Institution: University of East Anglia

Unit of Assessment: 22 Social Work and Social Policy

Title of case study: Preventing child death from maltreatment

1. Summary of the impact

Since 2006 the University of East Anglia (UEA) has led a series of Government commissioned studies of all Serious Case Reviews of child death and serious injury in England. This work has provided the largest national database of analyses of child deaths and serious injury where abuse or neglect are known or suspected.

Since 2008, the findings have informed public understanding, practitioner thinking, multi-agency child protection practice, policy and law - in the UK, and internationally. Both key child protection policy and practice reviews commissioned by the UK Government 2008-13, the Laming report (2009) and the *Munro Review of Child Protection* (2011), drew on this research.

2. Underpinning research

Context

In England, there is a requirement to set up multi-agency Serious Case Reviews following death or serious injury of children where maltreatment is a possible factor. National biennial analyses of these reviews have been commissioned by Government Departments since 1998 to improve child protection policy and practice. In undertaking these reviews the aim has been to identify what lessons can be learned from these cases and to find ways to minimise the circumstances that can lead to a child being harmed.

Research studies at UEA

The focus of this case study are the four (continuous) Government funded biennial studies of all Serious Case Reviews in England 2003-11.The studies were conducted **1.** 2006-8, **2.** 2007-9, **3.** 2009-10, **4.** 2010-12.

This research has all been conducted by teams led by Marian Brandon, using an approach which tries to understand more about both the circumstances which might trigger the death or serious injury of a child and the factors which influence the behaviour of the practitioners working with the children and their families. The mixed method, ecological and transactional approach requires a dynamic understanding and assessment of children and their families and of human development across the life span. This work has provided the largest national database of analyses of child deaths and serious injury where abuse or neglect are known or suspected. To date the research has produced a systematic analysis of more than 808 cases in total (from 2003-11) with 505 (62.5%) deaths and 303 (37.5%) serious injuries.

This research programme drew on previous UEA child protection studies led by Thoburn and Brandon since the 1990s, funded by the Department of Health and the NSPCC. Howe's expertise on child development and abuse has informed the theoretical approach. Thoburn and Howe are now Professors Emeritus. Since 2007, Sidebotham, a consultant community paediatrician and Associate Professor at Warwick University, who specialises in child death, has also contributed to the research.

Marian Brandon is Professor of Social Work and Director of the Centre for Research on Children and Families (CRCF).

Findings

Key findings from the CRCF biennial analyses of Serious Case Reviews include an enhanced understanding of the following:

- The vulnerabilities in children, stresses in parents and interactions between children, parents and workers that can lead to maltreatment resulting in death or serious injury.
- The ways in which workers become overwhelmed and the impact this has on their practice and

decision making (particularly where there is complex neglect), making the case for improved staff support, more robust supervision and a fully staffed workforce.
- The similarities of the profile of the cases where children die with other complex cases, making prediction very difficult, and requiring practitioners to be highly attuned to changes in family functioning.
- The particular vulnerability of infants, with a high proportion of infant cases of death and serious injury not being previously known to children's social care.
- The absence of awareness among professionals and policy makers of the impact of serious maltreatment on adolescents.

3. References to the research

All projects were government funded through competitive tender following peer review. Grants awarded to Marian Brandon from the Department for Children, Schools and Families/Department for Education (DCSF/DfE) total £364,347, (2006-2012). An advisory group, comprising policy makers, academics and stakeholders, provided a rigorous peer review for each study and each report.

Research reports for Government - also distributed to local authority safeguarding boards

1. Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J. and Black, J. (2008) *Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-05.* London*:* Department for Children, Schools and Families, DCSF-RR023.

2. Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A biennial analysis of serious case reviews 2005-07.* London: Department for Children, Schools and Families, DCSF-RR129.

3. Brandon, M., Bailey, S., and Belderson, P. (2010) *Building on the learning from Serious Case Reviews: a two year analysis of child protection database notifications 2007-2009,* Department for Education. Research Report DFE-RR040.

4. Brandon, M, Sidebotham, P, Bailey, S and Belderson, P, Hawley, C, Ellis, C and Megson, M (2012) *New learning from Serious Case reviews: a two year report for 2009-2011* London: Department for Education DFE-RR226.

Peer reviewed journal articles

5. Brandon, M., Belderson, P., Warren, C., Gardner, R., Howe, D., Dodsworth, J., and Black, J. (2008) 'The preoccupation with thresholds in cases of child death or serious injury through abuse and neglect, *Child Abuse Review,* 17(5) 289-364.

6. Brandon, M. (2009) 'Child fatality or serious injury through maltreatment: Making sense of outcomes', *Children and Youth Services Review,* 31:1107-1112.

7. Sidebotham, P., Bailey, S., Belderson, P. and Brandon, M. (2011) Fatal child maltreatment in England, 2005-2009. *Child Abuse and Neglect.* 35(4): 299-306.

4. Details of the impact

Brandon and the series of UEA studies have had a direct and significant impact on child protection policy and practice since 2008, with a *reach* across the UK and internationally. Findings from the two earlier studies **(References 1, 2, 5, 6, 7)** have continued to influence current policy and practice alongside the third study **(References 3, 7)** and the most recent study (**Reference 4**). The *pathways* to impact have been primarily through the publication and dissemination of the Biennial Reports **(References 1, 2, 3, 4)** to all Local Safeguarding Children Boards by the DCSF/DfE, the incorporation into required procedure and practice nationally and locally and the role of Brandon in dissemination and consultation on policy, practice and procedure, nationally and internationally. Journal articles **(References 5, 6, 7)** have broadened the reach, especially internationally. Beneficiaries are at all policy and practice levels.

National impact

- **Government Policy:** findings influenced the 2010 edition and the 2012 consultation edition of *Working Together to Safeguard Children* in England. The Brandon et al. (2008, **Reference 1**)

recommendation for greater numbers of health visitors was taken up in the 2009 Laming inquiry report, as well as four other references to the studies. Significant material from the studies was used in practice guidance for *Safeguarding Disabled Children* (2009). References to these studies appeared in the three Munro Review Reports. Brandon was invited to give oral evidence to the Government Select Committee on the Munro Review recommendations (October 2011) and to advise civil servants about changes to Serious Case Review reporting in the Working Together guidance being drafted (March 2012). Brandon presented at UK 'Four nations' events on the development of child death review work nationally.

- **Contribution to social work reform:** The NQSW Guide for Supervisors of Newly Qualified Social Workers (2009) draws heavily on Brandon et al (2008 **Reference 1**) The Social Work Task Force Interim Report (2009) uses UEA Serious Case Review evidence about supervision. This evidence led to consultation with the General Social Care Council and Children's Workforce Development Council on implications for social work education.

- **Practitioners:** National Government distribution of UEA reports (2008, 2009, 2010, 2012, **References 1, 2, 3, 4**), reinforced by two annual rounds of nine regional practice-focused seminars throughout England in 2008 and 2009. Brandon has given keynote addresses at Local Safeguarding Children Board (LSCB) conferences in England, Wales, Scotland and Northern Ireland. 'Case Studies' in the reports advise practitioners on how to link findings to practice. Many LSCBs have UEA's Serious Case Review reports on their website. UEA has organised national practice focused conferences in London and through the 'Making Research Count' network. The Metropolitan Police Service (Child Abuse Investigation Command) introduced a Child Risk Assessment Model using UEA biennial studies' risk factors in 2011. The Lead Officer's report to Child Protection Committees in Scotland (2011), commended Brandon et al for their 'excellent research report' on child development knowledge from Serious Case Reviews to all practitioners this report was initially published in 2011 and incorporated into **the 2012 biennial report Reference 4**).

- **Non-governmental groups:** The NSPCC used evidence from the Serious Case Review studies for its 2010 restructuring into seven themes. In 2011 their *All Babies Count* campaign used UEA's findings in their campaign leaflet illustrating the ways in which infants are at risk of serious harm. The report on which the campaign was based, mentioned the 'hugely influential' Brandon et al report (**Reference 1**). The 2013 NSPCC report *How Safe are Our Children?* uses the most recent study (**Reference 4**) substantially as a guide to its messages about child death and the level of risk children face.

- **Society:** Brandon played a significant role and led national debate on protecting children from abuse - particularly in the context of the death of 'Baby P', through media interviews e.g. Radio 4, Radio 5, local radio, BBC TV News, News 24, ITV News, Sky News, Guardian, Telegraph, Daily Mail, New Statesman and professional press, e.g. Community Care and Nursing Times.

International impact

Australia

- Brandon and Thoburn were asked to advise the State of Victoria's Minister for Families and Communities (March 2008).
- Consultancy for New South Wales (NSW) Ombudsman Office about child death review processes (April 2011) resulted in changed definitions of neglect in NSW. Presentation about child death through maltreatment to Melbourne Judiciary (August 2010).
- The keynote address and Masterclass at the 3rd Australasian Child Death Review Conference in Sydney in 2012, together with previous consultation, resulted in a significant change in policy- the involvement of the child's family in the child death review. This change is being implemented in Victoria (and considered in other states).
- Round Table events at La Trobe and Melbourne Universities in September 2007, 2010, and Melbourne University's Centre for Excellence 2010 and 2012.

5. Sources to corroborate the impact

Links to research /references by numbers in bold.

1. 19 February 2008: Letter from Kevin Brennan, Parliamentary Under Secretary of State, to Chairs of Local Safeguarding Children Boards emphasising 'the importance of acting on the findings' of the report *Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005* (Brandon et al 2008, **Reference 1**)

2. The Lord Laming (2009) *The Protection of Children in England: A Progress Report,* London: TSO (recommendations of the report draw heavily on Brandon's work, e.g. recommendations 13, 15,16, 20 and 24 on pp.85-88 reflect specific implications for safer practice from, Brandon et al (2008 **Reference 1**), also cited pages 24, 38, 57 and 65. These recommendations were taken up by the government and incorporated into guidance *Working Together* 2010 (see below). Laming Report http://dera.ioe.ac.uk/8646/1/12_03_09_children.pdf

3. Department of Children, Schools and Families (2009) *Safeguarding Disabled Children Practice Guidance,* DCSF-003474-2009DOM-EN (3 citations pages 34, 40, 47 Brandon et al, 2008 **Reference 1**, and 2009, **Reference 2**) https://www.education.gov.uk/publications/eOrderingDownload/00374-2009DOM-EN.pdf

4. *Facing up to the Task: Interim report of the Social Work Task Force* (2009) drew on Brandon et al's work to emphasise the inadequacies in, and the importance of, staff care and supervision in protecting children. This has contributed to the emphasis on social work expertise in child protection, as also reflected in the Munro Review. Citation page 17, Brandon et al, 2008, **Reference 1**)

5. Children's Workforce Development Council (2009) *NQSW Guide for Supervisors 2009-10* Leeds: CWDC. 11 separate citations, pages 101,102,103,105,107,115, 120,130,132, 136,139, (Brandon et al, 2008, **Reference 1**.)

6. Department of Children, Schools and Families (2010) *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* 4 citations pages 259, 263, 267, 271 (Brandon et al, 2009, **Reference 2**) https://www.education.gov.uk/publications

7. *The Munro Review of Child Protection (2011) 4 citations* pages.16, 86, 96, 150 **Reference 3** (Brandon et al, 2010). https://www.education.gov.uk/publications/eOrderingDownload/Munro-Review.pdf

8. Email from Wendy Mayne, Office of the Child Safety Commissioner, State of Victoria, Australia 'Your work on engaging families could not have come at a better time and will assist us to strengthen practice'. 19.11.2012

9. *National Guidance for Child Protection in Scotland: Guidance for Health Professionals in Scotland* (2013) draws on Brandon's research in several sections and on p.82 refers to 7 separate publications by Brandon and the research team under 'The Unseen Child' and 'High Risk Families', including **References 1, 2.** http://www.scotland.gov.uk/Resource/0041/00411543.pdf

10. NSPCC report *How Safe are Our Children? (2013)* 4 citations pages 12, 14, 64, 65 (Brandon et al, 2012 **Reference 4**) and uses the research to underpin their synthesis of child safety recommendations.