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Analysing Serious Case Reviews Involving Disabled Children

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The purpose of a Serious Case Review

- “not about apportioning blame but about allowing professionals to understand fully what happens in each case, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.” Tim Loughton 2010

But it doesn’t always feel like that

Recent UK Studies of Child Death/Serious Injury Review

- England: Biennial Analyses of *Serious Case Reviews* (Sinclair and Bullock 2002, Rose and Barnes 2008, Brandon et al 2008, 2009, 2010, 2011 and 2012) c1000 cases. New triennial underway (Brandon et al).
- Wales: Regular Studies of *Serious Case Reviews,* (Sanders et al 1996, Brandon et al 1998, 2002, 2010, Morris et al 2007) 100+ cases
- N Ireland: Evaluation of *Case Management Review* Process in NI (Lazenbatt et al 2009, Devaney et al 2011, 2014) 17 cases at 2009
- Scotland: Learning from *Significant Case Reviews* in Scotland (Vincent 2010; 2014, Short Life Working Group, MARS 2010) 100+ casesreview

Sources of data for today's presentation

1. **All national SCR reviews England** (primarily Brandon et al 2008, 2012)

2. **The child development study** (Brandon et al 2011, 2012)

6 serious case reviews from 2009-10 studied in depth (chosen from 33 available at the time but tested on all cases from 2009-10)

- 3 of the 6 cases included children with a disability or chronic health needs
- Cases were selected to represent age range in SCRs and include a high level of involvement with children's social care (for scrutiny of SW role in child development)

Patterns in SCRs (800+ 2003-2011)

Which agencies are working with the child?

- **CP Plan?** dropping number – 10% of children with a CP plan at time of death/incident (2009-11)
- **Known to Social Services? -** dropping number - 58% **NOT** known to CSC at time of death/incident (2009-11)

Implications for universal services staff in recognising and responding to abuse/neglect

- **Physical injury** the major cause of death. **Neglect** a significant underlying feature for 60% but rarely the *principal* cause of death.

  Multiple maltreatment common**.**

Child Disability in SCRs - England

- Proportion of disabled children in SCR population increasing over the years
- But - disability still likely to be under-recognised (young age of SCR population, disability not yet diagnosed?)
- Lack of protection for disabled children evident. In a number of the disability SCRs the risk of significant harm to the child had not been recognised.
- Disability in general child population 3-5%?

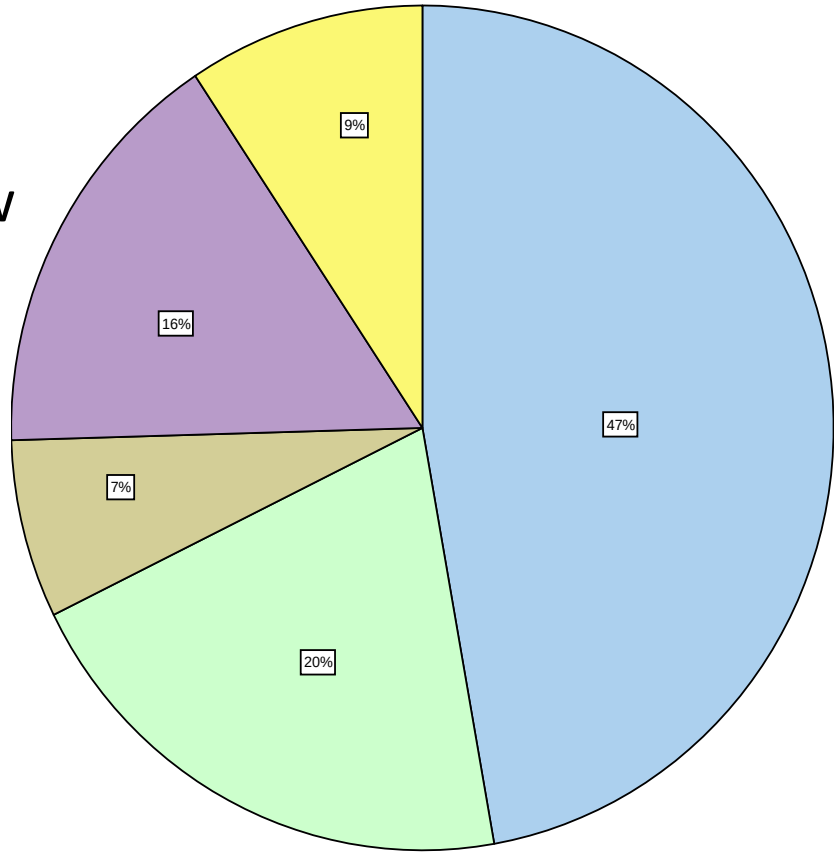
Child disability SCRs 2003-2011

Frequency 2003-5 (n=161)	Frequency 2005-7 (n=187)	Frequency 2007-9 (n=280)	Frequency 2009-11 (n=178)
8 (5%)	14 (7%)	24 (9%)	21 (12%)

Patterns in age of all children at time of death or serious harm

Older child, ‘hard to help’
or missing from view

Very young babies -innately vulnerable



School aged more protected. **children** – less vulnerable, Hidden adversity?

Child development and child protection (Brandon et al 2011/12)

- Importance of *knowing* and *understanding* the child (appearance and behaviour) in the context of their age, development and experiences (ecological niches)
- Emotional development and safety: *What does the child mean to the parent, what does the parent mean to the child?*
- Other clues to family life from development and behaviour of siblings

Pre-school aged children disability/complex health needs and development

Bruising and minor injuries (babies and young children)

Need to be considered in the context of the child's own development and capabilities – reasons that explanations for bruising accepted without scrutiny:

- Child had complex health needs or disabilities – bruising was (implausibly) linked to this
- The person who was perceived to pose a risk to the child was believed to be out of the picture
- Parents were hostile or difficult and somehow stopped the practitioner from seeing clearly

Case Study – Ben aged 18 months, physical injury

A lively toddler with complex health needs (which didn't restrict his mobility). He had repeated bruising before the physical assault which led to SCR. Already on a CP plan linked to domestic violence.

Multi-agency team thought bruising was linked to the demands made by his health care and because he was a lively toddler. Unusual pattern and site of Ben's bruising (not typically seen in a lively toddler) did not provoke curiosity or questioning.

The CP plan should have put practitioners on high alert. Need to consider the pattern of bruising in context of development – don't explain away the bruises because of health needs or disability without careful checking.

Repeated bruising should have caused professionals to think that these might be non-accidental injuries, "S*ome (professionals) had difficulty in believing such a sick child could be harmed deliberately*". It was Ben's mother not his violent father who was the cause of the bruising.

Middle years children – disability development and health needs

Disabled children age 6-10 - Health Issues

- Problems with growth and development, hygiene, recurrent and chronic illness, eyesight, hearing and speech issues, and underlying disability.
- Health issues not viewed as a priority by parent or, in some circumstances, by professionals
- Health issues identified by health professionals led to intermittent referral, monitoring and follow up, with little coordinated action to assess and manage the child's needs.
- High number of health and other professionals involved could 'paralyse' individual worker's ability to respond to the problem, each professional 'assuming' that someone else was taking the required action. These children often fell through the net.

Case Study: Aaron and Alan aged 5 and 6 - neglect and unmet health needs

School noticed injuries on Alan caused, he said, by his father. Medical assessment raised concerns about damage from serious neglect.

Both children known to health professionals pre-school: faltering growth, mild developmental delay, poor hygiene, repeat A&E attendances with minor injuries. None of these issues triggered child protection procedures. Parents intermittently engaged with medical care/treatment. Repeated non-attendance at health appointments. A lack of follow-up, and perceived 'willingness' by parents to engage meant this situation continued for over two years.

Learning: Neglect of health issues by parents and professionals. Lots of activity, but professionals were too readily 'reassured' that parents were trying to improve their care. Persistence of problems once children start school give opportunities to reassess ongoing concerns.

(Disabled) older children and child development

What should professionals know and do?

- Young people need inquisitive, research informed social workers who want to know why young people's behaviour is so difficult (eg at this particular point)
- Crucial for social workers to develop a relationship with young people and get to know them as individuals, involve them in planning.
- Social workers should be an advocate (or find one) for disabled young person
- Social workers should check that specialist assessments are being completed eg CAMHS assessments

Case Study: Andrew (age 15) severe neglect

Andrew was accommodated at the age of 15 in a severely neglected state. A large number of professionals were involved with the family and they differed in their opinion of his diagnosis. Andrew was educated at home from the age of eight and became socially isolated. Significant focus was placed on treating Andrew as a disabled child, focusing on his behaviour, with little assessment of the daily care he received. Several agencies assessed that he needed to be cared for outside of the home but there was a year's delay in this happening. The insistence of a senior health professional finally led to Andrew being placed in foster care.

Learning: not treating a child differently because of his disability; challenging parental power; the need for a lead professional; for professionals to have confidence to challenge each other's opinions and training in the recognition of neglect

Judgements and decision making

- Children still die and are harmed where there is good practice – not all children can be protected.
- All practitioners should bring their knowledge about the child and their overall development to the multi-agency grouping
- In most SCRs there will be at least one professional with a good understanding of the child and his/her development (HV, paediatrician, teacher, GP etc). If their information about (developmental) concerns had been known and understood, it could have helped to prompt action to protect the child sooner, or better.

More research

- Scope for more learning about disability and complex health needs from the SCR population
- This can be part of the new Triennial Study due for completion March 2016