Edi Carmi's Key Note Presentation: A Summary

ESCB Annual Conference 2016

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Introduction

Edi Carmi, an independent safeguarding consultant who led the first review into the death of Baby P and many other serious case reviews gave an overview of the learning from serious case reviews in relation to:

- Children and families
- Practice, and
- Organisations

Edi Carmi has been involved in the writing of serious case reviews since 2002 and was involved in the development of the Social Care Institute for Excellence (SCIE) 'Learning Together' methodology.

Edi has also been involved in work with the SCIE and NSPCC on a project aimed at improving the quality of serious case reviews. The report can be downloaded here.

Edi also spoke about the learning from a serious case review linked to child sexual exploitation.

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Brandon et al.

Much of the learning referenced in Edi's presentation was linked to the findings from Marion Brandon and colleagues work at thematic reviews of serious case reviews.

The latest report (published May 2016) can be viewed in full:
'Pathways to harm, pathways to protection: a triennial review of serious case reviews 2011-2014'.

Previous biennial reviews are also available; some are referenced in the presentation as Brandon et al.

The reports by Brandon et al, are reviews of all serious case reviews in the stated two-year period.

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Learning from Serious Case Reviews

Edi discussed the learning from serious case reviews under three key headings:

1. Learning about children and families
2. Learning about practice
3. Organisational learning

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1. Learning About Children and Families

Parental/carer/family risks

- Domestic abuse (Brandon & Lewis 1996) Parental mental health factors (Falkov, 1996) and alcohol and substance misuse (Sinclair & Bullock, 2002)
- Co-existence of the above risks for neglected children (Rose & Barnes, 2008) for over half the children –and all 3 risks for a third (Brandon et al, 2008)
- Young parent/s made up 60% of the families in the serious case reviews over the period 2009-2011(Brandon et al 2012)

The Children

- Nearly half the children who were the subject of reviews were under 12 months old (Brandon et al 2008) this age group is particularly vulnerable (Brandon et al 2016)
- 25% of the cases involved children aged 11 and over, 9% of these cases were over 16 years old (Brandon et al 2008)
- Neglect was a background feature for 60% of the serious case reviews (Brandon et al 2012)
- The serious case reviews highlighted the vulnerability of disabled children (Brandon et al 2012)

General Learning

- At the point of the incident/s that lead to the serious case review there were low numbers of children subject to a child protection plan (Brandon et al 2016)
- Transient lifestyles and inappropriate housing of families and young people living independently were factors. (Brandon et al 2016)
- Most, but not all, serious and fatal child maltreatment takes place with in the family with children living at home or with relatives. Pathways to harm include the context of the child's and the parents' characteristics, vulnerabilities and risks which interact with their environmental circumstances' (Brandon et al 2016)

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2. Learning About Practice

Quality of assessment

- Not updating/changing early assessment in light of subsequent evidence (Munro 1996) assessments are seen as a one-off piece of work rather than an ongoing process (Brandon et al 2016)
- Weakness in assessment of need/risk, especially in relation to pre-birth (Ofsted 2012)
- Assessments need to be planned, comprehensive, timely and involve all professionals working with the family (Brandon et al 2016)
- 'Start again syndrome' especially in cases of long standing neglect (Brandon et al 2008)
- Need to hear the voice of the child (Brandon et al 2016)
- Role of fathers is marginalised (Ofsted 2011)
- Assessments are not always rigorous in assessing and following through on all identified risks including domestic abuse. (Brandon et al 2016)

Information sharing

- Need for direct verbal communication (Brandon et al 2008)
- The lack of sustained professional challenge is due to a lack of confidence (Brandon et al 2008)

Practitioner knowledge, skills and expertise

- Difficulties dealing with avoidant families and disguised compliance (Brandon et al 2008)
- Lack of knowledge in relation to normal child development (Brandon et al 2010)
- Lack of appreciation of the fragility of a baby (Ofsted 2011)
- Focus on the young person's behaviour and not what is behind it (Ofsted 2011)
- Avoidance of taking professional responsibility: making assumptions of others (Brandon et al 2016)

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3. Organisational Learning

- Reviews highlighted the complexity and fragmentation of primary care health services which rely on a mixture of independent, public and private contractors, and where professionals are often working in relative isolation. The inevitable transitions within primary care services, such as those between midwifery and health visiting, and between health visiting and school nursing, mean that local teams need to ensure that there are appropriate structures in place for smooth transition, and that information is recorded and passed on. For vulnerable families in particular, any transition should be planned so appropriate support is maintained. (Brandon et al 2016)

- Navigating between complex agency structures can prove difficult for both professionals and families. Clear coordinated care pathways for families with particular vulnerabilities are needed to help ensure parents and children receive timely and accessible help. Local services need clear signposting and clear criteria for referral and acceptance/rejection of cases. (Brandon et al 2016)

'Brooke'

Edi Carmi then spoke about serious case review 'Brooke' jointly commissioned by Bristol and another LSCB, the full reviews can be read here: Brooke 1 and Brooke 2

These serious case reviews focussed in identifying the strengths and gaps in the multi-agency responses to child sexual exploitation.

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Seven key findings from serious case reviews

1. The multi-agency system is not set up to provide an effective response for adolescents (including those at risk of CSE) with a complexity of needs at the time and pace they need it, leaving children with a fragmented and reactive response to different aspects of their behaviour.

2. A confused and confusing stance in national policy about adolescent sexual activity, leaves professionals and managers struggling to recognise and distinguish between sexual abuse, sexual exploitation and/or underage sexual activity; this risks leaving some children at continued risk of exploitation in the mistaken belief they are involved in consensual activity.

3. The child protection process in England has primarily been designed for familial child abuse/neglect; in the absence of concerns about abuse or neglect by parents/carers, victims of sexual exploitation are likely to receive an inconsistent response to their safeguarding needs.

4. In cases involving sexual exploitation, there is a pattern of focusing primarily on trying to stop victims having further involvement with perpetrators, and less on the prevention of the abuse in the first place and the disrupting and prosecuting of perpetrators: this means victims often continue to be at ongoing risk of abuse by the same perpetrators.

5. Our current working methods and recording systems do not reliably identify patterns in individual and group behaviour. This reduces the chances of a timely response in the detection of victims and perpetrators of child sexual exploitation and leads to a more reactive rather than proactive approach.

6. The decision to make the investigation of these crimes into a complex investigation in May 2013 enabled the police to adequately resource an enquiry, which led to the successful prosecution of the offenders and the co-ordinated multi-agency support for the victims.

7. Locally LSCBs and the wider multi-agency partnership have collaborated to develop CSE/Missing strategy and action plans but these take time to embed so there is a disconnect between strategic understanding to drive improvement and the reality on the front line.

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