Socialstyrelsen
THE NATIONAL BOARD OF HEALTH AND WELFARE

The National Board of Health and Welfare's investigations into certain injuries and deaths in 2022–2023

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Summary

The National Board of Health and Welfare has a legal duty to conduct a serious case review under certain circumstances, such as the murder, manslaughter or attempted lethal violence against a child or the murder, manslaughter or attempted lethal violence against an adult by a family member or intimate partner. A serious case review must also be conducted when a child has been subjected to gross or exceptionally gross assault by a family member or other person in a close relationship.[1] The aim of the serious case reviews is to identify deficiencies in the social safety net[2] and to provide the Government with an evidence base for proposing measures to prevent child abuse and neglect and to prevent adults from becoming victims of domestic violence.[3] The assignment is regulated by law and ordinance.[4]

In this report, the National Board of Health and Welfare provides an overall analysis of the reviews conducted during the period 2022–2023. These reviews involve 69 victims of crime: 26 children and 43 adults.

The National Board of Health and Welfare has identified some 30 deficiencies in the social safety net. They are mainly deficiencies in the core activities of the societal actors (i.e. social services, the police and healthcare), and several of them have also been highlighted in previous reports from the investigation unit. The serious case reviews show that it is crucial that the entire chain of interventions works. This involves both the need for each individual actor to play their part and the need for the various actors to work together. It is by working together that the authorities can prevent child abuse and neglect and adults from being victims of domestic violence. To make this possible, it is important to continue initiatives in this area. Among other things, it is crucial that staff have the conditions needed to do work of good quality, such as sufficient expertise and a reasonable workload.

[1] See Section 2(1)-(2) of the Act on serious case reviews to prevent certain injuries and fatalities.
[2] The serious case reviews apply a broad definition of the term deficiencies. Deficiencies in the social safety net refer to situations where, based on the documentation available and the oral information obtained in some of the cases, the National Board of Health and Welfare finds that a different behaviour by the societal actors could have reduced the risk of the offences. This may involve, for example, non-compliance with regulations, guidelines and methodological support, but also "missed opportunities", i.e. situations where a societal actor did not do anything wrong but could have done something else. In addition, it may involve situations where, due to the prevailing regulations, there were limitations on acting in a different way.
[3] See, inter alia, Government Bill 2017/18:215 Investigations to prevent certain injuries and fatalities, p. 17 and Section 1 of the Act on investigations to prevent certain injuries and fatalities.
[4] See the Act on investigations to prevent certain injuries and fatalities and the Ordinance (2007:748) on investigations to prevent certain injuries and fatalities.

Children as victims of crime

The National Board of Health and Welfare has investigated cases involving 26 child victims of crime. Most were victims of murder or attempted murder. Of the victims, 12 died and the other children were victims of attempted lethal violence or of gross or exceptionally gross assault or attempted gross or exceptionally gross assault by a family member or other person in a close relationship, and in several cases the child suffered serious life-changing injuries.

For the majority of child victims of crime, the perpetrator was a parent. However, for about one third of the victims, the perpetrator was a peer. On average, children who suffered at the hands of a parent were younger than those who suffered at the hands of a peer.

In most cases where a parent was the perpetrator, there were concerns about problems with the parent prior to the criminal act, such as harmful substance use/addiction, mental health issues or a conflict-ridden separation between the child's parents. In cases where the perpetrator was a child, the majority were involved with Social Services for various serious delinquent behaviours prior to the offence in question, such as the physical abuse of peers or the use and sale of drugs.

Societal actors could have reduced the risk of the crimes

The following describes some of the deficiencies identified, broken down by different societal actors.

Social Services. The deficiencies identified relate to Social Services failures in the handling of cases concerning children's need for protection and support. Almost two thirds of the victims and just over half of the perpetrators had been in contact with Social Services in the year prior to the offence in question. The majority of the children (both victims and perpetrators) had had contact with a child and adolescent unit, and in most cases the children had an ongoing investigation or intervention.

The deficiencies in the handling of cases include the failure to conduct child investigations in such a way that the individual child's situation was adequately analysed from a holistic perspective, or that the children were involved in the investigation process. This resulted in children not receiving the protection and support they needed. Where interventions were provided, they were inadequate and/or did not meet the needs of the specific child.

Social Services also failed in terms of collaboration. Social Services had not initiated collaboration with any other actors in any of the cases reviewed, even though Social Services has an obligation to collaborate on matters

concerning children who are being harmed or at risk of being harmed and has primary responsibility for ensuring that such collaboration takes place.

Healthcare. The deficiencies identified mainly relate to deficiencies in the care of adult perpetrators who are parents. The majority of these perpetrators had contact with the healthcare system in the year prior to the offence, often due to serious mental illness or harmful substance use/addiction. The perpetrators did not receive the care they needed. This is partly because the conditions were not sufficiently investigated and the healthcare system did not consider risk factors for e.g. postpartum psychosis or psychosis, and partly because care was not provided as prescribed by guidelines and recommendations. The healthcare system did not pay sufficient attention to the perpetrator's children, even though the perpetrator's condition affected their parental capacity and the situation of their children.

Police. One deficiency identified is that the police did not pay attention to the children's situation when a parent with serious mental illness contacted the police to report a crime. This was despite the fact that it was clear that the parent was affected by a serious psychiatric condition. Another deficiency was that the police did not identify children as victims of crime, even though information about crimes against children emerged in connection with the reporting of a crime against a parent.

Swedish Prosecution Authority. Restraining orders are a protective measure that was rarely applied in the cases reviewed by the National Board of Health and Welfare. However, the National Board of Health and Welfare's reviews show that restraining orders, coupled with other support and protection measures from the police and Social Services, could have helped to better protect the victims from the perpetrators.

School. Several of the children (both victims and perpetrators) who attended school exhibited social problems, high absenteeism and difficulties in achieving educational objectives. Despite extra adaptations and special support, the problems did not diminish. The school, through collaboration with e.g. Child and Adolescent Psychiatry Services (BUP), could have contributed to better assessment of the child's difficulties to ensure the right measures were put in place.

Other – multiple actors. The deficiencies identified that concern multiple actors relate to two different things: 1/ No medical assessment of a parent who has been taken into care under the Act (1976:511) on the care of intoxicated persons etc., LOB, despite being intoxicated/under the influence of drugs and showing symptoms of a serious psychiatric condition. 2/ Inadequate child safety when a child has died as a result of negligence on the part of an adult.

Further efforts needed to identify at-risk children

Much has changed since 2008, when the National Board of Health and Welfare was tasked with conducting serious case reviews of lethal violence against children. A number of measures have been implemented to better prevent children from being harmed. The Convention on the Rights of the Child became Swedish law on 1 January 2020. Despite the many measures implemented, both the National Board of Health and Welfare's serious case reviews and research in the field show that the social safety net is inadequate and that children in vulnerable life situations do not always receive the support and protection they need.

Many of the deficiencies identified in this report have also been highlighted in previous reports and show that long-term and sustained efforts are still needed from all societal actors who encounter children and parents. It is important that societal actors recognise early on when a child is in a vulnerable situation, that they offer interventions in line with the child's needs and that they work together to obtain a holistic picture of the child's situation.

The National Board of Health and Welfare finds that there is much that societal actors need to do to remedy the deficiencies that have been identified.

The National Board of Health and Welfare has provided a number of assessments and proposals on how the work can be developed within the various societal actors' spheres of responsibility.

The National Board of Health and Welfare has also identified three overarching and central areas that concern several societal actors and that are important for developing the work to prevent child abuse and neglect:

The societal actors must be given the conditions needed to do work of good quality. Much of the work that would be needed for the entire chain of interventions to be effective is time-consuming. Supporting structures for collaboration are needed, as well as time and resources to provide intensive and specialised interventions/measures for children and parents with complex needs.

Professionals must have the right competence. All professionals who come into contact with children who are being harmed or are at risk of being harmed need to have sufficient training to work according to the best available knowledge and to make assessments and offer interventions in line with existing recommendations and methods. Existing knowledge support systems and guidelines need to be implemented, and the need for specialised training for e.g. social workers reviewed.

The child perspective must be strengthened. Children's rights must be safeguarded in all decisions affecting them. Children's participation must be increased and interventions for children and parents must be based on the specific needs of the individual child. For children's rights to be fully realised and for children to be protected from harm, all actors in society must take responsibility and work together, with a clear focus on the best interests of the child.

Adult victims of crime

The National Board of Health and Welfare has investigated cases involving 43 adult victims of crime. Of the victims, 35 were killed and 8 were victims of attempted murder or manslaughter. In most cases, the perpetrator was an intimate partner or former intimate partner of the victim. In a large majority of these cases, the victim was a woman and the perpetrator a male partner or former partner. The remaining cases mainly involved a parent killed by their (usually adult) child. There was a wide age range among both victims and perpetrators, from under 18 to over 80 years old. The average age was 48 for victims and 44 for perpetrators.

A majority of victims had been subjected to violence by the perpetrator before the offence in question was committed. This often involved a pattern of psychological violence in the form of controlling and degrading behaviour and threats, in some cases in parallel with physical violence.

The majority of the perpetrators had mental health issues, in many cases coupled with harmful substance use/addiction, were unemployed, or were receiving sickness or activity compensation due to illness or disability. Several had attempted suicide or had had suicidal thoughts before the offence.

Serious deficiencies in the social safety net

The following describes some of the deficiencies identified, broken down by different societal actors.

Social Services. About half of the perpetrators and a quarter of the victims had been in contact with Social Services in the year prior to the offence. The contact was most often with the income support unit, the child and adolescent unit or the substance abuse and addiction unit. The case reviews by the National Board of Health and Welfare show that questions about exposure to violence were rarely asked, which contributed to the violence going undetected.

Risk assessments and safety planning were often lacking, and few interventions were offered to victims of violence. The risks of psychological

violence appear to have been underestimated and not taken as seriously as physical violence. It was consistently found that the perpetration of violence was rarely given proper attention.

Police: One third of perpetrators and just over a quarter of victims had had contact with the police in the year prior to the offence, usually as a result of a police report of domestic violence. Deficiencies identified include the initial police response to a report of domestic violence. There are also cases where preliminary investigations into intimate partner offences have remained dormant for a long time without any action being taken.

Healthcare: Healthcare was the societal actor with whom most victims and perpetrators had had contact in the year prior to the offence. The most common contact was with psychiatry and primary care. Deficiencies include the fact that the violence went undetected. Healthcare providers failed to ask about exposure to violence, despite risk factors for violence. Nor did they recognise the victim's need for trauma treatment or other counselling as a result of the violence. In the case of perpetrators, who often had complex psychiatric issues, no attention was paid to the use of violence or the risk of violence against a family member or intimate partner.

Swedish Prison and Probation Service. Some perpetrators were under the supervision of the probation service when they committed the offences in question. One of the deficiencies identified is that the measures planned by the probation service during enforcement were rarely carried out, even though the perpetrators were assessed as having a high risk of reoffending and an extensive need for interventions.

Swedish Prosecution Authority. Restraining orders are a protective measure that was rarely applied in the cases reviewed by the National Board of Health and Welfare. However, the National Board of Health and Welfare's reviews show that restraining orders, coupled with other support and protection measures from the police and Social Services, could have helped to better protect the victims from the perpetrators.

The employer. In some cases, the victim's employer was the only actor who suspected or knew that the victim was exposed to violence. One of the deficiencies noted was that the employer did not ask questions about exposure to violence, which contributed to the violence going undetected.

Further efforts needed

Many measures have been taken by the Government and authorities in recent years to prevent violence against family members and intimate partners. Since 2017, a ten-year national strategy for preventing and combating men's violence against women has been in place.[5] Based on the

[5] National strategy to prevent and combat men's violence against women (Skr 2016/17:10).

strategy, several authorities have been given assignments in this area, which has contributed, for example, to greater knowledge in the area and increased access to protection and support to some extent. However, the National Board of Health and Welfare's serious case reviews, as well as research, supervision and official reports in the area, show that there are still many deficiencies in the social safety net when it comes to preventing domestic violence against adults.

It is therefore important that the Government's initiatives continue so that it is possible to conduct long-term and effective work in this area. The National Board of Health and Welfare has provided a number of assessments and proposals on how the work can be developed within the various societal actors' spheres of responsibility.

The National Board of Health and Welfare has also identified three overarching and central areas that concern several societal actors and that are important for developing the work to prevent domestic violence against adults:

The entire chain of interventions needs to work. Domestic violence is a complex problem that often requires interventions from several societal actors. It is crucial that the entire chain of measures to protect and support victims of violence works, and that work with perpetrators is further developed. This involves both the need for each individual actor to play their part and the need for the various actors to work together. It is by working together that authorities and other societal actors can prevent and combat domestic violence.

Follow up the results of implementation. Follow up the results of implementation. There is ongoing work in several authorities concerning the dissemination and implementation of different types of knowledge support systems. Follow-up is important to ensure that this leads to knowledge being used in the practical work of professionals.

Better conditions for doing work of good quality. In many organisations, staff often work under severe time pressure and are forced to impose tough priorities. Many find it difficult to live up to the demands of the organisation. It is of great importance that the authorities and organisations concerned are given the conditions needed for staff to be able to do work of good quality.

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