Transparency and the Publication of Serious Case Reviews

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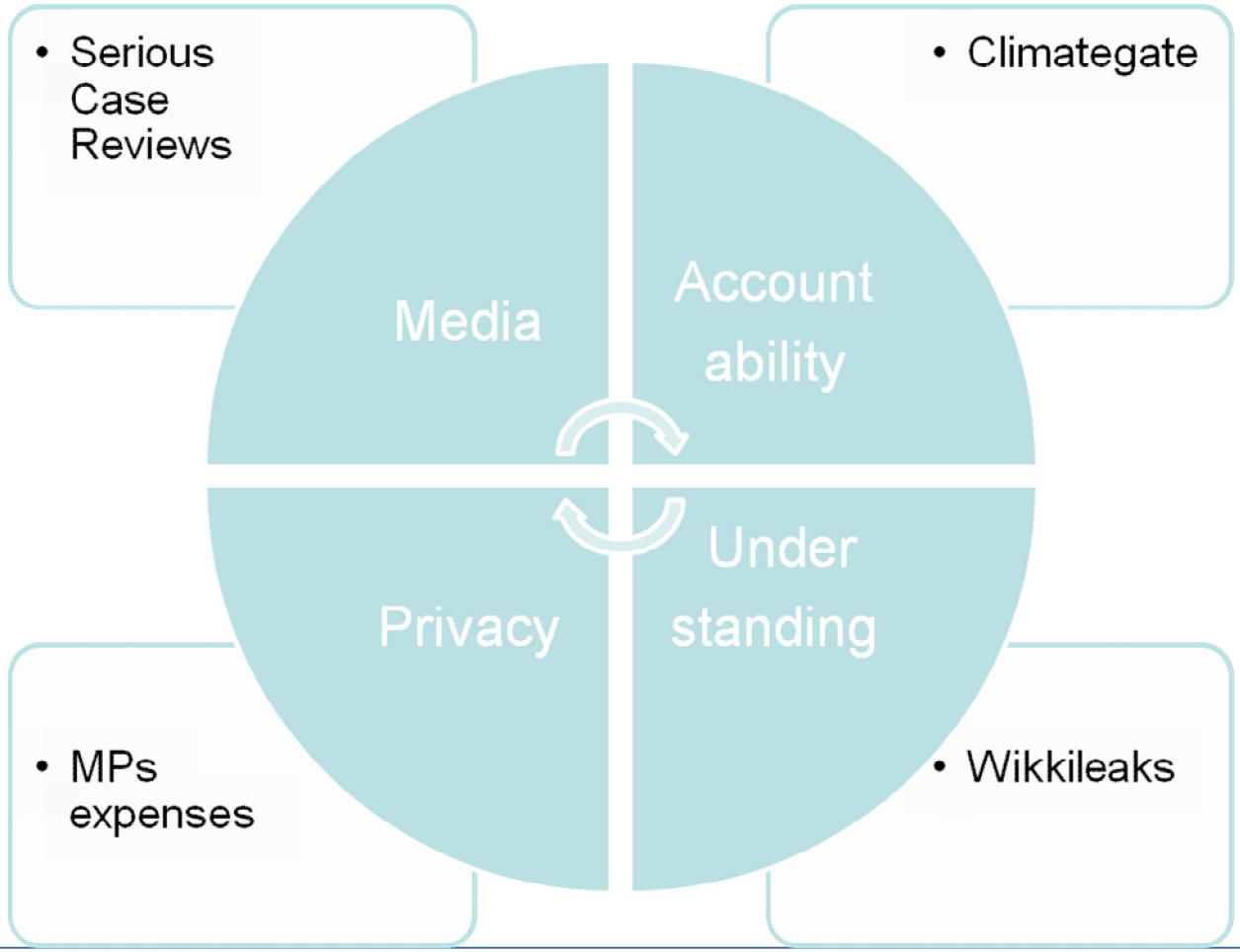
Transparency/Libertarianism



Publishing SCRs

- Commitment to publish 5 SCRs -Peter Connelly (October 2010), Kyra Ishaq (July 2010), Shannon Matthews and Edlington cases)

Other cases published:

- Hull case (from 2007)
- No cases begun after June 2010 have yet been published (some are being prepared)

Access to Executive Summaries:
Requirement to publish (*Working Together* 2006)

From 2007-2009: 50+ Executive Summaries found (out of 268 SCRs)

- Some LSCBs display links to Exec Summaries prominently – accessible
- Often not available on line or at all (or very hard to find)
- Some LSCBs provide only phone or email contact for summaries (easier tracking of use?)
- Variation in style and content, eg very brief, or very full with almost as much information as the Overview Report

Transparency: How many SCRs?

PATTERNS AND TRENDS

Numbers and patterns of SCRs in England from 2003-2009 (Brandon et al 2010)

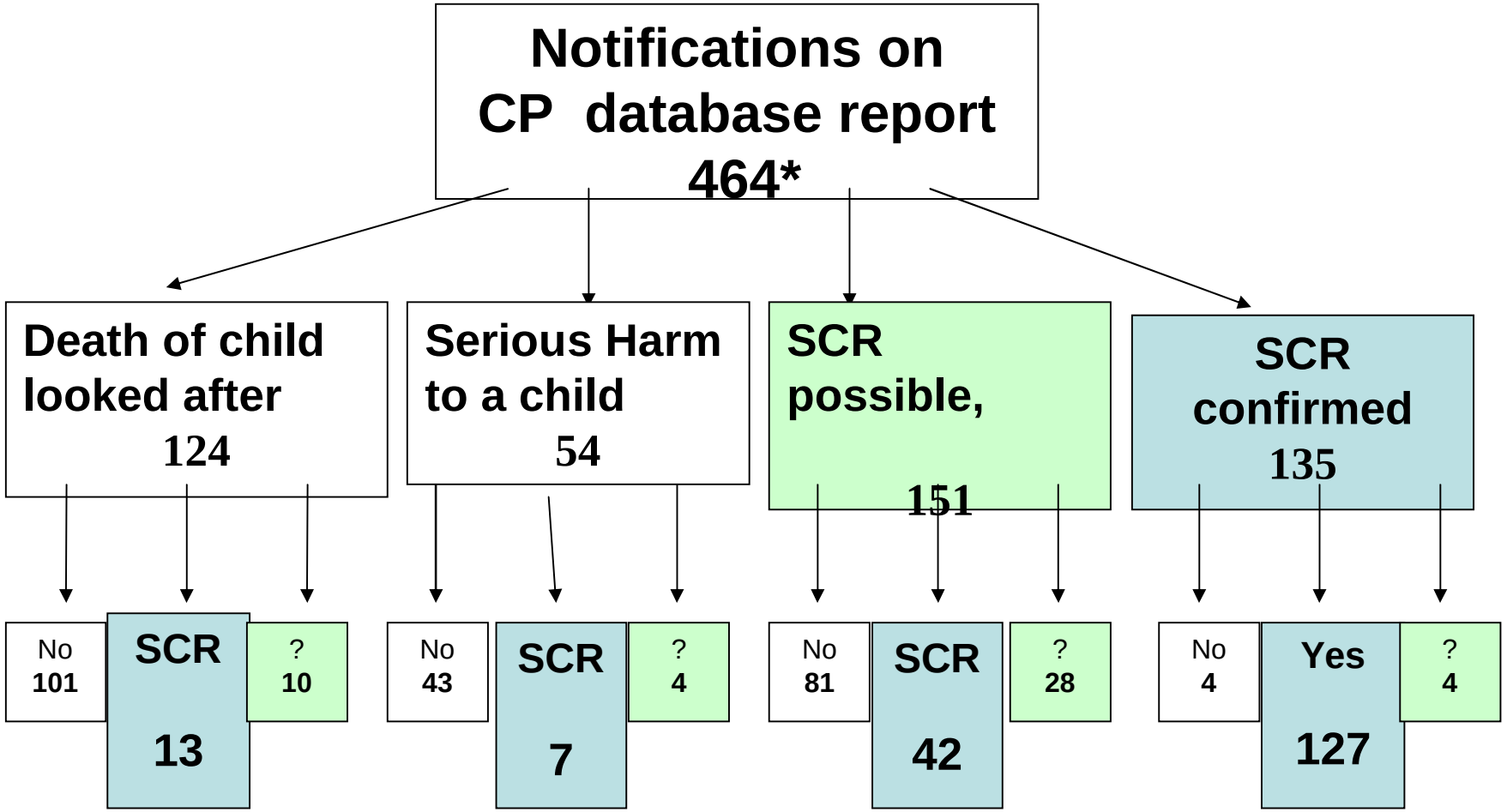
- 2003-5 - 161 SCRs 2/3 death 1/3 serious harm
- 2005-7 - 189 SCRs 2/3 death 1/3 serious harm
- 2007-9 - 268 SCR 57% death 43% serious harm

- 2007-09 - more SCRs than before, 43% rise in death cases, 111% rise in serious injury cases
- 2007-2009 675 'serious child care incidents' prompted 268 SCRs (152 death cases , 116 of serious injury cases)

Transparency: the route to a SCR

WHICH CASES BECOME A SCR?

Finding SCRs:189 from 464 ‘serious child care incidents’ (Brandon et al 2009)



*13 additional reports excluded

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SCR Yes or No? (2007-8)

SCR more likely

- Girls
- Younger children
- Physical assault and sexual assault
- Incidents occurring within 'family' context

SCR Less likely

- neglect
- adolescent risk taking cases (inc attempted suicide)

Little difference between cases selected/ not selected for SCR (44% of notifications did not lead to SCR)

Why not SCR?

BUT 4/10 physical/sexual assault cases did **not** become SCR (not clear why – seemed very similar)

- Some said not to meet the threshold in WT
- Some LSCBs emphasised some aspects of criteria not others (eg agencies working together)
- Some met criteria **but** decision not to proceed **or** to have an alternative method of review

Alternative methods of review

- Lessons learned review (similar to SCR but not defined as such)

"*The LLR follows the same structure, process and timetable as an SCR but outcomes will only be shared within LSCB agencies and not made public*"

- 'near miss' procedures
- Individual management reviews
- Case audits
- 'Appreciative Enquiry' reviews
- Workshop based approach
- Domestic homicide review, Serious further offence review (Criminal Justice)

Patterns in SCRs – what do we know?

2003-2009

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Patterns in Serious Case Reviews

- **Are SCRs unique or part of a pattern**? (Both).

618 SCRs from 2003-2009 studied – some patterns evident

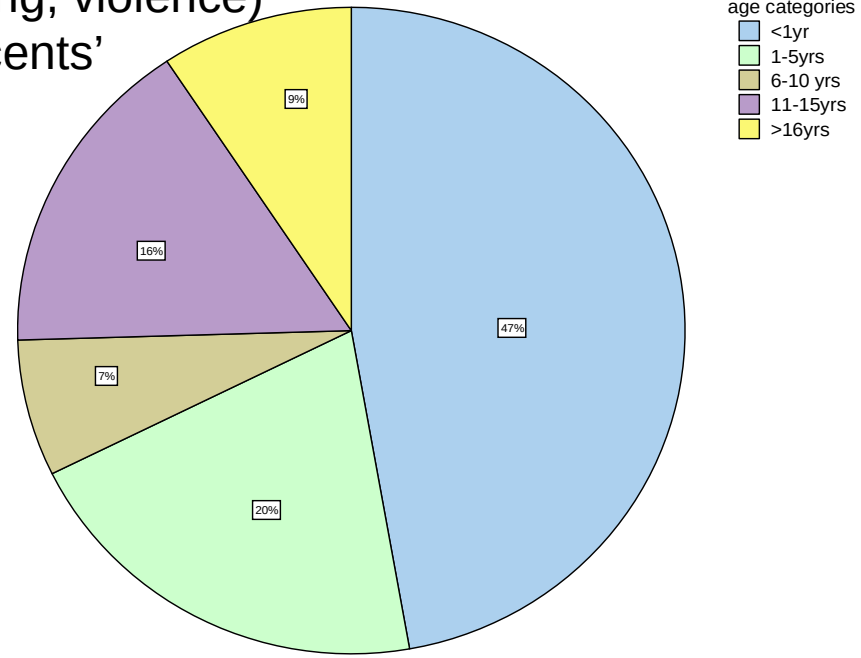
- **Known to Social Services?**: Just under half of children NOT known to CSC at time of incident (BUT ¾ known in past)

- **CP Plan?** Less than 1:6 children with a current CP plan (BUT in 1:3 cases, child or sib had plan in the past)

- **Physical injury** the major cause of death. **Neglect** an underlying theme in many cases but rarely the principal cause of death. More **neglect** and **sexual abuse** as prime concern in serious harm rather than in child death cases.

Age at time of death/serious harm

Older child, ‘hard to help’ or (self neglect, chronic illness, sexual exploitation, ‘going missing’, bullying, violence) or ‘lost adolescents’



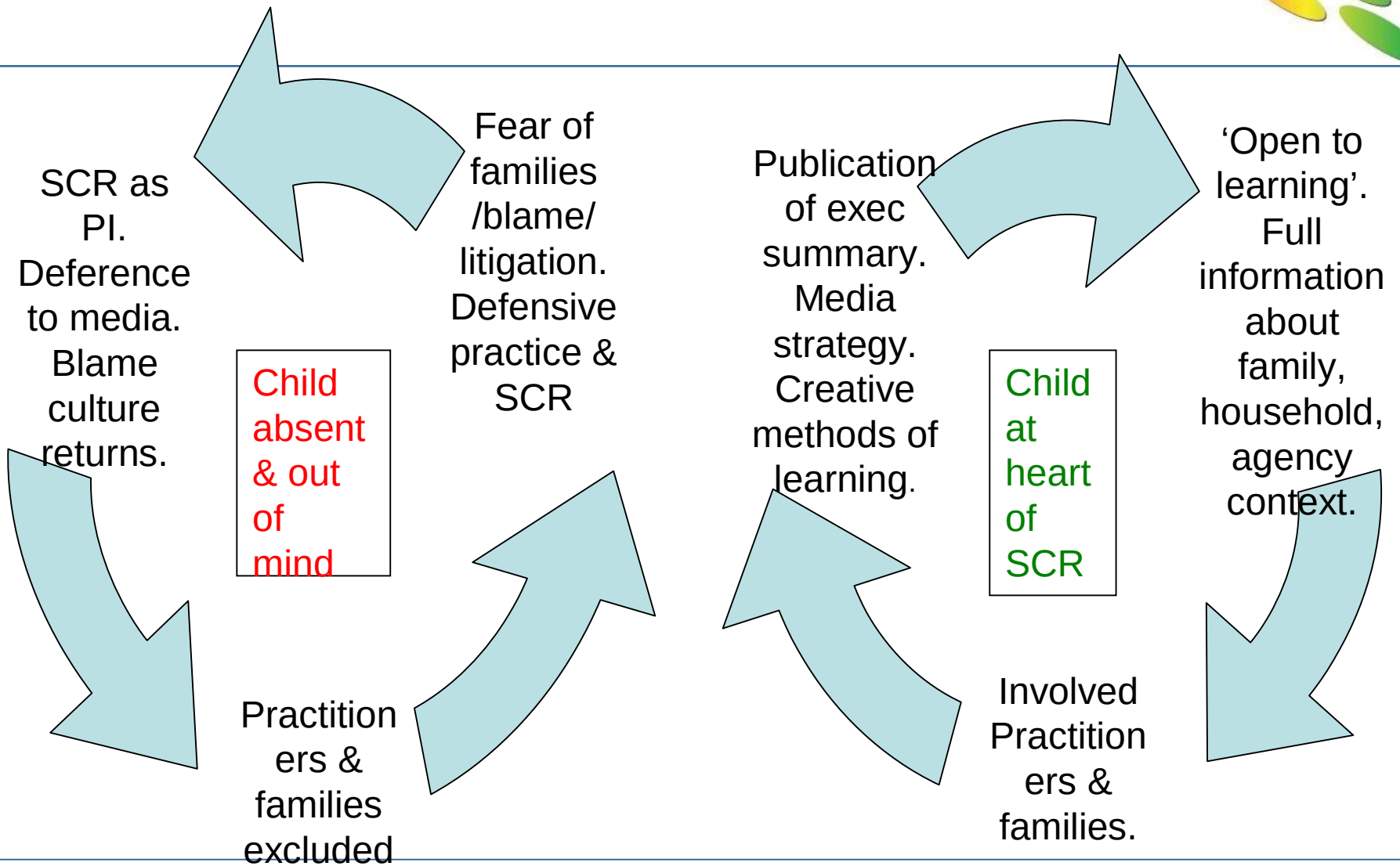
Very young babies (prematurity, admissions to hospital: types of injury eg head injury, overlying/accidents)

Transparency in the SCR process

POSITIVE AND NEGATIVE CYCLES

Negative SCR cycle

Positive SCR cycle



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