.x Briefing #172 May 2016
This triennial review represents a thorough and overarching analysis of the learning from serious case reviews. While one would be cautious about extrapolating learning from a relatively small sample of child protection activity, the ambition of serious case reviews to provide “a window on the system” means that there is a great deal of valuable learning about identifying risk particularly in more complex situations.

Contact Us

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