Department for Education

Complexity and challenge: a triennial analysis of SCRs 2014-2017

Final report

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Disclaimer

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

Executive summary

Introduction

The context of complexity and challenge provides an underlying theme in this triennial review of a total of 368 SCRs (SCRs) from the period 1 April 2014 - 31 March 2017. As we looked into the reviews of children affected by serious and fatal child maltreatment over these three years, we were struck by the complexity of the lives of these children and families, and the challenges – at times quite overwhelming – faced by the practitioners seeking to support them in such complexity.

A serious case review (SCR) is carried out by a Local Safeguarding Children Board (LSCB) where abuse or neglect of a child is known or suspected and either a child has died, or has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. The final decision on whether to conduct a serious case review rests with the chair of the LSCB. LSCBs had a statutory function to undertake SCRs and advise the authority and their Board partners on lessons to be learned. [1]

The study's primary aim was to understand the key issues, themes and challenges from the cases examined and to draw out implications for both policy makers and practitioners. The process for learning from reviews is undergoing change and this analysis provides a timely opportunity to capture rich learning from these serious cases to inform the new local safeguarding arrangements outlined in Working Together to Safeguard Children 2018 (HM Government, 2018).

In our last triennial review, we introduced the model of 'Pathways to Harm and Pathways to Protection' (Figure 1 and see below) and this model again provides the basis of our current analysis of SCRs.

[1] LCSBs are being replaced by the three safeguarding partners, as required by the amended Children Act 2004. The transition from LSCBs to safeguarding partners was completed on 29 September 2019. SCRs will be transitioning to local and national reviews. LSCBs have a grace period of 12 months from the setting up of the new safeguarding partner arrangements in their area to publish outstanding SCRs. LSCBs are to complete all SCRs by 29 September 2020. https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

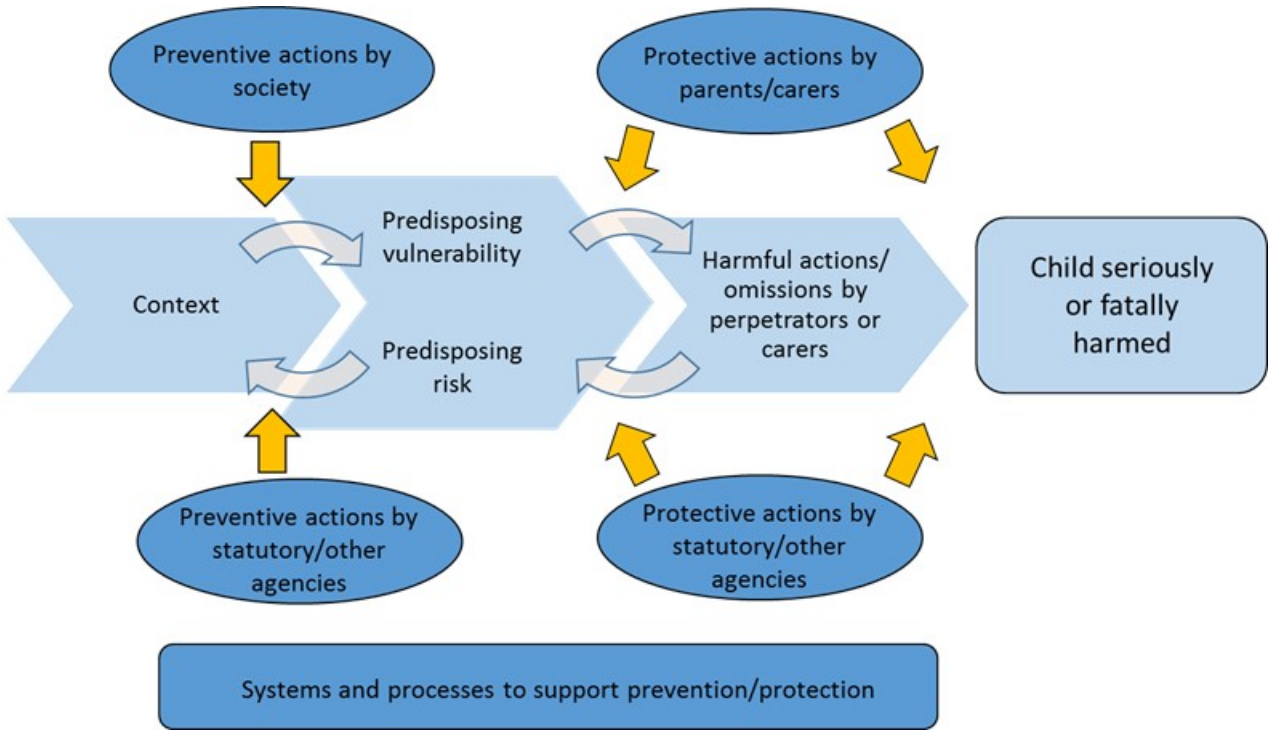

Figure 1

The model has proved helpful in enabling us to explore the complexity of families' lives within the central 'pathways to harm' component, and the challenges faced by practitioners in statutory and other agencies within the 'pathways to protection'. In addition, it has enabled us to look beyond the complexities and challenges to consider the opportunities for prevention and protection, and the values, systems and processes that might help support this work.

Methods

A mixed-methods approach was used, encompassing:

- Quantitative analysis of the full sample of 368 SCR cases, using information from the Department for Education notification data for the specified time period;
- Analysis of more detailed data available through in-depth reading and coding of a sub-set of 278 of these reviews;
- Qualitative analysis of 63 final reports, sampled from the 278 available reports, examining the themes of neglect, vulnerable adolescents, care and court cases, as well as the quality of SCR final reports;

- A national survey, distributed to all English Local Safeguarding Children Boards (LSCBs), about the implementation and impact of the SCR recommendations, with follow up phone interviews with 20 survey respondents; and

- Two regional practitioner/leader workshops to test emerging findings and gauge views about the impact of serious case reviews on child protection practice with 33 attendees in the Midlands workshop and 35 in the London workshop.

Key Findings

Numbers of SCRs

- While the number of SCRs fluctuates year on year, the number of children who die as a direct consequence of maltreatment has remained relatively steady at around 28 per year. This is in spite of a steady increase in child protection activity nationally.

The increase in the number of reviews observed between 2011-2014 has not continued into the three-year period 2014-17. The numbers of children who die each year as a direct consequence of maltreatment (overt and covert filicide, severe persistent child cruelty and fatal physical abuse) have held relatively steady at an average of 28 cases a year. By contrast, reviews for children experiencing non-fatal serious harm (physical and emotional abuse and neglect, sexual abuse and exploitation) have increased from 30-32 per year across 2009-14 to 54 per year in 2014-17. The rise in SCRs for children suffering serious harm mostly relate to cases of physical abuse, neglect and child sexual exploitation.

This plateauing of child death numbers and SCR activity is occurring in the context of year on year increases in child protection activity nationally, with a rise in the numbers of section 47 enquiries and in the number of children with a child protection plan. Within this context there are 50-60 children per year who die or suffer serious harm while receiving input from children's social care (Chapter 2, section 2.6.4). This needs to be interpreted in the light of over 600,000 children per year who are referred to children's services (Department for Education, 2017b).

Pathways to harm

We were able to identify pressure points at the boundaries into and out of the child protection system, and the need, in many cases, for ongoing support and monitoring of vulnerable children and families. This includes children on the boundary into the child protection system who will not have a plan and children whose protection plans have ceased. We identified the cumulative risk of harm to a child when different parental and environmental risk factors are present in combination or over periods of time and, in

particular, the damaging impact of poverty on the lives of children and their families. Learning from cases of neglect, from adolescent exploitation and from reviews of children in care and on special guardianship orders, a number of lessons for practitioners were highlighted. These build on previous lessons, and include recognition of the lived experience and the story of the child and their family; greater rigour in information sharing, assessment and planning at all stages of the process; and opportunities for building effective structures and promoting responsive cultures, even when constrained by limited resources.

Pathways to harm – children, parents and the wider environment

- Most serious and fatal maltreatment continues to take place within the family with most of the children living at home or with relatives but, as in earlier years, death and serious harm can also occur within the community and in supervised settings.
- Very little serious or fatal maltreatment involved strangers unknown to the child.

Pathways to harm include the context of the child's and parents' characteristics, vulnerabilities and risks which interact with their environmental circumstances. For this analysis we were able to obtain and carefully scrutinise a much larger number of SCR reports than previously. This meant we had better and more detailed information about child and family characteristics. Even so, because this information is not always recorded in SCR reports, this still represents likely under-reporting and hence an under-estimate of these factors. Most serious and fatal maltreatment continues to take place within the family home, involving parents or other close family members. Very little serious or fatal maltreatment involved strangers unknown to the child. As in earlier years, death and serious harm can also occur within supervised settings.

Child vulnerabilities and risks

- Infancy and adolescence represent the periods of greatest vulnerability to serious or fatal child maltreatment.
- Criminal exploitation covers a range of activities that victimise the child, not just sexual exploitation.
- When adolescents go missing this is a powerful signal that all is not well in their life and this requires a careful safeguarding response that is responsive to the child's underlying needs.

Among the vulnerabilities children demonstrated, age remains an important factor. Although the youngest babies form the biggest group of children at the centre of reviews, there was an increase in the number of adolescent cases. The adolescent cases produced a number of new insights from what Working Together 2018 has called 'emerging threats'. Some of these young people, both those living at home and in care,

were experiencing threats from various aspects of exploitation. Criminal exploitation covers a range of activities that victimise the child, including moving drugs, violence, gangs, sexual exploitation, missing children, and trafficking. Some children were both victims and perpetrators of harm to other children and all needed support and safeguarding.

When adolescents go missing this is a powerful signal that all is not well in their life and consequently it is not enough to find them and bring them home. A timely multiagency safeguarding response is required for all adolescents who go missing and should not depend on where they go missing from or to (for example, abroad).

Practitioners can feel unprepared for working with adolescents vulnerable to exploitation and need ongoing training and support. Likewise, even if practitioners feel confident and knowledgeable about technology use, they may still struggle to support a young person's usage in an ever-changing digital world and relevant, up-to-date training is essential.

Working with vulnerable adolescents requires openness and opportunities for young people to explore their concerns without fear of criminalisation (for example, in relation to harmful sexual behaviour).

Parental and environmental vulnerabilities and risks

- A wide range of family and environmental risks can combine to affect outcomes for children.
- While it is important to consider the needs of parents and the wider family, the voice and lived experience of the child must not be lost in a focus on parental difficulties.
- It is important for practitioners to consider the complex pathways through which vulnerability and risk may impact on parenting and outcomes for children, and not focus on single issues that do not address the underlying context.

Within the family, cumulative risks of harm were again apparent with different parental and environmental risk factors evident in combination and over time. As before parental mental ill health, domestic abuse, alcohol or substance misuse, and parental criminal records as well as other adverse childhood experiences featured strongly. There was often acrimonious parental separation. Most of these factors tended to occur at a higher frequency than in the wider UK population. It remains the case that when there is a focus on parental illness (mental and/or physical) and other difficulties, the voice and lived experience of the child can easily be overlooked.

Of particular note in this analysis were indicators of poverty or economic deprivation as a feature of the case. The detailed examination of neglect cases revealed the complex ways in which the links between domestic abuse, substance misuse and poverty are

often inter-dependent, so that addressing a single issue does not deal with the underlying causes or other issues present. Complexity and cumulative harm was almost invariably a feature of families where children experience neglect.

Pathways to prevention and protection

- The majority of children in SCRs were known to children's social care, although most are not directly involved with the child protection system.

As in our last triennial review, most children were not involved with the child protection system through a child protection plan or a court order, although many were receiving services as 'children in need'.[2] The Children Act 1989 emphasises that safeguarding children from harm can be achieved through both the more preventative services for children in need (s.17) and the less voluntary protective processes for children in need of protection (s.47). Only a minority of children needing safeguarding are the subject of a child protection plan.

Within the timeframe of this triennial review, a total of 191,930 children became the subject of a child protection plan; the majority of children came off plans in less than one year (Department for Education, 2017b). Given that during the timeframe of this review, just 54 of the children who died or were seriously harmed were on a child protection plan, these data suggest that children with a child protection plan in place are generally well protected from the most severe harm. In contrast, the majority of children in these SCRs were known to children's social care, but not at a level requiring a child protection plan. Children in need and children who no longer require a child protection plan to keep them safe should nevertheless be recognised by agencies as having potentially long-lasting vulnerability and/or risk of harm.

Using family and community resources

- The family and wider community may be valuable partners and important sources of support and intervention. However, opportunities for working with the family and wider community in preventive or protective interventions are often missed.

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[2] Children Act 1989 definition of children in need – s.17 (10) sets out that a child shall be taken to be in need if:
(a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part of the Children Act 1989
(b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
(c) he is disabled.

In our previous triennial review we identified some opportunities for preventive or protective intervention within the family and wider community. Family members, neighbours and community organisations may be valuable partners in safeguarding and some of the most important sources of support and intervention. This may be particularly pertinent in cases of neglect, where the problems are often longstanding and insidious, and where parents themselves, other family members and the wider community may have resources to combat some of the impact of adverse circumstances. The analysis of neglect cases underlined the importance of understanding the experiences of parents and the perspectives and role of fathers, as distinct from mothers, and other kin caring for the child.

Opportunities for preventive or protective intervention by statutory agencies

- Effective protective practice requires an ability to contextualise the lives of vulnerable children, understand the experience and perspectives of their parents or carers and engage with them through meaningful interactions and relationships with the professionals that are involved in their lives. This includes hearing the voice and understanding the lived experience of the child.
- Questioning and assessments can often be perceived by parents as blame, creating a barrier to collaborative working; professionals need to be both robust and compassionate in responding to this.
- Children in care or going through court processes have particular needs that require careful assessments, monitoring and support.
- Assessments should not only look at what has happened to the child in the past and what that implies for their needs now, but also look to the future and what help will be needed as the child grows.

A recurring theme among reviews that identify good practice is the quality of relationships with families. A good relationship with families is the primary vehicle for protective practice when it is based on a sound grasp of the family context, circumstances, and roles and relationships as an effective way of managing the complexity of compound and cumulative risk over time. While changes of staff and the re-allocation of cases continue to be a reality, especially within constrained resources, it is important that the impact of these changes on families and individuals is recognised and planned for.

The complicated and complex lives of many parents may have left them with negative experiences of statutory agencies, including the local authority, police and health who have joint responsibility for local safeguarding arrangements. When safeguarding practitioners ask questions about a child, parents can perceive such questioning as blame; and information may not be ‘heard’ and agreements not fully understood. In these

circumstances, professionals have to be both robust and compassionate in addressing the strategies parents use to defend themselves and their family from scrutiny.

New learning emerged from reviews of children in care or on a special guardianship order ("SGO") and from the changes made to court timescales. Many children in care have substantial needs which makes looking after them such a challenging enterprise. Furthermore, many of the children who go to special guardians or return home or remain with parents, come from similar backgrounds of deprivation and adversity to those in care. While these children are likely to have equally demanding needs, these carers may have fewer personal resources and less support than foster carers or residential staff to help the children. Therefore, thorough assessments are necessary, followed by suitable monitoring and support.[3]

Even with the 26-week changes to care proceedings it is essential that special guardianship assessments are suitably thorough. If necessary, the proceedings should be extended and there should be a trial placement. This is especially the case if the child has not previously lived with the proposed carers. Social work and other assessments should not only look at what has happened to the child in the past and what that implies for their needs now, but also look to the future and what help will be needed as the child grows up. Those caring for the child, be they parents, kin, foster carers or adopters, need to have the necessary knowledge and abilities to be able to care for the child through their childhood and be given help over time as well as appropriate monitoring.[4]

'Significant confusion' in relation to inter-agency understanding of the legal framework was apparent among practitioners in the SCRs about children in care.

Examination of cases of children in care and on SGOs from a Black and minority ethnic background revealed the importance of ascertaining and applying knowledge about background, culture, religion and 'personal identities' in assessments and planning. While ethnicity might be recorded, the implications for the day-to-day lives and experiences of the children are not explored and spelled out by social workers and other practitioners. What these factors mean for day-to-day life reflects a wider challenge for *all* children's cases not just those from minority ethnic groups.

[3] Special Guardianship is an order made by the Family Court that places a child or young person to live with someone other than their parent(s) on a long-term basis. The person(s) with whom a child is placed will become the child's Special Guardian.
[4] 26-week statutory timescale for completing care proceedings set out in the Children and Families Act 2014.

Effective multi-agency working

- The language we use to talk about children's circumstances can both support and hinder effective safeguarding.
- Fragmentation of services, with different front-line providers within the same agency, can lead to silo-working within as well as between agencies.
- Clear multi-agency plans at both child in need and child protection levels are central to effective working.

The language we use to talk about a child's circumstances can both support and hinder effective safeguarding. Vague, stock phrases and jargon can minimise or obscure the reality of a child's life. The use of clear, straightforward language that properly and explicitly depicts issues in ways that do not dilute impact and harm, or the reality of life for the child can lead to more effective safeguarding. This also applies to the review process where vague language in the report, for example in relation to ethnicity or culture to preserve anonymity, can dilute the child's story and the consequent learning.

Fragmentation of services, with different front-line providers within the same agency, can lead to silo-working within as well as between agencies. In such situations it is particularly important to have a clear understanding of the roles and responsibilities of different organisations, and clear pathways for information sharing and shared working.

Clear multi-agency plans at both child in need and child protection levels are central to effective working. This requires all relevant professionals (including those from specialist agencies and third sector organisations) to be involved in drawing up these plans, and a continued focus on the needs of the child(ren) as central to any plan.

Supportive systems and processes

- Within a fragmented service landscape, co-location of services, joint protocols, robust IT systems, and ongoing support and guidance for front-line practitioners can be particularly important in enabling consistent work with families.

The current service landscape with fragmentation and outsourcing of services, service cuts and corresponding high caseloads and high staff turnover, has profound practical and emotional impacts on staff who are struggling to work effectively with families in complex circumstances (Basarab-Horwath & Platt, 2019). Managers and commissioners need to recognise these impacts and put in place structures to provide support, time and guidance for front-line practitioners.

Within a fragmented service landscape, co-location of services, joint protocols and robust IT systems can be particularly important in enabling consistent work with families. Having a lead professional to coordinate multi-agency work and be a key point of contact with

families helps ensure consistency of work and avoids the risk of children slipping through the net.

Learning from reviews for practice

Recommendations and disseminating learning

- 'Recommendation overload' can produce pressure in following through on actions and learning.
- Recommendations should be few in number, specific, contextual and targeted.

In keeping with the last triennial review the number of recommendations remained steady at an average of seven per review. Even with this low number, study participants told us that 'recommendation overload' could produce pressure of follow through when an LSCB had carried out numerous reviews. Many types of recommendation were used but those thought to have the most impact related to training, policy and procedure development, audits and awareness raising. The need was noted for recommendations to be specific (and tied to action plans which are SMART, Specific, Measurable, Attainable, Relevant and Timely), contextual and at a systems level. The need to avoid the tendency to '*train issues away'* was also found.

Recommendations were felt to have most impact when they were either targeted at single agencies or clearly at a multi-agency level. However, when recommendations are addressed to 'all agencies' staff could feel absolved of responsibility and distance themselves from the learning. The type of recommendation mattered less than having a committed, motivated team or champion to take them forward.

Multi-agency training and the distribution of briefings or bulletins were the most popular methods of disseminating learning.

Views from study participants were divided as to whether some types of cases were harder to learn from - the greater difficulty relates to impacting change in practice. Reviews where there had been limited agency involvement, or conversely reviews with many agencies involved, were identified as presenting problems for learning and impact.

Impact and change

- Demonstrating the impact of SCRs on practice or outcomes for children is challenging.
- A preoccupation with process, tick-box responses, and organisational change can all present barriers to effective learning and impact.

- Keeping learning contextual, local and embedded in reflective practice helps to ensure the learning has an impact.

It was rare to find evidence of national change from reviews although local change was noted by almost all of the LSCBs who responded to our survey. However, demonstrating the change was challenging with any evidence coming primarily from audits and action plans.

Barriers to achieving impact included a preoccupation with process, and the limitations of action plans which could prompt a tick box response rather than a focus on systemic change. Other barriers were organisational change and a depleted organisational memory. Shifting priorities were highlighted by the retrospective nature of reviews.

Strengths in delivering impact included the positive elements that come from providing opportunities for reflection on practice and particularly from the story of the child at the centre of the review. Learning was thought to have added weight and be easier to embed if it comes from a local review. Keeping the learning real, local and close to home was helped by involving practitioners. SCRs were also thought to act as an accountability check on the system and the quality of leadership and practice.

Although repeated themes and learning points were mentioned as a barrier to learning, they were also identified as important ways of making sure key lessons were not forgotten. Looking to the future, there were primarily positive views about the flexibility promised by the new arrangements for local and national child safeguarding practice reviews. It is hoped that this flexibility may go some way to addressing concerns about the growth of the ‘SCR industry’ and the cost and disproportionate nature of some reviews.

Chapter 1: Introduction

1.1 Complexity and challenge

In the introduction to the recently-published third edition of *The Child's World*, editors Jan Horwath and Dendy Platt refer to the complexity and challenge of child protection work in our current time (Basarab-Horwath & Platt, 2019). They point out the increased pressures and stresses placed on vulnerable families, the rises in child poverty rates (Joseph Rowntree Foundation, 2017), cuts to services and changes in benefits. Alongside this, there are increasing demands for services, increasing numbers of referrals for children in need and those in need of protection, and increasing numbers of children in care (Action for Children, National Children's Bureau & The Children's Society, 2017; Family Rights Group, 2018). Practitioners, meanwhile, are working in contexts of high caseloads, cuts to services, and frequent reorganisations. Basarab-Horwath and Platt (2019, p.14) comment that:

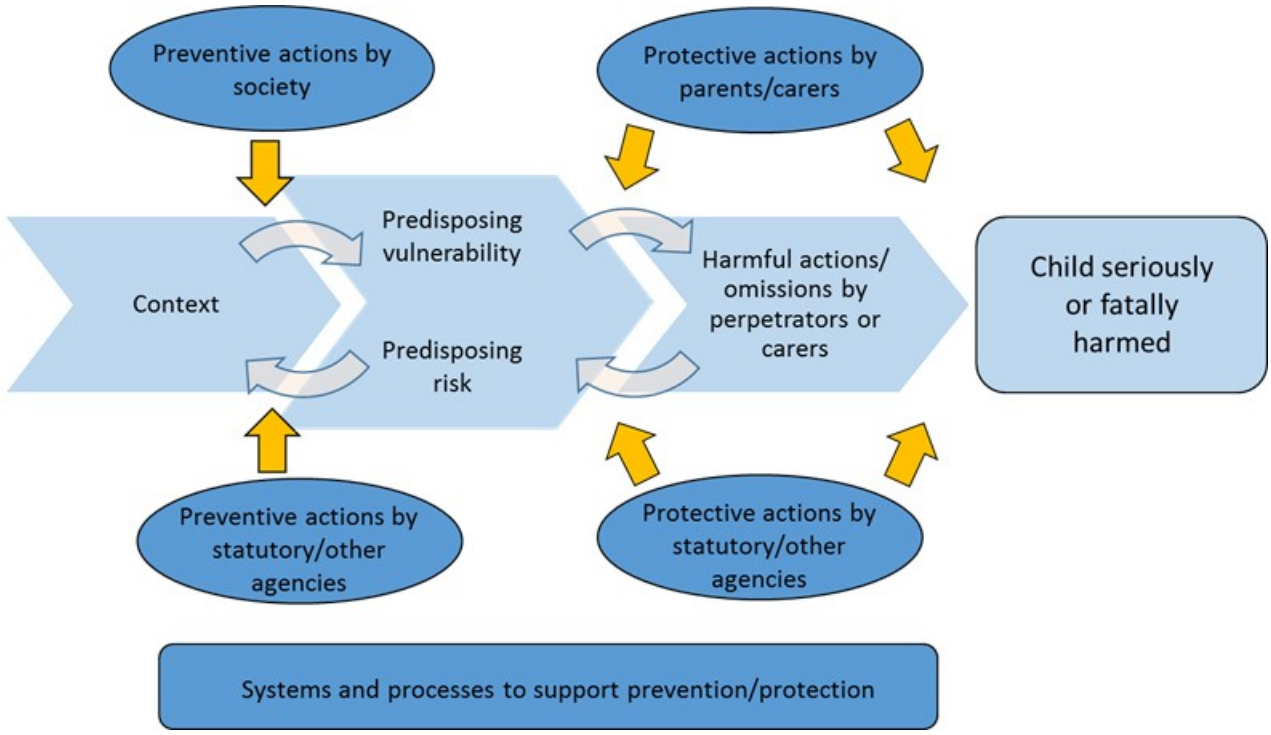
> *…the implication of all this is that child welfare practitioners are working within a context of widening adversities affecting children and families, adversities that make it increasingly difficult for many child welfare clients to overcome difficulties in their lives without support.*

It is this context of complexity and challenge that forms the underlying theme in this triennial review of SCRs. As we looked into the reviews of children affected by serious and fatal child maltreatment between 2014 and 2017, we, too, were struck by the complexity of the lives of these children and families, and the challenges – at times quite overwhelming – faced by the practitioners seeking to support them in such complexity.

1.1.1 Pathways to Harm, Pathways to Protection

In our last triennial review, we introduced the model of 'Pathways to Harm and Pathways to Protection' (Figure 1).

Figure 2: Pathways to harm, pathways to protection



This model provides the basis of our current analysis of SCRs. It has proved helpful in enabling us to explore the complexity of families' lives within the central 'pathways to harm' component, and the challenges faced by practitioners in statutory and other agencies within the 'pathways to protection'. In addition, it has enabled us to look beyond the complexities and challenges to consider the opportunities for prevention and protection, and the values, systems and processes that might help support this work.

1.1.2 Complexity in families' lives

As with our previous national analyses (Bailey, Belderson & Brandon, 2010; Brandon et al, 2009; Brandon et al, 2012; Sidebotham et al, 2016) we continued to identify a number of child vulnerabilities, including the ongoing risks in infancy and adolescence and the particular vulnerabilities of disabled children and those with chronic physical or mental health problems. Alongside this, the well-recognised parental risk factors which have come out in previous reviews were all present in this cohort: parental mental and physical ill-health; learning difficulties; domestic abuse; unstable relationships; social isolation; substance misuse and criminal behaviours among others. These findings, along with the overall patterns and trends in the SCRs are outlined in Chapter 2.

One issue that came through more commonly in these reviews, however, was the impact of poverty on families' lives. This forms the subject of a topic study in Chapter 3. Poverty

inevitably leads to additional complexity, stress and anxiety in families and this context can, in turn, lead to neglect or abuse. The impact of poverty is, perhaps, reflected in the increasing prevalence of neglect both in our national analyses of SCRs and in wider child protection investigations nationally. Neglect, therefore, formed the basis of our main in-depth qualitative study, reported in Chapter 3.

In our last triennial review, we looked in-depth at the issues of child sexual exploitation and of suicide and self-harm in the adolescent cases (Sidebotham et al, 2016). These issues highlighted some of the complexity of the world of adolescents in the early 21st century. These issues were equally present in the current reviews, and we found additional issues in relation to wider criminal exploitation, including gang involvement and drug dealing. All of these, along with issues such as harmful sexual behaviours, and social media and technology-assisted harm reflect the increasingly complex world of adolescents and are explored in-depth in Chapter 4.

1.1.3 Challenges for professionals

The challenges facing practitioners were strongly evident in these SCRs, particularly the challenges of working within limited resources, with high caseloads, high levels of staff turnover, and fragmented services. These challenges, and the approaches different places have taken to tackling them, are explored throughout the different chapters. We identified some specific issues for the police in working within an interagency context and these are explored in a topic study in Chapter 3. How agencies and local organisations learn from SCRs and translate that learning into recommendations and improvements forms the basis of Chapter 6, drawing particularly on a national survey, interviews and workshops, as well as our qualitative analysis of the recommendations in these reviews compared to previous analyses.

One further area for in-depth qualitative analysis was children who were, or had been, in care or the subject of care proceedings. The increasing numbers of children in care has been picked up by the Care Crisis Review (Family Rights Group, 2018). This places further strains on the system and challenges for practitioners working in the field. In particular, it places challenges on the courts and on how other agencies work effectively with the courts to safeguard children. These issues are explored in depth in Chapter 5.

In our previous triennial review we identified that the pattern of SCRs over time shows that once a child is known to be in need of protection, for example with a child protection plan in place, the system generally works well, with positive examples of creative and effective child safeguarding. We recognised that an increase in the number of SCRs carried out between 2012-14 occurred on a background of a steady year-on-year increase in child protection activity. This increase in the numbers of SCRs has not continued into 2014-17. We were able to identify pressure points at the boundaries into and out of the child protection system, and the need, in many cases, for ongoing support

and monitoring of vulnerable children and families. We identified the cumulative risk of harm to a child when different parental and environmental risk factors are present in combination or over periods of time, and in particular, the damaging impact of coercive control in domestically abusive relationships. A number of lessons for practitioners were highlighted, building on previous lessons, and including recognition of hearing the voices of children and families; greater rigour in information sharing, assessment and planning at all stages of the process; and opportunities for building effective structures and promoting responsive cultures, even when constrained by limited resources.

Coming at a time of significant change in children's safeguarding in England, with the implementation of the changes required by the Children and Social Work Act 2017 (which has amended the Children Act 2004), this triennial review builds on the learning of the previous national analyses and, we hope, provides fresh insights and learning. It is our hope that this will enable safeguarding partners, other agencies, organisations and individuals to work effectively together to prevent child maltreatment, to protect children from harm, and to promote the safety and wellbeing of children and young people. With increasing demand for children's social care services and the ongoing challenges facing practitioners, the importance of learning lessons from those cases where children are seriously or fatally harmed remains.

The complexities and challenges identified in this triennial review echo those expressed recently by practitioners contributing to the Care Crisis Review:

> *Many professionals described the frustration they feel at working in a sector that is overstretched and overwhelmed and in which, too often, children and families do not get the direct help they need early enough to prevent difficulties escalating. There was a palpable sense of unease about how lack of resources, poverty and deprivation are making it harder for families and the system to cope. Many contributors to the Review also expressed a strong sense of concern that a culture of blame, shame and fear has permeated the system, affecting those working in it as well as the children and families reliant upon it. It was suggested that this had led to an environment that is increasingly mistrusting and risk averse and prompts individuals to seek refuge in procedural responses* (Family Rights Group, 2018, p.4).

This sense of frustration, of practitioners feeling overstretched and overwhelmed, came through frequently in the SCRs we studied. At the same time, though, we also saw evidence of dedicated and committed practitioners who clearly want to help children and families. Many examples of good practice were reflected in the reviews, in spite of the challenges and constraints faced by those working in the field. As we commented in our previous triennial review (Sidebotham et al, 2016, p.162):

> *For many of these children, the harms they suffered occurred not because of, but*

in spite of, all the work that professionals were doing to support and protect them.

1.2 Methods

1.2.1 Aims and Objectives

The primary aim of the study was to understand the key issues, themes and challenges for practitioners and agencies, working singly and collectively, taken from SCRs relating to an incident date from 1 April 2014 - 31 March 2017, and to draw out implications for both policy makers and practitioners.

The objectives were to:

1. **Identify common themes and trends across all the 2014-2017 reports** by analysing factors including: child and family characteristics, the characteristics and circumstances of each case; the nature of agency involvement; and details about the progress of each SCR;
2. **Undertake an in-depth qualitative analysis of a small number of reviews,** in order to gain an increased understanding of the root causes of systemic strengths and vulnerabilities within local practice;
3. **Investigate the impact of recent policy initiatives**, including the reforms to SCRs announced in Working Together 2013; and
4. **Assess the extent to which recommendations in SCRs have been implemented** and the consequent impact on child protection practice.

1.2.2 Methodology

1. To Identify common themes and trends across all the 2014-2017 reports

We used a mixed-methods analysis of data from Ofsted notifications and published SCRs, sourced from the NSPCC repository and directly from LSCBs, to identify common themes and trends across all 2014-17 reports. We used our previously developed framework and methods of layered reading and a systems methodology approach to look beyond learning at an individual practitioner level, in order to understand the deeper systems issues that may have contributed to the child's death or serious harm. Further details of the methods used are given in Chapter 2 and Appendix A.

2. Undertake an in-depth qualitative analysis of a small number of reviews

As in our previous national analyses, the quantitative findings from the database were supplemented by a qualitative analysis of a smaller, purposive sample of overview reports. This qualitative analysis focused on three separate themes: neglect; adolescent risk and criminal exploitation; and care proceedings. All of these were identified by the

project team and advisory group as important themes for in-depth study. Further details of the methods used and the sample are given in Chapters 3, 4 and 5 and Appendix A.

3. Investigate the impact of recent policy initiatives

We examined the different approaches and models of learning used in the SCRs to ascertain how they reflected the reforms introduced in Working Together 2013 (HM Government, 2013a), and the quality of learning and recommendations from this triennial review in comparison with the 2011-2014 triennial review. In addition, we sought views from survey respondents (see below) on how well the different SCR models worked to support learning. Further details of the methods used are given in Chapter 6 and Appendix A. In light of the Wood review[5] and the further safeguarding reforms outlined in Working Together 2018 (HM Government, 2018b), this learning should help inform the approaches used in local and national safeguarding practice reviews and the work of the national safeguarding practice review panel.

4. Assess the extent to which recommendations in SCRs have been implemented

A national survey of Local Safeguarding Children Boards and new Safeguarding Partnerships was carried out using a survey constructed and adapted in consultation with the research advisory group and with the Association of Independent LSCB Chairs (AILC). This was followed by telephone interviews with survey respondents, and two workshops involving participants from a wide range of sectors and agencies with many different roles. Further details of the methods used are given in Chapter 6 and Appendix A.

[5] Wood Report - Review of the role and functions of Local Safeguarding Children Boards March 2016

1.3 Guide to Chapters

Chapter 2 provides an overview of the cases included in this triennial review, and over time since 2005, and sets basic demographic and other details in the context of wider activities to safeguard children. We include quantitative data on all 368 SCRs notified to the department over the time period, along with more detailed data from 278 cases for which we were able to obtain the final report.

Chapter 3 presents the findings of the in-depth qualitative analysis of a sample of 32 cases in which neglect was a recognised feature. The characteristics, background context and pathways to harm are examined, along with learning arising from opportunities for prevention or protection on the part of families, the community and practitioners, and the systems and processes that may support such interventions. The chapter includes four topic studies on poverty, enabling children to have a voice, multi-agency working between police and other agencies, and the role of supervision, along with two case studies.

Chapter 4 looks at the vulnerability of adolescents using an in-depth qualitative analysis of a sample of 25 cases, and particularly focusing on criminal exploitation, including gang-related violence, county lines, and sexual exploitation. The chapter also explores issues around young people going missing, harmful sexual behaviours, and the influence of social media and technology-assisted harm. It draws on the pathways to harm, pathways to protection model to look at opportunities for prevention and protection in the community and by statutory and other agencies. The chapter includes pertinent case studies drawn from the sample.

Chapter 5 presents findings from another in-depth qualitative analysis of a sub-sample of ten cases where children were or had been in care or subject to care proceedings. The chapter draws out issues around interagency working with the courts, as well as important challenges for the courts, the legal framework and court processes. The chapter includes two case studies highlighting some of the key learning.

Chapter 6 considers the ways in which learning from SCRs influences day-to-day practice, drawing on learning from all 278 SCR reports, along with a national survey, telephone interviews and practitioner/leader workshops. The chapter highlights the different methods used in SCRs and how well they are working; the number, type and quality of recommendations and their implementation; and how learning is disseminated, along with the overall quality and impact of the reports. It includes a case study on escalation of concerns.

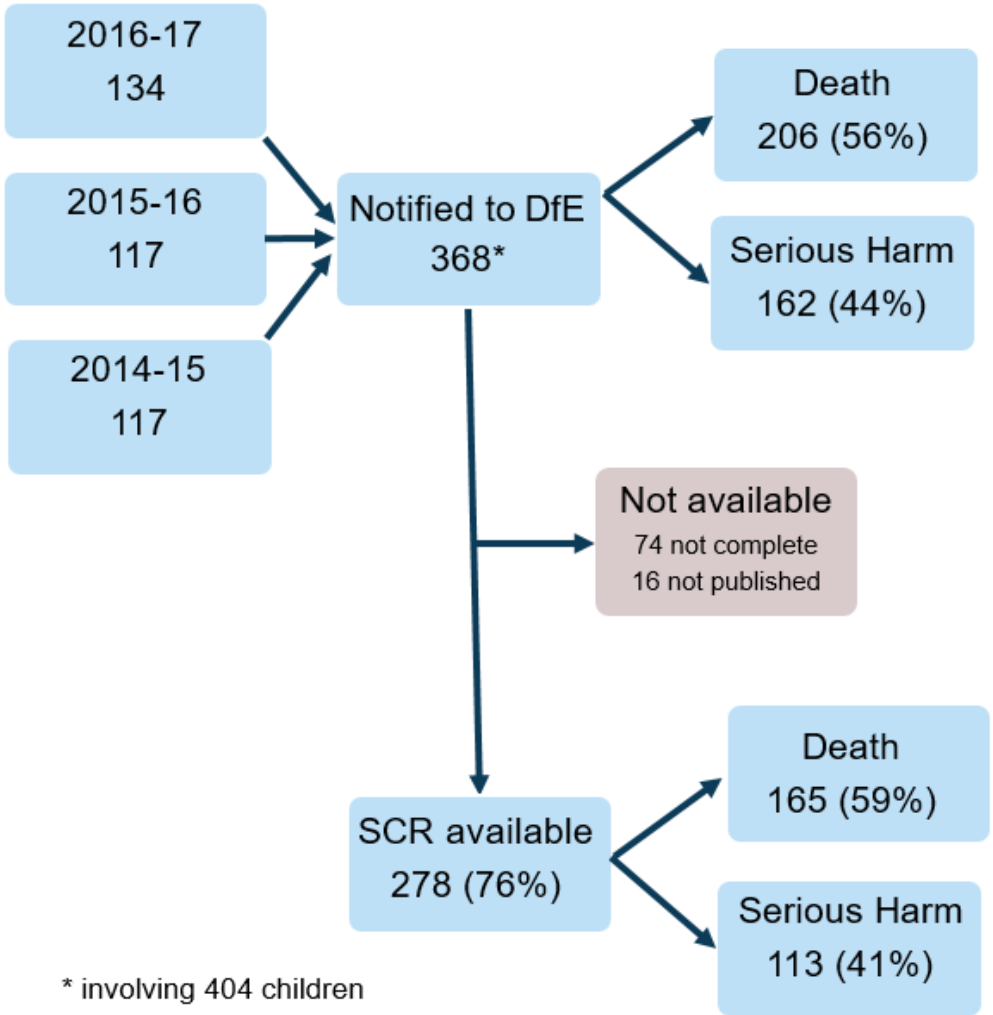
Chapter 2: Patterns and trends of maltreatment

The purpose of this chapter is to explore patterns of maltreatment for the period 2014-17. It also considers trends over the past 12 years (2005-17) based on previous biennial and triennial reports by the same research team.

2.1 Sources of information and approach to analysis

A spreadsheet containing notification data was provided by the DfE for the relevant time frame (incident date between 1st April 2014 – 31st March 2017). The data from this spreadsheet, for 1136 notifications, were refined and adapted in a number of ways which are detailed in the methodology (Appendix A). The final dataset used for analysis comprised 368 cases (see Figure 3).

Figure 3: Numbers of SCRs



The research team endeavoured to locate as many copies of SCR reports as possible for the triennial period, where these had been completed. These were obtained via a

combination of sources including the NSPCC national case review repository and from individual LSCB websites where we located published SCRs. A total of 278 completed SCRs (76% of all SCRs notified) were obtained by the research team by 31st August 2018 (Figure 3). These included 165 fatal cases and 113 non-fatal serious harm cases.

Of the 90 cases for which a report was not available, 74 SCRs had not been completed, and 16 had been completed but not published, primarily due to concerns about the impact of publication on surviving family members. A further 51 cases had not been published, but DfE had been provided with a copy which was then made available to the research team for analysis and were included in the 278 available reports.

2.2 The number of SCRs undertaken 2014-17

This section of the report provides an analysis of all 368 SCRs notified to the DfE, which relate to an incident which occurred in the three-year time period, 1st April 2014 to 31st March 2017. Comparison with numbers of SCRs per year since 2005 is provided in Figure 4 and Table 1.

Figure 4: Annual numbers of SCRs

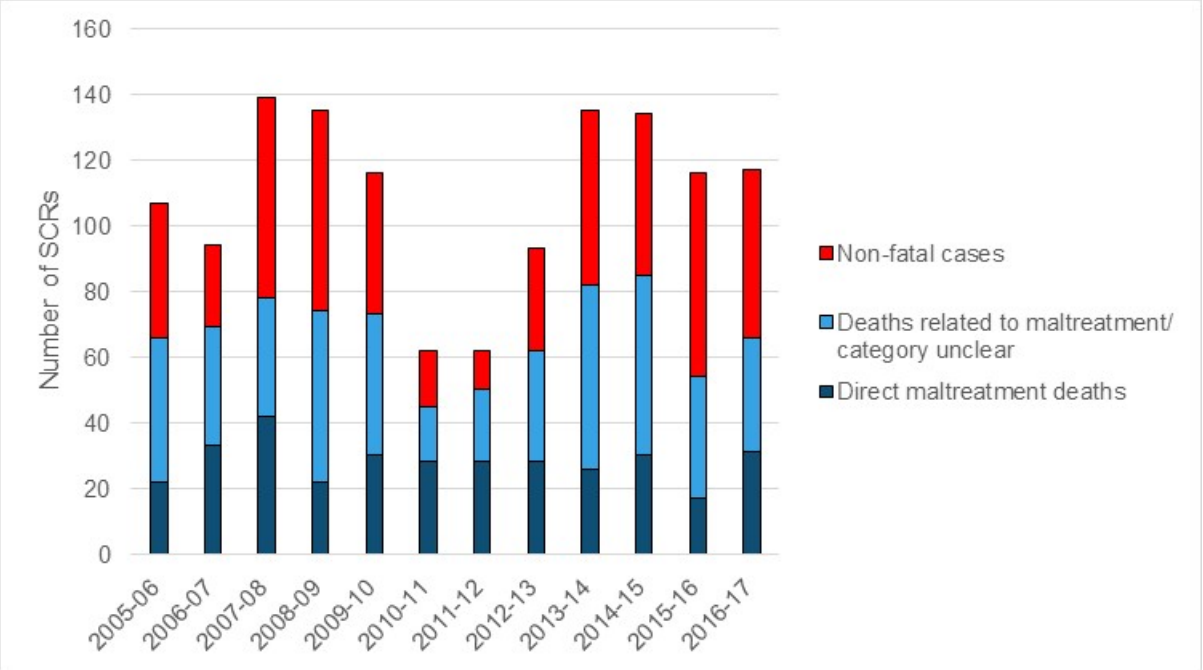


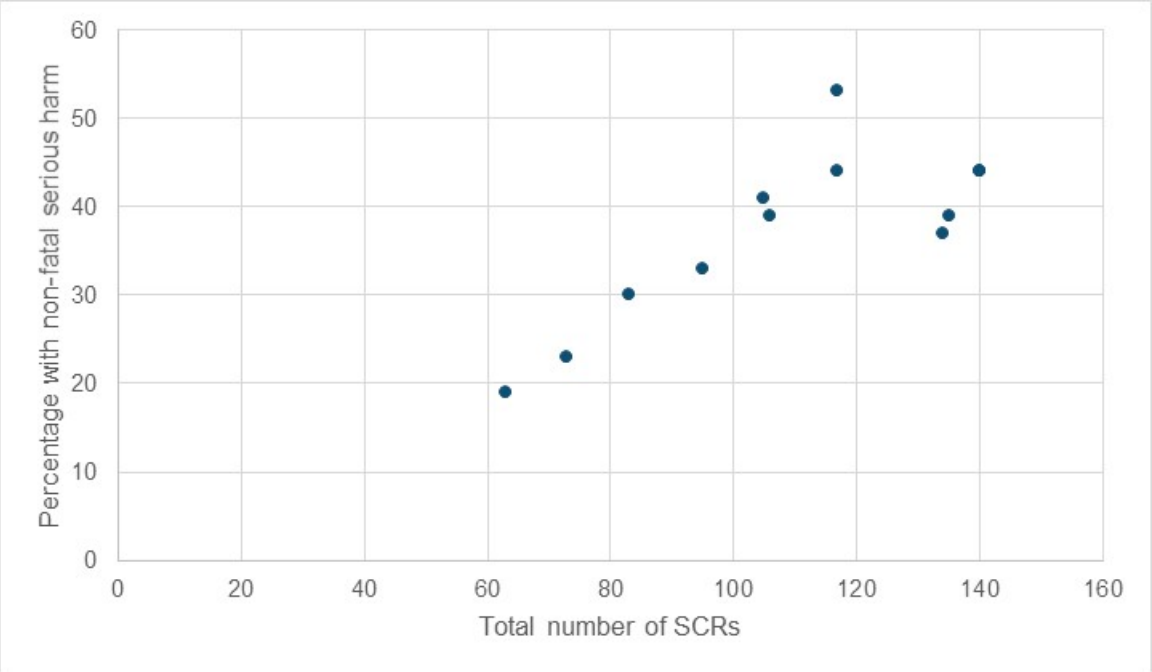
Table 1: Annual number of SCRs

Year	Total number of SCRs	Deaths	Serious Harm	0-17 child population in England (thousands)*
2005-06	106	65 (61%)	41 (39%)	11,112
2006-07	83	58 (70%)	25 (30%)	11,110
2007-08	140	79 (56%)	61 (44%)	11,153
2008-09	140	79 (56%)	61 (44%)	11,202
2009-10	105	62 (59%)	43 (41%)	11,232
2010-11	73	56 (77%)	17 (23%)	11,279
2011-12	63	51 (81%)	12 (19%)	11,341
2012-13	95	64 (67%)	31 (33%)	11,423
2013-14	135	82 (61%)	53 (39%)	11,506
2014-15	134	85 (63%)	49 (37%)	11,592
2015-16	117	55 (47%)	62 (53%)	11,678
2016-17	117	66 (56%)	51(44%)	11,785

* based on ONS mid-year population estimates for England[1]

The fluctuation has, at least in part, been related to the proportion of non-fatal serious harm cases, with a greater proportion of such cases in years when more SCRs are carried out (Figure 5). Compared to the fluctuation in the number of SCRs involving serious harm and deaths related to, but not directly caused by, maltreatment, there has been relatively little fluctuation in the numbers of deaths directly caused by maltreatment, which have averaged 28 cases per year.

Figure 5: Proportion of SCRs involving non-fatal serious harm compared to total number of SCRs per year



2.3 Geographical distribution of the cases 2014-17

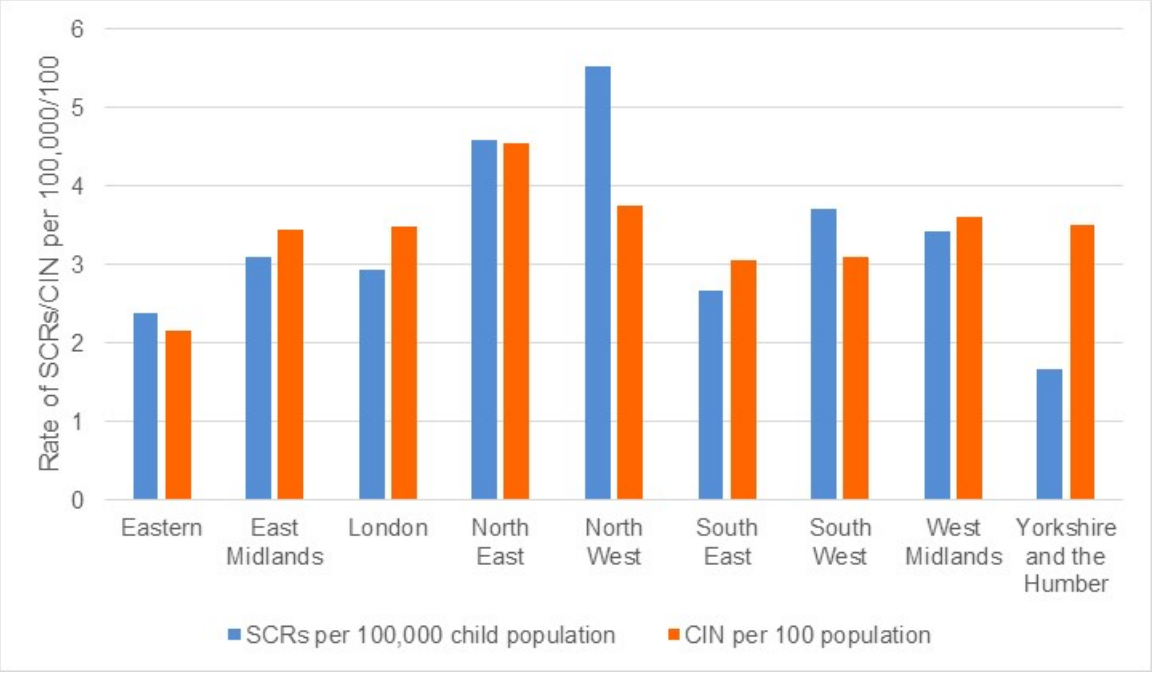
Table 2 and Figure 6 display the geographical distribution of SCRs conducted across the English regions. There is a wide discrepancy in the rates of SCRs per 100,000 child population with over a three-fold difference between the lowest and highest regions. As can be seen from Figure 6, the rate of SCRs mostly mirrors the rate of children in need (though note the different scales on the graph) at roughly one SCR per 1,000 children in need. However, there are two outliers, Yorkshire and the Humber, which has a very low rate of SCRs in comparison to the number of children in need, and the North West which has a very high rate. The reasons for these outliers are not clear.

Table 2: Geographical distribution of the cases 2014-17

Region	Death	Serious harm	Total SCRs	SCRs per 100,000 child population	Children in Need*	CIN per 100 child population	Child population 0-17
Eastern	15	16	31	2.38	27,800	2.14	1,299,957
East Midlands	13	13	26	3.09	33,330	3.43	971,509
London	36	21	57	2.92	68,010	3.48	1,951,735
North East	7	17	24	4.58	23,740	4.53	524,365
North West	46	36	82	5.52	57,060	3.75	1,521,579
South East	36	13	49	2.66	58,540	3.05	1,918,624
South West	15	22	37	3.70	33,360	3.08	1,082,154
West Midlands	25	18	43	3.41	45,480	3.60	1,262,413
Yorkshire and the Humber	13	6	19	1.66	40,210	3.51	1,145,520

*data from Department for Education, *Characteristics of children in need: 2016-17, England*, in *SFR61/2017*. 2017

Figure 6: Geographical distribution of SCRs and children in need



Summary points

Within the time period 1st April 2014 – 31st March 2017, 368 cases proceeded to an SCR and SCR reports were available for 278 of these.

There has been considerable year-on-year fluctuation in the number of SCRs carried out but over the 12-year period (2005-2017) there have been an average of 109 SCRs per year of which an average of 67 (61%) have been for fatal cases.

There is a wide discrepancy in the rates of SCRs per 100,000 child population with over a three-fold difference between the lowest (Yorkshire and the Humber, 1.66) and highest (North West, 5.52) regions.

2.4 The nature of the death or serious harm

All cases have been classified according to our previously developed categorisation systems for deaths and serious harm (Brandon et al, 2009; Brandon et al, 2010). The research team categorised cases using:

- Details drawn from close reading of 278 SCRs available to us.
- For the remaining 90 cases where a review was not available, we used the brief case information notes provided by the DfE to ascertain categories.

2.4.1 Categories of death

The nature of the fatal cases is presented below in Table 3 and Figure 7 following the framework (see Appendix B) developed in our previous biennial and triennial reviews (Brandon et al, 2012; Sidebotham et al, 2016). This suggests that 78 cases were direct maltreatment deaths (overt and covert filicide, severe persistent child cruelty, and fatal physical abuse) – equivalent to 26 cases a year, which is consistent with previous analysis which suggest 26-28 cases per year (Sidebotham et al, 2016). Sub-categories for the 106 ‘deaths related to maltreatment’ are shown in Table 4.

Table 3: Category of death

Category of death	Frequency	(%)
Overt filicide	17	(8%)
covert filicide	6	(3%)
fatal physical abuse	46	(22%)
severe persistent cruelty	9	(4%)
extreme neglect	0	
extra-familial child homicide	7	(3%)
extra-familial physical assault	3	(1%)
death related to maltreatment	106	(51%)
not maltreatment related	1	(<1%)
not clear	11	(5%)
Total	**206**	**(100)**

Figure 7: Categories of death

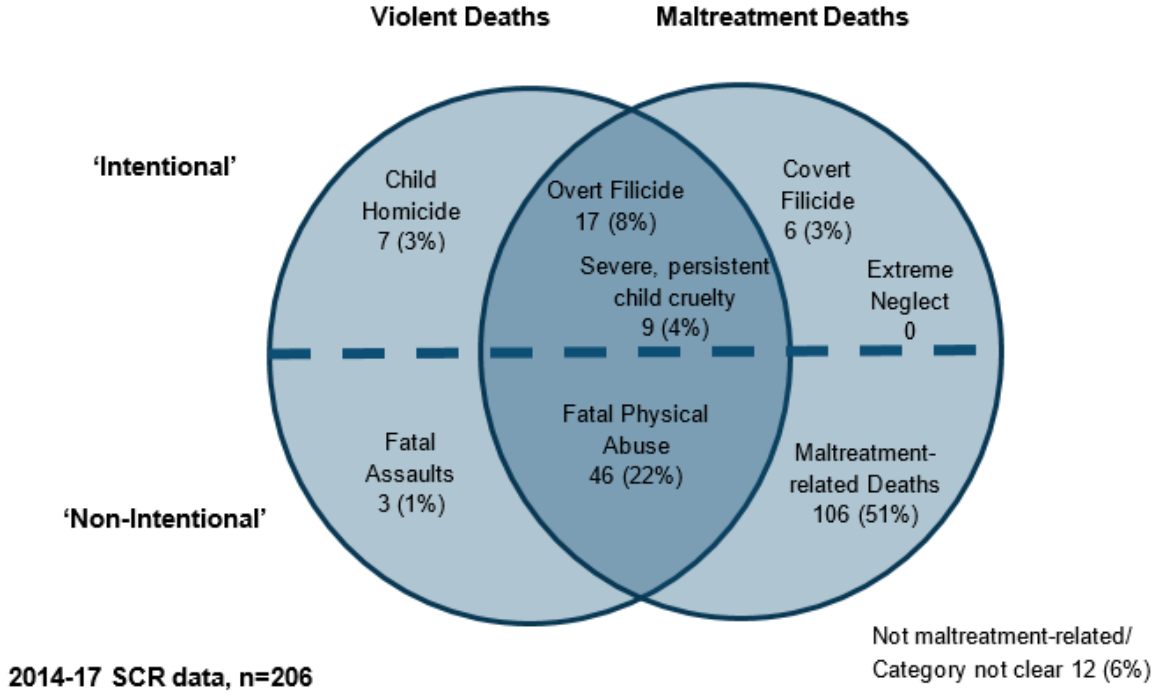


Table 4: Sub-categories for death related to maltreatment

Category of death related to maltreatment	Frequency	(%)
SUDI	38	(36%)
suicide	30	(29%)
risk-taking behaviour	3	(3%)
accident	15	(14%)
medical	13	(12%)
poisoning	3	(3%)
other	4	(4%)
Total	**106**	**(100)**

2.4.2 SCR deaths compared to national child deaths

There were 206 SCRs relating to deaths in the three-year period. Around 3,900 deaths of children aged up to 18 years are reported to Child Death Overview Panels (CDOP) each year (Department for Education, 2017a), therefore SCRs are held for less than 2% of all child deaths. CDOP data relate well to SCR data, as CDOPs review all child deaths from birth to 18 years. However, CDOP annual data are for deaths reviewed between 01 April and 31 March rather than for deaths actually occurring in that time period. Between 2014 and 2017, there were 88 SCRs for directly inflicted deaths due to extrafamilial homicide and fatal assaults, filicide, severe physical abuse, persistent cruelty or extreme neglect. CDOPs categorised 164 child deaths as due to deliberately inflicted injury, abuse or neglect during the same time period with 110 of these due to homicide (Department for Education, 2014a; 2016; 2017a). It is notable that CDOP data would include all deaths from extrafamilial assaults which would not necessarily meet the criteria for an SCR. In addition, CDOPs may classify some deaths related to, but not directly caused by, maltreatment within the category of abuse or neglect.

The most common categories of deaths related to maltreatment were sudden unexpected death in infancy (SUDI) with 37 cases and suicide with 30. Only a small proportion of these types of death are subject to SCR. The CDOP data from 2014-17 (Department for Education, 2014a; 2016; 2017a) showed 1,025 SUDI cases and 310 suicides, therefore approximately 4% of SUDI and 10% of suicides are subject to a serious case review. This would suggest that SUDI and suicides selected for SCR are not representative of these types of deaths more widely. However previous analysis of

SUDI SCR cases showed the majority of deaths involved the combination of parental alcohol or drug misuse and co-sleeping (Garstang & Sidebotham, 2018), which is a frequent finding in SUDI more generally (Blair et al, 2009).

2.4.3 Categories of non-fatal serious harm

Categories of serious harm in non-fatal cases are presented in Table 5, alongside comparison data for the previous two review periods. Note that this categorisation system highlights a primary cause of harm for each review and that a young person may experience multiple forms of harm.

The total number of cases of non-fatal serious harm has increased (from 30-32 per year across 2009-14 to 54 cases per year in 2014-17); this relates to increases in cases of physical abuse, child sexual exploitation (CSE) and neglect.

Table 5: Categories of serious harm in non-fatal cases

Category of serious harm	Frequency 2009-11[1]	(%)	Frequency 2011-14	(%)	Frequency 2014-17	(%)
Non-fatal physical abuse	31	(52%)	50	(52%)	83	(51%)
Child sexual abuse – intra-familial	6	(10%)	13	(14%)	16	(10%)
Child sexual abuse – extra-familial	6	(10%)	5	(5%)	7	(4%)
Child sexual abuse – CSE[2]	-		5	(5%)	11	(7%)
Neglect	6	(10%)	14	(15%)	30	(19%)
Risk taking/ violent behaviour by young person	8	(13%)	8	(8%)	11	(7%)
Other	3	(5%)	1	(1%)	4	(2%)
Total	**60**		**96**		**162**	

[1] Note that the 2009-11 figures relate to a two-year (rather than three-year triennial) period

[2] CSE was added as a new category in the 2011-14 review

2.4.4 Source of harm to the child/young person

The close examination of all SCRs has allowed the research team to obtain a much more complete picture of 'source of harm' to the child than in our previous analyses. The results (Table 6) reflect previous findings, showing that most serious or fatal child maltreatment occurs within the family home, involving parents or other close family members. Very little serious or fatal maltreatment (seven cases in total) involved strangers unknown to the child. The large proportion of 'not known/not clear' include cases of SUDI where it was not clear whether either parent was responsible for the

unsafe sleeping and cases of death or serious harm from abuse where neither parent had admitted responsibility.

Table 6: Source of harm to the child/young person

Source of harm	Death N=206	(%)	Serious Harm N=162	(%)	Total N=368	(%)
mother	27	(13.1)	19	(11.7)	46	(12.5)
father	32	(15.5)	21	(13.0)	53	(14.4)
father figure/ mother's partner	8	(3.9)	12	(7.4)	20	(5.4)
both parents	13	(6.3)	31	(19.1)	44	(12.0)
other carer	1	(0.5)	5	(3.1)	6	(1.6)
other relative	7	(3.4)	6	(3.7)	13	(3.5)
unrelated known perpetrator	7	(3.4)	6	(3.7)	13	(3.5)
stranger	3	(1.5)	4	(2.5)	7	(1.9)
self	31	(15.0)	10	(6.2)	41	(11.1)
not known/not clear	77	(37.4)	48	(29.6)	125	(34.0)

2.5 Neglect

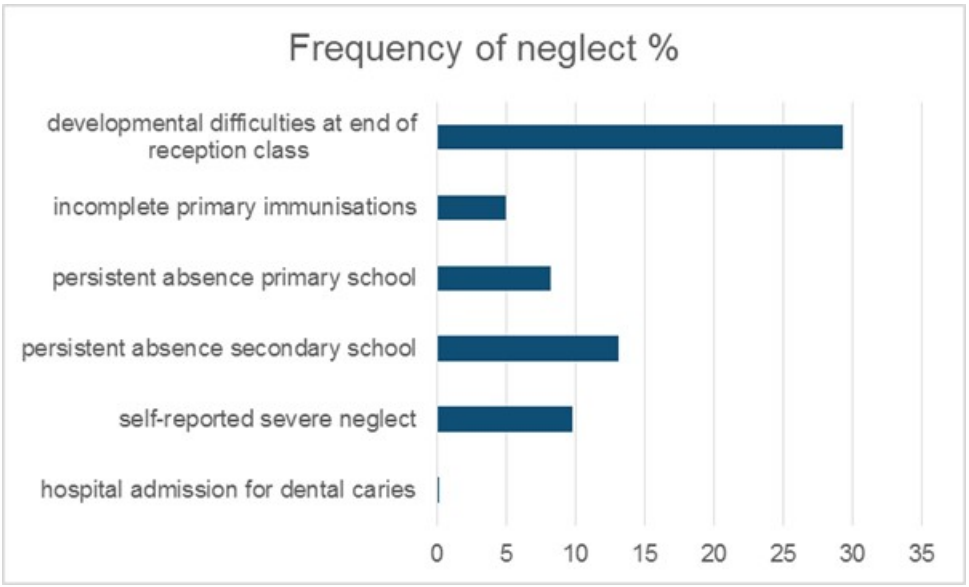
There was evidence of neglect featuring in nearly three-quarters (208 of the 278, 74.8%) of the reports examined, using our previously defined protocol (see Appendix C). Features of neglect were apparent in 112 out of 165 (68%) fatal cases and 96 out of 113 (83%) non-fatal serious harm cases. Findings from the detailed qualitative analysis on a sub-sample of cases where neglect was identified are presented in Chapter 3.

Neglect was the category of abuse in 50/84 (59.5%) children who were subject to a child protection plan at the time of or prior to the incident leading to the SCR and for whom the

data were available. Abuse and neglect are major reasons for referral to social care and these accounted for 52% of the total 203,760 children in need episodes nationally in 2016-17. Neglect was the initial category of concern for 24,590 children nationally who had a child protection plan (CPP) on 31 March 2017, and 44-48% of children during 2014-17 were on a CPP due to neglect (Department for Education, 2017a).

Neglect is reported frequently in the wider population but not as commonly. A survey of young people aged 11-17 years found that 9.8% reported experiencing severe neglect in the care of their parents (Bentley et al, 2018). However, national public health statistics report outcomes related to neglect much less commonly. SCR findings in neglect cases typically include poor dental hygiene and untreated dental caries, incomplete vaccinations due to missed routine healthcare appointments, poor school attendance and developmental delays due to lack of stimulation. These features vary in frequency in the general population; severe dental caries is rare with 0.2% of children less than 4 years old requiring hospital admission for severe dental neglect. In England, 95% of 2-year-olds have completed their primary course of immunisations against Diphtheria, Tetanus, Pertussis, Pneumococcus and Haemophilus. Poor school attendance occurs more commonly with 8.2% of children persistently absent in primary school and 13.1% in secondary school. Developmental difficulties are common with only 70.3% of children considered to have a good standard of development by the end of reception class, however there are many causes other than neglect for developmental delay (Public Health England, 2018a). The frequency of these outcomes in the general population are shown in Figure 8.

Figure 8: Frequency of neglect in the general population



Summary points

There were 206 SCRs relating to deaths in the three-year period. Seventy-eight cases were direct maltreatment deaths (overt and covert filicide, severe persistent child cruelty, extreme neglect and fatal physical abuse) – equivalent to 26 cases a year, which is consistent with previous analysis which suggests 26-28 cases per year.

The most common categories of deaths related to maltreatment were Sudden Unexpected Death in Infancy (SUDI) with 37 cases and suicide with 30 cases.

The total number of cases of non-fatal serious harm has increased (from 30-32 per year across 2009-14 to 54 cases per year in 2014-17); this relates to increases in cases of physical abuse, CSE, and neglect.

Most serious or fatal child maltreatment occurs within the family home, involving parents or other close family members. Very little serious or fatal maltreatment in SCRs (seven cases in total) involved strangers unknown to the child.

Neglect featured in three-quarters (208 of the 278, 74.8%) of the reports examined. It was the category of abuse in 50/84 (59.5%) children who were subject to a child protection plan at the time of or prior to the incident leading to the SCR.

2.6 Characteristics of the children and families

2.6.1 Age and gender of the child

The proportion of children in each age group is broadly similar to that in the four previous biennial/triennial periods. Table 7 and Figure 9 show age bands for the children at the centre of the reviews, with figures for 2014-17 reported in the final column. A total of 200 SCRs (54%) involved boys and 168 (46%) girls. This split reverts to that consistently found over previous review periods whereby more reviews relate to boys than to girls, with the exception of the 2011-14 cohort in which the proportion of boys was 45%. The predominance of boys is seen in the younger age groups, with a reversal to more girls in the two older age groups. This shift reflects the increasing number of reports about girls affected by child sexual abuse and exploitation.

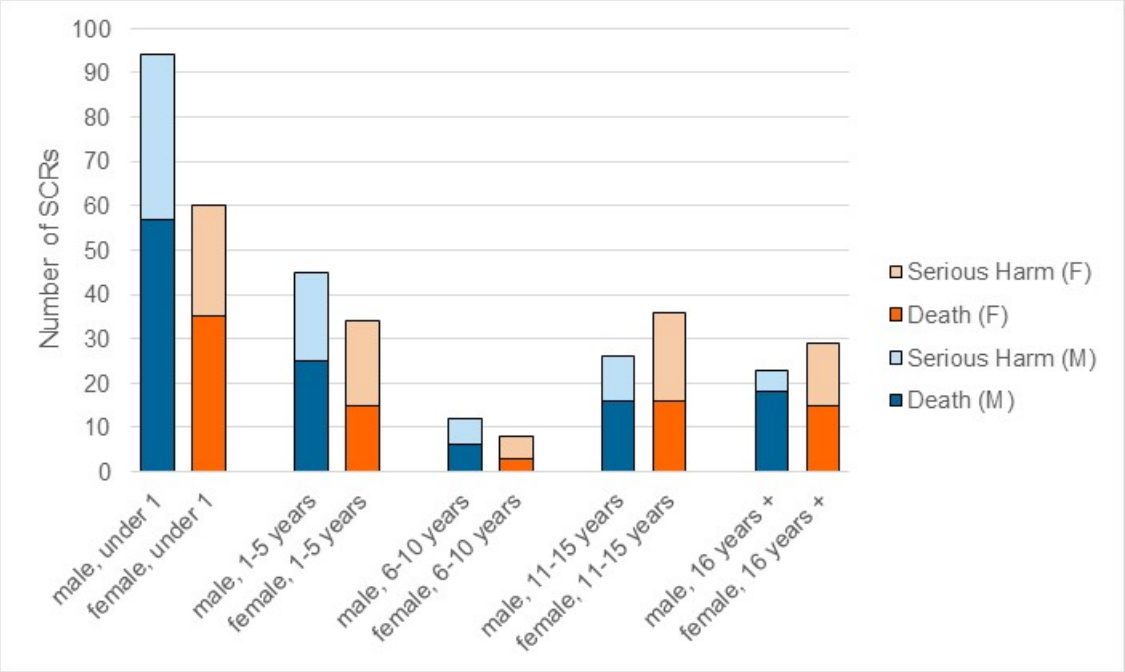
As in all the review periods, the largest proportion of incidents related to the youngest children, with 154 (42%) aged under one year. Of these, 79 (51%) were under three months of age, 47 (31%) were aged three to five months, 17 (11%) were aged six to eight months, and the remaining 11 children (7%) were between nine months and one year at the time of the incident which prompted the review. There has been a small

increase over the years in the proportion of SCRs involving young people aged over 11 years.

Table 7: Age of child at time of harm or fatality

Age (years)	Freq 2005-07 (n=189)	(%)	Freq 2007-09 (n=280)	(%)	Freq 2009-11 (n=178)	(%)	Freq 2011-14 (n=293)	(%)	Freq 2014-17 (n=368)	(%)
Under 1	86	(46)	123	(44)	64	(36)	120	(41)	154	(42)
1-5	44	(23)	60	(22)	51	(29)	64	(22)	79	(21)
6-10	18	(10)	26	(9)	21	(12)	28	(10)	20	(5)
11-15	20	(11)	40	(14)	27	(15)	41	(14)	63	(17)
16 +	21	(11)	31	(11)	15	(8)	40	(14)	52	(14)

Figure 9: Age and gender of child, and nature of incident



2.6.2 Ethnicity of the family

Data for ethnicity are given in Table 8. Note that for 25 of the 368 cases (7%) ethnicity was not stated in the 2014-17 notifications. The ethnicity breakdown is broadly consistent with previous review periods. From 2005 onwards, the families at the centre of the reviews have predominantly been white (between 72% and 80%). This is similar to the

overall proportion in the child population. In the 2011 census, 79% of all children aged 0-17 in England were of white ethnicity (Office for National Statistics, 2011)[6].

Table 8: Ethnicity of the family

Ethnicity	Frequency 2005-07 (n=173)	(%)	Frequency 2007-09 (n=267)	(%)	Frequency 2009-11 (n=172)	(%)	Frequency 2011-14 (n=282)	(%)	Frequency 2014-17 (n=343)	(%)
White/ White British	125	(72)	204	(76)	137	(80)	222	(79)	257	(75)
Mixed	23	(13)	25	(9)	11	(6)	21	(8)	30	(9)
Black/ Black British	13	(8)	24	(9)	14	(8)	17	(6)	26	(8)
Asian/ Asian British	8	(5)	12	(4)	7	(4)	15	(5)	22	(6)
Other Ethnic Group	4	(2)	2	(1)	3	(2)	7	(2)	8	(2)

2.6.3 Where were the children living?

Information about where the child was living at the time of the incident is displayed in Table 9. This shows that, at the time of the incident, most of the children (85%) were living at home or with relatives but, as in earlier years, that death and serious harm can also occur for children living in supervised settings. However, it is not possible to identify any trends in the children's placement, given the small number of children living outside of the parental home.

[6] http://www.nomisweb.co.uk/census/2011/DC2101EW/view/2092957699?rows=c_age&cols=c_ethpuk11

Table 9: Where living at time of harm or fatality

Where living	Freq 2005-07 (n=187)	(%)	Freq 2007-09 (n=278)	(%)	Freq 2009-11 (n=177)	(%)	Freq 2011-14 (n=293)	(%)	Freq 2014-17 (n=368)	(%)
Living at home	148	(79)	229	(82)	145	(82)	245	(84)	305	(83)
Living with relatives	10	(5)	11	(4)	8	(5)	10	(3)	9	(2)
With foster carers	7	(4)	8	(3)	4	(2)	8	(3)	16	(4)
Hospital, mother and baby unit or residential children's home	7	(4)	15	(5)	8	(5)	10	(3)	14	(4)
Semi-independence unit	5	(3)	3	(1)	1	(1)	3	(1)	8	(2)
Other, including YOI	10	(5)	12	(4)	11	(6)	17	(6)	16	(4)

2.6.4 Children's social care involvement

The key issues, when considering professional involvement with the child and the family, are what services were offered prior to the harm or fatality; were these services appropriate; should they have prevented or alleviated further harm; and if children were not receiving a service should they have been identified as being in need of the service in question?

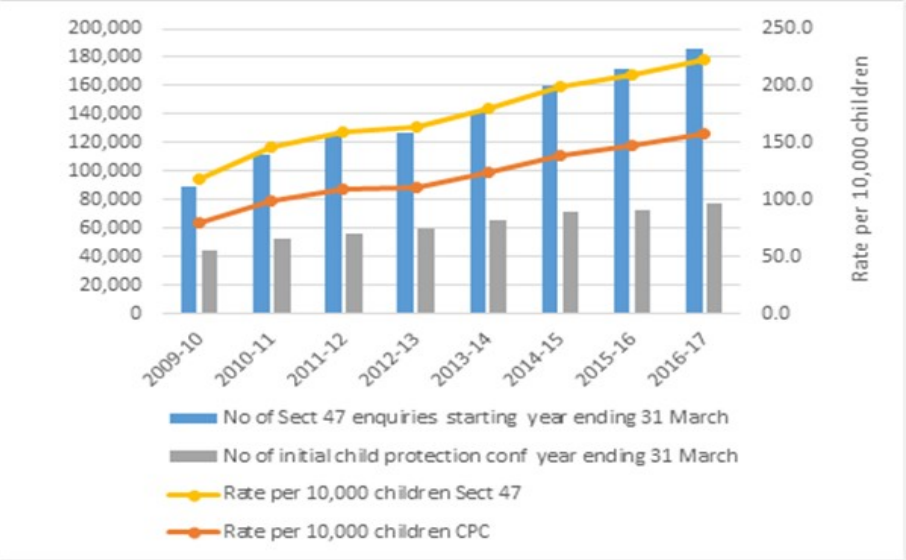
In contrast to our previous analysis, in the majority of SCRs the child was known to children's social care: 55% had current involvement; 22% were previously known but their case was currently closed; and only 16% had never been known to social care (Table 10). This represents a small and statistically significant increase in the proportion of SCRs in which the children were currently open to children's social care (Chi square 7.95, df=2, $p<0.02$). It is worth noting, however, that these data were more complete in the most recent cohort, with data on children's social care involvement being available on 285/368 (77%) of cases compared to 175/293 (60%) of cases in 2011-14, and the apparent rise may reflect this rather than increased identification of children in need/at risk by social care.

Table 10: Children's social care involvement

CSC involvement	Frequency 2009-11 (n=138)	(%)	Frequency 2011-14 (n=175)	(%)	Frequency 2014-17 (n=285)	(%)
Open case	58	(42)	79	(45)	157	(55)
Previously known, closed case	32	(23)	33	(19)	64	(22)
Enquiry or request for information, unaccepted referral, case below threshold for CSC	19	(14)	25	(14)	18	(6)
Never known to CSC	29	(21)	38	(22)	46	(16)

It is important, also, to see these data in the wider context of ongoing social care activity with children and families. The 50-60 children per year who die or suffer serious harm while receiving social care input need to be interpreted in the light of over 600,000 children per year referred to children's social care. In the year ending 31 March 2016, 646,120 children (548 per 10,000 child population) were referred for a social care assessment, of whom 22% had been referred at least once before in the previous 12 months (Department for Education, 2017b). During the period 2014-17, the number of section 47 enquiries and children with a child protection plan rose year on year (Department for Education, 2017b), both in absolute terms and per child population (Figure 10).

Figure 10: Section 47 child protection enquiries and child protection conferences



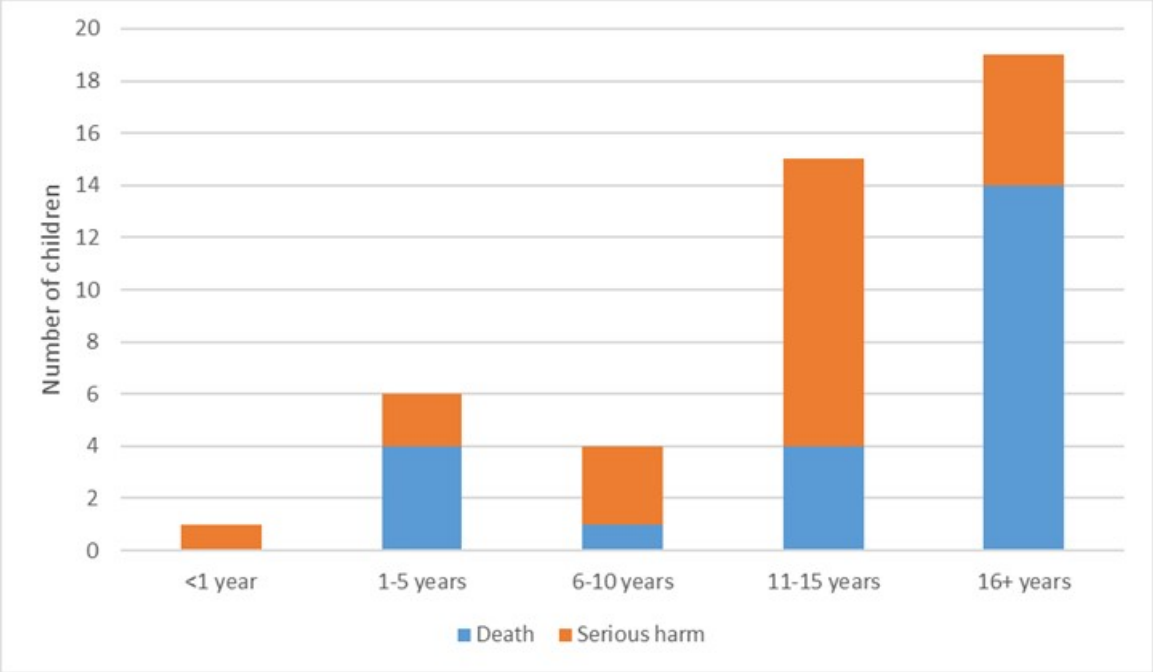
In contrast to the high proportion of children known to social care, a minority were on a child protection plan (CPP). At the time of the harm or fatality, 54 of the children (15%) had a child protection plan. A further 56 children had been the subject of a plan in the past (Table 11). These proportions have remained static over the years. This is at a time when nationally numbers of children with a child protection plan have been rising.

Table 11: Index child with a child protection plan (current or past)

Child protection plan status	Frequency 2005-07 (n=175)	(%)	Frequency 2007-09 (n=276)	(%)	Frequency 2009-11 (n=177)	(%)	Frequency 2011-14 (n=293)	(%)	Frequency 2014-17 (n=368)	(%)
Never on plan	127	(73)	198	(72)	136	(77)	223	(76)	258	(70)
Current plan	29	(17)	43	(16)	18	(10)	36	(12)	54	(15)
Past plan	19	(11)	35	(13)	23	(13)	34	(12)	56	(15)

Within the time frame of this triennial review, a total of 191,930 children became the subject of a child protection plan, of whom 19% had a child protection plan on more than one occasion. The majority of children came off plans in less than one year, with 15% remaining on a plan between one and two years and 2% for more than two years (Department for Education, 2017b). Given that during this timeframe, 54 children died or were seriously harmed while on a child protection plan, and a further 56 having previously been on a child protection plan, these data suggest that children on child protection plans are generally well protected from the most severe harm.

Figure 11: Looked after children in SCRs



Although full information for category of plan was unavailable for this analysis, where it was available the majority were recorded under the category of neglect, followed by emotional abuse, physical abuse and finally sexual abuse. These categories reflect the national picture of children on child protection plans, but as nationally they do not capture other harms such as community-based or cumulative, multiple harms.

Forty-five children were or had previously been looked after by the local authority. Of those, 23 had died and 22 were seriously harmed. Three-quarters of these children were aged over 11 years (Figure 11).

Summary points

A total of 200 SCRs (54%) involved boys and 168 (46%) girls. This split reverts to that consistently found over previous review periods whereby more reviews relate to boys than to girls.

As in all the review periods, the largest proportion of incidents related to the youngest children, with 154 (42%) aged under one year. There has been a small increase over the years in the proportion of SCRs involving young people aged over 11 years.

The ethnicity breakdown is broadly consistent with previous review periods. From 2005 onwards, the families at the centre of the reviews have predominantly been white (between 72% and 80%).

At the time of the incident, most of the children (85%) were living at home or with relatives but, as in earlier years, death and serious harm can also occur for children living in supervised settings.

In the majority of SCRs, children were known to children's social care: 55% had current involvement; 22% were previously known but their case was currently closed; and only 16% had never been known to social care.

In contrast to the high proportion of children known to social care, a minority were on a child protection plan. At the time of the harm or fatality, 54 of the children (15%) had a child protection plan. A further 56 children had been the subject of a plan in the past.

Forty-five children (from 278 reports available) were or had previously been looked after by the local authority. Of those, 23 had died and 22 were seriously harmed. Three-quarters of these children were aged over 11 years.

2.7 Background characteristics of the family

Our past reporting of family characteristics has been limited, as information within notifications could be sketchy or missing in so far as it could only represent what was known at the time of notification. For this triennial review, the team has placed a great emphasis on identifying these features through carefully scrutinising the sub-set of 278 final reports for information on parent, family and child characteristics. Even so, because this information is not always recorded in SCR reports our findings still reflect likely under-reporting and hence an under-estimate of these factors.

2.7.1 Parent and family characteristics

The presence of various parent characteristics drawn from this analysis is displayed in Tables 12 and 13. The numbers we present are those in which a particular feature was specifically identified in the SCR. The failure for any particular feature to be noted could indicate that the factor was not present, or was present but not commented on. As such, these figures represent a *minimum* prevalence for each factor in this cohort. Moreover, interpretation of the comparative prevalence of characteristics in mothers or fathers must be treated with some caution as it may reflect that the SCR reviewer did not consider the role of the father or that services themselves held little information about the father.

Table 12: Parental characteristics - frequency noted in SCR final reports (n=278)

Characteristic	Mother	Father	Father figure/ mother's partner	Both	Total number (%) where characteristic reported
Alcohol misuse	40	25	3	31	99 (36%)
Drug misuse	29	23	7	40	99 (36%)
Mental health problems	93	17	5	38	153 (55%)
Adverse childhood experiences	59	11	1	31	102 (37%)
Intellectual disability	20	6	2	8	36 (13%)
Criminal record	10	42	18	13	83 (30%)
Of which, violent crime (excluding domestic violence)	8	22	7	4	42 (15%)

Parental characteristics

The most prevalent parental characteristic reported in these SCRs was mental health problems, particularly for the mother (noted in 47% of SCRs) but also for the father or father figure. Parental alcohol or substance misuse were each noted in 36% of SCRs. In 37% of SCRs parental adverse childhood experiences were noted. As with all these factors, this is likely to be an underestimate, as many SCRs did not provide details of the parents' backgrounds. Of particular note was the number of SCRs reporting parental criminal records (30% of SCRs, of which half reported violent crime).

Parental mental health problems occur more commonly in the SCR population than the general population, depression and anxiety were found to have a prevalence of 13.7% in adults using the GP patient survey (Public Health England, 2018b). However, mental health problems occur in similarly high frequencies in families requiring social care support; 52.8% of adult social care users suffer from depression or anxiety (Public Health England, 2018b), and parental mental health problems were a factor in 40% of completed children's social care assessments (Department for Education, 2017b).

In 13% of these SCRs, parental intellectual disability was reported to be a feature, a higher proportion than in the general population. Approximately 2% of adults in the UK have a learning disability, but a further 7% may have borderline learning disabilities impacting on their ability to function in daily life. It is not clear however how many parents have learning disabilities (Working together with parents network, 2016).

The frequency of alcohol and substance misuse within this cohort is much higher than in the wider UK population. It is estimated that there are between 200,000 and 300,000 children in England and Wales whose parents have significant drug problems, accounting for 2-3% of the child population. The majority of these children live with their parents (Advisory Council on the Misuse of Drugs, 2011). Similarly, in the general population only 4% of adult men and 1% of adult women consume more than 50 units of alcohol per week which implies alcohol dependency (National Statistics, 2017). The figures within the SCRs are more aligned with those of families involved with children's social care: parental drug misuse was a feature in 20% of completed child social care assessments in England during 2016-17, and parental alcohol misuse a feature in 18% (Department for Education, 2017b).

Overall, 226 SCRs (81%) reported at least one of these parental characteristics as being present; 168 (60%) reported two or more; and 54 (19%) at least four.

Table 13: Family characteristics - frequency noted in SCR final reports (n=278)

Family characteristic	Total number (%) where characteristic reported
Parental separation	150 (54%)
Of which, acrimonious separation	41 (15%)
Domestic abuse	164 (59%)
Social isolation	51 (18%)
Transient lifestyle	81 (29%)
Multiple partners	67 (24%)
Poverty	97 (35%)

As in our previous national analyses, domestic violence/abuse was a common finding (reported in 59% of SCRs). Parental separation was also common (54%, of which over a quarter were felt to be acrimonious separations). Of note, 35% of SCRs noted indicators of poverty or economic deprivation as a feature in the case. Overall, 238 SCRs (86%) reported at least one of these family characteristics as being present; 187 (67%) reported two or more; and 54 (19%) at least four (Table 13).

Child characteristics and adverse experiences

A number of child characteristics and adverse experiences were noted in the SCRs (Table 14). Nearly half of SCRs involving children over 6 years of age reported mental health problems for the child; 24% reported alcohol misuse; and 29% drug misuse. In 28% the child was reported to have experienced bullying. In almost a quarter of the cases (24%) the child had experienced CSE, suggesting that these young people are often victims of more than one form of maltreatment, both intra- and extra-familial.

Table 14: Child experiences and features

Characteristic	<1 year N=113	1-5 years N=58	6-10 years N=17	11-15 years N=52	16+ years N=38	Total N = 278* (%)
Disability	2	7	5	15	11	40 (14%)
Behaviour problems	-	3	7	26	26	62 (38%)
Alcohol misuse	-	-	0	12	14	26 (24%)
Drug misuse	-	-	0	13	18	31 (29%)
Mental health problems	-	-	2	26	22	50 (47%)
Bullying	-	-	0	19	11	30 (28%)
CSE	-	-	0	17	9	26 (24%)

*For behaviour problems, we excluded children aged under 1 year; hence the denominator for this characteristic is 165; For alcohol and drug misuse, mental health problems, bullying and CSE, we excluded children aged less than 6 years; hence the denominator for these characteristics is 107.

Fourteen percent of children in these SCRs were reported to have a disability prior to the incident. Details of the impairment or disability are provided in Table 15.

Table 15: Child disability prior to incident

Nature of disability/impairment	Frequency (n=40)
Physical impairment	4
Intellectual/learning disability	10
Sensory impairment	1
Social/communication disability	5
Complex/combined disability	5
Chronic, disabling condition	7
Young child with developmental delay	4
Nature of disability unclear or unspecified	4

Summary points

The most prevalent parental characteristic reported in these SCRs was mental health problems, particularly in the mother (noted in 47% of SCRs) but also in the father or father figure.

Parental alcohol or substance misuse were each noted in 36% of SCRs. In 37% of SCRs parental adverse childhood experiences were noted. Of particular note was the number of SCRs reporting parental criminal records (30% of SCRs, of which half reported violent crime).

Nearly half of SCRs involving children over 6 years of age reported mental health problems in the child; 24% reported alcohol misuse; and 29% drug misuse.

Fourteen percent of children in these SCRs were reported to have a disability prior to the incident.

Chapter 3: Neglect

How we respond to and protect children from the harmful effects of neglect is one of the most pressing and challenging aspects of safeguarding work in this country. Neglect is consistently the most common initial category of abuse for children on a child protection plan, accounting for nearly half of all plans. Both the proportions and actual numbers of children on child protection plans for neglect have risen over the years from 41.6% (17,930 children) in 2013 to 48% (25,820 children) in 2018 (HM Government, 2013b; 2018a). This represents a 44% increase in the number of children subject to child protection plans for neglect. Neglect is also consistently a major factor in the lives of children who die or are seriously harmed as a consequence of child maltreatment. As highlighted in Chapter 2, while rarely a primary cause of death, neglect does feature in three-quarters of all SCRs (fatal and non-fatal) and was the primary issue in 19% of all serious harm cases. This continues an increasing trend seen in our previous biennial and triennial reviews (Bailey, Belderson & Brandon, 2010; Brandon et al, 2012; Sidebotham et al, 2016).

In order to gain an increased understanding of the issues relating to child neglect and how we respond to it, we therefore undertook an in-depth qualitative analysis of a sample of cases in which neglect was a recognised feature.

3.1 Methods

A sub-sample of 32 cases was selected for this qualitative analysis (Table 1; full details of the cases are provided in Appendix D). In each of these cases, neglect was an identified factor (though not necessarily the direct cause of death or serious harm). We aimed for a stratified sample representative of age group, gender, ethnicity, geographical region, and category of death or serious harm. We specifically included cases where prior disability was identified, and cases where extreme neglect was the primary cause of serious harm.

Evidence of neglect, for the purposes of selecting the sample, was taken to be any of the following:

1. A child protection plan under the category of neglect.
2. ‘Neglect’ given as the primary category of harm on the notification or as a case characteristic on the form.
3. Noted in the final report as an important, and often long-standing feature of the child’s life.

Table 16: Sample for neglect analysis

Characteristic		Deaths N=19	Serious Harm N=13	Total N=32
Gender	Male	11	8	19
	Female	8	5	13
Age range	Under 1 year	7	3	10
	1-10 years	5	6	11
	11-17 years	7	4	11
Ethnicity	White British	13	8	21
	Black	4	0	4
	Other	2	3	5
	Not known	0	2	2
Region	East	2	0	2
	East Midlands	1	1	2
	London	4	1	5
	North East	1	3	4
	North West	3	3	6
	South East	3	0	3
	South West	1	2	3
	West Midlands	2	3	6
	Yorkshire & Humber	2	0	2
Prior disability		4	3	7
Indicators of poverty		10	8	18
Child Protection Plan at time of incident		4	3	7
Looked After Child		4	1	5
Pathway to harm	Deprivational neglect	0	5	6
	Medical neglect	3	1	4
	Accident	3	1	4
	SUDI	3	-	3
	Combined neglect and physical abuse	6	3	9
	Vulnerable adolescent: suicide	2	-	2
	Vulnerable adolescent: risk-taking behaviour	1	0	1
	Vulnerable adolescent: criminal exploitation	1	3	4

All reports had previously been read and front sheets completed for the quantitative analysis. These front sheets provided baseline data and a case synopsis for each review. Two concurrent approaches to analysis were taken involving inductive, open coding to identify themes arising from the data, and thematic coding using a pre-determined

framework based on our 'pathways to harm/pathways to protection' model (Sidebotham et al, 2016).

Our previous research has identified a number of pathways through which neglect could lead to serious harm or death (Brandon et al, 2014; Sidebotham et al, 2016). Building on this and our review of the cases in this subsample, we classified the cases into eight categories of neglect (see below).

3.1.1 Categories of Neglect

1. ***Severe deprivational neglect*** where neglect was the primary cause of death or serious harm; neglect of the child's basic needs leads to impairments in health, growth and development; severe illness or death may result from malnutrition, sepsis, or hypothermia among others.
2. ***Medical neglect:*** failure to respond to a child's medical needs (acute or chronic) and necessary medication; such failure may lead to acute or chronic worsening of a child's health.
3. ***Accidents which occur in a context of neglect and an unsafe environment:*** hazards in the home environment and poor supervision may contribute.
4. ***Sudden unexplained death in infancy (SUDI) within a context of neglectful care and a hazardous home environment***: deaths may occur in dangerous co-sleeping contexts, or where other recognised risk factors are prominent and not addressed.
5. ***Physical abuse occurring in a context of chronic, neglectful care:*** the primary cause of serious harm or death may be a physical assault, but this occurs within a wider context of neglect.
6. ***Suicides and self-harm in vulnerable adolescents*** with mental health problems associated with early or continuing physical and emotional neglect.
7. ***Vulnerable adolescents harmed through risk-taking behaviours*** associated with early or continuing physical and emotional neglect.
8. ***Vulnerable adolescents harmed through criminal exploitation*** associated with early or continuing physical and emotional neglect.

These categories are not considered individually, as the main focus of our analysis was on identifying opportunities for prevention or protection arising from the reviews (both as missed opportunities and examples of good practice/recommendations for improvement) and the underlying systems and processes that would support such prevention or protection. Nevertheless, in order to fully understand this, we also analysed some of the main themes arising from the reviews in relation to the context and circumstances of neglect.

In the rest of this chapter we will explore:

3.2 The key themes emerging in relation to the circumstances of death or serious harm.
3.3 The background context of neglect in the cases, including issues related to parent/carer risk and child vulnerability.
3.4 Opportunities for preventive or protective intervention by the family and wider community.
3.5 Opportunities for preventive or protective intervention by statutory and other agencies.
3.6 The systems and processes that may support such interventions.

3.2 Circumstances of death or serious harm

As indicated in section 3.1, we aimed to have a broadly representative sample of the entire cohort. The proportions of male and female, age group, and ethnicity were similar to the overall cohort, with slightly higher proportions of males, children of non-white ethnicity, and children aged 1-10 years. All geographical regions were represented.

Although we did not select for this reason, a slightly higher proportion of children in the neglect sub-sample were the subject of a child protection plan (22% compared to 15%) at the time of the incident. Seven of the children were known to be disabled prior to the incident. Poverty was noted to be a feature in 18 cases (56%) compared to 35% of cases in the overall cohort.

As indicated in Table 1, the circumstances through which neglect led to death or serious harm varied widely. It was notable that no child in this cohort died in circumstances where severe deprivational neglect was the primary cause of death. In our previous national analyses the numbers in this category have been no more than 3% and again this emphasises that neglect is rarely the primary cause of death. There were, however, five cases where severe deprivational neglect had led to serious harm to the child (all aged under 5 years). There were seven cases in which a young child died or was seriously harmed as a result of an accident or SUDI in the context of chronic neglect and an unsafe physical environment. Neglect of a child's medical needs was the cause of death or serious harm for four adolescents in this sample. For the majority of adolescents, however, the circumstances suggested that earlier, long-standing neglect had led to the young person being particularly vulnerable, through mental health and behavioural problems or being at risk of criminal exploitation including gang involvement and child sexual exploitation.

3.3 Background context

While the circumstances leading to the SCR differed in the cases included in this subsample, an ongoing context of neglect was the common feature in all the cases. A wide range of family and environmental characteristics were identified in the cases studied, many of which were common to all forms of maltreatment. However, three overarching issues stood out from our analysis: poverty; the complex and cumulative nature of neglect; and the invisibility of some children and young people to the system. There were particular issues related to adolescents, both those who continue to experience neglect throughout their adolescence, and those who continue to live with the impact of neglect earlier in their childhoods. These topics are explored below.

Case study: Neglect and complex family circumstances

Cara was a two-year-old White British girl who died from ingesting 20ml of her mother's methadone. She was born the youngest of five children to a mother struggling with long-term drug addiction and domestic abuse. Like all her siblings, Cara was born unattended at home. On admittance to hospital she was found to have a cleft lip and, like her siblings, suffered from neonatal abstinence syndrome. The family had a long history of contact with adult and children's services; all the children had some degree of developmental needs.

Concerns over poverty and the state of the home had been identified some five years prior to the birth of Cara. At one point the family were living with no furniture or carpets, all the children shared a single bed and there was very little food in the house. On other occasions the younger children failed to attend nursery because of unpaid fees. There were times when Cara's mother borrowed money from relatives to buy food or depended on charities to supply food parcels.

The primary focus for agencies was to improve the physical conditions of the home and to ensure that the parents continued to attend their drug treatment programme. The parents sometimes struggled to manage their finances. The lack of assessment of the ways in which poverty affected the children, resulted in short term bursts of activity to clean up the home or provide cash or food for the children. Signs of improvement resulted in the case being closed to children's social care. The underlying causes of the family's poverty and its relationship with parental drug addiction were not explored. Perhaps most significant was the lack of any exploration of the children's experiences and how poverty impacted on their safety, health and overall development.

Key points:

The links between domestic abuse, substance misuse and poverty are complex and often inter-dependent. Addressing a single issue will not deal with the underlying causes.

Substance misuse can result in money needed for food and clothing being diverted to satisfy parental needs. Short-term solutions followed by case closure leaves children at risk.

Practitioners need to understand how poverty affects children and, through hearing their voices, seek to safeguard and improve the quality of their lives.

When families are receiving services from both adult and children's services, information sharing and joint working enables the development of more realistic plans to safeguard children.

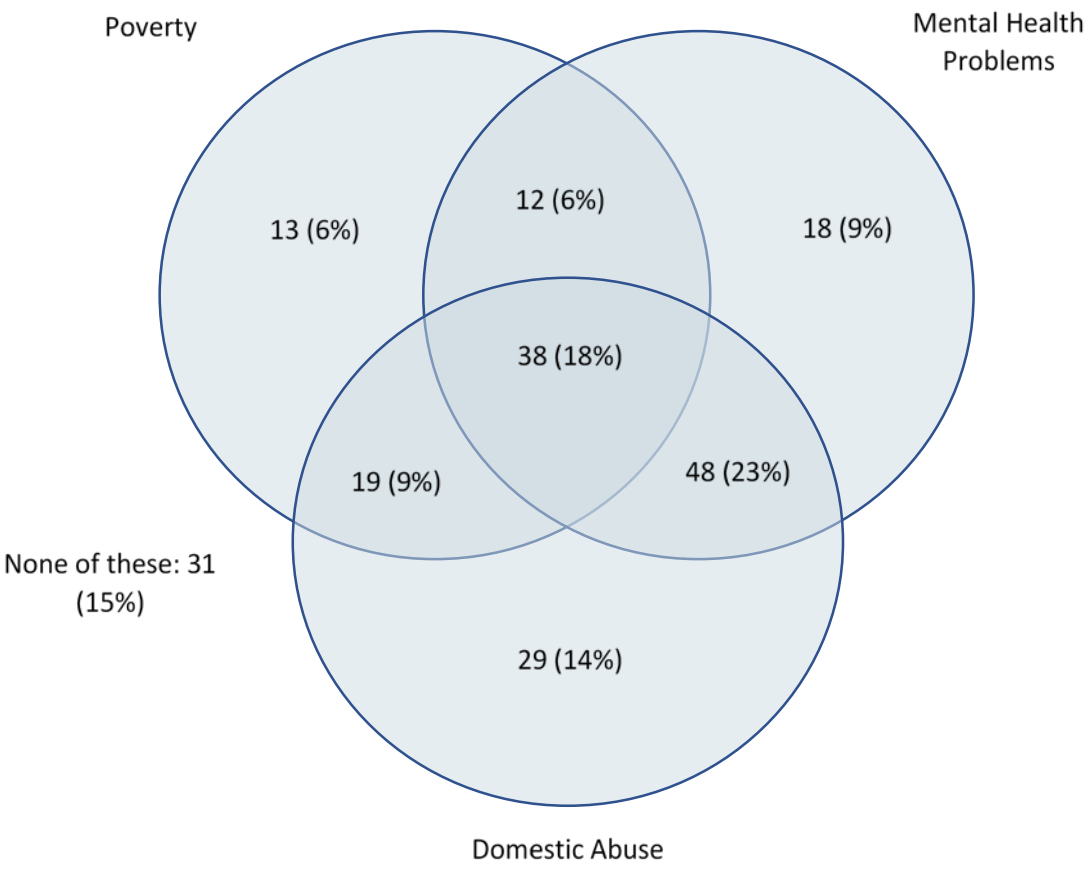
3.3.1 The complex and cumulative nature of neglect

The complexity of many families' circumstances, the cumulative nature of adversity within these families, and the impact of these on children have been highlighted in our previous national analyses (Brandon et al, 2012; Sidebotham et al, 2016). Complexity and cumulative harm are not unique to situations of neglect but almost invariably they are a feature of families where children experience neglect.

Overall, in this cohort of SCRs there were 208 cases in which neglect was noted to be a feature. Among these 208 there was an extremely high prevalence of adverse parental and family circumstances. Domestic abuse was noted to be a feature in 64% of these families; parental mental health problems in 56%; and poverty in 39% (Figure 12).

In addition to these, many of these parents were noted to have problems with alcohol or drug misuse (39%), criminal behaviours (34%), transient lifestyles (31%), multiple partners (27%) or social isolation (17%). Forty percent had experienced adversity in their own childhood. As illustrated in the Venn diagram (Figure 12), often these problems were found to be cumulative. Only 11% of cases did not have any of these family adversities documented in the review, while 42% had at least three different factors documented. As with all our analysis, conclusions about the presence or absence of any factor was dependent on whether or not it had been mentioned in the review. It is likely that the proportions for at least some of these would be much higher and were not documented either because the question had not been asked, or that it had not been felt to be relevant.

Figure 12: Adverse family circumstances in cases of neglect (n=208)



Cumulative harm is a concept adopted in child protection law in the Australian state of Victoria. It refers to the effects of multiple adverse circumstances and events in a child's life (Bryce, 2018). Cumulative harm and the coexistence of neglect with other forms of abuse was a feature in over three-quarters of the children included in the reviews.

One of the most significant findings was the frequency with which issues related to poverty were identified in these reviews. This appeared more frequently than in our previous national analyses (Bailey, Belderson & Brandon, 2010; Brandon et al, 2012; Sidebotham et al, 2016) and may reflect actual increases in families living in poverty, or a greater acceptance among practitioners and SCR authors to acknowledge poverty as a factor impacting on the lives of these children and families. These issues are explored further in the topic study on poverty.

Topic study: Poverty

One of the striking findings in our analysis of these SCRs was the dearth of information on families' socio-economic circumstances. Individual aspects of poverty such as a request for food parcels, debt problems, lack of money for basic needs, or frugal home conditions, were identified in a number of the reviews. Indeed, as noted in Chapter 2, indicators of poverty were recognised in 35% of SCRs. However, these were often shown to have been dealt with on an ad hoc basis and rarely was the impact on children or the relationship with abuse and neglect fully explored.

Yet the links between socio-economic factors and child maltreatment, and the damaging impact of poverty on children's outcomes are important. Evidence from a range of studies from across developed countries shows a strong association between families' socio-economic circumstances and children's chances of experiencing child abuse and neglect (Featherstone et al, 2019; Morris et al, 2018; Pelton, 2015; Rose & McAuley, 2019).

Poverty blindness and normalization

Poverty is not commonly recognised as a relevant construct for childcare practitioners (Featherstone et al, 2018). The work of Jack and Gill (2003) shows that poverty ignorance and 'poverty blindness' can afflict professionals with responsibility for children in need. Their work suggests that the attitudes of professionals towards poverty and poor people show *'ambivalence, confusion, lack of awareness … and reluctance to get involved'* (Jack & Gill, 2003, p.62). It has been argued that poverty has become invisible in practice because childcare professionals wish to avoid stigmatising families (Morris et al, 2018). The current analysis of SCRs found poverty was often reported as a co-existing factor among many, or seen as an outcome not the cause of family needs and difficulties. In one fairly typical case, a lone mother of three children and a newborn baby, struggled with depression, substance misuse and domestic abuse. Social workers and health visitors all held serious concerns about the home conditions, *'the children lived in a home that was chaotic, untidy and filthy, at times'*. In this case practitioners tried to address the issue and there was a *'massive input from core group members to support the mother and children and improve home conditions'.* However, the underlying causes were not addressed.

A scrutiny of the current reviews suggests that in the majority of cases references to poverty were oblique and there was little detail of how it impacted on parenting capacity or the children's lived experience. In some instances, practitioners sign-posted families to food banks and other relevant charities. This was the case for a family of three children previously subject to care orders because of neglect. A visit by the health visitor following the birth of the fourth child identified real need:

She had borrowed money from her mother to buy food for the children, but this would not last the weekend. The health visitor approached a charity asking for a food parcel.

The response appears to be incident driven and no long-term plan to address the causes and consequences of poverty was recorded.

Previous research has identified that childcare professionals working with families living in areas of high deprivation come to accept lower standards (Brandon et al, 2014; Jack & Gill, 2003). This was illustrated by the response to a referral concerning a family of five children already well known to children's social care and discussed in the previous case study about Cara (see section 3.3).

The reviews suggest that professionals become '*accustomed to working in areas with large numbers of children and high deprivation'*. As a result, there may be a normalisation and desensitisation to the warning signs of neglect such as poor physical care, smelly and dirty clothes, or poor dental care.

Learning Points

Poverty can have a profound and a long-term negative impact on children's lives but recognition of poverty and its impact is often missing from or only obliquely referred to in reviews. This may reflect a wider 'poverty blindness' within social care case work.

Practitioners can become desensitised to the impact of poverty and accept lower standards for children and families; supervision can support reflective practice that would challenge such assumptions, and enable practitioners to identify poverty and work proactively with families to address its causes and consequences.

Rectifying the physical manifestations of poverty and a chaotic lifestyle does not equate with children being safe; the child should always be the primary focus of any assessment.

When faced with families in situations of poverty, practitioners should seek to understand the pathways through which socio-economic issues interact with other factors to influence parenting and outcomes for children. It is important neither to ignore the impacts of poverty, nor to simplistically attribute the family's problems solely to economic hardship.

3.3.2 Parent and carer criminal activity

One of the key risks to children and young people is from parents/carers who have criminal convictions. While not exclusive to neglect, a criminal history was noted in 34% of cases where neglect was a feature, while in 18% of these cases one or both parents had a history of violent crime (excluding domestic abuse). The qualitative analysis identified parents and other carers with criminal convictions relating to offences of violence, including domestic abuse; criminality associated with drugs and alcohol misuse; and with mothers being involved in sex work.

Sometimes the information regarding the criminal convictions and intelligence relating to the parents and carers was recognised as a risk of harm to children and young people and was therefore shared by police early:

> *Concern about Child N's welfare began before his actual birth because of the history of domestic violence, parental drug misuse and neglect towards an older child. As a result, Child N's name was placed on the child protection register at birth.*

In some cases, agencies hold large volumes of information about the parents, including criminal convictions and criminal activity along with other recognised risk factors. This volume of information can at times get in the way of safeguarding children, leading to reactive rather than proactive work, or downgrading the actual risks:

> *Due to the family having a rather chaotic and transient lifestyle, poor attendance for appointments, late bookings for pregnancies, regular users of Methadone and a number of referrals, both to the Police and Specialist Children's Services, it appears that agencies became reactive rather than proactive; some protection plans were not clear, there was a lack of historic information about the adults and this was a family with high support needs balanced with high challenges. This resulted on occasions, in multi-agency working being disrupted.*

> *Child E's birth mother (and a generation earlier for similar reasons, their maternal grandmother) had been a long-standing source of concern to police, health agencies and children's social care. Both those adults have a lengthy history of drug and alcohol abuse and the mother of Child E has an extensive criminal history (much of it related to prostitution and alcohol-fuelled violence). A pre-birth child protection conference was held and concluded that it was not necessary to make Child E subject of a child protection plan.*

In these situations, information held by the police is crucial to understanding the context of these children's lives and hence to effective risk assessment and planning. Many of the SCRs examined highlighted the importance of information sharing between the police and other agencies, and also of police being active participants in decision-making

forums. This mirrors the findings of the March 2019, National Police Chiefs Council, Vulnerability Knowledge and Practice Programme (VKPP) briefing on learning for the police from SCRs (Allnock, 2019). These issues are explored further in a topic study later in this chapter.

3.3.3 Adolescent neglect

Particular themes emerged in relation to vulnerable adolescents in identifying and responding to issues of neglect where risks and need could overlap:

> *Professionals working in the multi-agency safeguarding system struggle to provide an effective service to vulnerable adolescents who display a range of complex behaviours and needs leaving them with a fragmented and reactive response to different aspects of their behaviour.*

The need for joint working agreements in supporting adolescents with complex health needs is prominent where the transfer of young disabled people to adult services can obscure needs that might previously have been met by children's disability services. Thresholds for child protection can become less clear or invisible for these young people unless specific arrangements for their identification across agencies are put into place.

In one case examined, there was no system in place for identifying the support needs of carers in the transfer between children's and adult services. The transitions protocol proved inadequate and did not contain sufficient details to identify what happened in the case of young people who were not in receipt of support from the children with disabilities team. In this case statutory services were for some years unaware that this young person with very complex health needs was living in the household at all. This case keenly illustrates how inadequate pathways between services can render some children and young people and their support needs literally invisible:

> *The transition process was thought by those involved to be compromised by the fact the case was not open to children's services. School were unclear regarding the need to notify the adult learning disabilities team (ALDT) of P in year 9 and did not appreciate the full extent this would allow for further planning for P future. The school indicated that as P was staying under the umbrella of the school until he was 19, they did not recognise the need for transition until the summer prior to his death.*
>
> *The process within the hospital had been aligned to other local hospitals and meant all children and young people, including disabled children and young people, who are over 16 are admitted to adult wards unless they are receiving ongoing acute paediatric care. P was not under a hospital paediatrician thus was*

admitted to an adult ward under adult physicians; this distressed him and was inappropriate based on his level of ability.

Summary points

Complexity and cumulative harm are not unique to situations of neglect, but, almost invariably, they are a feature of families where children experience neglect. Among these families there is an extremely high prevalence of adverse parental and family circumstances.

The complexity of these families' situations and the large volumes of information held can get in the way of identifying the risks faced by children. Practitioners need to be aware of this and to constantly come back to seeking to understand the lived experience of the child.

Adolescents living in situations of neglect may be particularly vulnerable to having their needs, and the risks they face, overlooked. Clear pathways for transition to adult services are important to ensure young people receive the care and support they need.

3.4 Opportunities for preventive or protective intervention by the family and wider community

In our previous triennial review (Sidebotham et al, 2016) we identified some of the opportunities for preventive or protective intervention within the family and wider community. These opportunities are often ignored or downplayed by professionals, thus missing some of the most important sources of support and intervention. This may be particularly pertinent in cases of neglect, where the problems are often longstanding and insidious, and where parents themselves, other family members and the wider community may have resources to combat the impact of some of the adverse circumstances identified above. In this section, we explore some of the learning identified in the neglect cases in relation to understanding parents' experiences, the role of fathers and partners and the wider family.

3.4.1 Parents – understanding their experiences

As highlighted above, for many of these families, parents' own lives are complicated and complex, with many issues combining as cumulative harm. The coexistence of issues such as physical or mental ill-health, substance misuse, poverty, criminal behaviour, learning difficulties, and domestic abuse can result in inconsistent and ineffective parenting and a disorganised lifestyle. It may mean parents have difficulty in controlling

their emotions and experience apathy and disengagement, resulting in an inability to provide adequate emotional warmth to their children or essential supervision (Cleaver, Unell & Aldgate, 2011).

Parents' own childhood adversity or behaviour during adolescence may lead to social isolation, stress and difficulties in engagement. It can result in parents not always 'hearing' what is said in meetings or remembering clearly the agreed plans, leaving them feeling out of control and defensive in future interactions with professionals, particularly, as noted in one review, where parents perceived having '*official agencies involved in the family as a negative experience and one to be avoided*'.

Likewise, services may struggle to engage with and monitor families or individuals with transient lifestyles, particularly those crossing local authority boundaries. Such families may present specific challenges for effective information sharing and for clarifying responsibilities both between agencies and across local authority boundaries:

> *What is clear throughout all these circumstances are the ongoing challenges that professionals face working with transient families who have multiple or complex difficulties. This becomes even more difficult with avoidant, hard to engage and resistant families when the need to safeguard vulnerable children is a primary concern, not least the sharing of information in a timely manner when different IT systems are used and they do not align.*

Avoidance strategies may involve blocking communication, pleading ignorance or trivialising the significance of an action (Cleaver, Nicholson, Tarr & Cleaver 2007). The review of a two-month old baby who died unexpectedly (SUDI) provides an example of a mother successfully closing down professional scrutiny when involvement was voluntary:

> *She denied any drug use and reacted negatively to criticism. She subsequently made a complaint against the school CAF Coordinator stating she did not want this person to come to her home or to be involved in the CAF process.*

While recognising the importance of identifying parental avoidance, there is a danger here in labelling the individuals as hard to engage or resistant, rather than exploring the underlying issues leading to such resistance, or seeking to identify the systemic issues that make it difficult for the practitioners to engage.

How best to balance the needs of the child with those of parents is a challenge for all those working with children and families. Assessments do not always consider why parents are neglectful or what support is available within the extended family or wider community. A mother of three children, all subject to child protection plans for emotional abuse, suffered from HIV/AIDS. There was little evidence that professionals explored fully the impact of her debilitating illness on her capacity to look after the children. As the review noted:

> *…the network did not appear to sufficiently appreciate mother's on-going and varying physical vulnerability and its consequences for capacity to parent i.e. that the excessive proportion of child G's waking and sleeping time spent unstimulated in his buggy may have been primarily a result of mother's health-related lethargy.*

In contrast, the focus in many cases was on addressing the needs of the parent at the expense of the child. When the chaotic and disorganised behaviour of the parent dominates (such as swings between non-compliance and co–operation) professionals' attention is taken up with encouraging compliance and the impact on the children may not be recognised or explored.

Parents who are offered or receive early help services need to have both the motivation and the ability to work on a voluntary basis with service providers. Vulnerable or overwhelmed parents may not have the emotional capacity or material resources to be able to take up the services offered or to attend appointments. In such circumstances, professionals need to take time both to understand the underlying issues and to build a trusting relationship. When that happens, offers of help are more readily accepted.

3.4.2 Assessing key roles and relationships: fathers and male partners

As has been highlighted above, these reviews often demonstrate a failure to consider all the significant figures in the family context and the roles they play in family functioning and dynamics. The invisibility of men in parental roles or the issue of absent fathers persists in this sample, echoing previous national reviews (Bailey et al, 2010; Brandon et al, 2012; Sidebotham et al, 2016):

> *The case was closed by children's services on the basis that the presenting issue was housing, which was being addressed by the housing department. This decision fell below the required standard as it did not gather sufficient information about the lifestyle of the mother, the role of significant others, such as the biological father, reasons for her poor attendance and engagement with professionals and its impact on the baby.*

> *The potential risks the father posed (and possible strengths he offered) remained un-assessed for the duration of the professionals' involvement. This was a significant omission.*

The SCRs included in this analysis reflect earlier findings concerning men and male caregivers (Brandon et al, 2009). Recent research of children with newly made child protection plans found that although fathers were present rather than absent in children's lives and the majority were involved in parenting, there was very little information about these men in children's case files (Brandon, Philip & Clifton, 2017). Similarly, there continues to be a dearth of information about men in SCRs. The primary focus of health professionals and social workers continues to be on the needs, circumstances and

perspectives of the mother. This is the case even in established relationships when the mother's partner has a major role in looking after the children.

In one example, where the children were having overnight stays with their father:

> *…there was no expectation or requirement, for an in-depth assessment of Father's parenting capacity and assessment within his own home environment*.

A similar lack of assessment is found when mothers form new relationships. In the same case, when facial bruising of the mother was identified during pregnancy this failed to trigger an assessment of her new partner to determine whether he presented any risk of harm to the unborn child.

It is notable that such lack of professional curiosity or interest in fathers and partners, not only potentially leaves women and children vulnerable, it can also leave fathers themselves feeling alienated, forgotten and their role in bringing up their children dismissed:

> *Father feels strongly that the system is weighted towards a positive view of mothers and that his voice was not heard in interactions with professionals*.

The difficulty in engaging with fathers is exacerbated when a personal history of social care makes them uncomfortable or fearful of childcare professionals. If there is a lack of support to enable men to get their voices heard, a comprehensive understanding of the child's life is not always possible. The father in the case quoted above had held significant information about the possible abuse of his daughter at the hands of her mother and current partner, '*including photos of bruises to P… on his mobile phone*'. He told the review that he had feared, at the time, sharing these with social workers because of his own personal experiences of the care system.

Studies have identified factors that can encourage fathers to become engaged with childcare services and enable them to get their voices heard (Berlyn, Wise & Soriano, 2008; Clapton, 2017; Philip, Clifton & Brandon, 2018). These include making services more male friendly such as rescheduling appointments and home visits to enable them to be present. Addressing communications to both parents recognises the role of men in families. When letters or messages are directed only to the mother, fathers can perceive that their input is irrelevant.

Summary points

The complicated and complex lives of many parents can leave them with negative experiences of statutory agencies; professionals have to be robust in addressing the strategies parents use to defend themselves and their family from scrutiny.

When childcare professionals ask questions about a child, parents can become extremely stressed; such questioning may be perceived as blame; and information may not be 'heard' and agreements not fully understood.

Disguised compliance continues to be an issue; however even when parents work cooperatively with practitioners this does not automatically result in improvements in parenting and children can continue to suffer neglect and abuse.

Fathers and partners can feel alienated and forgotten by childcare professionals; they need to be empowered and listened to when they raise concerns about a child.

Services need to find ways to become more male friendly if they are to encourage the involvement of men in the lives of their children.

3.4.3 The wider family – kinship care

In over two-thirds of the families included in the qualitative sample of SCRs, a relative had lived with or looked after at least one child.

In the majority of cases kinship care provides children with a good home environment, although for some (5-17%) the experience is not positive (Hunt, Waterhouse & Lutman, 2008). This study highlights the need for careful assessment of the parenting capacity of potential caring relatives and the support they may require to enable them to look after the children most effectively.

The commitment of close relatives was evident in a number of the reviews, but so also was the lack of assessment and, in some cases, the support needed. A girl of 12 years, whose mother died, was initially looked after by her 18-year-old half-brother with the support of her mother's sister:

> *J's aunt has stated that she visited the home regularly throughout the period of the mother's illness and after her death. Visiting at least three times per week and often daily. She also cared for J in her own home … at weekends and in school holidays.*

There was little recording of the support provided to the half-brother, particularly as it was known that he was '*experiencing a lot of problems (financially)'* and *'seemed quite depresse*d'.

When it became clear that J's half-brother could not meet his sister's needs she was placed with her aunt: '*J's Aunt sought help from services with these matters'.* Although referred to children's social care, no assessment was undertaken and no services provided. The Review noted:

> *The referral of J as a* child in need *with unstable care arrangements, recent loss and bereavement issues should have triggered an Initial Assessment.*

In another case, a grandmother looking after her four grandchildren, along with the school, '*made a referral to the Children and Families Service expressing concerns about the state of the family home and how the mother would cope after her discharge from hospital*'. In this case, their concerns were responded to, the home was cleaned up and the mother was supported. In other cases, however, professionals do not routinely talk to the grandparents when there are concerns about the child, or assess their parenting capacity*:*

> *Maternal grandparent was noted to be in the home but there is no record of a conversation with her as would have been best practice since she was a significant member of the household.*

When this happens the voice and perspective of a grandparent is lost. Also missing is the opportunity to explore the significance of the particular relationship between the grandparent and the child.

Grandparents may also play a role when mothers return to live with or are placed with their parents along with their newborn babies. In one such case of a baby born with neonatal abstinence syndrome, mother and baby went to live with her own parents and *'the family environment appeared to be stable'.* The mother's addiction continued and she went on to have two more children by the same father, who was also a heroin addict. It was noted in the review that both sets of grandparents supported the family '*specifically the maternal grandmother who undertook a number of caring duties for the children'.* However, there was nothing in the record to suggest their views about the children's welfare or safety were sought, a feature that was also observed in other reviews:

> *Although the maternal grandmother was seen by various professional staff on numerous occasions, she was never seen alone. Her views were not sought about the home conditions and the lives of her grandchildren, nor her contributions of support for the family.*

There was evidence in the reviews that the impact of relatives on children's welfare is not, however, always benign. In the following case, professionals appeared not to appreciate the extent to which the wider family continued to be a negative influence on the child's welfare:

> *There was insufficient appreciation of the abundant evidence that the birth family, across generations, was extremely dysfunctional and that continuing dependence or involvement would inevitably damage Child E.*

Having been placed away from home, the child's behaviour continued to be challenging and harmful, and running away from placements became frequent, often encouraged and facilitated by members of the birth family. The review noted '*the importance of preventing un-managed contact by parents (or unauthorised contact by the grandmother) was not sufficiently kept in mind across the years'.*

A scrutiny of the reviews indicates that professionals are generally unaware of the support provided by friends and neighbours to vulnerable children and families. When their involvement is known, little is recorded about what it entails or the extent to which childcare services are able to promote and support it.

3.4.4 Neighbourhood and community support

Neighbours are often well aware of the difficulties some families are experiencing and may keep a weather eye on the children. They may intervene directly by providing shelter and food to children shut out of the family home or report suspicions of abuse, neglect or abandonment. In many cases neighbours may not wish to be identified and the reports to the police or children's social care are anonymous. Whether the call is made anonymously or not, the reviews suggest that in some cases it does not result in any record of what action was taken. For example, in relation to a family well known to children's social care, an anonymous referrer reported a drug-fuelled house party where children were present and '*the mother's use of alcohol when caring for the baby*'. The response to this call was not recorded. In another case in which neighbours made numerous calls to both the police and children's social care reporting specific incidents of child neglect, the review findings highlighted that '*insufficient weight was given to concerns expressed by neighbours*'.

Mobilising community or voluntary services can provide both practical and emotional support to vulnerable children and families but their presence rarely features in the review reports. The potential supportive role of charities and other community resources is rarely referred to in the reviews.

The role and responsibility of housing services is also frequently absent. Although housing agencies may have valuable information about a family, they are not generally

seen as a safeguarding agency in children's plans and multi-agency meetings. The challenge of how best to involve them increases with the rise of private sector housing with no safeguarding point of contact. Despite the fact that many of the families are living in unstable and inadequate housing there is little mention of them in the reviews and when they are mentioned, their involvement does not result in decisive action. In one case of a lone mother with two children and a newborn baby, the social worker identified that the home was in a very poor state of repair and arranged for a property inspection. However, this failed to result in any meaningful action because the mother was not available for the pre-arranged property inspection and cancelled the next visit. There was no follow-up or any further action taken.

Summary points

Relatives and communities can help vulnerable families if given the necessary support and encouragement and should be considered as having the potential to be valuable partners in safeguarding children.

When children are cared for by relatives it is important to understand the relatives' experiences in order to provide appropriate support.

When children live with their mother or father and grandparents, or where grandparents or other relatives are frequently present in the home, in order to understand the child's lived experience, professionals should explore grandparents' perspectives on what is happening.

Where there has been a family history of abuse and neglect, grandparents and other relatives may not have a positive impact on children's lives. Careful assessment would ensure that contact is appropriate and children are kept safe.

Concerns reported by wider family, neighbours or anonymously should always be accurately recorded and taken seriously by those receiving the information. When nothing is seen to happen future concerns may not be reported. However, it is important to recognise that there is no opportunity to challenge the outcome of such referrals, unlike those from professionals. Consequently, these referrals should be scrutinised and triangulated with other sources of information.

3.5 Opportunities for preventive or protective intervention by statutory and other agencies

The issues identified earlier in this chapter include the impact of poverty on the lives of families and children, the complex and cumulative nature of vulnerability, risk and harm,

and the invisibility of some children and young people to the system. Effective protective practice requires an ability to contextualise the lives of vulnerable children, understand the experience and perspectives of their parents or carers and engage with them through meaningful interactions and relationships with the professionals that are involved in their lives. We consider below the implications of this for the ways in which those professionals are supported and empowered to provide effective child protection and safeguarding practice. One of the most crucial aspects of all safeguarding work, however, is to understand the lived experience of the child. Children of all ages need to be empowered to express their experiences, and make their voices heard, even when they are not able to verbalise their stories. How we can achieve this is explored in the topic study, enabling children to have a voice.

Topic study: Enabling children to have a voice

Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them and their families collaboratively when deciding how to support their needs. (HM Government, 2018b)

Empowering children to express their views and learning to listen to what children may be telling us about their experiences are crucially important issues in safeguarding practice. Whatever terminology is used, whether talking about the child's 'lived experience' or 'the voice of the child', the reality is that this is often a missing element in the cases that come to a serious case review:

> *There is no record as to whether Child M was seen and spoken to on these occasions and none of the incidents were referred to CSC… Child M was invisible...*

In this topic study, we explore the implications of enabling children to have a voice at different ages.

Recognising the needs of the unborn child

There are significant challenges for professionals in responding to the needs of an unborn baby: the unborn baby has no voice. In law, the unborn child has no rights, and yet, Working Together acknowledges that neglect '*may occur during pregnancy'* although limits this to maternal substance abuse (HM Government, 2018b, p.104).

In assessing the potential for harm to an unborn baby, practitioners need to take into account factors that may have a negative impact such as maternal physical and mental health, problematic use of drugs and/or alcohol, and physical violence directed at the expectant mother. These must be balanced by identifying protective factors such as good, regular ante-natal care, adequate nutrition, income support and housing, avoidance of smoking and severe stress, and social support for the expectant mother (Cleaver et al, 2011).

Balancing the risks and protective factors for the mother and her unborn child can be difficult. We found examples of absent or inadequate discharge planning, particularly where this planning was single agency and focused solely on the health needs of the baby, rather than considering the wider home and family services:

> *…when Child C was discharged from Hospital, the GP was only notified of the medical situation and no report of the social circumstances or vulnerabilities of the family. This resulted in agencies (either single or jointly) not being clear about the expected outcomes for the children or the parents.*

Even where concerns are identified prior to the birth, the possible impact on the unborn child may not be fully understood and if no action is taken to protect mother and baby both may be left vulnerable:

> *A consultant obstetrician who saw the mother at approximately 36 weeks discussed the previous domestic abuse and the current state of the relationship, and it was recorded that the ex-partner was now not in contact, and that her new partner was supportive. A week later the mother reported that she had had a 'fall/blackout' and had bruised her arm; she also disclosed that there were family arguments. This was followed up at the 38-week appointment when it was reported that the mother was tearful, 'doesn't feel like speaking to anyone' and is a 'bit snappy with her partner'. She expressed that she felt like hiding away. The midwife did not explore this further at these visits.*

Hearing the 'voice' of a baby and young child

When a family has been well known to children's services but are currently not receiving services, the care of the mother and baby is generally the responsibility of the health visiting service. Their role is to ensure that children have the best start in life by working with parents. An important aspect is the collaboration with other organisations to safeguard and protect children.

A number of cases within this triennial review found that health visitor assessments had a specific focus. Babies were weighed and measured and, in most cases health visitors observed the degree of bonding between mother and baby. Although health visitors will be aware of the many ways in which a dependent baby may communicate his or her lived experience, the pressures of unrealistic caseloads may leave health visitors insufficient time to observe, in any depth, the interaction between mother and baby or talk to siblings to gain a child's perspective.

There were instances where health visitors identified difficulties in the relationship and care of a small child, and made the relevant referrals, but over time the focus on the child's lived experience was lost:

> *…observations do not appear to have extended to critical reflection on what life was like for the children within the home and in relation to the parenting provided.*

When families are well known to a range of adult and children's services and there are high thresholds for intervention, the focus may become task orientated, or may shift to the needs of the parents. Professionals' attention can be distracted from the children and their voice is lost as indicated in the case study in section 3.3. The example below also illustrates the phenomenon.

Child B was born into a family with four children all with significant developmental delay, living in very poor and unhygienic conditions. The mother of the baby identified as male and the father identified as female. The issue dominating the majority of the meetings was their gender identities and each parent's wish to be appropriately addressed. The report noted that the voice of the child was missing:

> *In examining reports and records, and the comments from professionals, there is a marked absence of reference to the perspective and the daily lived experience of the children. The children through age and complex needs had difficulty with communicating. This creates an imperative to look closely and with healthy scepticism – and with clearly evidenced observations - at what the daily lived experience of the child might be in order to better understand their views and ensure their voice is heard.*

Enabling children of middle years to tell their story

Middle childhood is generally defined as the years between six and 11 or 12 years and is qualitatively different from either younger or older age groups. It is a period of important transformations, as children become more independent, self-aware and, as a result, more self-conscious.

Children in their middle years have the advantage, over the younger age group, of greater contact with different responsible adults as they enter school and interact with teachers, school nurses and others.

The child's voice when heard is not always understood or responded to appropriately. A girl of six years was part of a family with a multitude of challenges including domestic abuse, substance misuse, mental health problems, poverty and poor housing. While attending the medical practice with her mother, she told the doctor about her sexual abuse at the hands of a family member that had occurred 2 years previously:

> *The GP* (General Practitioner) *noted that Child M had recounted this 'slowly and clearly' and that Child M presented as "alert and happy" apart from when recollecting what had happened.*

The GP made a referral to children's social care but *'there was no assessment of Child M's emotional and developmental needs and there was no consideration toward the need of support or counseling despite the request from the GP'.* From the child's perspective, little changed regardless of what she had revealed to responsible adults.

School-based assessments by the school nurse can often enable children's voices to be heard, although this may not lead to any meaningful intervention. An eight-year-old

child and his younger siblings had previously been subject to a child protection plan and a short period in foster care. This child was observed by the school nurse:

> *…to be very tired and wearing a dirty ill-fitting school uniform; his face was unwashed and nose dirty. He reported the children were given biscuits or crisps with tea instead of an evening meal. He contrasted this with the proper cooked dinners (meat and pasta) whilst fostered.*

This resulted in a social worker being tasked with monitoring the children's evening meals. Once again the outcome was unclear and as the review identified:

> *How SW7 was to achieve her task is unclear and no evidence has been provided to confirm that she did so*.

In summary, the report noted '*Very few records capture the lived or day-to-day experiences of any of the children*'.

Empowering adolescents to tell their story

Adolescents may be particularly vulnerable through the impact of earlier neglect on their mental health, their behaviour, or their vulnerability to exploitation by others (Hicks & Stein, 2015). They may also remain vulnerable to ongoing neglect of their health needs, education, or supervision. Issues relating to suicide and self-harm in young people were explored extensively in our previous triennial review, along with vulnerability to child sexual exploitation (Sidebotham et al, 2016). Chapter 4 of this current triennial review explores adolescent vulnerabilities in more detail.

One example of neglect and subsequent suicide included in the reviews is that of an adolescent who took a fatal dose of opiates aged 15 years. Born with serious narcotic withdrawal symptoms into a family with a long history of substance misuse, sex work, alcohol-fuelled violence and domestic abuse, the harmful influence of the family shaped this child's life. Signs of distress and self-harm were first identified by a schoolteacher when the child was 12 years old. When asked about the cuts on her arms the teacher reported being told '*when I am feeling this pain, I am not feeling anything else'.* Examples of self-harm escalated to the extent that prior to the fatal overdose, 32 episodes had been recorded. Although all the professionals working with this child were aware of her extreme vulnerability, there was little recorded of what life was like for her or her perspective, views and wishes, in the SCR.

When police officers are called to incidents where young people have harmed themselves, although their key role is to seek urgent medical help for that young person, it is also important for them to think about the wider implications of safeguarding:

> *In this particular case, if the incidents of self-harming had been managed as safeguarding concerns there is greater likelihood that the police and children's services along with other professionals would have engaged in a strategy meeting that focussed on the nature of risk and supported a much clearer sharing of information.*

Listening and taking the views of children and young people seriously is essential, however practitioners have to balance the child's wishes with a responsibility to ensure his or her safety and welfare. This can be compromised when children's competency to make decisions is not based on an assessment that takes into account their life-experiences and vulnerabilities.

'Gillick competence' is a term used to decide whether a child is able to consent to his or her own medical treatment, without the need for parental consent (NSPCC, 2018). It helps practitioners to balance the need to listen to the child's wishes with the responsibility to keep them safe. In the case discussed earlier '*it emerged that Child E had informed the examining doctor they were 'sexually active' and had injected drugs and shared needles with their drug-using mother'.* The review noted that the girl, then aged twelve and a half years old had been judged 'Gillick-competent' and her wish that her adoptive mother should not be told, was accepted.

The balance of Gillick competency and the child's safety was also raised in another case where a 14-year-old girl died by suicide:

> *Overall, it was felt that undue weight was placed on J's 'Gillick competency' and that there were times when decisions needed to be made by someone who acted with parental responsibility (as a reasonable parent would) and, as a result, on occasions make decisions that did not concede to J's wishes.*

The difficulties in getting the balance right are also prominent in cases where a vulnerable child has reached the age of consent and child sexual exploitation is suspected. Child LA was 16 years old and very vulnerable. She had a long history of neglect, was thought to have a learning disability and during the last year of her life, made and retracted allegations of sexual molestation. She had numerous 'missing from home' episodes and when found by the police, was in circumstances where child sexual exploitation (CSE) was known or suspected. In this case cursory attention was given to exploring the child's emotional world and the reasons behind why she went missing. Going missing is explored in Chapter 4.

To understand the emotional world of a child requires a holistic approach which takes account not only of the here and now, but also his or her past experiences. Often, the SCRs revealed a focus on individual incidents, for example of self-harm, violence or

going missing, and the underlying causes and the lived experience of the child is not explored.

Learning Points

Recognising that the unborn child does not have a voice, practitioners need to be particularly alert to when the circumstances of a pregnant mother may be putting that baby at risk, and consider how best to safeguard the mother and the baby both prior to and following delivery.

Pre-birth child protection conferences and other multi-agency meetings, along with inter-agency discharge-planning meetings can help to ensure a positive transfer to home and subsequent safe and effective care of a vulnerable baby**.**

Health visitors play a significant role in the lives of babies and young children and are in a good position to help ensure the focus is kept on the child, particularly when parents have complicated and complex lives which may come to dominate professional intervention.

Teachers spend considerable time with school-aged children and the development of a trusting relationship enables children to talk about what is happening to them. School staff are well placed to notice a child's distress and any worrying behavioural changes.

Particular attention should be paid to those children who, through communication or learning difficulties, or their home circumstances, may find it particularly difficult to express their experiences.

Professionals working with adolescents who have a long history of disturbing and disturbed behaviour may become reactive rather than proactive. When children self-harm or disclose suicidal ideation professionals may focus on each individual incident, a holistic perspective helps to understand better the underlying causes.

3.5.1 Supporting consistent, relationship-based work with families

A recurring theme among reviews that identify good practice is that of the quality of relationships with families. This can be regarded as the primary vehicle for protective practice when it is based on a sound grasp of the family context, circumstances, and roles and relationships as an effective way of managing the complexity of compound and cumulative risk over time.

The last triennial review (Sidebotham et al, 2016) outlined the importance of moving from episodic, incident-based intervention to extended models of support which are characterised by long-term planning and a cumulative perspective on safeguarding

needs. This includes an historical understanding of family patterns of service use and the subsequent implications for the ways in which services should seek engagement.

As an example of good relationship-based protective practice, the following review described the return of a young mother after her child's birth to a home situation characterised by multiple and persistent safeguarding concerns. A community midwife provided lead intervention in the context of relationship-based support to the mother:

> *Following her discharge home after nearly three weeks in hospital, the community midwife went out of her way to see the mother at home for her appointments (most appointments are held at GP surgery or hospital). She was very sensitive to the needs of the mother for support but also involved in child protection processes, working closely with the social workers to address the safeguarding concerns. She saw child S on several occasions after her birth and had no specific concerns about her health and wellbeing during this four weeks period. The IMR author commends the community midwife for her exceptional care of the mother, alongside her alertness to child protection concerns, including her potentially lifesaving action to ensure that the mother received urgent medical treatment.*

This review also recognises the need to support the community midwife in providing this level of intervention, met in this case by the safeguarding midwife who '*persistently monitored the actions in relation to this family'.*

While there are such examples of good relational practice, many cases in the sample showed poor outcomes resulting from the failure to find meaningful mechanisms for engagement:

> *The mother appeared to try and control different relationships with the professionals involved with her and her family. A range of factors including: experience of seeking help in the past which will influence the present, trust and attachment, experience of authority, any cultural racism/ discrimination or something to hide will all have an influence on how a family or individual will engage. The influence of other adults who are 'behind the scenes' including 'shadowy males' must also be considered. With the benefit of hindsight what might have been perceived by professionals as disguised compliance or non-engagement at the beginning; it is now evident that the mother and her extended family were giving false information and on occasions lying directly or failing to pass on information in the best interests of the child(ren).*

Changes in staffing and the re-allocation of cases continue to be an inevitable feature of services working with families and it is important that the impact of these on individuals and relationships is recognised. The achievement of a positive, consistent relationship can result in increased protection for a child and for some parents the relationship with

their key worker may represent the most significant and supportive relationship in their lives. In the following example a young, socially-isolated mother described to the reviewer how she had experienced the re-allocation of her case to a more experienced male worker:

> *A more experienced male social worker (SW2) was allocated to the case to oversee the care proceedings. In an interview by the lead reviewers with M, she reflected that the change of social worker was a significant loss to her as she had a strong relationship with her female social worker. Although she did also acknowledge that the new social worker had tried exceptionally hard to support her. A learning point that may be worth exploring more is how much the gender of the social worker, or impact of a change of social worker is taken into account in supervision when working with vulnerable young mothers who find building trusting relationships very hard.*

While recognising the benefits that relationship-based working can bring, child protection systems and procedures also need to ensure that close or long-term working with families does not result in a loss of focus on the outcomes of intervention and drift.

In particular, cases describe issues arising from over-familiarity or over-optimism. In a case illustrative of the tensions that arise for professionals in long-term work, a drug treatment service offered stability and continuous support to a family but, overly encouraged by small improvements in a mother's management of drugs, professionals failed to recognise other risks and understand the experience of the child:

> *There was limited challenge to the mother to change her lifestyle, and her ongoing engagement with a drug treatment programme (Methadone) was seen as a positive. This resulted in professionals being over optimistic. It did not necessarily mean that the children were safe…There was not enough challenge for non-attendance at medical appointments or robust follow up of missed appointments. These are consistent features in cases on long-term neglect.*

3.5.2 Supporting purposeful intervention

Persistent and recurring themes relating to case management in the sample include: the recognition and identification of risk; the use of risk assessment and planning to provide a structured framework for intervening to protect children; and the provision of appropriate oversight to ensure that assessments and plans are purposeful and outcomes-focussed.

Previous national reviews have raised the challenges of recognising risk, particularly in complex cases of neglect where immediate concerns in relation to household, environment and the presenting needs of parents can obscure the lived experience and reality for children over the longer term (Brandon et al, 2012; Sidebotham et al, 2016). These themes once again proliferate in the cases reviewed here:

> *Risk factors are cumulative – the presence of more than one increases the likelihood that the problems experienced and the impact on the (unborn) child and parent will be more serious. What is difficult to determine is whether the professionals working with this family were identifying the risks or understanding the significance of them or recording the information given with little if any analysis being carried out.*

Evidencing neglect is difficult and often requires the piecing together of a picture of family life from the perspectives of different professionals. Very often indicators are based on issues concerned with the home environment and perceptions of these conditions and their acceptability are subjective. They can also vary across the different agencies involved, creating conflicting accounts, a confused picture of the household context and subsequent barriers to effective information sharing:

> *Varying views of home conditions – sometimes clean and tidy whilst at other times reported there was no furniture, poor conditions, no heating and children sleeping in one bed and curtains drawn all day and rooms were dark.*

The reviews provide many examples of unfocussed interventions across the range of agencies engaged in child protection practice resulting in ineffectual practice and drift. Even where neglect has been evidenced there can be a tendency to respond to the indicators with practical support in improving conditions rather than a focus on the longer-term presenting needs of children. Sometimes even intensive and 'busy' support can 'miss the point', responding to incidents on an individual basis rather than attempting to analyse and address the underlying and endemic causes of neglect or identify and build on a family's strengths and resources:

> *In this case professionals highlighted quickly the neglectful conditions that the child and her siblings were experiencing. The intervention of the Family Pathfinder Team provided early support to a family with a clear history of involvement with Children's Services and other agencies. The support provided to the family was intensive yet all too often the incidents reported to them resulted in a focus on the practical needs of the parents and their need to engage with service providers, to the detriment of the harm being experienced by the children.*

Several reviews identify an over-reliance on physical presentation in the evaluation of risks and support, and professional anxieties can understandably be raised by encountering poor or filthy living conditions. However, in several of the cases reviewed, a decision not to act was based on a temporary improvement in the home environment which acted to ameliorate professional concerns and resulting in undue optimism, complacency and drift.

Reviews also point to the reluctance professionals can feel in naming neglect and challenging parents/carers on what could be interpreted as a subjective, value-based assessment, thus provoking further barriers to engagement. This underlines the importance of a multi-agency approach to assessing and identifying neglect through which views and perspectives can be shown to be robustly triangulated.

3.5.3 Identifying, assessing and managing risk

For all these reasons risk assessment is essential in identifying opportunities to protect children. Several reviews describe circumstances where early help assessments would have generated such opportunities much earlier on in the history of engagement with a family:

> *Early help assessments and services can play an important role in identifying what help the child and family require to prevent needs escalating to a point where intervention would be needed via a statutory assessment. The definition of neglect set out in statutory guidance clearly states that neglect includes a failure to meet a child's basic physical needs (including the provision of adequate food) as well as neglect of emotional needs. In this case the main concerns over time related to whether Child J's physical and emotional needs were being met and the lack of a formal early help assessment meant that the potential for identifying neglect was lost…Child J was not identified at any stage as a child who may benefit from an early help assessment due to their physical and emotional needs not being met.*

This case also brings to light the importance of capturing and recording low-level concerns over a period of time (in this case for a pre-school) in order to be able to demonstrate the potential for an early help assessment. This learning has been responded to by putting a system in place for recording issues that come to light on a day-to-day basis. Identifying and prioritising risk is an important component of effective risk management and can help in developing appropriate multi-agency plans:

> *At the learning event, during the discussion on the coordination of parallel plans, the phrase 'hierarchy of risk' was used by one of the third sector agencies. This is a very useful concept and the process of professionals identifying what the risk factors are, prioritising them, and allocating 'risk managers' is a good way forward. The nature of the risk helps identify the agency best placed to coordinate activity and secure clarity of purpose. This should not detract from the statutory responsibility placed on agencies in relation to specific roles in relation to child protection plans or the management of offenders.*

The recognition and naming of neglect is an issue for all practitioners, as highlighted in the section above. In our review of these cases, particular issues came out in relation to the role of the police in recognising and responding to neglect. Frontline police officers

will, on a regular basis, attend incidents where they come into contact with children who are suffering neglect:

> *Later that same day police responded to Address 1 following an anonymous call expressing concern for the safety of the three children. It was suggested that the house was full of "drug users". Police attended the address and saw mother and all three children alone. Police officers attending described the home conditions as poor.*
>
> *On February 2016, the police visited the family home on an unrelated matter. This visit prompted police officers to contact children's social care to raise their concerns about the poor state of the house and the potential impact on the children living there. This was good practice. The police were advised that the family had an allocated social worker and therefore did not generate a non-crime number and record details on the system. However, this would be the expected practice*.

These issues extend to work with adolescents. Police and partner agencies need to understand that adolescents who may be perceived as putting themselves at risk of harm, are vulnerable from neglect:

> *There is insufficient understanding of adolescent neglect across the multi-agency network and the link with complex adolescent behaviour leaving young people at risk of harm.*

The Ofsted led Joint Targeted Area Inspection (JTAI) in July 2018 published a thematic report, *Growing up neglected: a multi-agency response to older children* (Ofsted, 2018a). The inspections reviewed practice in children's social care, education, health services, the police, youth offending services and probation services and highlighted specific learning for police in relation to their work with adolescents:

> *Despite a clear determination by police leaders that officers should routinely identify children who are vulnerable, police officers were not consistently identifying older children as potentially vulnerable to neglect or abuse. Often, police officers focused on other complex factors such as drug offences and anti-social behaviour. Quantitative police performance information drives leaders and officers to concentrate on the quantity of child protection incidents as opposed to the nature and quality of decision-making. This does not then encourage police officers to think more deeply about the vulnerability of the older children they come into contact with* (Ofsted, 2018a, p.14).
>
> *In too many cases, police officers were dealing with incidents involving children in isolation, without considering previous incidents or the wider context of risk and vulnerability including evidence of cumulative neglect* (Ofsted, 2018a, p.14).

We also found in the reviews that some frontline police officers and youth offending team staff saw older children who are being neglected simply as perpetrators of offences. As such, they did not always use their professional curiosity to look further than the immediate incident or presenting issues and consider the child's needs in the context of neglect. Children's offending behaviour needs to be addressed but also understood in the context of their experience of neglect.

3.5.4 Anticipation and identifying spiralling risk

A common feature in these cases of neglect is a period of low-level underlying concerns followed by a sudden escalation in risk. This could be in response to unexpected life events or a change of circumstances within a family that goes on to trigger a series of events that swiftly become unpredictable, as the case study illustrates. The author of this SCR concluded that:

> *During S's short life the number of risk factors within the family increased dramatically, unfortunately the professionals working with the family either failed to recognise the significance of the risks or analyse the potential impact that these risks might have on the parents' ability to care for S.*

Case study: Neglect and spiralling risk

Sam's mother ended her relationship with the father early in pregnancy, due to mental health, substance misuse and domestic abuse issues. She then began a relationship with a new partner. Shortly after the birth of Sam, the mother, step-father and baby re-located near to the stepfather's extended family.

Mother expressed 'low mood' during the antenatal period which continued after the birth. The stepfather worked away from home for two weeks at a time. Mother felt lonely and isolated in a new area where she didn't know anyone and felt her partner's family to be critical and unsupportive. Professionals were unaware that stepfather was not the father of the child. Questions asked by the health visitor at the six-week assessment pointed to post-natal depression.

During the first six months of Sam's life the number of risk factors within the family increased dramatically: the stepfather experienced an unexpected and traumatic bereavement; the emotional and mental well-being of both mother and step-father deteriorated; both were prescribed anti-depressants, the step-father lost his job and started to go out drinking during the day and reportedly using cannabis. The mother found it difficult to support him due to her own bereavement issues.

At six months old Sam was presented at the GP with a five-day history of vomiting and a floppy episode. Three weeks later he suffered a non-accidental brain injury that left him with severe and irreversible brain damage.

Key points:

Rather than concentrating just on the 'here and now', the implementation of multi-agency pre-birth planning guidance should ensure a good assessment including family history, relationships and roles within the family, and known risk factors, concluding in a strong plan and appropriate level of intervention.

Risk factors are cumulative - the presence of more than one increases the likelihood that the problems experienced and the impact on the (unborn) child and parent will be more serious. Professionals must consider the significance of spiralling risks and analyse the potential impact they might have on the parents' ability to care.

During the antenatal and postnatal period there is still a culture among professionals that the primary focus is on the needs and circumstances of mothers. This needs to be addressed so that father figures are included and that the contribution they make, the stress they experience and the risks they present are properly understood and addressed.

A striking feature in several of these cases, particularly where pre-birth planning has taken place, is a failure to anticipate risks to children even when family history might suggest that these are present. An understanding of cumulative risk would also enable professionals to better anticipate and create opportunities for protecting children:

> *Remind staff about the importance of history, the past may be a significant pointer of the future.*

One approach to comprehending cumulative risks and exercising anticipation is the more effective use of case chronologies, both in order to inform the individual practitioner's planning but most importantly in reaching a more comprehensive picture of life for the child through cross-agency chronologies:

> *The use of a chronology identifying missed appointments and untruths should have formed part of the historical information available to professionals working with the family so they could triangulate such information and at least catalogue the extent and nature of the "non-compliance". While this historical information should not determine current thinking it should have significant impact on decision making.*
>
> *The overview reviewers found there was a tendency to focus on "the concern of the moment" rather than seeing the whole picture. There was an inadequate use of chronologies which, had they been used, may have aided in an earlier identification of problems in this case.*

Summary points

The quality of relationships with families is the primary vehicle for protective practice when it is rooted in a sound grasp of family context and roles and relationships, as an effective way of managing the complexity of compound and cumulative risk over time.

While changes of staff and the re-allocation of cases continue to be a reality, especially within constrained resources, it is important that the impact of these changes on families and individuals is recognised and planned for.

Professionals can feel reluctant to name neglect especially where they feel this could present barriers to engagement. This points to the importance of a multi-agency approach to identification and assessment through which differing views and perspectives can be robustly triangulated.

When confronted with adolescents who engage in risky behaviour, practitioners need to look beyond the immediate issues to consider how the young people might be vulnerable from neglect rather than simply seeing them as putting themselves at risk.

The use of chronologies, particularly combined chronologies, can enable practitioners to see beyond the immediate presenting concerns to develop a picture of the child's life and of how circumstances may combine to increase the risks to the child.

3.6 The multi-agency workforce

> *It is well known that neglectful parenting is almost inevitably a sign of complex and longstanding problems such as mental ill health, domestic abuse, a poor physical environment or entrenched behaviour by a parent or parents. The understanding of neglect is a partnership requirement and must not just be the responsibility of children's social care. In this SCR the initial assessment carried out by children's services had focused on the issue of housing and did not fully explore the chaotic and poor engagement in a wider context and assess the parenting capacity of the mother in a meaningful way. The absence of information about the father was a feature throughout. Different information was held by the agencies attempting to work and support the mother and was not pulled together.*

This case is typical of many of those in the sample where failures in putting together the picture of neglect across the agencies involved resulted in lost opportunities to protect children. The level of communication required between agencies to deal with the complexity of neglect cannot just be left to chance or to individuals within services but must be embedded into systems so that it is integral to practice. This section explores

how and why these failings appear at a systems level, provides some examples of good practice and ways in which local recommendations or emerging developments aim to address them.

3.6.1 Silo working within agencies

The issue of silo-working has been highlighted in our previous national analyses and is a common finding within SCRs. Where an agency is made up of different front-line organisations or different teams within the same organisation, this silo-working may occur within as well as between agencies. This was specifically seen in the current analysis in relation to the police.

In order to combat the effects of austerity and in some cases to improve the spread of those officers that are able to be involved in specialist child protection investigations, a number of police forces have moved away from having specialist child protection investigation teams. This has had a knock-on effect on the quality of safeguarding work:

> *The changes have made it harder to ensure good relationships between social workers and police officers, quality joint child protection work, and the meaningful involvement of children's social care professionals in what may be seen as a police task. The police accept that just 6 months into the redesign there were issues, but that the investment in mainstream CID will lead to a better service as more officers are trained in child protection and gain more experience.*

In other areas however, the police service is made up of different teams, for example, uniformed frontline police officers and specialist child protection investigators. This breakdown of specialisms can cause problems in safeguarding children and young people. In particular, partners may not understand the difference in knowledge of training between the different specialisms. The police officers themselves also may not know what is exactly required of them in relation to partnership working. The following extracts demonstrate this point:

> A *feature of the multi-agency system relates to the strong understanding of child safeguarding within the police safeguarding investigation team, which is not always reflected in partnership working with police officers outside of this specialism. Hence, for example, they are not used to attending child protection conferences and do not know exactly what information can and cannot be shared.*

> *…the GP contacted the police to report the allegation of sexual abuse and was advised to inform children's social care. The call handler recorded this call on 'ENotes', noting that the Public Protection Unit were aware. However, there is no record in PPU, which raises the question as to whether the PPU was notified, but it was not recorded, or the PPU was not notified.*

3.6.2 Enabling effective multi-agency working

Examples that show effective multi-agency working within these cases emphasise good overall co-ordination and coherence around a central, purposeful plan which keeps the safeguarding of children as its primary focus:

> *There were some very good examples of inter-agency communication, cooperation and coordination. The hospital allowed the mother and baby to remain there for a few days while court hearings took place; the police and social workers generally collaborated well together. There was a huge level of coordinated support to the mother and children from August 2015, with a clear focus on safeguarding the children. All staff involved with the family were committed to doing their best for the children…There was a core group of professionals collaborating proactively to safeguard her and oversee the written agreement in place through the care proceedings.*

One of the key elements in achieving adherence to a central plan, be that a child protection plan, a child in need plan, or any kind of safety plan, is a clear understanding of the role of individual agencies in its delivery:

> *In these circumstances the impact on the children and their lived experience within the family was not always addressed. This was in part due to a lack of understanding between professionals about roles and responsibilities.*

Effective multi-agency plans – whether at a child in need or a child protection level – are dependent on all the relevant agencies being represented at meetings. There were repeated examples where key professionals, particularly those offering specialist interventions, were not present or not invited:

> *The child protection conference plan, in relation to achieving a change in behaviour around the substance misuse by Child R's mother, was insufficiently robust. Substance misuse services were not invited to be active participants in the child protection conference process, and there was, therefore, no expert input to the child protection plan in respect of the substance misuse concern.*

One important vehicle for framing decision-making between partner agencies and in determining whether thresholds have been met for a child protection enquiry under section 47 is the strategy discussion. These also determine the roles of the key statutory agencies in such an enquiry. They can be undertaken as telephone meetings or face-to-face, dependent on the nature and urgency of a situation. Too frequently, examples are described where strategy discussions failed to involve all the key agencies – namely the police, children's social care, any relevant health agencies and other significant professionals involved with the family:

It is also important to note that the review was told that problems with the strategy discussion process extend beyond this specific case. At the first discussion in 2013, no health professional was involved and this has historically been a problem. Cafcass have also told the review that they are frequently not involved in strategy discussions where they have had (or currently have) extensive involvement and could share useful information. The Safeguarding Children Board will wish to be reassured that the system for managing the strategy discussion process is currently effective.

One review in particular highlighted the practice of preceding a strategy discussion with an initial telephone call between children's social care and police and cautions that this can act to exclude multi-agency involvement in investigation and assessment. This has now been addressed by introducing telephone conferencing to ensure that all agencies are invited to and are able to participate in strategy discussions.

Topic study: Multi-agency working between police and other agencies

As one of the three key 'safeguarding partners', the police play a crucial role in multi-agency working to protect children from harm. At times however, in these reviews, police investigations appeared to run in parallel with other agencies' efforts to protect children, rather than being seen as an integral part of the process. This was perhaps particularly so in cases of neglect, where if immediate risks to the child were not recognised, or if the information held seemed insufficient to pursue a criminal investigation, police officers tended to take a back-seat role. In our review of the neglect cases, we identified issues around information sharing between police and other agencies; police engagement in strategy meetings and understanding by other professionals of the role of the police and powers available to them.

Information sharing

It was clear in many of the SCRs that the police held significant information about parents, carers or other family members. Where no system exists for checking with the police to identify whether parents or carers are known or have a criminal record this can lead to gaps in assessing potential risks to the child.

In order to facilitate effective sharing of information, police must be involved at all stages of an investigation, from initial inquiries through multi-agency safeguarding hubs or other intake processes, through strategy meetings, and child protection conferences, and subsequently in follow up on cases where children are subject to child protection or child in need plans. This is an issue that is explored further in the VKPP briefing (Allnock, 2019).

As in previous studies of SCRs one of the key recurring issues was the lack of safeguarding referrals by police following attendance at incidents, particularly those involving domestic abuse:

> *Police responded to seven separate 'domestic abuse incidents' during the 14 months prior to the death of Baby J. On each occasion, the attending officers completed a risk assessment based on that specific incident, some of which were recorded as a 'verbal argument' between the adults. Only one of the domestic abuse incidents (March 2014) was shared with CSC prior to the death of Baby J; however, CSC have no record of this incident.*
>
> *Officers did not recognise that while Child N was not at immediate risk of serious harm, the combination of circumstances of which they were aware would have merited a referral to children's social care. There were procedures in respect of information-sharing which could have guided the officers' actions had they recognised the need to refer to them, but they did not.*

Strategy discussions

The importance of police presence at strategy meetings was emphasised in one SCR relating to a vulnerable adolescent:

> *The police were invited to the strategy meeting but they decided as there were no current concerns that a crime had been committed, they would not need to attend, but would provide full information about the backgrounds of mother, her current and former partners. The nature of strategy meetings is that they are intended to explore whether there is a risk of significant harm to a child or young person and what action is needed to address it. This will mean that the need for police attendance may only become apparent during the meeting itself.*

The risk to children and young people is not only from parents and carers with criminal convictions or activity but also from other carers or relatives who have criminal convictions. However, when the police do not perceive that the criminal activity is related to child protection, sharing the information may not happen. Likewise, where offences relate to children in another force area, or within previous relationships, the risk to children in the current relationship may not be considered. There is clear learning in relation to mothers with new partners who have previous convictions even when they involve violence to someone else.

There are particular issues in relation to obtaining information on immigrants to this country, which were highlighted in two cases. There is in place a facility to check criminal convictions through the National Police Chiefs' Council criminal records office (ACRO). The International Portfolio part of ACRO supports the UK Central Authority for the Exchange of Criminal Records, which obtains, on behalf of police forces and public protection agencies, criminal conviction data from European countries and outside the UK.

Emergency protection and police powers of protection

The qualitative analysis of the SCRs reveals in a few cases that there is still confusion among both police officers and social workers in the powers conferred by police protection, and also a general lack of knowledge of emergency protection orders:

> *EDT SW3 had real concerns for the welfare of the children, and contacted Durham Constabulary to seek the attendance of a Police Officer who could enact a Police Protection Order so that the children could be removed to a place of safety. Several calls were made to the Police. The content of those calls is subject of inter-agency disparity.*
>
> *The local authority decided to initiate care proceedings and to seek an interim care order. The police, however, did not agree with the local authority's*

approach and were concerned that, since police protection had lapsed, there was 'no order in place to protect the child now'. The local authority advised that, in the circumstances, there would be no grounds for an emergency order: parents were cooperative and had indicated their willingness to adhere to 'a letter of expectation'.

Police protection refers to the powers of individual police forces to intervene to safeguard children. These powers are governed by section 46 of the Children Act 1989. Under this law, the police have the power to remove children to a safe location for up to 72 hours to protect them from "significant harm". An emergency protection order is one granted by the family court for up to a maximum of 8 days but can be extended for a further seven days. The order grants the applicant (normally the local authority) parental responsibility but only so far as taking such action is reasonably required to safeguard the welfare of the child.

Achieving Best Evidence

The police are the lead agency for any criminal investigation. They should be informed immediately whenever there is a suspicion of a crime, to ensure that the evidence is properly secured and that any further interviews with family members and other relevant people accord with the requirements of *Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses and Using Special Measures* (Ministry of Justice, 2011). The analysis of the SCRs showed in a number of cases that this guidance is not being fully adhered to and is often being treated as a single agency activity and not a joint one. This may reflect a deeper tension between police and social care about who leads these discussions and about whether the interviews are designed to enable children to talk about what has happened (the social care perspective) versus the need to adduce evidence designed to secure a prosecution (police view):

From the meetings with practitioners, it is apparent that generally the guidance in this protocol is not impacting on practice and that interviewing of child witnesses is more often a single agency activity by the police.

The police and children's services need to ensure that both agencies are aware of their respective responsibilities under Achieving Best Evidence Guidelines and that this case is not symptomatic of wider difficulties.

There is a need for a step change in ensuring that ABE interviews are a joint agency activity. In order to do this effectively there needs to be an increase in the number of police officers and social workers trained in ABE:

> *The detective sergeant who was on duty… stated she does not have enough staff who are trained and experienced in child protection and in undertaking ABE interviews at any time, particularly on bank holidays… The officers however did not question what had been agreed prior to their involvement and they were not aware that there had not been a strategy discussion and that the expectation was that they would request one of children's social care emergency duty team social worker when they arrived at the interview suite. This might be due to a misunderstanding, inexperience, or a lack of understanding of procedures.*

The SCRs also highlight that better use of intermediaries is required in child protection cases (intermediaries work within the justice system to enable vulnerable victims, witnesses, suspects and defendants to give complete, coherent and accurate evidence to police and to courts):

> *…the police officer said he was concerned that he was in danger of the questions becoming leading in order to establish the alleged victim's statement. Given that this child had significant communication difficulties and cognitive delay, a better outcome could possibly been achieved if an intermediary had been used... For children with additional needs, the use of skilled intermediaries should always be given consideration.*

Learning Points

A parental history of criminal activity, including previous criminal convictions, is a risk factor for both neglect and abuse. It is essential that in all cases of suspected maltreatment, information is sought from the police about any records held. This extends to parents, carers and other family members or close contacts.

It is particularly important for police to check information that may be held in relation to previous relationships or in other areas, including checking intelligence from other countries where the parents or carers are immigrants to the UK.

The involvement of police in strategy meetings and child protection conferences extends beyond merely providing information to active engagement in evaluating risks and effective planning.

Clarity over the appropriate use and limits of both police powers of protection and emergency protection orders could help to ensure more streamlined interventions, particularly in situations where there may be very immediate risks to a child.

Investigative interviewing under the auspices of Achieving Best Evidence needs to be treated as a joint agency activity, combining purposes of securing evidence and helping children to talk about their experiences. The use of intermediaries can be

particularly helpful when working with children with intellectual or communication difficulties.

3.6.3 Effective information sharing

Working Together guidance consistently emphasises the importance of effective information sharing between local agencies and professionals, and the responsibilities of all services to inform CSC specifically if there are concerns that a child is at risk and this issue is routinely considered through the case review process. Some cases usefully demonstrate how good, effective information sharing practice helps to consolidate multi-agency working:

> *Following the allegation that was made in respect of Sibling A there was evidence of the effective sharing of information as part of the section 47 investigation and the undertaking of the Child and Family Assessment. Agencies at the Learning Event stated that they felt there was good sharing of information and a commitment to multi-agency working. The attendance at strategy meetings and the Initial and Review Child Protection Conferences was good and minutes and notes were usually shared quite soon after meetings had taken place. Similarly, there was generally good representation at the Core Group.*

We have commented above on the reluctance, among some practitioners, to effectively name or describe both poverty and neglect. The language we use can paint a vivid picture of the context and risks of child neglect and abuse when making a request for protective interventions. Conversely the use of stock, jargonised phrases can dilute or obscure concerns. The following example highlights how pertinent this can be in cases of neglect:

> *Ambulance staff made a good referral, using descriptive language that conjures a picture of the environment P was living in, the school also made a referral that conjured up a similar picture of the environment. However, when the home environment is described within carers assessments or within meetings the language used dilutes the level of concern for the reader. An example of this would be the Ambulance Crew described the home as 'unsanitary with a foul smell and a fire hazard' whilst the minutes of the section 47 strategy meeting state 'poor home conditions'.*

It follows that referral forms, assessment tools and incident-logging tools should all encourage the use of language that properly and explicitly depicts issues in ways that do not dilute impact and harm, or the reality of life for the child.

Some services may be less familiar with passing on information than leading statutory agencies. They may be unclear about what information should be shared and when. Although it is the responsibility of these agencies to understand their role in safeguarding children, statutory agencies might also be more creative in eliciting information other than through formal, documented channels:

> *It is of concern that the pre-school manager told this review that they would be reluctant to put anything negative in writing that may be shared with a parent. The inappropriateness of this stance is a lesson for the pre-school but organisations asking for information from settings that may be less familiar with their system should bear in mind how the request may be received. A conversation between Cafcass and the pre-school may have elicited better quality information.*

> *Although the borough had determined that the family did not meet the threshold for statutory intervention it could be argued that the mother and the Child's sibling were vulnerable given that housing had been and was now an ongoing risk. Key learning from this is that consideration should be given to implementing an information sharing agreement between Housing and CSC when tenancies are cancelled and there are young children in the household.*

Effective information sharing is one of the most basic tenets of good child protection practice and is one of those lessons that is '*so important that* [it must] *be re-emphasised and potentially relearnt as people, organisations and cultures change'* (Sidebotham, 2012, p.190).

3.6.4 Fractured perspectives

The issue of fractured or partial perspectives of the context for the child is prolific within the sample, ties in with the issues around effective information sharing, and also emphasises the importance of both collating and reflecting on the information held by different professionals and agencies:

> *Despite this information being shared with the professionals that the family was in contact with not all of them had the complete picture. For example, the nurse practitioner was unaware that Sam's mother's partner was the stepfather and the GP treating the stepfather for depression was unaware that he was in a relationship with the mother of a young baby. There was no evidence of any consideration by the professionals given to how these risks may impact on the parents' ability to meet the needs of Sam, who had identified health needs of his own and his weight gain was faltering.*

It is inevitable in such a complex service landscape, when multiple agencies are involved with a family at one time, that this holds significant challenge. For this reason solutions

need to be identified at systems level as far as possible. This can involve building flags and triggers into IT systems or ensuring that regular information sharing meetings are embedded and made an integral feature of daily or weekly practice:

> *Information shared by the mother with the nurse practitioner was not shared within the practice, nor was it shared with the health visiting team. This was a missed opportunity for staff working in Primary Care to consider and share the information about the family, had this happened then the GP treating the stepfather would have been aware that there was a baby living in the household.*

These issues again highlight the value of cross-service chronologies and the need for these to be routinely undertaken when multiple agencies are endeavouring to address different support needs and risks over a period of time:

> *There are no flagging systems in health services for children for whom there have been previous safeguarding concerns or where other children in the family are looked after. For example, there is no chronology of D's family history on the community nursing records, the GP was not aware of any previous safeguarding concerns having not received her records and D's college also had no access to any records about D's family history.*

Summary Points

Fragmentation of services, with different front-line providers within the same agency, can lead to silo-working within as well as between agencies. In such situations it is even more important to have a clear understanding of the roles and responsibilities of different organisations, and clear pathways for information sharing and shared working.

Clear multi-agency plans at both child in need and child protection levels are central to effective working. This requires all relevant professionals (including those from specialist agencies and third sector organisations) to be involved in drawing up these plans, and a continued focus on the needs of the child(ren) as central to any plan.

The language we use to talk about children's circumstances can both support and hinder effective safeguarding. Vague, stock phrases and jargon can minimise or obscure the reality of children's lives. The use of clear, straightforward language that properly and explicitly depicts issues in ways that do not dilute impact and harm, or the reality of life for the child can lead to more effective safeguarding.

3.7 Systems and processes that may support such interventions

The Working Together Guidance available at the time (HM Government, 2013a), is reflected in the variety of methodologies used in these reviews which demonstrate increased focus on systems learning, both in the nature of the recommendations made, but also in providing evidence of change occurring in the wake of local reviews. Challenges arising specifically from the identification of neglect (as opposed to other forms of harm) across agencies recur throughout the sample. There is also recognition that, consistent with advice from Ofsted (2014), the strongest responses are framed within local neglect strategies. Examples below include the emergence of local policy, developing service structures, new protocols or joint working agreements that have been introduced in light of SCR or thematic review learning.

An incident-based approach to child protection and the identification of neglect has served children and adolescents poorly (Sidebotham et al, 2016). When each involvement with a family is treated as a discrete event, information is not accumulated or may be lost over time resulting in professionals failing to develop a comprehensive understanding of the child's life experiences (Bromfield, Gillingham & Higgins, 2007).

In a majority of cases incidents were seen and dealt with in isolation resulting in fragmented perspectives. This can be exacerbated when practitioners are operating in challenging circumstances, such as with high caseloads and unfilled vacancies. A different practitioner may see families at each visit. A family of four children with a long history of involvement with children's services in relation to neglect had seven different health visitors. Poor communication and a failure to read the observations of previous workers *'resulted in an inconsistency of approach to address home condition*s'.

Good quality record keeping and communication of relevant issues and incidents with other agencies will provide a clearer picture of all the significant aspects in a child's life and help identify patterns of events, concerns, strengths and unmet needs. When this does not occur, identifying the link between past and current concerns can be missed and result in practitioners failing to understand the long-term impact of neglect on children's lives.

A further issue identified in the reviews, which may hamper professionals' understanding the cumulative harm children are exposed to, is when families move from one borough or local authority to another. When children's social services close a case they may not be aware when a family moves out of their jurisdiction and even if they did, it would not be appropriate to make a referral. However, without this knowledge it will be difficult to understand how a new incident is, or is not, part of a cumulative pattern of neglect.

Examples in systems thinking with regard to these cases included testing a local policy for working with 'non-compliant' families to see if it might be used to frame the engagement of young people. Others demonstrate the efforts made to address complex issues arising for young people including strengthening joint working arrangements. These included drawing on the voluntary sector in recognition of the skills and expertise in methods of engagement that a third sector organisation can bring. In one case a local voluntary organisation was contracted to undertake 'return home' interviews when young people go missing, for example (see also Chapter 4).

Joint protocols can provide a pragmatic solution to specific issues arising for groups with differential needs and for co-ordinating responses to neglect and safeguarding concerns:

> *The Safeguarding Children Board carried out an evaluation of practice for children subject to police protection which noted the need for improved communication between police and children's social care prior to or at the time of police protection. The report recommended the development of a joint protocol which would promote regular dialogue, joint visits and joint decision making; all issues that are relevant in this case.*

New policies or joint working protocols that address visibility issues must be accompanied by a corresponding take-up and use at practice level and this requires rigorous dissemination, regular and repeated workforce training and monitoring through management and supervisory processes. Otherwise policies and protocols can be made redundant, as in the case of this local protocol supporting early opportunities for pre-birth intervention in the protection of children:

> *Clearly the professionals involved did not consider referring to the Pre-birth Protocol to Safeguard Unborn Babies; had they done so there might have been the opportunity for professionals working with the mother to share information and consider the larger picture. Midwives and health visitors and GPs have a unique role during the antenatal period and are critical in identifying and supporting vulnerable mothers; in this case the mother's vulnerability was not identified, nor was her ability to protect her child explored.*

3.7.1 Service landscapes

The services that are available to support families in the local context are particularly salient at a time when the impact of austerity is increasingly in evidence and resulting in changes to the local availability and configuration of services (Webb & Bywaters, 2018; Bywaters et al, 2018; Hicks & Stein, 2015). This can be felt as a downward pressure on individual agencies, and we found evidence within the reviews of staff shortages and higher caseloads having an impact on families and the effectiveness of services' engagement with them. These have implications for the level of support required through

management and supervision processes to both manage the emotional impact of the work on staff and facilitate thoughtful case evaluation and analysis:

> *It is also important to encourage professionals to take time to review all available information to support their professional judgements and decision making. It is recognised that this can pose a challenge when professionals have heavy caseloads and limited time available.*

A changing service landscape not only puts pressure on resources but also on services and staff to understand those changes and the implications for families they work with. In some instances, professionals were not aware when essential support services, particularly from third sector agencies, had ceased to be provided and the implications for child protection practice had not been sufficiently grasped. In this example, a young woman with high support needs received intensive and daily support, amounting to several hours a week, from a housing association in a supported accommodation scheme for vulnerable young women – an example of good practice within an agency without a primary safeguarding role. However, the funding for the service ended prior to her becoming a mother and with it important opportunities for protection were lost:

> *The only replacement support offered was a limited housing management and two hours per qualifying resident weekly floating support by another agency. The role of the support worker had been very positive… as she was involved in multi-agency arrangements for support and safeguarding/protection. Her daily presence also meant that she was able to offer some supervision of the family, when direct engagement was a challenge. It transpired from the learning event that knowledge of this change in circumstances was not widely known or understood amongst professionals who attended the premises. Therefore, professionals may have assumed that there was at least some support at close-hand…but, in fact, this was not the case.*

The coherence and cohesion of child protection systems is not only reliant on awareness of the services available, but also on those services being identified and self-identifying as part of the safeguarding system. In the case quoted below, a contact centre played a key role in engaging with parents, with important implications for information sharing with regard to family dynamics, roles and relationships where domestic abuse is a feature:

> *A conversation with the [contact] centre would have elicited a much fuller picture of family relationships and their impact on the child than was contained within an e-mail. The contact centre informed the review that their impression is that they are not always seen as a full member of the professional network yet they have much important and relevant information about children using their service.*

It is important that where services provide a specialist support role they do not perceive themselves as outside of the safeguarding system, as was the case in this example of support to a traveller family:

> *Professionals were unaware of the Access to Education Team (AET) for travellers and refugees and the specialist knowledge and experience that the team has. It became apparent during the review that staff within the team had acclimatised themselves, or believed that they were uniquely placed to help Travellers without going through the legitimate safeguarding channels. As a consequence there continues to be a risk of the Access to Education service not referring concerns*.

3.7.2 Co-location and other joint service responses

> *Currently, systems and services around families can be highly complex and fragmented due to the number of different agencies/organisations involved in delivering care; resulting in fragmented and uncoordinated care. The possible result of this is that the ability to clearly identify the needs and risks within the family as a whole becomes more difficult. There will be a focus on either the child or the adult with little consideration of the interrelated and dynamic context of the family - leaving children and adults without the services that they most need. Professionals who work predominantly with children or adults, can further polarise the assessment of the family as they do not always consider the impact of risk from the perspective of the children, or what the child's experience is.*

The collective effectiveness of services within the child protection system can be significantly dependent on the local configuration of services and a matter of where services are physically located in relation to each other. The last few years have seen an increase in co-located, multi-agency teams led by the police or children's services that provide a central referral point and processes for triage such as Multi-Agency Safeguarding Hubs (MASH). These provide additional opportunities to involve key agencies in piecing together the variety of indicators that might be present in meeting thresholds for neglect.

For these arrangements to work effectively, IT systems need scrutiny in ensuring that they do not present barriers to the progress of referrals or to effective information-sharing between agencies. This is essential in reducing confusion and delay and in maximising opportunities for investigation and response. Several cases in the sample illustrate the importance of regular review of these processes so that thresholds remain appropriate and risk assessment processes robust. Appropriate threshold criteria are pre-requisite in creating opportunities for protection and ensuring a proportionate response to concerns, with serious consequences for individual children if these are set too high:

By the time MASH responded to the Education Welfare Officer they would have received a referral from the GP who had seen Child J and was very concerned about Child J's weight and apparent malnourishment. The GP asked Mother to take Child J to Hospital 1 and the GP also contacted the hospital via telephone to alert them of their pending arrival. A referral was also made to children's social care citing concerns about neglect… The records of Hospital 1 state that Child J was admitted with severe malnourishment and a referral was made to MASH. The decision within MASH was that the case did not reach the threshold for child protection enquiries but Child J should be allocated to a social worker for a child in need assessment.

Aside from these formally integrated structures providing 'front door' responses, there are examples of local authorities reviewing the physical proximity of services in order to reduce service compartmentalisation and increase opportunities for informal liaison. In the example below, a local authority has responded to concerns about information-sharing between health visitors and midwives. In this case the professionals working with a family had found it difficult to express their concerns about neglect both within their own service and with colleagues in other organisations. In response, health visitors have been re-located out of GP surgeries in order to trigger more informal mechanisms ('corridor conversations') for information sharing:

Information sharing with other agencies within the safeguarding system was also highlighted as being problematic particularly between midwives and health visitors. Since the completion of this review the midwives and health visitors are co-located in the same building and in adjacent offices; anecdotally this has improved communication but an audit needs to be done to ensure that this change has made the desired improvement. The midwives and health visitors now meet on a monthly basis to 'flag' any concerns and midwives now have 30 minute appointments with pregnant women.

One of the key elements for ensuring effective joint working in complex service environments is having a lead professional, acting as the key contact for the child or family, co-ordinating activities and interventions delivered by involved agencies, and 'holding' the full picture of the context which is the child's reality:

It would have been helpful if one professional had taken time to draw together all information and undertake a critical analysis of professional issues/concerns and decisions made. There was no evidence that at any one time, professionals clearly considered: the impact of the parents' behaviour on the family as a whole; the impact on the children, specifically the emotional impact of drug abuse and domestic incidents; the impact on professionals working with a family with significant vulnerabilities, chaotic lifestyle and parenting capacity/capability.

The role of lead professional was not clear. The Board should assure itself that the lead professional role is understood and embedded to provide oversight and ownership of early help cases. This includes an understanding of who would be involved where parental mental health may be an issue.

In many cases this lead role is clearly absent, underlining the importance for this to be embedded at a systems level and providing checks to ensure that the role is appropriately allocated and identified to all involved agencies.

One other vital tool for supporting effective practice is having effective and regular supervision, as well as joint supervision for more complex cases. How to promote such supervision is considered in the topic study.

Topic study: The role of supervision

The demands of relationship-based work with families require robust systems of management, oversight and support. Effective supervision represents the mainstay of protective practice. Reviews identify variable supervisory practice between agencies, not just in terms of the level of support provided but also in the selection of cases for supervision and in the regularity with which it is provided.

In some cases it appears that the selection of cases for safeguarding supervision lies with the individual practitioner. This can be problematic, particularly if a practitioner lacks experience in identifying and evaluating the significance of risks within the individual or family context. This was identified as an issue in this case for a newly qualified member of staff:

> *The Health Visitor did not identify this as a case that she wanted to take to safeguarding supervision during the timeframe of this Review. There is a potential risk to the rigour and strength of supervision if the cases under consideration are only those with very evident high risk factors such as previous physical abuse, excluding those with longer term but repeated concerns, such as those associated with neglect. This is particularly a risk for services such as health visiting where supervision prioritises cases known to be high risk, but is equally applicable across services.*

This authority has subsequently introduced regular safeguarding supervision accompanied by a mentoring programme for newly qualified health visitors.

Unless accompanied by effective mechanisms for ongoing review and re-evaluation, the application of a threshold approach to the selection of cases for supervision can engender too static a view of risk over time; the reality is that for many families risks fluctuate and sometimes on a daily basis, as described in the last triennial review:

> *The interaction of child vulnerability with parent/carer risk…is not a linear process which results in single episodes of harm to the child; rather it represents an ongoing, fluctuating and at times cyclical interplay of vulnerability and risk within which a child may suffer multiple and ongoing harms, even without any specific, serious incident* (P Sidebotham et al., 2016).

Opportunities for protection therefore can only be identified if cases are the subject of active and ongoing review. This may be particularly so where thresholds for child protection have not been reached. This ten month old baby was assessed as a child in need with ongoing involvement from a number of agencies over a period of time:

> *There is little evidence to suggest that individual agency managers were aware of the changing circumstances of the family. Further work needs to be done on*

reviewing the types of cases that are discussed in supervision; to ensure the correct cases are taken to supervision and that there is a clear plan to support the professional in working with families and children. Such a review should focus on those cases that may not immediately present as a high risk, but may need attention for example due to being on the edge of thresholds for long periods, or to help workers identify where they are becoming 'stuck' with a particular family.

Often it is those cases already within child protection procedures that are identified for safeguarding supervision, rather than those where agencies are working with lower-lying but nonetheless persistent concerns that should be brought to attention and monitored through supervision. This is particularly pertinent in the context of neglect where risks may be ongoing and cumulative over a period of time.

Support for authoritative practice

The identification of these risks highlights the role for supervision in supporting practitioners to apply critical thinking in the evaluation and analysis of context, risk and harm for families and for individuals. Presenting issues can be additionally complex when families' involvement in services is accompanied by fear or anxiety about the consequences. Behaviours that are symptomatic of this might include reluctance, disguised compliance or open hostility. In these scenarios, professionals can find their practice, approach and perceptions challenged in various ways and will need support in managing their responses:

The IMR author commented that some of what influenced boyfriend's view of Children's Social Services was a significant history of his own involvement with them. She suggests that whilst there is little that can be done to counteract that, there are learning points for Children's Social Services about how managers support workers in dealing with aggression and challenging behaviour which can influence future interactions and decisions and the impact this might have on the child.

In addition, interventions are often delivered within complex service environments where multiple agencies must interact and communicate effectively in order to assess and meet overlapping risks and vulnerabilities.

The 2016 triennial review describes authoritative practice as the ability to negotiate the complexity and ambiguity of child protection work with confidence and competence. It enables '*professionals to be curious and exercise their professional judgement in the light of the circumstances of particular cases… to adopt a stance of professional curiosity and challenge from a supportive base rather than relying on undue optimism*' (Sidebotham et al, 2016, p.201).

Effective supervision helps the professional to pick their way through this complexity in applying rigorous analysis of the presenting issues. A consistent message within the reviews is the need to support professionals in developing ecological perspectives of the families they work with, understanding the contexts in which they live, the issues and tensions they negotiate on a daily basis, family-based roles and relationships, and their interactions with the other services involved in their lives. The subject of this review was the death of a two year old in the context of long-term parental substance misuse and cumulative neglect, where:

> *Safeguarding supervision would have offered robust challenge, critical reflection, looked at evidence and risks and provided support to professionals. Supervision may also have recommended undertaking a detailed chronology*.

In this complicated case supervision was provided but did not support the practitioner to engage sufficiently with the complexity of the case. It describes a family context characterised by a transient lifestyle, unclear family roles and a history of difficult relationships with services in which an infant is failing to meet developmental milestones:

> *Supervision was provided throughout and whilst it gave direction it did not encourage professional curiosity or ensure the assessment was completed in full. It is well documented that in working with families to safeguard children, the sense that professionals make of information they receive will inevitably be vulnerable to common errors of human reasoning.*

Reflective supervision processes

Professionals need support both in applying a robust analysis but also in examining their own values and preconceptions, and understanding how those inevitably contribute to their interpretation of safeguarding events and presenting issues:

> *All professionals need to be mindful of the possibility of and the need to understand cognitive bias, particularly in regards to confirmation bias; to be aware of the risk of only accepting views which accord with their own personal view and so confirm their own interpretation of any situation, in this case, that things were noted to be better as the family were no longer living in what was viewed as risky and inadequate accommodation. The issue is whether this in any way distracted professionals from the focus on the child as the primary client.*

Reflective supervision may also support a professional in recognising the role and importance of language in cultivating empathetic practice with families. This has been a repeated theme in previous reviews, particularly where professionals have used such terms as ‘non-engagement’ to describe families or young people’s interactions with a

service. This is counter to relationship-based practice and discourages exploration of individuals' perceptions, historical experiences of services or their anxieties about accepting support. In many cases the labelling of families as not willing to engage has led to opportunities for intervention being missed and cases closed inappropriately:

> *Agencies must review their professional supervision/training/models of practice to ensure that they adequately address the need for authoritative/relationship-based practice and challenge the use of the term non-engagement.*

A key aspect of authoritative practice is the exercising of respectful uncertainty or scepticism accompanied by the confidence to offer challenge. This is the case, not just in the context of direct interactions with service users, but also in negotiating joint working arrangements with other services. Here, professionals are required to take responsibility, not just for their own safeguarding practice, but for advocating for it among other agencies juggling different concerns and priorities:

> *Supervision can become even more important when a family has been known to agencies for "years" to provide a critical and challenging view that allows the facts to be viewed from a different perspective. It also allows professionals to be able to communicate and express their anxieties about the work that they are undertaking with the family, and identify gaps and risks in the multi-agency system.*

Also noted in reviews, but perhaps not receiving as much attention as it might, is the importance of supervision in acknowledging the challenging nature of the work and its potential impact on the wellbeing of professionals who can experience feelings of powerlessness, frustration or guilt in relation to their practice with families:

> *There is a significant need to consider the appropriate levels of support, guidance and challenge for front line professionals (in all disciplines) to ensure that they are protected and supported to recognise and work with the often overwhelming feelings that working with families such as this may evoke.*

Planning

Supervision plays an important role in effective planning as illustrated in this case of a premature baby born into a family with multiple issues relating to poverty and parental behaviours:

> *Supervision took place between the team manager and social worker, the safety plan was reviewed; it was agreed that Child C should not be discharged from hospital until the situation about accommodation was clear and deemed safe. The mother had also failed to disclose details about the father of the children and no further information was known. It was also agreed that if the mother's*

pattern of behaviour continued then the case would be escalated through Child Protection Procedures. This was good practice with a clear instruction to escalate and recognition that the risks for the children were increasing.

The above provides an example of structured and planned intervention with monitoring in place, contingencies and escalation routes identified, and where the practitioner is appropriately supported through managerial oversight. It illustrates how the plan is the vehicle for providing the purposeful intervention essential to protective practice. However, too few examples have been identified through these reviews, questioning the degree to which current systems skill and prepare professionals in applying planned approaches that have a clear focus on outcomes for the child:

> *The preparation and need for social workers and, I would argue, other professionals, to really prepare and understand what they want to achieve when supporting a child on a child protection plan is crucial to a child's welfare; yet it would appear that supervisors and educators, spend little time preparing or supporting professionals to be skilled in the area*.

Good planning with key objectives and milestones identified also provides a means of measuring and monitoring progress. This is as important in 'child in need' planning as in child protection as the plan provides an opportunity to identify when interventions are failing and escalation is required.

Learning Points

Effective supervision is important in enabling good, authoritative practice; enabling practitioners to reflect on their work; supporting relationship-based partnership working; and facilitating effective decision making and planning.

Supervision also offers the opportunity to support the practitioner in the challenging and, at times, overwhelming aspects of their work; to help them reflect on and work with the feelings and emotions that arise from this work.

Selection of cases for supervision should not be left solely to the practitioner; review of cases below the threshold for child protection intervention is as important as those within the child protection system.

When working with cases of neglect, supervision needs to help the practitioner in recognising the complexity of the issues facing the child and family, and to take a rigorous approach to analysing these issues and formulating plans for working with them.

3.7.3 Tools and resources

Assessment and planning tools are important vehicles that support the collation and systematic recording that is required to evidence neglect. They are also vital in the communication of concerns across agencies and must be carefully designed to facilitate this. The following example illustrates how tools that are not fit for purpose can impede the assessment and identification of risk and the ability of agencies to show how they have met statutory responsibilities:

> *The design of the child protection incident report, utilised within the local constabulary at the time, did not require a police constable to set out:*
>
> - *his or her assessment of safety for the child*
> - *how decisions were made regarding the safe placement of the child, if removal from the family home was required*
> - *to whom in children's social care the case had been communicated*
> - *what the position statement was, 72 hours after the child had been placed with 'another' person, other than his/her parents.*
>
> *The form design did not place a police officer in a position of being able to demonstrate retrospectively that the responsibilities conveyed by the Children Act 1989 were known, understood, and delivered.*

In another example a review identified that a patient registration form used by a GP practice didn't include a field to identify if children were subject to child protection plans or if they were a looked after child (LAC). This appeared to be the case for all the standard forms used in Primary Care; the implication being that GP practices are reliant on parents sharing that information at the point of registration, especially where there are delays in transferring notes and records from a previous Practice. This omission is particularly significant in working with families who have a history of mobility and transience and increases the potential for selective information to be given to GPs.

Assessment and planning tools are often developed in response to concerns about practice and so must be appropriately disseminated, accompanied by the requisite training and their use monitored through management and supervision processes. In several cases reviewers identified that assessment tools had not been used appropriately:

> *The practitioners who contributed directly to this Review were asked directly why the Graded Care Profile was not used for this family, the response was that it would take too long to complete. Training for the Graded Care Profile (GCP) has been implemented… since April 2014 and has trained a total of 114 staff; prior to this individual agencies were responsible for training their own staff in the tool. What is apparent is that the GCP was not at the forefront of practitioners' minds in*

working with this family and did not appear to be part of any routine consideration. The current Board strategy (advocated by children's social care) is that the Graded Care Profile is a tool that can be used by professionals should they wish to use it or think it appropriate to use.

This case reviewer suggests that agencies should be challenged to ensure that they are working in line with local safeguarding strategy for neglect and makes the point that if the Graded Care Profile was being used successfully to identify concerns and offer help to families then this would reflect in the numbers of children subject to child protection plans for neglect.

Examples are also provided where tools have been developed, adopted and are making a difference to practice. In this example a healthy child programme had been devised and developed by staff which promotes the use of evidence based antenatal guides for health visitors. The review reports that most of the workforce had been trained to use the guide which:

> *…has become embedded in practice and has received excellent feedback from parents. It has also had a marked impact on record keeping including details of action plans, greater depth of analysis and better focus on preparation for parenting.*

Summary points

The current service landscape with fragmentation and outsourcing of services, service cuts and corresponding high case loads and high staff turnover, has profound practical and emotional impacts on staff who are struggling to work effectively with families in complex circumstances. Managers and commissioners need to recognise these impacts and put in place structures to provide support, time and guidance for front-line practitioners.

Within a fragmented service landscape, co-location of services, joint protocols and robust IT systems can be particularly important in enabling consistent work with families. Having a lead professional to coordinate multi-agency work and be a key point of contact with families helps ensure consistency of work and avoids the risk of children slipping through the net.

Assessment and planning tools need to be evidence-informed, rigorously designed, tested and disseminated to ensure they are fit for purpose and appropriately used.

Chapter 4: Vulnerable adolescents

4.1 Introduction

Adolescence remains a time of vulnerability for many children and working with adolescents continues to cause difficulties for practitioners when resources are scarce and time limited. Much of the following is a story often told but within the SCR population some noticeable additional risks are emerging, mirroring concerns applicable to all adolescents and highlighting the changing and additional pathways to harm for young people. For example, social media use and exploitation, identified as *'new and emerging threats*' in Working Together to Safeguard Children 2018 (HM Government, 2018b, p.14).

Wellbeing in adolescence is influenced by early childhood experiences and can in turn determine adult behaviour, health and wellbeing (WHO, 2016). Understanding adolescents' experiences, including their family lives, local community and wider social networks, is necessary for understanding adolescent harm. Adolescence is a time when children spend more time with peers and less with family. Harm can continue to come from the family but there is also potential for increased harm from the community.

Safeguarding measures that work with younger children may not be suitable for adolescents experiencing harm from their peers and community and an ecological view of safeguarding is required to assess and develop multi-agency responses in local communities (Firmin, 2018; HM Government, 2018b). In the case of adolescent community harm, it is not enough to work with individuals when a whole peer group is participating in harmful behaviour. Contextual safeguarding promotes awareness of vulnerability in the context of the spaces where adolescents spend their time, for example online, in parks or at school (Firmin, 2018).

The chapter looks at findings in relation to going missing, exploitation, harmful sexual behaviour and social media/online behaviour. Opportunities for prevention and protection are also identified.

4.1.1 Adolescent SCRs

Within the total number of reviews (368) during the period 1st April 2014 – 31st March 2017, 115 involved children aged 11 years and over (31%). Sixty-five reports related to deaths and 50 involved serious harm. Forty-seven deaths were maltreatment related (72%).

Risk-taking/violent behaviour and child sexual exploitation was the cause of serious harm in almost half (44%) of the notifications about adolescents. It is important to note that the

number of children harmed by sexual exploitation is an under-representation as some SCRs related to a number of children.

The adolescent sample

The preliminary adolescent sample of 41 reviews was selected purposively from the 115 SCRs that involved an adolescent in order to facilitate learning related to new themes. A final selection of 25 reviews was then made, chosen from the researcher summaries of reviews and considered as likely to best illustrate the new emerging themes (see Appendix E for brief summaries of the 25 cases).

4.2 Going missing

Running away from foster care, residential placements or home is not a new phenomenon (Payne, 1995). The increased vulnerabilities of young people who go missing have also been recognised for some time. However, adolescents live in a world that is changing fast and experience a range of new pressures and risks both online and in their communities (NSPCC, 2019).

Data published by the National Crime Agency's UK Missing Persons Unit show that there were 179,953 incidents of children being reported missing to police forces in England and Wales in 2016/17 (some children go missing more than once). Twenty six police forces provide data on children missing from care, which showed 44, 291 incidents. Where data was available, nearly 83% of children missing from care went missing on more than one occasion (NCA UK Missing Persons Unit, 2019).

There is statutory guidance in place to safeguard children missing from home or care, and schools have to put their own procedures and policies in place when a child goes missing from education.[7] Children who regularly go missing are at increased risk of harm and therefore it is important for police to undertake a prevention interview when found to ensure the child is safe and well and for a statutory independent 'return home interview', commissioned by Local Authority Children's Services, to take place within 72 hours of the child's return (Department for Education, 2014b). The 'return home interview' is normally best carried out by an independent person (i.e. someone not involved in caring for the child), commissioned by the local authority, who is trained to carry out these interviews

[7] The Department's statutory guidance for local authorities on 'Children Missing Education' provides advice to schools on their responsibilities. The Department's non-statutory guidance for maintained schools, academies, independent schools and local authorities on 'School Attendance' provides advise on children at risk of missing education. The Department's statutory guidance for schools and colleges 'Keeping children safe in education' provides guidance on safeguarding policies and procedures.

and is able to follow-up any actions that emerge. Of course, adolescents may not engage with the return home interview even if it is offered, as was the case for child AC and many of the other adolescents:

> *AC declined the offer of the return home interview. This was later followed up by the third sector agency that made contact with the Pupil Referral Unit to again offer AC a return home interview. A teacher at the unit spoke with AC but he declined the offer again*.

Young people may refuse a return home interview several times but steps can be taken to increase the likelihood of the offer being accepted including it being offered by the same worker, gathering information about why the offer was previously refused (The First Step: How return home interviews can improve support and safeguarding for missing young people, The Children's Society, May 2019; Pona, Raws & Chetwyned, 2019).

Return home interviews are intended to be child centred and should provide opportunities for children's voices to be heard with a focus on their needs and experiences (Pona, 2016). It may be a problem finding an independent person, who is able to build trust with the young person, to undertake the interview. There may also be difficulties completing an interview within the 72-hour timeframe if there are a number of children who require interviews or if information about the return of a missing child is not shared by the police in a timely manner (Maslin, 2018).

One child went missing from education when just 10 years old. She was seen walking to school but did not arrive. The school reported the episode to the police and she was found. It was known that she had a much older 'boyfriend', an adult male, but despite her young age, a decision was made to take minimal action and log the incident for information only:

> *This event was perceived as an isolated incident and primary education indicated this was an initial event, having previously had no problems with Charlie. There is no multi-agency evidence to suggest that any further risk assessment or interventions were considered at the time, in line with either safeguarding or missing children guidance. Whilst Charlie was seen by the police officer there is no evidence she received a formal safe and well check on recovery. Current guidance is not clear whether this would be offered when children go missing from education, as happens when they go missing from home or care, which could be an inconsistency in practice.*

The school was aware of Charlie's learning difficulties and previous disclosure of violence that indicated that a multi-agency response was required to provide holistic support for her. Charlie did not appear to receive a prevention interview by the police and the SCR does not say whether an independent return home interview was undertaken in

line with statutory guidance (Department for Education, 2014b). A prevention interview could have explored the risks of sexual exploitation clearly present in Charlie's life and had a return home interview been offered it might have identified potential interventions to avoid escalation of the harm she was experiencing. This was a missed 'reachable moment' in the cycle of abuse and exploitation (Hudek, 2018, p.4).

Child K did receive return home interviews when he was found after going missing from care, as required, but outcomes were not shared with relevant agencies, which reduced the usefulness of such an interview:

> *The purpose of completing the interview is to identify particular issues of risk and to contribute to assessment and management of that risk and vulnerability. Although interviews were generally completed with Child K, none of these were shared with services such as the police.*

Case study: Going missing

Reece was a 16-year-old White British boy who died by suicide whilst looked after in a children's home. He was part of a very large sibling group. His parents received disability related benefits and the family lived in poverty. He experienced abuse and neglect throughout his childhood and witnessed domestic abuse and alcohol misuse. He became looked after by the local authority at the age of 10 years and was initially in a long-term foster care placement for seven years. During that time, he attended school regularly and achieved well, participating in many school activities. His parents regularly missed contact meetings and eventually stopped any contact with Reece for some years but he continued to have regular contact with his maternal grandmother. He moved to a children's home after an escalation in going missing episodes, substance misuse, self-harm and excessive consumption of high-energy drinks.

Reece had multiple presentations to A&E with serious self-harm. He sometimes shared images of the harm on social media. He attempted suicide several times and disclosed to practitioners his feelings of rejection, being unwanted and unloved. He went missing from foster care, school and the children's home where he was placed during the latter part of his life. During 'missing' episodes, he had increased substance misuse and self-harming behaviour. When found by police they appeared to complete interviews with Reece (when he was willing) in line with local procedures at the time. They diligently completed vulnerable child forms requesting urgent assessments and review of plans but there was little discussion between other agencies and the police. After every missing episode, he returned to the same environment. Reports collated when he self-harmed or went missing focused on his immediate circumstances and feelings rather than underlying issues.

Key points:

When children go missing they are demonstrating that things are not right for them and while they are missing they are at increased risk of harm. Communication and information sharing can support practitioners to see a developing and more holistic picture when adolescents repeatedly go missing.

All incidents should be reported and guidelines followed which includes a prevention interview by police (Authorised Professional Practice: Missing Persons, College of Policing, 2016) and an independent 'return home interview' to take place within 72 hours after return (Department for Education, 2014b), in addition to a safe and well check by police.

Children who experience abuse and neglect carry those experiences with them into adolescence. Their perceived rejection by family, foster carers and agencies has an effect on their self-efficacy that can lead to feelings of worthlessness and lack of agency.

Although difficult when an adolescent moves from one crisis to the next, it is essential to look at the cause of the problems as well as reacting to the immediate crisis. Practitioners

need to understand the strong link between non-fatal self-harm and subsequent suicide (Hawton and Harriss, 2007).

The reviews about Anita B and siblings W and X concerned young people missing abroad. In the two reviews explored, risks related to going missing abroad were radicalisation and cultural views of the causes of mental illness. In both reviews about young people missing abroad, there was an escalation of issues, which included worsening mental health, criminality, lack of school engagement, disengagement from family and friends and engagement with fundamentalist Islam.

When the risk of travelling abroad is recognised it is possible to hold a child protection conference but children who are not subject to child protection processes do not benefit from potential protection strategies once missing:

> *If children who go missing abroad are not subject to the child protection processes, and the investigation is left entirely to the police and the authorities of the country where the child is suspected of being, there may be a potential loss of both information and potential strategies to protect the child. For instance, full involvement of parents, family and others in consideration of what actions could be taken to assist in helping the child to return.*

The review about siblings W and X above also suggests that the different responses, depending on *where* the child is, caused inconsistencies in interventions when the incident happened in 2014. The issue, the report suggests, would be better managed by situating Prevent (part of the UK Government counter-terrorism strategy) within child safeguarding. By doing so, it acknowledges that, in the context of radicalisation, the child must be safeguarded against being drawn into terrorist-related activity (HM Government, 2015). The local authority where the incident happened now treats the risk of travelling as a safeguarding issue in accordance with Department for Education guidance (Department for Education, 2015a).

There are examples of young people who go missing but incidents are not reported to the police or reporting is delayed. In the case of Child U, he was missing for 12 days but not reported missing until he had been away from home for seven days. In the review about James, the parents were certain that the adolescent would return and therefore did not always report the missing episode:

> *There were times when he was not reported missing by either parent due to their frustration, as they knew he would always return, but his missing episodes persisted*.

Eventually James' relationship with his father broke down and he was accommodated by the local authority. Staff at his semi-independent placement also became weary as he continued to go missing and they were not compliant in reporting him missing. On one occasion, they were not aware that he was missing.

Anita B went missing abroad in April. Her mother reported her missing and a day later the police informed children's social care. As she was missing abroad, children's social care did not open the case, viewing it as a police investigation only. That view ignored her risk of significant harm and it was not until the following August that a strategy meeting took place:

> *When a child goes missing, and there is concern s/he is at risk of significant harm, a s.47 enquiry should be initiated and a strategy meeting held. In this case there was no s.47 enquiry, and instead CSC did not open a referral, and closed the communication of Anita B being missing five days later. A strategy meeting was only held nearly four months after she disappeared without her medication and to a place in the world which was at the time unsettled following political events.*

Practitioners face many challenges when working with adolescents who go missing. Some adolescents repeatedly go missing, some refuse checks on their wellbeing when found and others go missing abroad. However, adolescents go missing for a reason and their going missing should be seen as a signal that all is not well and that they face increased risks of exploitation (Pona, 2016).

Summary points

Going missing can be a powerful signal that all is not well in the adolescent's life and it is therefore not enough to find them and bring them home. A timely multiagency safeguarding response is required for all adolescents who go missing and should not depend on where they go missing from or to (for example, abroad).

When a child is found or returns, they should have a prevention interview by police and the local authority should offer an independent return home interview within 72 hours.

The child's individual needs identified within return home interviews should be shared with relevant agencies to enable a holistic safeguarding intervention to be developed. Knowledge of hotspots of activity in local areas combined with the specific concerns for individual children can encourage a contextual safeguarding response.

4.3 Exploitation

Exploitation can occur in a range of circumstances but when adolescents are missing from care, home or education, and missing abroad, vulnerability to different forms of exploitation may be heightened. The overarching term ‘criminal exploitation’ includes moving drugs, violence, gangs, sexual exploitation, missing children, trafficking and radicalisation (Home Office, 2018). The young people involved should be seen as victims and safeguarded accordingly. Within the sample chosen for further exploration there were incidents of criminal exploitation including gang related activity, radicalisation, child sexual exploitation, harmful sexual behaviour, social media use and technology-assisted abuse.

Harm was cumulative (see section 3.3.3) and adolescents’ experiences often included many traumatic incidents and neglect over time. Therefore, the adolescents, although grouped by type of harm within this report, often experienced many different types of harm concurrently from family and their community. For example, a child involved in gang activity and criminally exploited can also be sexually exploited (online and/or offline), neglected and abused within the home and self-harming. The exposure to multiple types of victimisation may have detrimental impacts over and above the impact of specific types of harm (for example, sexual abuse) and is referred to as polyvictimisation. The concept of polyvictimisation has been explored in depth elsewhere (Finkelhor, Ormrod & Turner, 2007) and is useful for understanding the impact of abuse in the context of other traumatic experiences such as the themes covered here.

4.3.1 Child criminal exploitation

Both virtual and local communities can provide spaces for exploitation. The All Party Parliamentary Group on Runaway and Missing Children and Adults published a briefing report in March 2017 (APPG RMCA, 2017) suggesting that the patterns of grooming for sexual and criminal exploitation are similar. Learning from previous child sexual exploitation (CSE) cases, it is clear that some professionals in the past saw the child as at fault due to their risky behaviour (Sidebotham et al, 2016; The Children’s Commissioner’s Office, 2019). The APPG believes ‘that in some areas of the UK a similar culture currently exists around criminal exploitation by gangs’ (APPG RMCA, 2017, p.1).

The adolescents vulnerable to exploitation cannot be said to differ remarkably from other adolescents within the SCR population. Their early experiences included abuse and neglect, witnessing domestic abuse, parental substance misuse, parental mental illness, time in care and separation and/or loss. In addition, significant risks came from the community as the young people were often not in school, going missing and seeking a sense of belonging with others. Responses by agencies and workers to previous harmful experiences within the home are likely to influence young people’s confidence in

statutory services, including police. The combination of lack of confidence in services, young people seeking to be more autonomous and abuse within the home can push them out of the home which can end with young people going missing and seeking a sense of belonging elsewhere (Firmin, 2018).

Four cases of criminal exploitation were analysed. The four SCRs concerned adolescent males (aged 14-17), three were Black/Black British and one was White British. Three died from stab wounds and one by suicide. Criminal exploitation in these cases is closely linked to school exclusion, going missing, substance misuse and previous experiences of loss and separation (see Table 17). However, the circumstances of individual adolescents are complex and it is not possible to speculate about causation, only to identify commonalities between the SCRs examined.

Table 17: SCR final reports analysed for criminal exploitation

	Adolescent 1	Adolescent 2	Adolescent 3	Adolescent 4
Age	15	17	14	17
Substance misuse	Cannabis	Cannabis	Cannabis	Cannabis
Separation/loss	Separated from family for seven years. Parental separation.	Emigrated from Caribbean. Father imprisoned and then deported. Siblings living elsewhere.	Lived with both parents and siblings until secure centre.	Lived abroad for two years with extended family. Parental separation.
School exclusion	Multiple exclusions. Managed move.	Attended college until his death. Erratic attendance.	Permanent exclusion. PRU and secure centre.	Poor attendance; exclusion; NEET.
Going missing	Many incidents	Not recorded	Yes	Many incidents
Criminal activity	Assault; robbery; carrying knife; drug dealing.	Sexual assaults; robbery; possession of drugs.	Offending from age 10; criminal damage; minor offences; non-compliance with court orders.	Burglaries; drug dealing; affray.
Community harm	Brother's gang affiliation; older males; threats; fearful.	Poverty; immigration status; mugged; fearful; associating with offenders.	Associating with older known offenders.	Associating with offenders and county lines activity.
Children's social care involvement	No referrals during review period. Two MERLINS* passed to CSC not acted on.	Child in Need but stepped down. No Recourse to Public Funds team.	Child protection plan - neglect.	Looked after in semi-independent accommodation.

* The name of the Metropolitan Police database for information that has come to their attention about children for any reason.

Child U had spent the majority of his childhood abroad without his parents. He returned to the UK significantly behind in learning, became disruptive, was excluded from school, started going missing, was using and dealing drugs, carried weapons and became involved with gangs. In addition, an older brother was involved with gangs and crime and served a prison sentence. The local community was clearly a frightening place for him:

> *U explained to his mother, in a letter found by her after his death, that he was staying away from home because he was frightened of one particular young man (and possibly others) who had threatened to beat him up, or worse.*

Another adolescent, Child F, also felt unsafe. He lived in housing that was due to be demolished and accommodation was offered in an area where he felt particularly threatened. More suitable accommodation was then offered in what was thought to be a safer area. However, he still experienced intimidation and felt frightened:

> *He said he was scared to leave his house as he had been threatened by a gang from x area, and referred to a fellow pupil at college whom he believed watched him for the x area gang. Fearing repercussions, he did not want police involvement.*

There was much evidence of multiple difficulties for the adolescents including substance misuse, special educational needs and school exclusions, anti-social and criminal activity, loss and separation and involvement with children's services due to abuse and neglect. However, agencies did not always share information about current and previous circumstances and therefore a more complete picture of an adolescent was rarely available to practitioners. Returning to the SCR about Child U, it was clear that there was a lot of key information known but not shared. For example, incidents such as assaults at school which were not shared with the police and going missing incidents which were not always shared with children's social care or his school. The review authors suggest that there are several reasons why information may not be shared:

> *Some of these relate to systems failures in the use of electronic databases and the accuracy and completeness of data held within them. Some may relate to the principles of confidentiality and 'need to know'.*

They also suggest that schools may try to manage incidents in-house to avoid criminalising young people. Unfortunately, that leaves other professionals without the full picture and less able to safeguard the adolescent. For Child U, that meant that when he attended emergency departments with injuries, few questions were asked, as they were not aware of any other concerns. Flags were only put on the IT system if the child had a child protection plan. Had hospital staff been aware of Child U's escalating difficulties they could have followed the process within the hospital for advice to be sought from the safeguarding team (named doctor and named nurse). Both hospitals also had youth worker projects that could pick up referrals regarding youth violence or gang membership and offer services on a voluntary basis. Involvement with such services may have prevented escalation of the exploitation of Child U.

Long-term work with adolescents was seldom possible for statutory agencies due to lack of resources or lack of engagement by the adolescent and/or family. Voluntary agencies

are sometimes better placed to encourage engagement through mentoring and mutual experiences. One youth charity supported an adolescent and the rest of the family for five years. The charity provided a mentor for Child U and he engaged with football and a programme aimed at diverting him from offending.

The previous section set out the vulnerabilities of adolescents who were missing but adolescents sometimes went missing *because* they were being exploited. This could be to get away from their abusers or because forced criminal activity took them out of their local area:

> *AC had been reported as missing from home in the early hours of the morning. Home visits established that he was growing more nocturnal in his routine and there was information that he was using cannabis and associating with offenders. This lifestyle was clearly putting him into contact with older offenders, increasing significantly his risk of re-offending and compromising his long-term health and educational prospects.*

Guidance produced by the Department for Education for practitioners list potential indicators of child sexual exploitation (Department for Education, 2017c). Many of those indicators, for example acquisition of expensive items and excessive receipt of texts/phone calls, are relevant to broader child criminal exploitation (Home Office, 2018). When adolescents returned with expensive items practitioners were aware of the possibility of exploitation but did not always have firm evidence:

> *They were not convinced by his denial of gang affiliation. He was living above his limited means, bringing home expensive takeaways and still able to pay for his regular cannabis habit, which he said he had for three years. His parents confirmed that they did not give him extra money and they did not know how he paid for an iPhone that was seized by* […] *Police.*

One adolescent, James, was found in the wardrobe of a much older woman when police were searching her house. Despite the woman in her 50s telling police that they had had 'a fling' – he was 16 at the time – concern was focused on the fact that he was homeless rather than his risk of exploitation and involvement with county lines activity. It was clear that he was travelling around counties where he had no connections, a typical behaviour of someone coerced into moving or selling drugs (Home Office, 2016). He was returned to his parents but did not appear for two weeks:

> *After further negotiation by the social worker dealing with James, his father agreed he could return home to him. James was furnished with a travel warrant and allowed to travel home alone. He missed his late night train, causing the [county] social worker, who could not find him, having to report him as a missing person to Police.*

4.3.2 Child sexual exploitation

Child sexual exploitation continued as a persistent theme for the 2014-2017 SCRs and was noted in 26 (9%) of the SCR reports available to us (from the sample of 278). Despite many public documents related to the issue and previous SCRs, there was evidence that practitioners were still slow to recognise vulnerabilities to CSE and respond to risks, particularly if the child was male. In the SCR about Mark, who was associating with older males, the risk of CSE was recognised '*but no disruptive or preventative actions were taken'*. The SCR suggests that had Mark been female then he would probably have received a more urgent response by professionals. Such gendered perceptions of vulnerability are challenged within recent guidance for professionals (The Children's Society, 2018a). Males may find it more difficult to disclose but practitioners need to be aware that the risks for males who are victims of CSE are no less serious than those for females. The guidance suggests that practitioners should ask themselves if their response would be different had the victim been a girl (The Children's Society, 2018a).

In another SCR, Jack went missing and was known to be in the company of an older man (aged 25 years). Despite early information from his parents about Jack's intentions to see the older man, the police were not proactive in preventing the incident, referring to the matter as a 'parenting issue'. Once he was identified as 'high risk', officers were quickly able to locate the address with the help of information from pupils at Jack's school. The way that he was subsequently supported was insensitive and helps explain his subsequent reluctance to engage with agencies:

> *On return from London an Inspector spoke to Jack and his mother and, according to Jack's mother, gave Jack a "dressing down" which included threatening that Jack would be removed to a "secure unit". As a direct result of this meeting, Jack and his mother feared the police and felt there was no hope left for them. The meeting served only to further alienate the police from Jack and his family.*

Later, other agencies failed to follow safeguarding procedures. When he attended the hospital emergency department with a genital injury and despite knowledge of him being a victim of CSE, there was no involvement of a named doctor for safeguarding children or curiosity about his life:

> *Reference is made to a history of sexual exploitation; however, staff did not appear to recognise there could have been a current risk of further exploitation and abuse. There is no reference in the documentation to the staff talking to Jack's parents regarding any change in his behaviour or how he was managing. There is a lack of documentation of staff talking to Jack and finding out what his life was like. At no time was it recorded whether Jack was spoken to alone.*

For this adolescent, the best support was again from a non-statutory agency specifically for young men and boys vulnerable to being sexually exploited. The agency worked with him for four years:

> *The support Jack required was long-term in nature and developing trust is not an easy or quick position to achieve. As events unfolded for Jack the BLAST[8] worker provided a constant that was lacking from some of the other individuals.*

There was confusion among safeguarding practitioners when monitoring and managing children who are at risk of or experiencing CSE. As there is no specific category for CSE, child protection plans may seem less appropriate than management through a dedicated and specialist CSE team. There is therefore a need to clarify safeguarding pathways for the management of CSE. Eaton and Holmes (2017, p.83) critically appraised evidence in their scoping review about safeguarding practice with children who are sexually exploited. Drawing on the evidence, they developed six key principles that are worth repeating here:

1. Young people must be at the centre and should not be held responsible for their harm or their safety.

2. CSE is complex; therefore the response cannot be simple or linear. Responses need to be based on evidence from a wide range of sources of expertise.

3. No agency can address CSE in isolation; collaboration is essential.

4. Knowledge is crucial.

5. Communities and families are valuable assets, and are likely to need support.

6. Effective services require resilient and supported practitioners.

The principles clearly indicate the need for multi-agency and community collaboration to support adolescents and share relevant information. Additionally, the complexity of CSE requires ongoing support at variable intensity over time. Returning to the case of Jack, the report sets out the lack of meaningful involvement of children's social care despite multiple referrals. A child in need plan lacked specific actions and '*failed to appreciate the high risk Jack faced*'. A support worker who was not social work trained was responsible for the case and it was managed through the CSE strategy group. The case was never referred to an initial child protection conference.

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[8] The BLAST Project is a male only sexual exploitation service supporting and working with boys and young men who have experienced, are experiencing or are at risk of experiencing child sexual exploitation in Leeds and Bradford.

Some practitioners had a better awareness of CSE even when it involved young males. Child A was looked after in a therapeutic unit. He told staff that he planned to meet a man for sex whose number he had seen on a toilet wall. An immediate strategy meeting was convened, all agencies informed and a criminal investigation initiated.

When practitioners were concerned about CSE, there was at the time confusion as to how to talk to young people about their concerns or experiences as in the case of Becky who was not offered an opportunity to be heard by someone she really trusted, as they were too worried about asking leading questions:

> *They felt constrained by the advice in the child protection procedures which say that when dealing with disclosures "the child must not be pressed for information, led or cross-examined" and did not know how far to explore the concerns.*

Children with life experiences of abuse and neglect and those who have experienced other trauma leading to instability, separation and loss are at greater risk of exploitation but it is, of course, important to recognise that any child can become a victim of sexual exploitation. The presence of a predatory and persuasive sexual offender and a vulnerable young person is a toxic combination:

> *The outcome for Child Q was possibly due to an accumulation of negative life experiences and long-term abuse/neglect. This resulting in the child developing strategies and behaviours to cope with day to day life. Ultimately, these behaviours placed the child at significant risk from sexual predators determined to abuse Child Q through CSE.*

Being looked after by the local authority increases feelings of loss and decreases a sense of belonging when permanency is not achieved. For Child Q, there were many failed foster placements and she was placed in a specialist residential care home as a sole occupant due to her behavioural difficulties:

> *The preferred option could have been that Child Q was placed with specialist foster carers who could support a child at high risk of CSE, in a nurturing home environment, however, such placements were difficult to identify at the time. Nationally such models of care are described that demonstrate improved outcomes for children. Unfortunately, this option was not available for Child Q who at the time, seemed to respond better to sole placements with one to one care.*

With numerous moves, it is hard to engage a child in psychological interventions despite the need for such interventions for children who have experienced CSE:

> *… trauma based interventions are crucial for children who are survivors of child abuse. The same principles should be applied for children as victims of CSE. At times, the focus of attention for professionals was the management of the child's*

behaviours without a true understanding that the presenting behaviours were a legitimate response to the abuse.

Protecting a child from sexual exploitation is challenging, especially when the child frequently goes missing. Local authorities have a duty to place a looked after child in the most appropriate placement available, subject to their duty to safeguard and promote the welfare of the child. Placing the child in an appropriate placement should help to minimise the risk of the child running away. The care plan should include details of the arrangements that will need to be in place to keep the child safe and minimise the risk of the child going missing from their placement.[9] For residential care staff looking after Child S, who was at high risk of CSE, it meant that the child should have no time unsupervised until the risk was de-escalated:

> *The risk was never de-escalated and the expectation remained that the child would never be left unsupervised on outings. The challenges for residential workers in balancing the restrictions to the child's liberty, which could have been described as a deprivation, and managing the risks of harm were challenging.*

The legal challenges in restricting a child's movements were not always understood by other safeguarding partners. Within a family setting, a written agreement expected parents to supervise two sisters, Sam and Charlie, at all times when not at school and confiscate any mobile phones found in their possession. As suggested below (see section 4.5), it is possible for children to access the internet on other devices and such punitive practices may not be successful when trying to get young people to understand and co-operate with safeguarding measures.

[9] Missing from Home and Care Statutory Guidance from DfE, 2014. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307867/Statutory_Guidance_-_Missing_from_care__3_.pdf

Summary points

Criminal exploitation covers a range of activities that victimises the child, including moving drugs, violence, gangs, sexual exploitation, missing children, trafficking and radicalisation.

Communities and virtual spaces provide hidden opportunities for exploitation.

Agencies need to work together to safeguard adolescents from exploitation which requires a new way of thinking about safeguarding.

Working with adolescents vulnerable to exploitation requires time to build relationships and voluntary organisations are often well placed to do that work over a number of years.

Adolescents who are victims of exploitation are vulnerable and have often experienced polyvictimisation (multiple types of victimisation).

4.4 Harmful Sexual Behaviour

Harmful sexual behaviour has been defined as:

> *'Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult'* (The Children's Society, 2018b, p.3).

Severity of harmful sexual behaviour (HSB) is on a continuum and age and stage of development will influence the perceived severity of the behaviour and relevant interventions. Harmful sexual behaviour can be assisted by technology (use of internet via phone or other devices) and can occur within a group setting.

It is important not to assume that harmful sexual behaviour in children is due to their own experiences of sexual abuse as evidence suggests that non-sexual maltreatment is often present in children's developmental histories (Hackett, 2016). Experience of any form of maltreatment can be an indicator of HSB including neglect, but neglect alone is not a predictor for the development of HSB and children with harmful sexual behaviour are likely to have experienced polyvictimisation (Hackett, 2016; Finkelhor, Ormrod & Turner, 2007). All of the adolescents within this sub-sample had experienced neglect as identified using our neglect tool (Appendix C).

Seven SCRs were examined where the adolescent displayed harmful sexual behaviour towards others, reflecting the impact of their own trauma. Their behaviour should, therefore, be seen in the light of their own experiences of abuse and neglect which is set out below (Table 18).

Table 18: Family history of the adolescents who displayed harmful sexual behaviour

Adolescent	Family history
A	Witnessed DA. Father imprisoned for serious drug offences. Mother experienced childhood abuse and violence in country of birth.
B	Parents separated. Little contact with father. Lives with mother, stepfather and half-siblings.
C	Historically exposed to physical, emotional and sexual abuse. Mother experienced DA. No contact with father. Looked after.
D	Family arrived in UK after time in a refugee camp. Traumatic events. Parents have poor language and literacy skills.
E	Mother has ambivalent relationship with child. Family mental health issues.
F	Poor parenting. Parents separated. Physical and emotional abuse. Looked after.
G	Significant harm (emotional, physical, sexual abuse). Mother controlling.

One SCR recognised that *'in the violent world of some young groups, workers at assessment must consider that being a victim and being a perpetrator is very closely related'*. This is particularly the case when offences are committed as part of a group, suggesting exploitation.

One example is Child F who was a victim of muggings and stabbings but also part of a group perpetrating sexual assaults on two young girls. After the first assault, he did not receive any therapeutic or educational input. This appeared partly to be because the case was not pursued by the Crown Prosecution Service (CPS) as it was not deemed to be in the public interest. However, there was an additional problem as the family had No Recourse to Public Funds at the time and the cost of a specialist service was seen as too expensive. Thus, the response was neither therapeutic nor criminal justice. He was not seen by CSC and neither his school nor the GP were aware of the offence. He was aged 15 at the time and there should have been a strategy meeting around safeguarding. The lack of prosecution made it appear that the offence did not take place:

> *It cannot be proven that the absence of any work with the 15 year old F about sexual behaviour or peer pressure after the first rape led to or failed to stop the second, but at the least its absence may have contributed to his understanding of right, wrong and consent being unimproved.*

Similar reasoning was used in another case where Child N was accused of sexually assaulting another child in a school taxi and the CPS decided not to prosecute which *'can often be translated into a view that the incident did not occur as stated by the alleged victim or did not happen at all'.* That does not mean that there is no risk from a safeguarding perspective.

In the case of James, there were allegations of harmful sexual behaviour towards his sibling and later towards another child. The first allegation was withdrawn and the police saw the latter incident as *'inappropriate sexual behaviour as opposed to an incident of sexual assault'.* The risk he posed was not fully assessed but it was noted by professionals and impacted on future placements available to him.

The National Institute for Health and Care Excellence (NICE) has guidance available for practitioners who work with children and young people who display harmful sexual behaviour (NICE, 2016). More recently an evidence-informed framework was developed by NSPCC (2019) based on work by Hackett (2014; 2016). The aim is to avoid harmful sexual behaviour escalating which can then lead to criminalisation of young people. That is clear in the cases about children F and N referred to above but what appears to have happened is that in the quest to avoid criminalisation, the episodes have simply been forgotten. NICE (2016) recommends an early help assessment to determine whether a statutory or criminal justice response is needed. As a criminal justice response was not seen as appropriate in the cases above, child protection services and specialist services should have been offered.

Case study: Harmful sexual behaviour

Carlton, a 17-year-old boy who originated from the Caribbean, died from stab wounds. He was brought up in a family where the father had been in prison for drug offences and later deported. His mother had fled her home country due to violence. She had also experienced domestic abuse in her relationship. She had overstayed her visitor's visa and had no recourse to public funds until a year prior to the fatal stabbing of her son. The family lived in poverty and poor housing, which exacerbated Carlton's chronic health condition and affected his social and emotional development. They were eventually offered new accommodation funded by the No Recourse to Public Funds (NRPF) team.

Carlton had low-level special educational needs and saw the school counsellor as he felt depressed. His behaviour at school deteriorated. At age 15, he sexually assaulted a young girl with a group of peers but the case did not proceed to prosecution, as that would *'have a disproportionate adverse impact on his future prospects'*. A year later he was involved in another rape of a young girl. It took a year before the case was put to the Crown Prosecution Service. This time a decision was made to proceed and he was awaiting trial at the time of his death. He did not receive a specialist service for children who display harmful sexual behaviour as the cost was deemed prohibitive by the NRPF team.

He worried about his safety in the community and felt threatened by local gangs. He was the victim of a mugging and a stabbing prior to the fatal stabbing. He believed he was being watched at college by a gang member and was given a personal alarm by the police. There was confusion as to which council Carlton resided in and therefore he was without agency monitoring and support during the last few months of his life.

Key points:

Young people with insecure immigration status require the same support, at the very least, as any other young person particularly when they are victims as well as perpetrators of crime.

Long delays in the criminal justice system are not helpful for young people. They create uncertainty about the seriousness of an incident for young people and practitioners.

When there are no criminal justice consequences, it is necessary to provide other support to divert young people from criminal activity.

Practitioners must consider contextual safeguarding when working with young people to keep them safe, which involves assessing and intervening in the spaces beyond the home.

Communication across local authorities is vital when safeguarding young people who move between addresses.

4.4.1 Sexting

The practice of sharing youth produced sexual images online by children and young people is called ‘sexting’ (Barnardo’s, 2016; UK Council for Child Internet Safety, 2017). The sharing of images can expose adolescents to risks and exploitation if the images are shared further as they can be used for bullying or blackmail to continue the abuse. The seriousness of such technology-assisted abuse was not always recognised by practitioners, as demonstrated in the SCR about sisters Sam and Charlie:

> *The school’s safeguarding lead contacted the key social worker advising that inappropriate videos had been seen on Sam’s mobile phone. The safeguarding lead was advised to bring the phone to the next CIN meeting and to hand it to the police. Feedback from the practitioners was that this related to Sam having taken inappropriate pictures of Charlie on her mobile phone in the family home. After the phone had been seized the images were viewed by the police. The risk assessment outcome at the time was that this had been an isolated incident which did not warrant further action. It was understood that Sam had been coerced into taking the pictures by a third person on the phone and the incident was not perceived to pose an ongoing risk.*

Although current police guidance is to minimise criminalisation of young people who share sexual imagery, the coercion by a third party to take the pictures is a criminal offence. Offender disruption should have been considered and the incident treated as a safeguarding issue (College of Policing, 2016b).

Children may be too worried about the consequences of disclosing sexting. Becky was not able to talk to her family about images she had taken and shared but spoke to staff at her hospital education service (HES):

> *Becky shared concerns with staff at HES about a young male peer threatening to publish explicit photographs on the internet and worries about ‘sexting'. HES made verbal contact with early help with the intention of linking this information with the recent referral, but this did not happen and this request for help and advice was treated in isolation.*

She was not prepared to disclose the information to police as she worried about the repercussions from the abuser if she did so. A referral to CSE specialist support did not happen in this case, as there was confusion about who had responsibility for a referral.

Summary points

Harmful sexual behaviour should be understood on a continuum. Age and stage of development will influence the perceived severity of behaviour and guide relevant interventions.

There must always be a therapeutic and/or safeguarding response to harmful sexual behaviour in addition to any criminal justice response.

Being a victim and a perpetrator can be very closely related and both require support and safeguarding.

Practitioners need to be aware of the link between sexting and exploitation. Shared sexual images can be used for bullying and blackmail to continue abuse.

4.5 Social media and technology-assisted harm

Adolescents are increasingly using social media to communicate, explore friendships and find information. Immersive engagement with social media, including video material, can be powerful, especially if there is little to counter the messages and ideas young people receive which might include extremism, pornography, gaming and criminal and sexual exploitation. Adolescents who feel disconnected from family and society may turn to social media and online activities to find a sense of identity and belonging.

Jack's SCR is an example of a young person exploring his sexual orientation online, which included contact with older men, but also using online support such as Childline. Adolescents usually explore their sexual identity with their families and broader environment such as peer networks at school (Harper et al, 2016). Jack found that his male peers distanced themselves from him when he disclosed his sexual orientation and he became isolated. This led to his increased use of the internet to connect with others who he felt would understand him:

> *Jack's naivety, youth and need for contact with, and understanding from, other gay people, made him an easy target for abusers. This was a classic case of grooming.*

At the same time as young people turn to online interactions, practitioners and parents try to catch up with evolving technology. Even if practitioners feel confident and knowledgeable about technology use, they may still struggle to support young people's usage in an ever-changing digital world (Simpson, 2016). It can be difficult to understand

online influences on adolescents as the SCR about brothers who were groomed into radicalisation indicated:

> *Parents and professionals often do not understand the different elements of social media, in terms of its impact, messages, sites and changing format, so it is difficult to discuss and explore with young people. In this very quick moving environment, it becomes difficult for those in authority to develop effective strategies, when perpetrators online will change and adapt their techniques to avoid detection*.

Clearly social media provides a space and opportunities for children to be groomed and exploited. It has produced a shift in adolescent safeguarding from mostly parenting issues to protecting them from community harm both online and offline. Technology-assisted abuse is hard to control for parents and practitioners as removing access or even monitoring access is almost impossible:

> *Jack's initial access to the internet was through his phone, laptop and iPad. When these were removed, he accessed the web by using the phones of his friends. Given the ubiquity of phones with internet access amongst teenagers, he must have had many opportunities to do this.*
>
> *The police seized Jack's devices; his parent's restricted access. At no point in three years did this prevent Jack contacting men over the internet and social media.*

When practitioners come across inappropriate or concerning use of the internet and social media platforms, they need to take action but it is not always clear to them what they are meant to do other than attempt to remove devices as in the case of Jack. The lack of action other than recording is demonstrated in the SCR about Child J:

> *Later J's aunt raised concerns about J communicating with an older man and posting a photograph of herself in what was felt to be inappropriate clothing. On these occasions professionals correctly reported their concerns for J's safety and wellbeing. However, apart from recording the information within the case narrative, there appeared to be no further curiosity or management overview of the possible significance of J's use of social media or of the potential safeguarding action that may have been needed.*

Social media was also a platform for bullying behaviour from peers:

> *The chat included Child A threatening to 'get' her dad (who she commented was mad), threats of stabbing and abusive language including from an unknown cousin of one of the students who had posted comments about Child A being bisexual and an EMO (in this context someone who self-harms).*

Online grooming was not limited to grooming by strangers. For one adolescent who died by suicide, it was a member of her extended family who was a known sex offender. He had images of her, and after her death it became clear that he may have threatened to post them online:

> *We know that step grand uncle took indecent images of Alex and it remains a possibility that he used them, as he had done on these earlier occasions, to threaten and exert control over her.*

The family member, who was not allowed access to the internet as part of his offender management plan, appeared to access the internet freely, further indicating that access is almost impossible to control for offenders as well as victims:

> *His access to email, as evidenced by the 2008 episode, suggests that he misled officers in saying that he had no internet access. It should have been apparent from the facts of this episode that he did have internet access.*

The family member was managed under the terms of the Multi-agency Public Protection Arrangements (MAPPA). They considered him low risk, which means that '*current evidence does not indicate a likelihood of causing serious harm'* (Ministry of Justice, 2017, p.62). His two previous, known offences had involved the use of intimate photographs and threats to distribute. Despite not being allowed access to the internet as early as 2008, it was clear that he was using email. Movement between two local authorities and known access to children did not result in increased probing about his activities or revisiting the risk assessment. Information about the registered sex offender travelling to visit family in another local authority and staying for extended periods was not shared with the receiving authority. This meant that a risk assessment was not undertaken when he visited his family and children's social care was not alerted.

In addition to preventing perpetrators from accessing the internet there are also difficulties in protecting their victims from technology-assisted harm. Adolescents often had access to several of their own or their friends' devices and could easily set up multiple new accounts. In the SCR about Child Q, it was a challenge for police to access social media activity when trying to protect her from exploitation due to the number of devices and accounts she had:

> *The child provided details of the account and gave permission for the Constabulary to access the account. However, the child then created a new account that the Constabulary were unaware of. Regular physical searches of the accommodation by the Constabulary and care staff were unable to find an additional hidden mobile device.*

The review suggests that physical searches for devices are difficult for practitioners to undertake. Unlike some practitioners, for example prison officers and police, care staff

did not have any training in search procedures. If they had access to and competence to use software that can identify unknown devices there would not be the need for a physical search. The physical removal of possessions can leave adolescents feeling disempowered and isolated and should be done with sensitivity and clear explanations as to their use for evidence and a timescale for their return (Beckett & Warrington, 2015).

Technology was also used for online gaming and in one review, it clearly provided a place to belong for an adolescent male who had immigrated to the UK with his father and brother and experienced some bullying at school. He was so involved in online gaming that he stole from his father to support his gaming habit:

> *Child B no longer had to use the main computer which could be monitored, and he began to spend increasing amounts of time playing online games where the entry level may be free of charge, but which become paying as one progresses. Child B's father felt that for his son, this was out of control and he was effectively addicted. To fund his playing of games, Child B used his father's credit card. Child B's father seemed to feel somewhat powerless about this*.

Internet based companies and those managing social media platforms share some responsibility for regulating the internet, which has been recognised and addressed by the White Paper on online harm, published (HM Government, 2019).

Alongside regulation, education of parents, children and practitioners should be undertaken as suggested in an SCR about sexual exploitation:

> *The need for e-safety knowledge is a significant one for parents, carers and practitioners, as in general terms, adults are often less knowledgeable than children about the changing pace of technology.*

Information is available for children, parents/carers and practitioners and reporting harmful online content has become easier using Report Harmful Content Online[10] provided by UK Safer Internet Centre[11]. Online sexual images of the under 18s should be reported to the Internet Watch Foundation[12]. A number of reports about online safety related to specific topics (for example, bullying, sexting and racism) are available on the UK Council for Internet Safety webpages.[13]

[10] Report Harmful Content online
[11] UK Safer Internet Centre - Advice Centre
[12] Internet Watch Foundation
[13] UK Council for Internet Safety

Summary points

Social media provides a space and opportunities for children to be groomed and exploited with associated safeguarding challenges. Adolescents who feel disconnected from family, community and society may turn to social media and online activities to find a sense of identity and belonging.

In addition to preventing perpetrators from accessing the internet there are also challenges when trying to protect their victims from technology-assisted harm. However, adolescents (and the perpetrators) have access to multiple devices and accounts, making monitoring unachievable. Therefore, alongside regulation of the internet, ongoing education of parents, practitioners and children must be undertaken. This can be done by subscribing to updates and newsletters from relevant organisations (for example, UK Safer Internet Centre).

4.6 Opportunities for prevention

The themes explored above present contemporary challenges for vulnerable adolescents which put them at risk of serious harm or death. The following sections will explore opportunities for prevention and opportunities for protection identified within the SCRs in this adolescent sample.

4.6.1 Education

For the adolescent age group education or training is compulsory. The adolescents still engaging with education had opportunities for protection at school or training placements and schools were often instrumental in noticing, alerting and managing potential harm. Schools made plans to improve integration and educational attainment when education changes took place. Often school staff identified and referred adolescents to children's social care and worked closely with other agencies as in the case of Jack who was sexually exploited over several years:

> *School was 'a beacon of good practice' –worked closely with parents and pupils, put in place practical measures and ensured other agencies were kept informed*.

Staff at one primary school were particularly proactive in collecting Child S from home when she was not brought to school and her secondary school provided new shoes and a uniform. However, it was not possible for the secondary school to provide the same intensity of support as that experienced at primary school. Nonetheless, the secondary school actively sought to develop a positive relationship with Child S and contacted other agencies to express their concern for her welfare.

At another school, one member of school staff managed to build trusting relationships with two young people who were sexually exploited:

> *Both Y and X's parents described the involvement of one particular member of school staff who communicated well with the children, their carers and agencies on a regular basis and whom Y reported as being only one of two individuals that she could trust.*

Education staff were thus able to support young people and were well placed to share information with other agencies. In some cases, the support took place at alternative education providers such as pupil referral units or hospital education services.

As indicated above, school staff were closely involved in supporting the young people but they were also aware that they could not work as the sole agency and referred to other agencies. Unfortunately, when referrals did not meet the threshold they rarely challenged decisions or escalated the challenge, as illustrated by the examples below:

> *A formal request was made by the Constabulary for a strategy discussion, due to concerns the child might be at risk of significant harm. Child S was returned home, following a visit to the child's mother who said she was using amphetamines, struggling to manage Child S's behaviour and needed help. The outcome was the environment was concerning but not at the "level of neglect". A section 47 investigation was completed and the school were informed by the social worker the case would be closed. The school verbally challenged the decision believing that Child S was at risk of significant harm but did not activate the escalation policy.*

> *School did not receive adequate response when they contacted CSC about James' missing episodes. They did not challenge CSC or escalate their concerns.*

Working Together 2018 (HM Government, 2018b, p.73) clearly sets out the need for the three safeguarding partners (local authority, police and health) and relevant agencies to '*challenge appropriately and hold one another to account effectively*'. There should also be local arrangements in place clearly setting out escalation policies and how disputes will be resolved. Chapter 6 discusses escalation and professional challenge in more detail.

4.6.2 Relationships

Working with adolescents is different to working with young children and their families. This is partly because during later childhood harm is often community based and cumulative, having started in early childhood.

Many adolescents had experienced relationship losses. Some were separated from parents through an informal arrangement (for example, staying with relatives abroad) and some had been or were looked after by the local authority. Many had fractured family and peer relationships due to parental separation or death and frequent school or placement moves. Siblings were sometimes dispersed, particularly when adolescents were looked after. Due to previous relationship difficulties, many adolescents found it difficult to form trusting relationships with practitioners who aimed to support them. The availability of time and resources were key to working preventatively with young people.

The focus on younger children in the child protection system was raised in the review about Mark. Different professionals worked with him short-term which was not helpful in preventing his drug and alcohol abuse escalating:

> *The need to develop authentic and sufficiently intensive long-term relationships with young people is not fully recognised and is not yet part of the service response.*

Practitioners involved in the review quoted above, felt frustrated that there was rarely time to build a relationship with adolescents that could lead to a better understanding of their wishes and feelings and to truly hear the voice of the adolescent. The author of the review found that practitioners were very vocal as they expressed the view that working with adolescents required a different way of working to that of work with younger children.

Non-statutory agencies made it possible for practitioners to work with the young people long term and this enabled them to build sustainable relationships. There were examples of non-statutory agencies working with young people for up to five years and evidence that agencies supporting young people over a period of time can have a positive influence:

> *XLP[14] staff knew the family well, and Mother considered them a positive factor in U's life.*
>
> *He describes his circumstances and says how BLAST was a big help, and stresses how important the consistency element of support is. Jack credits much of the improvement in his position to the understanding and support he received through BLAST.*

[14] XLP is about creating positive futures for young people growing up on deprived inner city estates, struggling daily with issues such as family breakdown, poverty, unemployment and educational failure, and living in areas that experience high levels of anti-social behaviour, criminality and gang activity.

4.6.3 Loneliness

Like many others in society, young people can feel lonely especially if they lack supportive social relationships (Sital-Singh, Nicklin and Fry, 2018). Loneliness can affect wellbeing and is associated with risk-taking behaviour and increased risk of depression and low self-esteem. It can also impact the way young people respond and cope with diversity and trauma yet remains a relatively neglected aspect of childhood and adolescence (Besevegis and Evangelia, 2010; Action for Children, 2017).

Adolescents may be more connected than ever through social media but that can increase feelings of loneliness as looking at pictures of others or being bullied online, for example, further reduces a sense of belonging (BBC, 2018).

Experiencing loss and separation due to family and social disruption can leave adolescents feeling lonely. Child A was recognised by his link-worker as being lonely when he was 14 years old. He had been looked after in a therapeutic unit since the age of eight. His behaviour suggested a need to belong as he was persistent in trying to trace family members and was vulnerable to grooming by older men both in the community and through online sites. He had limited contact with his mother and '*Staff referred to him feeling very sad and experiencing lots of loss'*.

Another adolescent was referred to as 'friendless':

> *The head teacher described him as a friendless child who experienced difficulties in reading social cues or complying with social norms.*

Children who do not experience secure attachments are less able to develop the capacity to trust others and therefore they may appear harder to engage in supportive interventions (Mental Health Foundation, 2016). Child A's early childhood had exposed him to abuse and neglect and chronic domestic abuse. He had 20 different placements during his 12 years in care of the local authority. His feelings of loneliness, sense of loss and sadness were likely to be because of his cumulative harm and lack of permanency.

Even within the home, some adolescents experienced loneliness. This was evident when children took on caring duties or the role of managing difficult parental relationships as in the SCR about Child B:

> *Child B's views were included in the Core Assessment where she says that she was worried about her mother's drinking. The children felt that with their father away, they had no-one to talk to.*

Child B and her siblings undertook household chores and dog walking and found the responsibility for their parents' harmony burdensome.

Feeling responsible for a parent can add a significant burden during adolescence and in the case of Child B, caring for a very unstable parent felt like a lonely and isolating experience. Despite the benefits of attending a young carers group, she was not able to continue going as her mother's mental health deteriorated and she felt the need to be with her:

> *B was recognised as a carer but appeared to have been given additional responsibilities to monitor the welfare of her mother; with no recognition of her own age and vulnerability and that she was still a child. B stopped going to Young Carers as she thought her Mother could not be left at home alone.*

Signs of loneliness can manifest as withdrawal and lack of engagement as in the case of Becky. She felt isolated and had significant fears about the outside world:

> *Becky reported feeling scared about a lot of things, including going back to school and being out alone, caused, she said, by reading about abduction cases and watching horror movies.*

Her behaviour became the focus of the problem rather than the circumstances she was living in and her experiences, which included a traumatic past and complex family relationships. Services offered were to address her 'troublesome' behaviour and did not include the contextual factors such as her family and school environment or the causes of her behaviour and non-engagement. The many single agency assessments in this case meant that there was little transfer of care or information between services and a lack of coming together of agencies to explore fully what Becky needed. The fragmented provision was further highlighted by the number of professionals, seventeen in all, she was expected to engage with during the three-and-a-half year review period.

Relationships are crucial to enable practitioners to work with adolescents. Taking time to build those relationships can be difficult in a climate of few resources and high caseloads.

Case study: Loneliness and isolation

Annabel is a 16-year-old Black British girl who was seriously assaulted by her mother during the night. She lived with her mother who had a long history of mental ill-health with paranoid and psychotic thoughts. The mother also used alcohol and the relationship between the parents was marred by domestic abuse incidents. Her father wondered if African spiritual beliefs had an impact on the mother's mental illness but that was not explored by practitioners. Annabel was a carer for her mother from a young age. When her mother was hospitalised she lived with her grandmother or father which was a long way from her school friends. School was an important place for her and she felt supported there as they advocated for her needs and worked sensitively with her to respect her privacy.

She tried to keep secret the situation at home to protect her mother and herself. To alleviate her loneliness and pain she self-harmed. She attended a group for young carers for a while which she found very helpful and supportive but she had to stop attending as her mother could not be left at home alone, further increasing her isolation. Agencies were not aware that she had stopped attending. Despite being in sole charge of her mother most of the time, she did not feel involved in any decision-making or listened to by practitioners. When her mother was discharged from hospital, Annabel was, however, treated as an adult and a partner in her mother's care, which was inappropriate.

Key points:

Young people can become isolated and lonely particularly if they keep their carer responsibilities a secret. Practitioners must invite the child to speak about their experiences and listen to what they have to say.

When it is known that a child cares for a parent, a Young Carer's Assessment should be undertaken to address additional needs and any plans should be shared with other agencies. Loneliness is a subjective feeling common amongst young people and should be considered in the assessment.

Self-harm is strongly associated with completed suicide and should be referred to health services for thorough assessment and intervention.

Cultural and religious beliefs can impact on the understanding of mental illness and practitioners should be supported through supervision or training to explore such issues and to feel confident in discussing them with families.

4.6.4 Early help and support

Many of the young people in the SCRs examined had displayed behaviour indicative of something being wrong long before reaching adolescence. The cause of behaviour was not always explored and incidents were instead dealt with as they came up.

Child AC developed behavioural problems during primary school and received support focused on managing the behaviour. By the age of ten, he had his first encounter with the criminal justice system but there was still no sense of why he was behaving as he did. Despite early help to manage symptoms of maltreatment there was little support to make life better for him and he was eventually accommodated in a secure centre, which appeared to be helpful for him. The routine and boundaries were said to suit him and he adhered to them:

> *Whilst at the centre AC attended education daily, achieving over 25 hours a week. He was reported to have formed positive relationships with the staff and his peers and managed to achieve the highest level in the incentive scheme.*

Although Child AC eventually responded favourably to an intervention, it took some time and multiple criminal acts for him to get support that suited him and he felt able to engage in. Children and young people are not always able to express clearly what is happening to them but practitioners who work with adolescents should be alert to changes in behaviour as a sign that all is not well (Cossar et al, 2013)[15]. In the case of Child S, there was little support for her as she experienced ongoing neglect with neither early help nor escalation to any child protection process:

> *Child S was left for too long, living with neglect, without any effective ongoing multiagency support or intervention. The child's risk taking behaviours began to escalate, placing Child S at risk of harm and CSE.*

Early educational assessments were not always undertaken, which could leave children struggling, failing and turning to disruptive behaviour. In addition to his poor level of English, Child U was achieving well below his expected level for his age:

> *His inability to read and understand material meant that he could not access the mainstream curriculum. Had this been known several years before, a different approach might have been taken, possibly as early as in primary school.*

[15] The iCAN framework based on research by Cossar et al (2013) can be accessed at https://www.uea.ac.uk/ican/home

Early help and support still relies on building trusting relationships with children, young people and their families:

> *If authentic and sufficiently intensive long-term relationships are not part of the service response to young people, and professionals are not actively supported to invest time in establishing these relationships, then interventions to reduce risk and promote resilience in young people is likely to be ineffective*.

4.7 Opportunities for protection

The above section has suggested some difficulties with preventive work with adolescents and highlighted that there may be missed opportunities for prevention when the child is younger such as timely assessments and ongoing work with adolescents that takes time and resources.

4.7.1 Suitable placements for vulnerable adolescents

At times, it is necessary to balance the safety of a child with restricting their liberty. Within the SCR population, some young people were placed in secure settings for their own safety or that of others. The adolescents who needed to be kept secure included those where there was an escalation of risk-taking behaviours and exploitation by others and where the young person lacked insight into the risks to themselves and/or others. Secure children's homes provide a locked setting and children may enter through youth justice or welfare routes (Hart & La Valle, 2016). Since 2011 and during the period of this triennial review of SCRs, there has been a steady increase in the percentage of children placed by local authorities in secure children's homes on welfare grounds from 28% in 2011 to 51% in 2017. The overall share of Youth Justice Board places has decreased during the same period from 66% in 2011 to 46% in 2017 (Department for Education, 2017d, p.5).

Children who are placed in secure children's homes benefit from short-term protection with the hope that it may produce long-term improvements for the child (Hart & La Valle, 2016). However, if a placement is not in the local area then there can be difficulties with continuity of support during and after the placement.

In one SCR about an adolescent who self-harmed, exhibited suicidal ideation, self-neglected, and frequently went missing, a secure placement provided a period of stability and an opportunity for a thorough assessment. Unfortunately, as soon as the placement ended and they were back in residential care the behaviour escalated and there was yo-yoing between residential care and secure placements over a period of two years suggesting a lack of a robust exit plan when leaving a secure placement.

Sir James Munby, previous President of the Family Division, brought attention to the shortage of suitable secure and safe placements for young people when he commented during the case *Re* X *(A Child) (No 3)* [2017] EWFC 2036 (Fam):

> *If, when in eleven days' time she is released from ZX, we, the system, society, the State, are unable to provide X with the supportive and safe placement she so desperately needs, and if, in consequence, she is enabled to make another attempt on her life, then I can only say, with bleak emphasis: we will have blood on our hands.*

In the case of Child AC, it was possible to prevent the escalation of his offending and allow him to improve academically and socially whilst in a secure centre.

The SCR about Thomas, who displayed harmful sexual behaviour, disputed the appropriateness of placing him in a residential special school during weekdays and term time only. The placement was seen as a way to keep him safe but it did not remove him from a family where he experienced abuse, neglect and controlling behaviour from his mother:

> *…even whilst he was at school there were concerns that Mother continued to have a negative influence through, for example, refusing to allow him to go on school outings.*

There were additional difficulties as the placement was out of his area and therefore it was difficult to arrange for the child and adolescent mental health service (CAMHS) to work with him as there was no service level agreement between the two local authorities leaving him without much needed support for this behaviour whilst in the placement:

> *The complex commissioning landscape for CAMHS can result in poorly co-ordinated services and a lack of clarity about roles and responsibilities, leading to gaps in provision and poor transitions.*

The lack of a suitable placement can lead to prolonged stays in hospital for young people with mental health crises or those labelled with behaviours seen as difficult to accommodate such as harmful sexual behaviour. This led to one young person staying on an adult ward. Later, he was discharged into an unsuitable semi-independent setting after a serious overdose, as there was a shortage of beds within the hospital and a shortage of suitable placements outside the hospital. His mental health deteriorated significantly and he was detained under section 2 of the Mental Health Act (detention up to 28 days) but it was still difficult to find a bed and James managed to abscond before a bed was found eight days later. The review included the voice of the young person who thought of hospital as a safe place and staff saw that he responded and co-operated when he felt safe:

> *James was happy that he had been admitted to the secure psychiatric hospital and felt that he was getting the help that he needed and so was making progress. He seemed anxious about the future as he was aware that he would shortly have to leave and that at present it was not clear about future plans.*

It was a sad reflection of the services provided when a senior manager in the local authority said '*James's most stable placement in recent months has been* […] *Hospital'.*

In the case of Jack who was groomed online and sexually exploited, there were discussions among professionals about a placement in secure accommodation to protect him from the perpetrators in his life and provide him with support:

> *It seems that the discussion around secure accommodation arose more out of desperation than a realistic prospect of using this as a realistic option. There was never any prospect of Jack being placed in secure accommodation as he simply did not meet the stringent criteria…*

Jack's parents were opposed to the idea of secure accommodation as they felt it was a police motivated response due to their complaint against police handling of the case. He was not looked after by the local authority and legal advice was not sought from local authority lawyers when two main agencies considered using section 25 of the Children Act 1989[16]. That may have been due to professionals feeling that Jack did not need to be kept safe from his family but from perpetrators online and in the community, a clear illustration of the dilemma of keeping young people safe when harm is community-based rather than family-based.

4.7.2 Working together and sharing information

Delays in sharing information at times made it difficult when working with adolescents, particularly when incidents were happening frequently. There was a delay of 19 days after a young person was arrested for rape before the information was shared with children's social care. When a 14-year-old girl was admitted with an episode of self-harm there was no communication with CSC at all and when a police notification of a stabbing was sent to a school where the young person had left 15 months previously there was no indication that staff responded by letting the police know that he had moved on:

> *It appears that the school nurse who was informed did not identify that F was now at college in a neighbouring borough.*

[16] https://www.legislation.gov.uk/ukpga/1989/41/section/25

In other cases, information was simply not shared at all. A useful way of sharing information is through strategy or review meetings although that only works if representatives from relevant agencies are invited. In one SCR, a strategy meeting took place between the social worker and her manager only and the CSE strategy meetings did not include invitations to police, school nurse or GP. It was fortunate that despite not sharing an electronic recording system, the GP and the school nurse communicated through paper updates. There were, however, also plenty of examples of good practice and agencies coming together to share and discuss vulnerable adolescents, as in the example below:

> *Once AC came to the attention of YOS, there was further evidence of good information sharing and communication between YOS professionals and the Secondary School. The Team Around the Family meetings that were established by the school ensured that appropriate professionals were engaged in supporting AC and his parents.*

Sharing historical information and sharing information across local authorities remained an issue but again there were cases of good practice which highlights that it can be done:

> *The Children Looked After Social Worker had the insight to explore the child's early years, through discussions with family members. It was only known then that up to the age of 6 years, the child's life was stable, receiving good enough care from the mother and maternal grandma. Following two significant bereavements (grandfather and uncle), the child's grandmother went missing for one year. The child moved to live with the mother and following this the quality of care for Child S significantly deteriorated. The importance of the child and parent's history is crucial especially when working with chronic neglect to help work with the root cause of neglect and prevent repeated "start again" assessments.*

However, information sharing across boundaries with health was not successful which resulted in health reviews being undertaken without historical health information available. Sharing information is a challenge and the increased complexity of sharing across health boundaries and local authorities clearly exacerbates the complexity and challenge.

There is still some confusion as to what can be shared, particularly by GPs. The issue was highlighted when an SCR was undertaken and the reviewer had challenges when requesting medical data from a GP:

> *The request for information was not made until late in the process by the named doctor, due to some confusion as to whether the request for relevant personal and sensitive medical information for undertaking an SCR was valid.*

Practitioners also described uncertainty about what information could be shared, particularly with parents, and which information could be legitimately shared with professionals, all of which impacted on a shared understanding of the children and risks they were facing.

Thresholds

Practitioners are at times unsure if a referral will meet the threshold for children's services or they have experiences of cases that have not met the threshold in the past. Such experiences can make them reluctant to refer again:

The school did not make referrals to CSC, as they did not think the case would reach their threshold.

If a case does not meet the threshold then there is a risk that the referring agency feels reassured. In one case, the reason for not opening the case was that CSC thought the young person was engaging with another service. However, they did not ascertain that and he was in fact not engaging which left him with little protection and support from agencies. In this case, as in others, there was an assumption that other people were dealing with the problem.

Challenging decisions

Challenging other professionals can be difficult and requires a high level of understanding of a specific case as well as self-confidence. It is therefore not surprising that often decisions went unchallenged by practitioners. It can also be the case that practitioners assume that the lead agency knows best and leave key decisions and accountability to that agency. When a decision is challenged, it is not necessarily heard:

Practitioners become attached to their judgements and can employ strategies to ensure that challenge is not recognised or explored. The dominant view of the key professionals can result in an outlying view being ignored or not heard, as was a possible hypothesis in this case.

If a challenge is not heard practitioners should be aware of their escalation policy but in some cases they lacked knowledge of the process of escalating concerns:

Professionals did not understand escalation procedures or that it would be possible to step Jack up and consider a child protection plan. When questioned as to why no one escalated these concerns, there was again a lack of understanding of process.

There was evidence of inter-agency challenge in a CSE case where both police and the CSE team disputed the decision by children's social care to complete a CAF with a child who was found in the early hours of the morning with an older male. Despite insistence

that the case should be treated as a child protection issue and not as a Child in Need, as determined after an assessment delay of four months, there was no change in the CSC decision:

> *This incidence provides evidence of oversight and challenge but, given the subsequent actions, no effective feedback loop, as no assessment was completed for four months, which again concluded a need for Child In Need services.*

It is good practice to challenge decisions but merely questioning something that seems to be a poor decision is not always enough. More challenges that are robust are necessary and need to be escalated as appropriate (following local safeguarding policies) which will only happen as practitioners increase in confidence and become familiar with escalation policies and escalation routes for individual agencies. It is the responsibility of professionals to problem solve whilst remaining focused on safeguarding the adolescent.

4.7.3 Written agreements

The use of written agreements was common in the adolescent cases where the child was still living at home. They aimed to ensure the safety and wellbeing of the adolescent. They were not used in an effort to prevent risky behaviour but as a way of protecting the young people from harm by restricting their movements or use of the internet, for example, and increase supervision by parents/carers. They rarely appeared to be developed with parents and/or adolescents.

In one review, parents were asked to sign a written agreement aimed at ensuring that two sisters did not contact or send photos and videos to an older male:

> *This written agreement was more detailed and included that Sam and Charlie were to be supervised always when not at school, the police should be notified immediately of any missing incidents, any mobile phones found in the possession of either Charlie or Sam should be confiscated and the police and Children's Services to be notified immediately.*

The above is just one of several examples of the use of written agreements. A recent report exploring the multi-agency response to children living with domestic abuse found that the use of written agreements was widespread but often ineffective (Ofsted, 2017). When parents are struggling to keep their adolescent safe, written agreements do not appear to be effective partly because they are hard for practitioners to monitor but also because expectations are often not realistic.

In the case of Child N, who had allegedly assaulted another vulnerable child on the journey to school, the mother was expected to ensure that there was no unsupervised contact with younger siblings. As they all lived in the same home, that was an almost impossible task for the mother. It is not clear how such an agreement was monitored.

It is important that parents understand the content and expectations of a written agreement. Parents may indicate that they understand as they are likely to be concerned about the consequences of not signing a written agreement. For the mother in the SCR about Sam and Charlie above, an interpreter was used at the time of signing the agreement but she would not have been able to refer back to the content of the agreement as there was not a written translation and she was not able to read English. The agreement required the parents to supervise the sisters at all times, including on their journeys to and from school. As the quote below indicates, that was not possible for the parents to manage:

> *The key social worker visited the family in their new home on this date and discussed the recent concerns. Parents stated at the visit that they had not reported Charlie missing in June due to having no phone and mother said that she had not been aware of the girls being out the previous Saturday night as she was asleep in bed. The key social worker advised parents that legal advice was to be sought due to the concerns about their lack of supervision of the children.*

For Charlie and Sam, lack of cultural competence made it difficult for practitioners to understand the parents' lack of engagement with the written agreement which attempted to ensure that there was no contact with older males (Charlie's 'boyfriend' was almost seven years older than her). Lack of understanding of the fear the mother had of her children being removed and cultural differences in age of marriage made it difficult to keep the children safe as Sam told practitioners:

> *Since being removed into local authority care, Sam has provided further information about cultural norms including Roma gypsy marriages of young girls aged 11-12 years being "married" to older males with the parents of girls receiving a sum of money for this.*

Written agreements had little or no effect in the cases examined. They were used in cases where parents were already struggling and where intensive work with the family was necessary.

Case study: Written agreements

Stacey is a White British girl aged 15. She lived with her mother and stepfather who was a known and convicted sex offender. The stepfather was involved with the family for 10 years and sexually assaulted Stacey on two occasions. She had poor school attendance from the age of 5 years (at times as low as 50%), unspecified behaviour issues and experienced bullying at school and in the community. The GP saw Stacey for a number of minor illnesses and her school mistakenly believed that her poor attendance was because of various illnesses. There was no school/doctor liaison. The mother suffered from a chronic but manageable illness, which she exaggerated, and Stacey worried about her dying. Both the mother and maternal grandmother had experienced sexual abuse. Children's social care were involved with the family for eight years during which time they drew up four written agreements:

1. After stepfather indecently assaulted a child related to Stacey, the mother had to promise she would not allow unsupervised contact between Stacey and her stepfather (they all lived in the same home).
2. Mother physically assaulted Stacey and she had to promise not to use physical punishment.
3. Stacey had an unexplained bruised eye and a third agreement specified similar actions to the ones above.
4. The fourth written agreement was drafted without regard to the knowledge that all previous agreements had been breached. Stacey was assumed to be safe staying with her maternal grandmother who undertook not to allow stepfather contact with Stacey.

Life for Stacey continued to be the same despite written agreements and agencies being aware that agreements were not adhered to. CSC closed her case, preventing effective monitoring of agreements whereas the intended consequence of non-compliance with the agreements was that an initial child protection conference would be convened. Other agencies were reassured by a written agreement and saw it as evidence of parental commitment to keep the child safe. The mother and stepfather later said that they did not understand the agreements as they were not explained in terms they could understand.

Key points:

Written agreements need to be explained clearly to parents/carers and non-compliance must be acted upon and challenged by other agencies if necessary. The repeat use of written agreements and case closure can serve to wrongly reassure other agencies that the risk to a child is low.

Practitioners cannot assume that a mother or grandmother will have an understanding of sexual abuse and the ability to protect her child because of their own experiences of sexual abuse.

When there is a focus on parental illness and other difficulties, the voice and lived experience of the child can easily be overlooked.

4.8 Conclusion

Adolescents are particularly vulnerable to online and community harm in addition to previous or ongoing harm within the home.

The pathway to harm for adolescents is often triggered by episodes of going missing which increases the risk of exploitation in the community. The pathway to harm online may be triggered by feelings of loneliness and isolation that leave adolescents with a need to find a sense of belonging. That can lead to exploitation through grooming, in particular sexual exploitation and even radicalisation.

Adolescents who have had adverse experiences throughout childhood often struggle as they reach adolescence and may be poorly equipped to manage or even recognise healthy relationships. They can, therefore, have trouble with friendships, become socially isolated and experience feelings of loneliness.

Children are not quickly made safe when they have had traumatic experiences. The adolescent reviews analysed here have demonstrated the need for prolonged and persistent engagement as a means of supporting adolescents. There needs to be a balance of preventative work and crisis management. Agencies should also find ways to record patterns in adolescent group and individual behaviour to capture a more holistic picture of potential harm.

Chapter 5: Messages from care and court cases

The purpose of this chapter is to highlight the key messages from a sub-sample of ten cases where the children were in care at the time of the harm that led to the review, or had previously been in care; and/or where there had previously been care proceedings. There are two reasons for this focus. First, these are children where there had been serious concern about their welfare, such that the local authority instituted care proceedings, even if the court did not actually make a care or supervision order at the end of the proceedings; and yet all these children subsequently suffered further harm. Second, there have been major changes to the care proceedings system since 2013, with a significant increase in the number of cases going through proceedings, and a changing pattern of orders, with more cases ending with children returning to (or remaining with) their parents under supervision orders, or going to kinship carers under special guardianship orders (SGOs). (Details of these changes are given in the chapter.)

5.1 Introduction

Ten cases were purposively selected for this part of the study. The aim is to identify learning points from them, for local authorities, the courts and other agencies and professionals who work in the family justice system (for example, Cafcass, lawyers, independent experts and assessment services). Brief outlines of the ten cases are given in Appendix F and in Table 19 below.

We have highlighted issues about inter-agency working and the involvement of the courts in one of our earlier reviews of SCRs (Brandon et al, 2012, pp.86-88), but the increasing number of care proceedings, and the much higher profile of court activity and judgments, mean that it is important to take a new look at cases where the court has been involved. The number of care proceedings starting each year rose dramatically over the period covered by this report, from just over 11,000 in 2014-15, to an all-time high of 14,599 in 2016-17. It has fallen back over the last two years, to 13,536 in 2018-19 (Cafcass, 2019). The period also saw an increase in the number of children in care, rising from 68,840 on 31 March 2014 to 72,670 on 31 March 2017. It rose again in 2018, to 75,420. Another significant change has been in the proportion of children looked after under a care order. This rose to almost three-quarters, 73% (55,240 children) in 2018, up from 58% (40,090) in 2014 (Department for Education, 2018a).

Alongside these changes, since 2013 (that is, starting just before the period covered by this triennial review), there has been a national drive to speed up care proceedings. Section 32(1) of the Children Act 1989, as amended by s.14 of the Children and Families Act 2014, requires the courts to timetable care and supervision cases with a view to concluding them without delay and, in any event, within 26 weeks of an application being issued. This change has had a dramatic impact, with the average duration falling from 50

weeks in 2011 to 26 weeks by 2016, although it has risen again since then, reaching 30 weeks in the second quarter of 2018 (Ministry of Justice, 2018).

Table 19: Brief summaries of the ten 'care and/or court' cases

SCR name	Age & gender	Ethnicity	Brief summary
Child J	7 years female	Mixed	Died from brain injury in the home of her aunt where she lived under special guardianship order.
Shi-Anne	18 months female	Mixed	Died from multiple injuries in the home of her guardian where she lived under a special guardianship order.
Child A & Child B	<5 years both male	Mixed	Both boys physically and sexually assaulted by a carer whilst placed under a special guardianship order.
Polly	22 months female	White British	Died at home. Pre-birth CP plan; care proceedings; interim SO and interim care order.
Child G	3 years male	Black African	Died from force-feeding at the home of his parents. Had been subject of police powers of protection; fostered briefly under section 20; CP plan (neglect) stepped down to child in need.
Child K	16 years male	White British	Died by suicide in residential setting. Subject of care order at age nine. Had stable foster carer placement for seven years until it disrupted due to extremely challenging behaviour.
Child F	4 months female	Black African	Injuries consistent with shaken baby whilst in foster care. Complex contact arrangements with both parents.
Peter, Tom, John & Christopher	17y, 11y, 15y, 9y all male	White British	Peer-on-peer sexual abuse by four boys placed in the same foster home. All were on care orders and had significant needs.
Child H1	14 years female	Black African	Raped by mother's partner while her mother was detained under the Mental Health Act. Accommodated three times under section 20.
Child N	5 years male	British Asian	Died in house fire. Acrimonious separation of parents. Three sets of private law proceedings; one set of care proceedings; removed from father under police powers of protection; accommodated briefly under section 20; residence order granted to father.

At the same time, there were also a number of prominent court judgments which have had an impact on local authority practice and court decision making. Two notable cases, both in summer 2013, are *Re B (A Child)* [2013] UKSC 33 and *Re B-S (Children)* [2013] EWCA Civ 1146. Both cases concerned adoption without parental consent, with Re B (A Child) holding that making the care order must be "necessary"; this was only the case where 'nothing else will do'. These two cases have been seen to lie behind a substantial fall in the number of care proceedings ending in care and placement orders (adoption plans). The impact of these judgments was striking. Masson (2017) describes them as 'disruptive judgments', and there is an awareness of them amongst local authority social workers that is quite different to the usual levels of knowledge about specific judgments. There were also a series of judgments that were highly critical of local authorities' use of section 20 of the Children Act 1989 (local authority accommodation for children, which does not require a court application)[17]. These have contributed to the increase in the number of care proceedings, and the increase in the proportion of looked after children who are on care orders rather than section 20 (Department for Education, 2018a).

The national pattern of orders made at the end of care proceedings has changed significantly in the context of these developments, although it is worth noting that there is considerable variation between different areas, and patterns continue to change. Masson et al (2018), comparing outcomes of cases which started in 2009-10 with cases starting in 2014-15, found that the proportion ending in care and placement orders had halved, from 30% to 15%. This was accompanied by a near-doubling in the proportion of cases ending with plans for children to live with relatives or other 'connected persons' under SGOs, up from 13% to 24%. Cases ending with the child returning to/remaining with one or both parents rose from a quarter to just under a third (25% to 32%), whilst the proportions ending in care orders stayed nearly the same, at about 30%. Comparable findings are reported by Harwin et al (2019). In the last two years the number of children leaving care through SGOs has gone down (3,860 in 2016, 3,720 in 2017, 3,430 in 2018), but is still far higher than 2012, when it was 2,150.[18]

This changing and contested context explains why this triennial review is taking a closer look at cases where the child was looked after by a local authority, or had been the subject of care proceedings.

[17] The leading case is *Re N (Adoption: Jurisdiction)* [2015] EWCA 1112 (discussed more fully later in the chapter). Para 160 of the judgment refers to a number of other cases.
[18] https://www.gov.uk/government/collections/statistics-looked-after-children

5.2 The ten 'care and court' cases

The ten cases come from ten different local authorities in England, but it is important to appreciate that this is not a random sample, nor a representative one. For example, it includes all the cases that ended in special guardianship orders (SGOs) (three)[19]. Well over half of the cases (28) which involved care and/or the court (45 in total) were adolescents but as there is a separate chapter on adolescents, we only included one adolescent case in our sample of ten. Also, purely by chance, the sample over-represents the number of Black, Asian and minority ethnic children, which is discussed further below.

The reason for over-sampling the SGO cases is that there have been widespread concerns about the outcomes of a minority of SGO cases, and the depth of the assessments. There are also general concerns about the burdens placed on special guardians and the levels of support available to them. It is important to state that the evidence on SGOs is that the large majority continue with the children doing satisfactorily or well (Wade et al, 2014; Bowyer et al, 2015; Harwin et al, 2017), but even so, there are long-standing concerns about a minority of cases, which led to a government review of SGOs in 2015 (Department for Education, 2015). In response to the 2015 review, the government introduced changes to the assessment requirements[20] and extended the scope of the adoption support fund to cover special guardianship cases, where the child had previously been in care. A further review undertaken CoramBAAF for the Family Justice Council was published in August 2019 (Simmonds et al 2019), discussed later in the chapter.

But further high-profile cases have kept the issue of special guardianship in the public eye. The case of Ellie Butler, which hit the national news headlines in 2016 after the conviction of her father for her murder, brought particular attention to the issues of SGOs, the role of the court and the court's relationship with the SCR process.[21] The case of Keegan Downer, also known as Shi-Anne Downer, made front-page news in 2017, and is one of the SCRs included in this sub-sample. The number and proportion of care

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[19] Special guardianship was introduced in 2005. A special guardianship order (SGO) gives one or more individuals parental responsibility for a child who cannot live with their birth parents. Special guardians are usually family members, although this is not a requirement – for example, they could be family friends or former foster carers. An SGO does not remove parental responsibility from the child's parents, although special guardians are able to exercise their parental responsibility 'to the exclusion of any other person with parental responsibility for the child (apart from another special guardian).' (Children Act 1989 ss. 14A-14G).

[20] *Special guardianship guidance: Statutory guidance for local authorities on the Special Guardianship Regulations 2005 (as amended by the Special Guardianship (Amendment) Regulations 2016)*, published January 2017.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/656593/Special_guardianship_statutory_guidance.pdf

[21] Please note that Ellie was not harmed whilst in the care of her special guardians, but after she was removed from them and placed back with her parents.

proceedings cases ending in SGOs has risen notably over recent years. Harwin et al (2017) observe that in 2014-15, the proportion and the number of SGOs and placement orders almost converged, for the first time (20.1% v 20.9%; 3,591 v 3,749). In these circumstances, it made sense to over-represent SGO cases, to help to identify any key messages that might assist courts and other agencies.

The ethnicity of the children was not known to the researcher who selected the sub-sample, but it turned out that seven of the selected cases involved children from Black, Asian or minority ethic families (BAME). This is quite different to the profile of all the children in the looked after/court proceedings group, and of the whole SCR sample. The child's ethnicity was known for 44 of the 45 children in the care and/or court case sub-sample, and of those 29 were White British/White Other (two-thirds); this compares to 75% in the whole sample of SCRs (Table 20). Meanwhile, seven of the children in the care and court group were Black British, which is 16%, compared to 8% in the whole sample. Given the profile of the ten cases, there is a discussion later in the chapter about the issues raised by working with families from BAME groups.

Table 20: Ethnicity of the child for the whole sample compared to the care/court cases

Ethnicity	Whole sample SCRs 2014-17 (n=343)	Care and/or court cases (n=44)	Selected care and/or court cases (n=10)
White British/White Other	257 (75%)	29 (66%)	3 (30%)
Mixed	30 (9%)	5 (11%)	3 (30%)
Asian/Asian British	22 (6%)	3 (7%)	1 (10%)
Black/Black British	26 (8%)	7 (16%)	3 (30%)
Other	8 (2%)	-	-

5.3 Children's needs and voices

The cases reveal the substantial needs of many of the children in care, which makes looking after them such a challenging enterprise. Furthermore, research shows that many of the children who go to special guardians or return home or remain with parents, come from similar backgrounds of deprivation and adversity to those in care. While these children are likely to have equal trouble coping, these carers may have fewer personal resources and less support than foster carers or residential staff to help the children.

Therefore, thorough assessments are necessary, followed by suitable monitoring and support, as the cases discussed in this chapter demonstrate.

It is known that children in care are more likely than the general population to suffer from mental health problems, to have physical and learning disabilities, special educational needs, and emotional and behavioural difficulties (for example, Meltzer, 2003; Sinclair et al, 2007; Department for Education, 2018b). The harm that the children have suffered in the past affects their expectations and behaviour. The report about Child J emphasises the importance of trauma-informed understandings and approaches from professionals, to help the children and those caring for them. In Child J's case, it is worth noting that her special guardian, her aunt, had herself been ill-treated as a child. This affected her own expectations and behaviour, making it even less likely that she could manage Child J's behaviour.

There are messages here for social work assessments and court decision making. Social work (and other) assessments should not only look at what has happened to the children in the past and what that implies for their needs now, but also have to look to the future, for what it means for the help they are likely to need as they grow up. And then, of course, it is vital to ensure that those people who will be caring for the children – whether that is parents, kin, foster carers or adopters – have the necessary understandings and abilities, and that appropriate help is given to them, alongside suitable monitoring. Child J's trouble coping proved very demanding for the foster carers she lived with before she moved to her aunt's, so in a sense the warning signs were there. While the foster carers were provided with help, and were able to use it, help was offered to Child J's aunt, but her own ability to accept and learn from any help was gravely compromised. Agencies continued to respond to her as someone needing help to deal with a demanding child when (with hindsight) they should have been focusing on Child J's needs.

The SCR report about Child J raises familiar issues about the importance of observing and listening to children. She lived with her aunt for two years, and throughout that time there were many occasions when she had bruising, and there were ongoing concerns about her behaviour and health. At times Child J did speak about the harsh treatment she was receiving, but she later retracted what she had said. The SCR report observes:

> *There was never any discussion regarding why a child of 6 or 7 might lie, what this might mean about her wellbeing or how this might impact on her own help seeking behaviour*.

The aunt's explanations for the injuries were accepted, and she was able to dominate meetings and deflect any attention on her own role.

These observations highlight an important perspective to weigh alongside the awareness of the impact of early harm on children's behaviour. The necessary balancing act is well

captured by a comment in the SCR about two brothers, A and B, both aged under five, who became the subjects of special guardianship orders. This notes that:

> *There was a tendency too readily to conclude that distressed behaviour was an inevitable consequence of early neglect and then the changes in the arrangements for the children's care.*

In fact, it was a sign of the harm they were currently suffering. So, social workers and other practitioners have to take account of the impact of trauma and instability, but not to allow this to constrain their assessment of what children may be saying and doing, which can be a crucial clue to maltreatment.

Other examples of not listening to children's voices, and being deflected from them by the needs and behaviour of the parents/carers, are shown in the cases of Child F and Child G. Both of these children had older siblings, who had previously said things which could have alerted agencies to their risk of harm, but these had not been responded to with sufficient clarity and determination. In the case of Child G, a three-year-old boy, the report concludes that the children's voices were not sufficiently sought, evaluated or explored, and that they were silenced by their parents. As an example, it recounts an incident when the older siblings told a school nurse about their inadequate diet at home, contrasting it with the '*proper cooked dinners*' they had received in foster care. This was discussed at a core group meeting but the plans for pursuing the concerns were unclear. Later a social worker had spoken to one of the children about food, and the girl had said that her father had prohibited her from speaking to anyone outside the family about '*family business'*. Of course, children also communicate by their behaviour, and the report notes that:

> *…the needs of the children could also have been usefully explored if the reasons underpinning the aggressive attitudes of both siblings observed at school had been explored in their own right.*

Case study: Special guardianship order

Nala was a Black British girl, who lived with her mother until she was four years old. Her mother had mental health problems and struggled with Nala's behaviour. There were also concerns about possible harm from members of the extended family. At the age of four, Nala was placed in foster care under section 20 of the Children Act 1989. She had trouble coping, Child and Adolescent Mental Health Services (CAMHS) were involved and with support, Nala's foster carers were able to manage. Care proceedings were started, and a kinship foster care placement was sought.

Nala's father suggested his sister, who had only met Nala once before. A viability assessment was undertaken, and then a special guardianship assessment. Nala's views were not ascertained or considered in the assessment, because it was considered that she was too young. Nala was placed with her aunt under an interim care order, aged 5. The aunt reported finding it hard to manage Nala's behaviour, but after three months the special guardian order was made, along with a one-year family assistance order. A family support worker took over the case.

Over the next two years there were numerous occasions when the school noticed injuries to Nala, and her unhappy demeanour with her aunt; and many times when the aunt complained of Nala's difficult behaviour, including deliberate self-harm; and there were concerns about harsh discipline. CAMHS were involved, and a continence nurse, and frequent meetings at the school, but the aunt's explanations were usually accepted. The case was closed in July 2014, and Nala died the following month, aged seven. Her aunt and grandmother were convicted of child cruelty.

Key points:

The special guardianship assessment had relied too much on what the aunt said. It did not investigate her background sufficiently, or consider how that might affect her ability to care for a traumatised child. The aunt had only met Nala once and had no experience of caring for a child.

Even with the 26-week changes to care proceedings that have taken place since Nala's case, it is essential that special guardianship assessments are suitably thorough. There are detailed regulations about what the assessment should cover (Schedule 1 of the Special Guardianship Regulations 2005 (as amended by the Special Guardianship (Amendment) Regulations 2016). If necessary the proceedings should be extended and there should be a trial placement. This is especially the case if the child has not previously lived with the proposed carers.

Nala's views were not taken into account or properly understood in the assessment or the post-court two years. Again, this is a key requirement in the Special Guardianship Regulations.

Despite repeated incidents when Nala was seen to have injuries, agencies continued to respond to the aunt as someone needing help to deal with a demanding child. The aunt was able to dominate meetings and deflect attention from her own role. The focus was on her, not on Nala's needs, experiences and views.

The case of Child K, an adolescent boy who died by suicide, raises further challenges and complexities about listening to children. It is important to avoid overly-simplistic messages. Child K had profound trouble coping, and his behaviour included frequent and severe self-harm, drinking, violence and threats, going missing, and not engaging with support; but he was not assessed as having a mental health issue that warranted in-patient treatment. It is noted that '*concerted effort'* was made to help Child K talk about his thoughts, wishes and feelings, but he had great difficulties in articulating the emotions and thoughts that lay behind his disturbed behaviour, and he often minimised the issues. The report highlights the dilemma: his voice *was* influential in determining what treatment he was offered, and who participated in key meetings such as looked after children reviews; but this actually contributed to the difficulties, because he did not get the treatment he needed and there were communication gaps between the different professionals involved.

Returning to Child J, it is also notable that the aunt had only met her once, when she was much younger, before she was proposed (by Child J's father) to be Child J's special guardian. She had not had full time care of any child before she took on the care of Child J. The issue of assessments of potential special guardians who do not know the child is discussed further below, in the section on court principles and processes.

The SCR finds that Child J's wishes and feelings about the move to her aunt were not included in the assessment because it was considered that she was too young to understand the process. As the SCR observes, she was five-years-old by this stage, and did have views about where she would like to live in the future. However, all the parties including the Cafcass children's guardian[22] accepted the assessment. It is not the task of a children's guardian to complete a special guardianship assessment, but the children's guardian should ensure the child's wishes and feelings are ascertained and taken into consideration.

Local authorities are under legal duties to ascertain the wishes and feelings of children they are looking after, for whom they are delivering services under section 17 or section

[22] Children's guardians are social workers who are employed by the Children and Family Court Advisory and Support Service, Cafcass, and appointed by the courts in care cases to make an independent analysis of the case during care proceedings and advise the court on the wishes and best interests of the child. They should not be confused with special guardians, who are carers for the child.

47 of the Children Act 1989, or for whom they are assessing someone as a prospective special guardian. Courts are also under a legal duty to consider the child's wishes and feelings in a wide range of cases, including for care and supervision orders, SGOs, and section 8 orders. But always, the child's wishes and feelings have to be considered in the light of their age and understanding, and their welfare (s.1 of the Children Act 1989). When a case is in care proceedings there is a special responsibility on the children's guardian to ascertain, assess and report back to court on the wishes and feelings of the child (Family Procedure Rules 2010, Part 16 and Practice Direction 16A). The role of children's guardians is a crucial part of the care proceedings system in England and Wales, and highly valued by the courts; and in so far as it is mentioned in the ten SCRs in our sample, the comments are generally favourable. However, the SCR about Child F concluded that the children's guardian had been overly influenced by a wish to 'give mother a chance', and that his/her decision to oppose the local authority's plan to take the children into foster care and recommend a residential placement *'did not seem logical then, or with hindsight*'.

There are also some concerns about the effectiveness of children's guardians in hearing the voice of the child and pursuing it. Such concerns are raised in the review of Shi-Anne Downer, which comments on the need for children's guardians '*as the challenging voice of the child to ensure all checks have been carried out*'. In the report about Child F, it is noted that the wishes and views of the older siblings had not been fully taken on board by the children's guardian.

The high workload pressures on children's guardians because of the increase in the number of care proceedings has led Cafcass to introduce a model of 'proportionate working', but there are concerns that this means the children's guardians do not always see children enough before reaching their conclusions. This was noted in the 2018 Ofsted inspection report on Cafcass, para 23, which awarded the organisation an 'outstanding' rating (Ofsted, 2018b).

5.3.1 Ethnicity

Issues relating to the ethnicity of the child and his/her family are discussed in some detail in the SCRs about three Black African children (G, F and H1). They are also discussed, but in less depth, in the SCRs about Child J and Child N. They are not discussed in the Shi-Anne or A and B cases, nor the three cases involving White British children (Polly, Child K and the four boys).

There are parallels between the discussions about the Black African children. In each of those cases, there were concerns about the impact of cultural beliefs and expectations on the care and wellbeing of the children, and how to investigate and assess this whilst also respecting diversity and the families' cultural and religious beliefs. There were concerns about the mothers' mental health in cases of Child F and Child H1, and

particularly how this overlapped with their cultural beliefs, notably in witchcraft. In the case of Child G the concerns were to do with the parents' attitudes towards physical punishment. In the case of Child N (from a South Asian background), there were also concerns about the mother's mental health.

Research studies have long found significant shortcomings in mental health services in providing appropriate services to minority ethnic patients. The report of the Independent Review of the Mental Health Act 1983, published in December 2018, commented that:

> *The profound inequalities that exist for people from ethnic minority communities in access to treatment, experiences of care, and quality of outcomes following mental health service care are longstanding* (IRMHA, 2018, p.5).

The SCR about Child F includes a summary of findings taken from the website of the Mental Health Foundation. One of the challenges in diagnosing a mental health condition is to take account of the patient's beliefs, background and culture, and to give these due weight; in that sense, exactly the same challenge that faces child welfare practitioners in their work assessing the risks to a child. In the case of Child F, the SCR notes there was '*evidence of some confusion'* about this balancing, and recommends that:

> *Professionals should be supported by their agencies through training and supervision to be confident in exploring cultural and spiritual beliefs to fully understand the family dynamic and daily life for the child.*

The point about understanding 'the daily life for the child' is an important one, taken further in an article by Bernard and Harris (2018). They discuss the ways that race, culture and ethnicity are addressed in SCRs, drawing on an in-depth qualitative analysis of 14 reports published between 2010 and 2017. By coincidence, two of the cases in their sample are also in the ten cases in our care and court sample. They found that details of ethnicity were often missing or poorly recorded, a lack of focus on the daily realities of life for the children and little evidence of the views and feelings of the children; as they put it:

> *…the SCRs consistently highlight a lack of professional curiosity about the children's lived experiences within their cultural and ethnic context. For the most part, though the ethnicity is stated in the SCRs, they tend not to comment in any meaningful way to gain an understanding of the lived experiences of the child* (Bernard & Harris, 2018, p.4)

It is not a new finding that ethnicity might be recorded but the implications for the day-to-day lives and experiences of the children are not explored and spelled out by social workers and other practitioners – for example, it was a finding in a study of court reports in child protection cases as long ago as 2003 (Brophy et al, 2003). But it is also worth adding that a poor focus on children's day-to-day realities is not just a problem in BAME cases, but reflects a wider challenge in *all* cases.

The SCR about Child H1 spells out the messages that work with BAME families bring for all cases. Child H1's mother had witnessed genocide and lost family members in her home country, and entered the UK as an asylum seeker. The report makes the point about needing to find out about people's backgrounds, culture and beliefs, and then *apply* that knowledge:

> *What mother's beliefs meant in practice, how this manifested in her internal world and the part it played in her identity, her relationships and in the life of her children was unexplored and so not understood. Instead, assumptions were made and these assumptions found their way into assessments and plans.*

The report goes on to say that practitioners from the various agencies seemed to have little knowledge about the mother's background, culture and religious beliefs and practices:

> *When this was explored further, beneath what appeared at first sight to be ambivalence was something more. Practitioners spoke about a fear of exercising curiosity about the cultural background of people from BME communities, there seemed to be a fear that recognising difference and diversity by asking these questions might be at best intrusive at worst perceived as racist and this had to be avoided at all costs: 'we fear asking the question for fear of being seen as racist'.*

The report broadens this out, seeing it not solely in terms of work with families from BAME communities, but more generally to do with understanding the personal identities of service users. They conclude:

> *Being fearful of asking curious questions about past experiences, culture and beliefs for fear of being seen as overly intrusive or, in the case of families from BME groups for fear of being seen as racist, has a significant impact on the ability of professionals to make assessments and provide services. It is an approach that seriously hampers the way children from all racial and cultural groups are safeguarded and as this finding has shown, has particular implications for children from BME groups.*

5.4 Local authority and inter-agency systems

The needs of the children and the scrutiny of care proceedings mean that effective inter-agency collaboration is crucial, for assessing, evidencing and meeting those needs. The ten cases discussed in this chapter illustrate some of the challenges of this work. The sorts of issues raised here are familiar in child protection work and work with children in care, but the courts' involvement gives them an added dimension.

5.4.1 Workloads and resources

Workload and budgetary pressures stand out as factors that threaten professional practice and through that, imperil children's safety and welfare. These issues are addressed very clearly in the reports about Child H1, the four boys and Child N.

In the case of Child H1, a Black African girl aged 14, the local authority had been rated 'inadequate' in an Ofsted inspection the year before the incident which led to the review, but coinciding with an earlier occasion when the children had been accommodated by the local authority. The report notes the issues that led to this rating – high caseloads, long waiting lists, changes of social worker, poor inter-agency working (notably in understanding thresholds and poor engagement in early help), poor management oversight and lack of effective challenge by child protection conference chairs and independent reviewing officers (IROs). It also notes the negative impact of the Ofsted rating itself, leaving staff feeling 'battered and bruised'.

The report notes that just before the inspection, the authority had introduced a new child in need service intended to help 'step down' families from higher-level intervention. Child H1's family was one of the first to be referred to it, but the report comments:

> *There was little sense that the perspectives of the children were known or their needs understood, there was no clarity about what outcomes were being pursued or what impact mother's mental health had on her ability to meet the needs of her children or on her ability to make the necessary changes, this compounded the delays in this case. At this time, the volume of work held by CSC was very high; there was a need to either close cases or move the work to other services. Ofsted were due to make an inspection, and this provided an important incentive to move cases through the system to lower levels of intervention.*

In the case of the four boys, the local authority concerned had been under great pressure and the SCR overview report comments on:

> *…the additional pressures of inconsistent and temporary staff (including managers and supervisors) and caseloads as high as 50 cases. In a climate where workers are responding to crises it is almost inevitable that professional standards cannot be maintained.*

In the case of Child N, a British Asian boy who died in a house fire with his mother, the report notes that the local authority received an Ofsted rating of 'requires improvement', and identifies heavy workload pressures from high caseloads, staff sickness rates and turnover, poor record keeping and inconsistent management oversight. In the context of the workloads and what it calls a 'challenging organisational climate', the review is able to understand why the case was not given greater priority.

5.4.2 Evidence, thresholds and inter-agency working

Another issue is that in order to launch proceedings, or to argue for a particular order, local authorities require evidence that they consider likely to stand up in court. For this they often rely on other agencies and professionals; and it is important that the evidence is relevant and timely. The courts have a high threshold for ordering the removal of a child from his/her parents. For example, for an interim care order it was deemed that separation was only to be contemplated if his/her safety demanded 'immediate separation' (*Re H (a child) (Interim Care Order)* [2003] 1FCR 350).

The case study of Polly, below, (this is the pseudonym used in the review report) illustrates some of the tensions that these requirements create. Polly had been returned to her mother under a supervision order, as a result of previous proceedings, but there continued to be considerable concern about her welfare. The supervision order was still in force, and there were two occasions when the social worker took legal advice on how to proceed. In the first instance, the legal advice was to start the 'pre-proceedings process'; in the second, to start proceedings at once. This did not happen. The SCR overview report draws out some of the practice dilemmas that lay behind this, of how 'evidence' can be weakened as it is double checked, how other information and the passing of time can change how things appear. For example, it notes that from the social worker's perspective:

> *…each time he felt worried about Polly, medical opinion was that there was no non-accidental injury, the heath visitor continued to see her as thriving and reaching her developmental milestones, and the mother continued to convince him that she was not seeing the boyfriend or that their relationship was not violent.*

Case study: Supervision order

Polly was a White British girl, whose mother had a long history of drug misuse and mental health problems. Polly was on a child protection plan from birth. Care proceedings were started when she was 10 months old, because of the risks from her mother being in a violent relationship (not with the birth father). Polly was initially on an interim supervision order and placed with a family member, but she soon went into foster care under an interim care order. Her mother co-operated with assessments and the proceedings ended with a one-year supervision order (SO).

Polly was on a child in need plan after the proceedings, rather than a child protection plan. Her mother was in a new relationship, again violent. Four months after the SO was made, Polly was taken to hospital because of a sudden collapse. This was considered to be a febrile convulsion, and she was discharged after a few hours, in the middle of the night. There were several other medical incidents and minor injuries over four months. The mother and Polly were evicted from their flat and moved to a neighbouring local authority.

Further reports of domestic abuse led the local authority to decide to take new care proceedings. However, as the social worker gathered information for this, he felt that the evidence for an immediate return to court weakened, so it had not been done before Polly died, at the age of 22 months. Her mother was found guilty of murder and child cruelty, and the boyfriend of causing or allowing her death.

Key points:

Agencies should be realistic about the chances of parents sustaining changes made under the spotlight of care proceedings; suitable support and monitoring is required.

Polly had a series of injuries over the four months after the court proceedings ended. Although each of them by themselves might not have raised concerns, if they had been seen as a whole they should have raised concerns.

Some professionals were unclear about their roles and responsibilities for a child on a supervision order.

Local authorities should have clear plans for monitoring a supervision order, including where appropriate, starting with a child protection plan.

There were two occasions when a return to court was considered and delayed. The first time, the recommendation was to use the pre-proceedings process, the second to start proceedings promptly. Both times, the social worker then made further enquiries and felt that the concerns were not as significant as originally presented. With hindsight this was mistaken. Professional supervision should be used to identify and challenge this tendency.

Different professional perspectives on behaviour, events and circumstances are inevitable, as are (from time to time) different interpretations of whether and how the law should be applied. Even when the different partners are clear about their statutory responsibilities, there may be differences of opinion, and decisions which do not fit with the plans or hopes of another agency.

An example is in the case of Child N, when the local authority planned to move the child from the care of his mother and her relatives, to paternal relatives. They asked police officers to attend while this happened. There was a discussion between the emergency duty social work team and a police inspector, who recorded that the court order did not allow the police to physically enforce the transfer of the child, and there was no suggestion that the child was at immediate risk of harm. The inspector did visit the family, who refused to hand the child over, but given the terms of the order and that the child appeared well and happy, he decided there was no basis for using police powers of protection. Within two weeks the child and his mother had died in the fire she started; but at the time, the police officer made a reasonable decision (indeed, the only one he could have done in those circumstances). The review comments that it would have been better if a social worker had attended the visit with the inspector, but even if one had, it seems unlikely there could have been a different decision that day.

5.4.3 Inter-agency understanding of the legal framework

Inter-agency understanding of the post-proceedings legal framework arises as an issue in the SCRs on Polly and Child J. Polly was on a supervision order, and Child J on a family assistance order for the first year alongside the SGO. The report for Polly comments that there was ‘significant confusion’ about the implications of the supervision order and the role of the different agencies and professionals in monitoring her. The care proceedings concluded in October 2013, with all parties agreeing that Polly’s mother had made significant progress. Polly had a child in need plan, rather than a child protection plan, alongside the supervision order. The SCR considered that this plan was not suitably focused; and it found that other agencies saw a supervision order as a lesser process than a child protection plan. There was a misunderstanding that if concerns did arise, the only option was to return to court rather than to institute child protection procedures.

The review considers whether it might be more appropriate for cases where there is an on-going risk to conclude with a care order with a plan for placement with parent(s), rather than a supervision order. Such outcomes are well known but not widespread; they are more common in the north of the country (Harwin et al 2018). In another of the cases in this sub-sample, it was the order that the local authority sought (Child N), but on that occasion the court did not make it. From the local authority perspective, there is often unease because they give on-going parental responsibility to the authority and weighty duties as the ‘corporate parent’ for the child, that may be hard for them to exercise

consistently and effectively given that the child is actually living with the parent(s). These issues are considered in *Re FC (A Child: Care or Supervision Order*) [2016] EWFC B90.

The SCR about Polly recommends that:

> *Any child who is returning to a carer where there have been safeguarding concerns should have a child protection plan rather than child in need plan, running parallel to the supervision order for at least the first six months.*

This is the policy that Polly's local authority adopted in light of her case, although perhaps raises a question about the wisdom of determining policy on the basis of a single case.

As regards a family assistance order (FAO), as used in the case of Child J, this may be regarded as an even 'lower' level of order than a supervision order. A court cannot make a FAO unless it has obtained the consent of every person to be named in the order, apart from the child. It does not require the local authority to prove the occurrence or risk of significant harm, and is more likely to be used in private law cases than public law. It simply gives the relevant officer the duty to 'advise, assist and (where appropriate) befriend any person named in the order' (Children Act 1989, s.16). In Child J's case, the staff member allocated to the case was a local authority family support worker and the review considers the fact there was an FAO actually undermined the plans to support and monitor the placement with the aunt. The report notes that a FAO does not require multi-agency working or regular monitoring, and considers that the existence of the order *'created some confusion about planning processes and Child J's status'*.

So, the key point from the Polly and Child J cases is that all agencies need to be aware of the existence and implications of court orders, but not to assume that because there is a court order there is no need for other, well-established multi-agency child safeguarding procedures and practices to be in place.

5.5 Court principles and process

The sample of care and court cases illustrates some of the strengths and challenges of the division of powers between local authorities and the courts, and the overlap of responsibilities. Many of these are not new issues (see Brandon et al, 2012, pp.86-88) but as noted earlier, the high profile of court proceedings over the last few years merits a closer look. Key issues concern the tight timescales of new-style care proceedings; the legal and social priority given to returns to parents or kin; the very high profile that critical court judgments have come to have; and the non-participation of the courts in SCRs.

5.5.1 Parental and kinship care

The legal and policy preference for parental care may be seen in the cases of Polly, Child K, and Child N, all of whom had been the subject of care proceedings which ended with the children going back to the parent(s). In Polly's case it was under a supervision order, after her mother engaged with assessment and support services during the proceedings. The messages from SCRs do not mean that children should not be returned home – that would be legally and socially unacceptable. Rather, assessments have to be thorough and realistic about the challenges that many of the parents face, and the support they are likely to need. It is also important to acknowledge that some placements will not endure or, in those that do, the children may not fare as well as one would have hoped. These points are well known from research into returns home (Farmer & Lutman, 2012; Biehal et al, 2015).

The three SGO cases in this sub-sample epitomise the issues regarding kinship care (the cases of Child J, Shi-Anne, and brothers A and B), although none of them involve potential special guardians who came forward very late in the proceedings. Nala's case study above (section 5.3), illustrates some of the challenges. Shi-Anne's case also has important messages. In her case, a number of potential kinship carers had been proposed early in the course of the proceedings. There was an assessment of the person who became the special guardian, by an independent social work agency, which was completed in just seven weeks. There was then a period when the prospective special guardian appeared to change her mind, but the order was made in January 2015 and Shi-Anne was placed with her shortly afterwards.

Shi-Anne's SCR makes powerful criticisms of the assumptions and practices behind the assessment and recommendation. It concludes that '*there was no reflection for Shi-Anne of the potential merits of adoption versus special guardianship*' and that:

> *…the local authority had adopted the stance that placement with a relative or connected person was the preferred permanence option for this child in any circumstances.*

Furthermore, the SCR is highly critical of the quality of the SGO assessment, commenting that it is strikingly superficial compared to those provided for adoption placements. The review holds that the quality of the assessment should have been challenged by the social worker and their manager. The children's guardian did query it at first, but then accepted it, as did the child's solicitor. The review notes that the local authority concerned no longer commission SGO assessments from external providers, and say they allocate enough time and resources to complete them in-house to the appropriate standards. The review observes that the SGO was uncontested at the full hearing with the care plan being fully supported by the local authority and the children's

guardian. It notes that the decision was made by lay justices (magistrates) and suggests they:

> *…may be less likely to challenge the recommendation of the local authority supported by the children's guardian, than a judge would have been.*

The SCR about brothers A and B warns against the dangers of hindsight, but echoes the comments of the Shi-Anne review by asking whether the priority given to kinship placements had placed the children at undue risk:

> *This was a risky placement choice which, in my view, was more likely than most to fail. It is not clear that placement options outside the birth families of the children were given enough consideration.*

But, against some of these comments, it has to be said that law and policy does give a preference to placing children with parents or kin over adoption (section 22C Children Act 1989), and this weighting was given additional force by the *Re B* and *Re B-S* judgments, which held that non-consensual adoption is 'a very extreme thing, a last resort', only to be made where 'nothing else will do', 'only in exceptional circumstances'. Furthermore, one cannot assume that a judge would have taken a more inquisitorial role than magistrates; partly because that is not the nature of care proceedings, and also because of the workload and time-limit pressures on the courts.

The courts have since retreated from the position of *Re B* and *Re B-S*, holding that those cases did not change the law and that local authorities certainly should apply for adoption if they consider it to be in the child's best interests. In the case of *Re W (A Child) (Adoption: Grandparents' Competing Claim)* [2016] EWCA Civ 793, (para 68) the court held that the phrase 'nothing else will do':

> *… is meaningless, and potentially dangerous, if it is applied as some freestanding, shortcut test divorced from, or even in place of, an overall evaluation of the child's welfare …. The phrase 'nothing else will do' is not some sort of hyperlink providing a direct route to the outcome of a case so as to bypass the need to undertake a full, comprehensive welfare evaluation of all of the relevant pros and cons.*

Nevertheless, as noted earlier, the number of SGOs has remained high and the number of placement orders is substantially lower than it was before the judgments. Concerns about rushed assessments of special guardians, especially those coming forward late in the day, have been prominent in view of the 26 week deadline. There are broadly three options for the court. It could decide to stick to the timetable and oblige the local authority to do the best assessment it can in a very short time; it could make a care order and leave it to the authority to complete the assessment, place the child if appropriate, and agree with the prospective special guardian when best to bring the case back to court for an SGO; or it could extend the proceedings beyond 26 weeks. The judgment in *Re P-S*

[2018] EWCA Civ 1407 discusses the matters at length and proposes that if something unexpectedly emerges late in the day to change the nature of the proceedings, such as the emergence of a realistic alternative family carer, an extension of the 26 week time limit may be necessary. The judgment called for further research on the processes and outcomes of different practices around special guardianship orders. In November 2018 the Nuffield Family Justice Observatory commissioned CoramBAAF to undertake a 'rapid evidence review' of Special Guardianship to assist the Family Justice Council to revise the protocols and guidance for family courts and local authorities, which was published in August 2019[23]. Interim guidance was published in May 2019 by the Family Justice Council (FJC) with the approval of Sir Andrew MacFarlane, President of the Family Division[24].

5.5.2 The role of the court

The considerable impact that highly critical court judgments have had on local authority practice over recent years, and the non-participation of judges in SCRs, are the final issues to be considered in this discussion.

The impact of the *Re B* and *Re B-S* cases has already been discussed, but here it is worth noting the extremely strong language used in them. For example, in *Re B-S*, Sir James Munby, then President of the Family Division, criticised local authorities for evidence that is too often 'anodyne and inadequate', insisting that 'this sloppy practice must stop', paras. 39-40. As noted earlier, there was also a succession of judgments in 2013-15 that were highly critical of local authorities for misusing, even, in the court's opinion, 'abusing', section 20 of the Children Act 1989 which deals with the provision of accommodation for children. The judgment given by Sir James Munby in *Re N (Adoption: Jurisdiction)* [2015] EWCA 1112 was particularly influential. Once again, the language was searing: a 'melancholy litany' of failures, 'a denial of the fundamental rights of both the parent and the child', 'it will no longer be tolerated'.

The criticisms sparked off a wider debate about the use of s.20 and led to the Association of Directors of Children's Services and Cafcass issuing their own practice guidance note (ADCS et al, 2018), and a review by the Family Rights Group (Lynch, 2017). The impact of the *Re N* judgment was considerable, reflected in the SCR about Child H1. Munby's strongly worded criticisms are repeated in the review.

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[23] There are four parts to the review, available at https://corambaaf.org.uk/about/what-we-do/policy-and-practice-development/rapid-evidence-review-special-guardianship

[24] See https://www.judiciary.uk/announcements/family-justice-council-interim-guidance-on-special-guardianship/

It is widely accepted by legal practitioners, researchers in the field and special interest groups that these judgments have had a significant impact on social work and legal practice, although of course there are many other factors at play as well. They raise important issues about the quality of social work assessments and evidence, informed consent and proper regard for parents' rights. But such high-profile criticism may have had a disproportionate and destabilising effect, changing the pattern of outcomes of care proceedings, and at the same time increasing the use of compulsion by reducing the use of section 20. In 2018, the Chief Social Worker for England called for a re-valuing of s.20 accommodation (Trowler, 2018).

The last point is about the non-participation of the courts in SCRs. This is raised in two of the SCRs in the sub-sample, those on Child N and Child F. It became a high profile public issue in the aftermath of the Ellie Butler case, after the father's conviction for her murder in summer 2016. The office of the President of the Family Division wrote to the author of the SCR that 'For constitutional reasons, it would not be appropriate for the judiciary to produce an Individual Management Review' (Ellie Butler – Sutton LSCB,2016: para 1.4) although copies of the relevant judgements were provided.

The issue was later discussed in the House of Lords committee stage on the Children and Social Work Bill, when Lord Nash (then a Conservative minister for schools) reiterated the argument:

> *The judiciary is independent and, for constitutional reasons, it cannot and should not be held to account by the current SCR process, or, in future, by the Child Safeguarding Practice Review Panel.* (*Hansard*, 18 October 2016: the link is available via the *Transparency Project*[25] website, which discusses the Ellie Butler case in detail).

In light of the debate, the President of the Family Division issued guidance on judicial cooperation with SCRs in May 2017. The guiding principle was that:

> *Judges should provide every assistance to SCRs which is compatible with judicial independence. It is, however, necessary to be aware that key constitutional principles of judicial independence, the separation of powers and the rule of law can be raised by SCRs* (Munby, 2017, para 1.3).

Working Together 2018 draws attention to the President's guidance on judicial involvement in its discussion of local child safeguarding practice reviews (page 89).

[25] http://www.transparencyproject.org.uk/?s=Ellie+Butler

But the issue has a longer history than the Ellie Butler case, as Munby's guidance document shows. It gives a lengthy quotation from Sir Mark Potter, who was President of the Family Division from 2005-10, saying that he established the judicial position in relation to SCRs. The quotation sets out the view that judicial independence:

> *…may be put at risk if judges are seen to be participants in a review conducted by a government or local authority agency … which deals with far wider questions than those which may have preoccupied the Court at any particular stage.*

The issue was raised in the SCR about Child N, where there had been protracted private law proceedings. The author comments on the pivotal and continual role of the court throughout the child's life, but accepts the argument that the judiciary cannot be involved for 'constitutional reasons'. On the other hand, the SCR about Child F recommends that:

> *…the DfE considers a mechanism for including the option to involve the Family Court system in SCRs, where the child/ren are subject of care proceedings.*

The two reports therefore neatly encapsulate the debates and different positions about judicial involvement in SCRs.

The role of the court in child care cases is to determine whether the relevant criteria for an order are satisfied, and reach decisions on the plan for the child according to his/her best interests. The child's welfare is the court's paramount consideration (Children Act 1989, s.1), but of course there may be different views about what constitutes the child's welfare and how it is best safeguarded and promoted; and other principles including questions of justice, proportionality, timeliness and appropriate use of court resources are also important (the court's 'overriding objective' in child and family proceedings – Family Procedure Rules 2010, Rule 1.1). In an adversarial system, judges make their decisions on the evidence and arguments presented to them, and it may be that weaknesses in local authority practice and/or the way it presents its case explain decisions which subsequently appear to be 'wrong'. Without knowing more about the detail in individual cases we cannot say that a court's decisions were 'right' or 'wrong'; and just because a case ends sadly, it does not necessarily mean it was the wrong decision at the time – unpredictable events happen, things can and do change. But no-one would claim that courts are always right – that is why there is an appeal system, a point made in the SCR on Child N, and judgments are sometimes overturned. However, that may not be the most productive system for inter-agency learning. There could be much to be learned from respectful and reflective discussions between courts, local authorities and other agencies.

At the present time, though, Munby's 2017 guidance sets the framework, and it clearly states that an SCR should have full access to all the material the judge had in the case, including all expert reports, court orders, and transcripts of the proceedings and the

judgments. It also states that if any SCR raises issues for the family judiciary that should be addressed through a President's practice direction or guidance, then that would be issued.

Summary points

Key messages have emerged from this analysis of children in care or subject to care proceedings (including children returned to or remaining with parents, and those in special guardianship). These children are likely to have already suffered significant harm, and likely to have trouble coping and need particular nurturing care. This likelihood has to be taken into account in assessments and support plans and requires trauma-informed practice.

Examination of the BAME cases here revealed the importance of ascertaining and applying knowledge about background, culture, religion and 'personal identities' in assessments and planning. What these factors mean for day-to-day life for all children, not just minority ethnic children, then need to be explored.

The court's tight timescales should not be allowed to undermine the thorough assessments needed of all potential carers, notably kinship carers. On-going support and monitoring after the proceedings are also important.

Other professionals and agencies may need help to understand legal orders and the significance of court involvement. There is useful advice in the SCR about Child N:

> *Where children are involved in court proceedings – private or public law – do not assume you have a lesser role or that simply because the court is involved it will offer a greater level of protection to the child. Seek confirmation about your role, expectations of you and how this links to the wider plans for a child.*

This chapter has added to the discussion about the participation of the judiciary in SCRs. The two reviews examined highlight the differences of opinion about this. It may be possible to devise a mechanism for court involvement that preserves judicial independence, because there is potentially great learning from judges' involvement. The Family Justice Council and local Family Justice Boards may also be good vehicles for this learning.

In addition to the key safeguarding professionals, others involved, for example judges, lawyers, and policy makers, could benefit inter-agency working by contributing a nuanced and realistic view of the role of the law and the court related to their own agencies and disciplines. There are many competing imperatives in this challenging work: for example, duties to protect children from harm, but also the wider context of the 'no order' principle in the Children Act 1989, and the legal priority given to placements with parents or kin; and all in a context of very tightly constrained resources. As always, it is important to be thorough and challenging, but to avoid unfair blame and unrealistic expectations (of practitioners and of families). Courts, local

authorities and partner agencies need to recognise the strengths and constraints of the others, and their own role and limitations.

Chapter 6: The impact of SCRs for practice

This chapter considers the ways in which learning from SCRs influences day-to-day practice. This includes an examination of the impact of recent policy initiatives including the reforms to SCRs first included in *Working Together to Safeguard Children 2013*, and how this might have affected the model of review undertaken and the subsequent quality of reviews. The main focus of the chapter is the discussion of the findings from a national survey, phone interviews and practitioner workshops to explore the ways in which recommendations made in SCRs have been implemented, and what factors influence their consequent impact on child protection practice. Not all review models include recommendations and some use alternative means of prompting learning and change. For the purposes of understanding how *learning* influences practice, we are treating these in the same way as recommendations.

The analysis brought together here includes and incorporates findings from five separate stages:

1. Learning from the 278 available SCRs from 2014-2017;
2. A national survey about recommendations and their implementation;
3. Following the recommendations survey: phone interviews with 20 survey respondents;
4. Two practitioner/leader workshops (one in Birmingham and the other in London) to test emerging findings and gauge practitioner/leader views about the impact of SCRs on child protection practice; and
5. An examination of the quality of learning and recommendations from this study of SCRs from 2014-2017 in comparison with our previous study of SCRs from 2011-2014 (Sidebotham, et al, 2016).

6.1 SCR models

An early stage in the SCR process involves the decision about which model of review to employ. Working Together to Safeguard Children 2013 instituted reforms which made it possible to carry out SCRs using any methodology or model 'which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro' (HM Government 2013a, p.67). To help explore the influences of the reforms and understand which models are being used, we examined the methodologies adopted for the 278 review reports available to us.

Table 21: SCR methodology

Review Method	2014-17 (n=278)
Traditional with IMRs	63 (23%)
SCIE learning together	38 (14%)
SILP (Significant Incident Learning Process)	16 (6%)
Welsh Child Practice Review	23 (8%)
'Hybrid' or 'Unspecified systems-based'	51 (18%)
Unclear	68 (25%)
Other	19 (6%)

Table 21 shows that for incidents between 2014-17 the most commonly cited methodology remained the 'traditional' approach with Independent Management Reviews (IMRs) and a chronology (23% of reviews) followed by the Social Care Institute for Excellence (SCIE) learning together approach (14% of reviews). A further 8% had used the Welsh Child Practice Review (CPR) model, and 6% had used the Significant Incident Learning Process (SILP). A small proportion (6%) of SCRs cited use of 'Other' specific methods, including the learning lessons review, partnership learning review and root cause analysis.

Of note is the high proportion (43%) which did not follow any specified 'named' review model. Of these, 18% described methodologies which were classified as 'unspecified systems' or 'hybrid' while 25% did not explicitly state what methodology had been employed.

Table 22 provides details for review methodologies used over the three individual years covered by the triennial review period 2014-17. The results suggest there are some changes in review methodology occurring over time, including a drop in the proportion of SCIE reviews from 20% for incidents during Year 1 (2014-2015) to 7% in Year 3 (2016-2017) and in reviews using a traditional method with IMRs, with 29% of reviews undertaken during Year 1 (2014-2015) dropping to 14% of reviews in Year 3 (2016-2017). There is some indication of concurrent increase in the proportion of SCRs using SILP. Use of the newer CPR model was also increased over time.

Findings from both the survey and interview elements of the study, discussed in Section 6.2, shed light on the underlying influences behind the choice of review methodology.

Table 22: SCR methodology use by year

Review Method	Year of incident*			
	Year 1 (2014-2015)	Year 2 (2015-2016)	Year 3 (2016-2017)	Total
Traditional with IMRs	35 (29%)	20 (20%)	8 (14%)	63 (23%)
SCIE learning together	24 (20%)	10 (10%)	4 (7%)	38 (14%)
SILP (Significant Incident Learning Process)	5 (4%)	4 (4%)	7 (13%)	16 (6%)
Welsh Child Practice Review	5 (4%)	10 (10%)	8 (14%)	23 (8%)
Other, including unspecified systems-based and hybrid methods	54 (44%)	55 (56%)	29 (52%)	138 (50%)
Total	**123**	**99**	**56**	**278**

*Note the decrease in total SCRs for each annual period reflects the number completed and available to us (August 2018) for analysis.

6.2 Recommendations and implementation survey

The recommendations survey was intended to shed more light on review methods as well as the integration of learning into practice from recommendations and other aspects of the review. The survey was constructed and adapted in consultation with the research advisory group and with the Association of Independent LSCB Chairs (AILC). It was piloted with the Business Manager of one LSCB before being distributed to all LSCBs, on our behalf, by the AILC.

6.2.1 Survey respondents

A total of 91 survey responses were received, with some respondents representing more than one LSCB and local authority area. Overall, these responses represented 101 of the 152 (66%) top tier English local authorities. The surveys were mostly completed by Business Managers or Chairs of LSCBs, with some returns coming from operational or strategic senior managers in various roles.

6.2.2 How well are models of review working?

As part of the survey, we sought views on how well the various SCR models worked to support learning. Table 23 indicates that there was most awareness (as suggested by the proportion of 'don't know responses') of the traditional model and the SCIE Learning Together model. There is a suggestion that Traditional, SCIE and SILP models were less favoured as means of supporting learning (with over 30% rating this as poor or fair) in comparison with hybrid or other systems methodologies, Welsh Child Practice Reviews or Partnership Learning Reviews (which were mostly rated as good or very good). See Appendix G for a brief description of selected models.

Table 23: How well do these SCR models work to support learning?

SCR model	Frequency (%)* n=91		
	Poor/Fair	Good/Very good	Don't know
Traditional (IMR and chronology) model	38 (44%)	49 (56%)	4
Learning Together (SCIE) systems model	24 (32%)	51 (68%)	16
SILP	17 (30%)	39 (70%)	35
Other systems methodology	6 (14%)	37 (86%)	48
Welsh Child Practice Review	6 (16%)	32 (84%)	38
Partnership Learning Review	5 (9%)	53 (91%)	33
Bespoke Hybrid Model	5 (7%)	56 (94%)	31

*Percentage calculated excludes 'don't know' responses.

While experiences and views of different models varied across survey responses, comments revealed some common themes.

Methods tailored to fit type of case

Comments from survey respondents and from interviews described selecting models on a case-by-case basis – as one interviewee commented '*I think adopting one model and then just applying it to everything isn't the right answer*'. Study participants drew attention to the importance, from the outset, of considering both the type of case and what the

review is aiming to achieve when deciding which of the range of available models would be the 'best fit' and be proportionate:

> *The model selected is determined by the features of the individual case. For example, period of time covered by the review, involvement of other processes for example, coronial, profile of case and potential for media interest, sensitivity for the practitioners involved.* (Survey)

> *SCIE can be useful for challenging the LSCB to consider findings as opposed to recommendations, but because the usual guidelines suggest not looking back at a case beyond two years, this can have limitations in a complex case.* (Survey)

> *One SCR was a systems model plus IMRs because it was quite a complex case, there was a lot of medical information so there were IMRs, a collated chronology and individual interviews with practitioners… that is very time consuming but it was a very complex case with a lot of practitioners involved whereas [for another SCR] we were able to do some group work and generally we just have a collated chronology, it is split down by the reviewer into episodes and then we have a practitioner day or maybe two days to work through those episodes*. (Interview)

The Welsh Child Practice Review model was not familiar to all interviewees and there was varied experience of using this approach. It was described in one instance as '*very slick'* and enabling a quick process while still gathering sufficient information to ensure a good report is written. In another example the model had to be switched during the review process as it did not enable the case to be explored at the level of depth needed.

Skills of individual reviewers

It was also apparent that the choice of model often revolved more around the individual reviewers than the method employed, as one survey respondent commented: '*Success depends on the skill of the lead reviewer'.* Variation in the way reviewers worked also meant that the way a 'branded' model was applied was not necessarily uniform.

There was an emphasis on being clear from the outset about what the LSCB wants to get out of the review and that the lead reviewer then works to that stated commission. The quality of reviewer was a crucial element in making any model work:

> *It has worked best when we have found a high calibre reviewer, whose report style is incisive and concise and whose analysis is clear and able to distil simple messages from complex information. Then, as a partnership, we are happy to trust their approach and style, which is generally bespoke to them but delivers excellent outputs. Their level of challenge is robust and enables good reflection on partnership working.* (Survey)

It was clear that established relationships with trusted 'go to' reviewers known to the LSCB were also important: '*We have found a couple of reviewers with whom we work well'.* It was evident nevertheless that there were unresolved issues in relation to recruiting authors:

> *We do find it difficult to recruit high quality authors for SCRs due to the lack of training and standards for the role. Those we do know of are very busy and/or very expensive. We have experimented with trying to seek independent authors on a reciprocal basis from other areas but this has not proved very successful as the process is time consuming and requires someone to increase their normal workload for an extended period of time.* (Survey)

Finding BAME reviewers was identified as a problem in one interview and the dearth of reviewers, generally, was a theme returned to in interviews and workshops:

> *…the reviewers are the scarce commodity at times and you have to go with what your reviewer wants as well to some extent.* (Interview)

The problem was also raised of the 'better' authors having a longer waiting list so that it takes longer for them to deliver the report. Having only a small pool of reviewers to call on was noted to result in a lack of creativity.

Non-publication

Some study participants suggested that the complexities surrounding the publication of SCRs meant that practice / partnership learning reviews, which tend not to be published, could be undertaken as an alternative (in circumstances where the SCR is not mandatory). There was a suggestion that learning could be improved since there is less need for caution about how the lessons gleaned are used or illustrated without publication:

> *Practice learning reviews rather than SCRs often have greater impact on learning as publication is not an issue.* (Survey)

The value of practitioner and family involvement

Different iterations of the guidance *Working Together* have, since 2006, highlighted the importance of involving both professionals and family members in reviews. These have been noted as part of the principles for learning and improvement and in the case of family involvement, as a means of keeping the child at the centre of the process (HM Government, 2013a; 2015b; 2018; Morris et al 2012). Practitioner and family involvement are also 'quality markers' 11 and 12 from the NSPCC/SCIE project of quality in SCRs (NSPCC/SCIE, 2016).

Many survey responses highlighted the importance of involving practitioners from the start of the review to inform the learning and the learning that can be gained from involving families. These messages were also forcefully reiterated in the two workshops and in interviews:

> *The direct involvement of staff and families allows you to hear the stories and the journey and better informs learning.* (Survey)

The importance of learning stemming from practitioners' and family members' participation in the review was a prominent theme to emerge from all evidence sources used in this chapter. Studying reviews in relation to quality revealed that all methods in use made it possible to involve practitioners and family members – a point emphasised in one of the workshops. Indeed, several workshop participants said it would now be unthinkable to carry out a review without involving practitioners.

All methods could be adapted, for example, to include a learning event to enable practitioners and families to participate. Nevertheless, particular review models (for example SCIE, SILP) were sometimes identified as being the most effective for an inclusive approach. The traditional review approach was mentioned by one survey respondent as possibly less flexible in this respect:

> *SILP has been effective in the engagement and involvement of those front line practitioners involved in the case. Feedback from those involved very positive.* (Survey)

> *IMRs do not allow for system learning and are too static a form of review and don't allow for the influence of front line practitioners and managers.* (Survey)

The effort made to ensure family involvement, in particular, was elaborated on in one interview:

> *We always try and involve the family if we can. We always if necessary go to prisons to speak to parents - so we don't use that as a reason not to go and see them - and if there are siblings we try and engage with them as well.* (Interview)

This interviewee described how family involvement shed a different light on the quality of assessments in one review where the child's mother had learning difficulties:

> *And we felt that the depth of her understanding wasn't properly grasped when the practitioners were involved so that was crucial… if we hadn't held that meeting with her the whole review would have been weakened in terms of our understanding.* (Interview)

Involvement was taken a step further in a child sexual exploitation focused review involving numerous young people, where two convicted adult perpetrators were interviewed. The SCR report notes that whilst there has been, quite rightly, a spotlight on the experiences of victims, there is a need to focus more on perpetrators and prevention:

> *There is much more to learn from perpetrators' childhood experiences in order that professionals gain more of an understanding of risk areas and how to identify early warning signs.* (SCR report)

Chronologies and hybrid approaches

There were mixed opinions about the value of chronologies which are an important component of the traditional IMR method but used in other models too. Some survey respondents regarded chronologies as essential, for example in helping to create a timeline:

> *Chronologies are the basis of any good review in our experience followed up with practitioner learning events and family engagement.* (Survey)

One interviewee, however, felt that a full chronology left the reader '*drowning in information'* and unable to pick out key events. There were other criticisms from survey respondents:

> *I don't think chronologies work and can be labour intensive and do believe focussed agency reports support the process.* (Survey)

The survey gave some indication of LSCBs favouring bespoke or hybrid models which combined elements of different kinds of reviews. Most often this entailed agency reports, summaries and a chronology alongside practitioner events and discussions:

> *We have found that a hybrid model best suits our purposes - depending on the complexity of the case. Chronology, agency analysis reports and a good genogram are useful for triangulating responses from practitioners and family. For our last couple of SCRs we have combined this with practitioner events based on the Welsh model. Although very challenging for practitioners to contemplate we have found that it enables a more holistic analysis and can in actuality be a cathartic process.* (Survey)

The rationale behind using a hybrid model also includes benefits in relation to flexibility and timeliness.

> *Hybrid models allow for flexibility and can enable key learning points to be extracted more quickly.* (Survey)

The cost of review models

Cost was cited as an important factor influencing a move away from some models. Using a traditional or some 'branded' models was found to be more expensive:

> *Some lead reviewers insist on taking a more 'forensic' approach that is time consuming, expensive and resource intensive without adding to any learning.* (Survey)

> *We would use SCIE more if there was not the additional cost.* (Survey)

> *Alternative, collaborative and less expensive methods of learning is the way forward.* (Survey)

Lancashire Safeguarding Boards (Kingston, Eost-Telling & Taylor, 2018) have recently completed a comparison of different review methodologies. Using figures from the time and hourly cost for each case, they calculated the overall cost of completing three reviews using a traditional method and three using the Welsh Child Practice model. They then calculated that the average cost for the traditional method is £55,866.12, in comparison with the Welsh model which has an average cost of £16,531.90 giving a cost reduction of 70.41% (p.27).

Summary points

Models of review were selected on a case-by-case basis to achieve the best fit and be proportionate, flexible, timely and to enable the involvement of practitioners and family members.

The availability and skill of the reviewer as well as the cost often influenced the choice of model.

While the traditional model incorporating IMRs was still commonly used, over the three years there was an increase in the use of other methods. Locally adapted ‘hybrid’ models were felt to work well to support learning from reviews.

Practitioner and family involvement contribute to the value and learning from reviews and can be achieved using any model.

6.3 Learning about recommendations

Not all review models include recommendations and some use alternative means of prompting learning and change. The SCIE ‘Learning Together’ model, for example, has

'findings' and questions for the LSCB, while the Welsh Practice Review has 'learning points'. In the survey questions, for the purpose of understanding implementation of *learning* for practice, we treated these in the same way as recommendations.

6.3.1 The number of recommendations and reviews

Our examination of recommendations in the previous triennial review (Sidebotham et al., 2016) showed that their number had dropped dramatically. In our 2009-10 study there was an average of 47 recommendations per SCR (Brandon et al, 2012), which fell to an average of seven in the period 2011-14 (Sidebotham et al, 2016). This drop had helped to stem the problems caused by the proliferation of actions prompted by each of the numerous recommendations (Brandon et al, 2012). In this triennial review, the examination of the 368 reviews from 2014-2017 showed that this decline has held to the same median of seven per review. This time the range in the number of recommendations also reduced from a wide 0-53 in the last triennial, to a somewhat tighter range of between 0 and 39.

Nevertheless, a continuing pressure caused by recommendation overload was voiced in the workshops used to 'sense check' findings. The pressure of following through recommendations was compounded in areas that held many reviews:

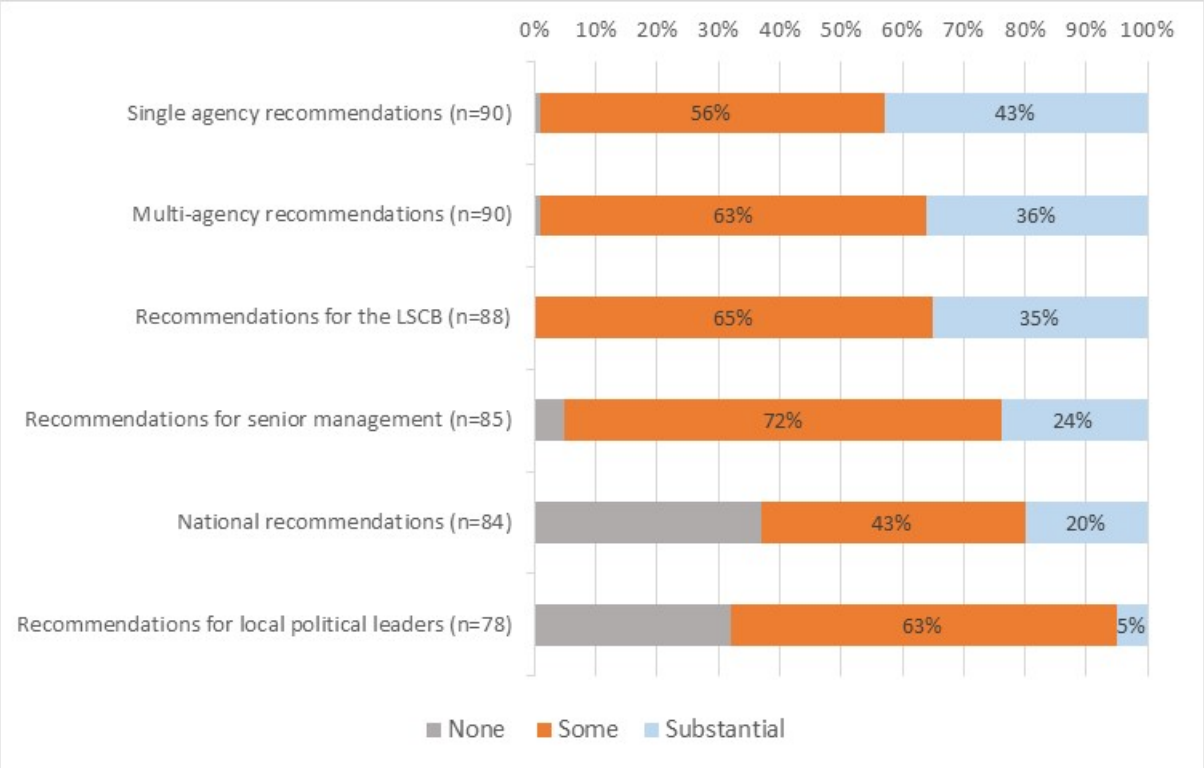
> *Due to the amount of SCRs there are numerous recs. In some instances there becomes a recommendation overload and they lose their impact.* (Survey)

6.3.2 Types of recommendations

What kind of recommendation targets make a difference to practice?

We were interested to discover the extent to which the intended 'targets' of recommendations, at both a local and national level, were felt to make a difference to practice. The results, in Figure 13, indicate that in terms of having 'substantial impact', single agency recommendations made the most difference to practice (43%), followed by multi-agency recommendations (36%) and recommendations for the LSCB (35%). Recommendations for senior management were viewed as having slightly less impact, with 24% of respondents viewing these as having 'substantial impact'. Recommendations for local political leaders and national recommendations are felt to have the least impact.

Figure 13: To what extent do you feel the following recommendation targets make a difference to practice?

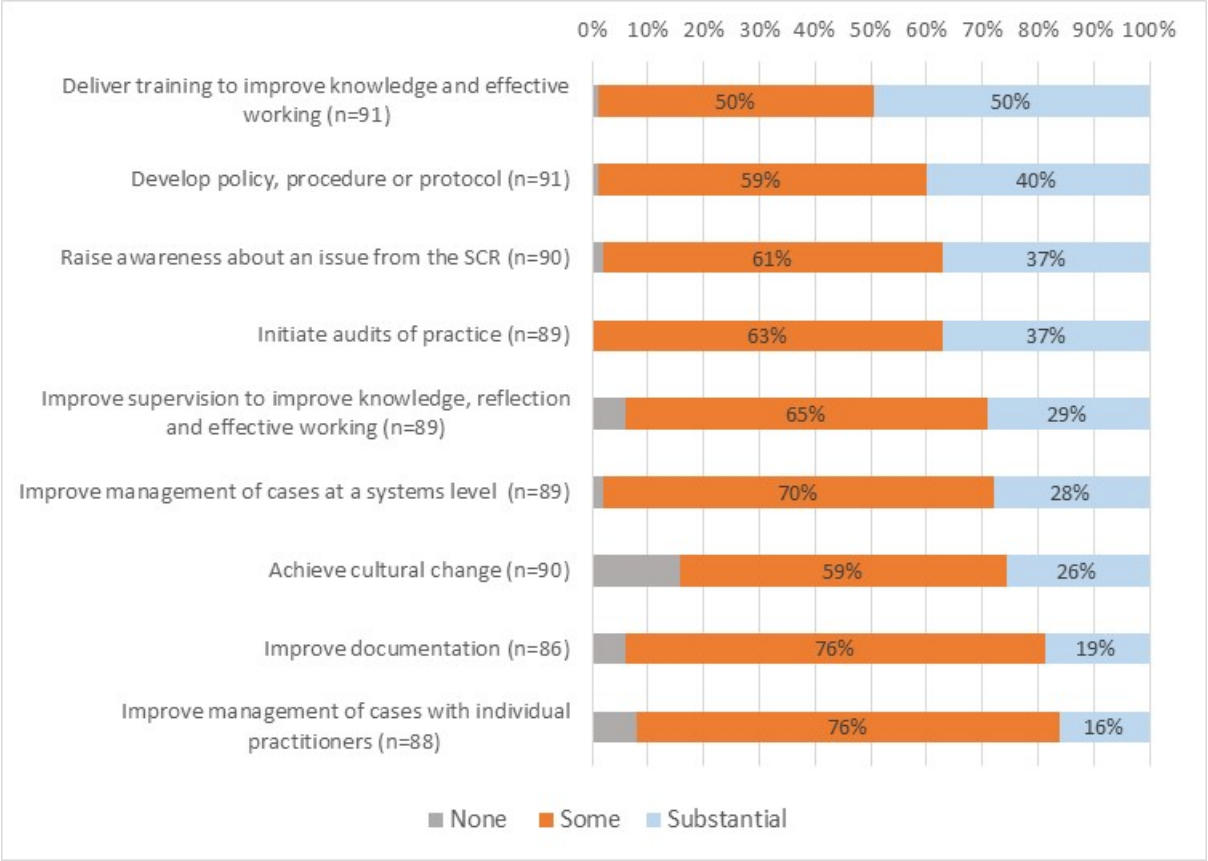


A point raised in the regional workshops was that some agencies do not identify with multi-agency recommendations when the wording of a recommendation starts with ‘all agencies’. Single agency recommendations were felt to be better at avoiding this distancing from responsibility.

What types of recommendations make a difference to practice?

We compiled a list of common types of recommendations and asked survey respondents to indicate the extent to which they felt these made a difference to practice. The results, in Figure 14, suggest that the most impact on practice was felt to come from recommendations relating to training, with 50% feeling these had ‘substantial’ impact. This was followed by recommendations relating to procedure or protocol development (40% citing ‘substantial impact’); awareness raising about an issue from the SCR (37%), and audits of practice (37%). The least substantial impact was felt to come from ‘improving documentation’ (19%) or ‘improving management of cases with individual practitioners’ (16%).

Figure 14: To what extent do you feel the following recommendations types make a difference to practice?



The importance of training also received some critique. One survey respondent highlighted the tendency to rely too heavily on training and was among a number of respondents stressing the value of recommendations being at a systems level:

> *Still too much reliance on wanting to train issues away, rather than address systemic issues that are harder to address.* (Survey)

> *Systemic recs are more helpful as may not be a solution but require more thought and wider discussion.* (Survey)

Recommendations aimed at achieving cultural change garnered varying responses across the range from 'no impact' to 'substantial impact'. Interestingly, some of the interviewees suggested that cultural change was beyond the scope of SCRs and was, instead, a leadership issue*:*

> *I personally don't believe that the SCRs actually drive the cultural change, I think that that is very much driven by Ofsted or driven by inspection regimes or driven by the senior management leadership team...I think if you go back probably ten years I think it would be a very different story but I think at the moment with all the*

agencies having massively reduced cuts I don't think that it is the SCRs that are driving the culture, I think it does come down to the cuts. (Interview)

Another interviewee commented that recommendations about cultural change were difficult to achieve because of change and 'churn' in the system. The example given was of losing a really good police superintendent:

So you lose institution knowledge and those people who are champions move on so the emphasis changes at a senior management level and at operational level - that is why you don't get that consistency. (Interview)

Some survey comments offered examples of the types of recommendation that were thought to make a difference to practice. Some emphasised the importance of being specific or SMART (specific, measurable, achievable, realistic and timely) in order to translate into definite actions:

As long as the recommendations are SMART and contextual they can have a huge impact on practice. (Survey)

A number of study participants emphasised that the type of recommendation matters less than having a committed and motivated team, or individual senior manager, who can take recommendations forward:

My experience is that the type of recommendation matters less than getting buy-in from the agency responsible. Having one person take responsibility for moving an action forward is critical. (Survey)

I think there is something around individuals, not organisations…You need a champion that gets it and to actually redevelop something they are moving it forward. (Interview)

Summary points

Over the 2014-2017 period the number of recommendations ranged from 0-39 with an average of seven per review. The pressure of following these through - 'recommendation overload' - was compounded when an area had carried out numerous SCRs.

Recommendations were felt to have a substantial impact when they were targeted at single agencies and at a multi-agency level although when recommendations are addressed to 'all agencies' staff could distance themselves.

Many types of recommendation were used but those thought to have the most substantial impact related to training, policy and procedure development, audits and awareness raising.

The need for recommendations to be specific (SMART) and contextual was commented on as well the need for them to be at a systems level, avoiding the tendency to '*train issues away'.*

Many respondents felt that the type of recommendation mattered less than having a committed motivated team or champion to take them forward.

6.3.3 Monitoring implementation and quality assurance

We asked about ways of monitoring the action plan or its equivalent. Audits and the RAG (red, amber, green) system appear to be the most popular approaches and are used by over 80% of LSCBs responding to the survey (Table 24).

Other monitoring methods noted by respondents included:

- Learning through dedicated LSCB sub-groups reporting progress;
- Visits to frontline practitioners;
- Surveys to agencies;
- 'Dip-sampling' the evidence provided from agencies so that the action plan is robust; and
- Trainers testing the knowledge of recommendations with case scenarios in training.

Table 24: How do you monitor the implementation of your action plan or its equivalent?

Monitoring method	Frequency (%) (n=91)
Audit	77 (85%)
RAG traffic light system	75 (82%)
Annual LSCB report	63 (69%)
Tabulating responses to recommendations e.g. actions that have been taken and are continuing to work	46 (50%)
Strategy development	32 (35%)
Multi-agency peer review	13 (14%)
Other	17 (19%)

6.3.4 Quality assurance

Numerous comments within the survey (over 40) explained that it was the role of the SCR panel, sub-group, or 'task and finish group', to be critical friends and quality assure the final report, in particular to agree the learning and recommendations. This was often with the statutory partners or the main board providing a final check or sign off:

> *The SCR Panel challenges the content, then it is presented to the LSCB SCR sub-group for further challenge and discussion before presentation to the main Board meeting.* (Survey)

There were a number of ways in which in which independence, quality assurance and learning could be approached. An example includes using the case review and governance subgroup of the LSCB for quality assurance to ensure consistency and develop principles for good case reviews, clearer expectations of reference group members, parallel processes, reports as well as publication processes.

There was an emphasis on reviews being completed by someone not involved in the case*:*

> *Previously there was always someone totally independent who may complete the review with an internal reviewer. In line with 2018 Working Together, reviews may be completed by partners who have had no involvement in the case. All reviews*

> *are additionally QA* [quality assured] *by a multi-agency think family panel…before being presented to the board.* (Survey)

One respondent commented that their LSCB used the NSPCC quality markers for quality assurance (NSPCC/SCIE, 2016). These quality markers include the involvement of practitioners. Practitioner involvement could also include checking the SCR findings:

> *Consultation with the staff involved at the outset regarding the Terms of Reference and again to check the findings against their perception/experience. In addition, the multi-agency review panels always include independent members with appropriate expertise.* (Survey)

Independent critical readers

Only 27 survey respondents (30%) indicated that they had an independent critical reader to check on the recommendations/learning points from the review. In line with earlier comments, some interviewees said that recruiting independent authors provided sufficient independent scrutiny. One interviewee, an LSCB chair, said they read and checked through each SCR meticulously, which added a satisfactory layer of independence. This was supported by other similar comments from the survey. Most respondents relied on peer review and the SCR panel or its equivalent to provide a critical eye on the process and the review.

Summary point

Audits and RAG systems were the most popular approaches to monitoring although a range of other methods were suggested. Most LSCBs relied on peer review to quality assure the SCR and act as critical friends.

6.4 Dissemination of learning

All but one of our survey respondents indicated that their Board delivered multi-agency training and almost all distributed briefings or bulletins to feedback learning from SCRs (Table 25). Examples of feedback documentation included powerpoint presentations, a supervision pack published to support smaller group sessions with practitioners, and '*7 minute briefings'.* Most of the SCR learning and outcomes in this array of documentation were then used to feed into and update training. Workshop participants discussed briefings and added '*1 minute briefings'* to the list of feedback. They also commented that it was difficult for practitioners to find the time to read even these very short briefings, especially when they were so numerous and distributed by email '*almost daily'.*

Table 25: What are the ways in which you disseminate learning from SCRs to the workforce?

Method	Frequency (%) (n=91)
Multi-agency training	90 (99%)
Briefings or bulletins	87 (96%)
Awareness raising	78 (86%)
Conferences or events based on themes	73 (80%)
Single-agency training	67 (74%)
Action learning sets	15 (17%)
Performance/drama	13 (14%)
Other	9 (10%)

The varied range of approaches to dissemination, often within individual Boards, was apparent as exemplified in the following comment:

> *As well as usual single/multi-agency training the* [LSCB] *offers bi-monthly learning from SCRs (nationally and locally) training and an annual full day learning event. Recently we have been working with a local drama performance group to develop performances linked to CSE and CE* [Child Exploitation] *to illustrate learning. We also have a detailed section on our website and we use social media to disseminate learning.* (Interview)

We were also alerted to Boards' widespread use of social media for dissemination (for example Twitter, Facebook, Instagram) during the workshops and interviews.

Some survey comments and interviewees raised the involvement of young people in dissemination. Examples included involvement through children and young people's forums, children and young people developing resources and their inclusion in sub-groups and other partnership forums:

> *The LSCB has done some innovative work on this, for example using the transcripts from interviews with children during the SCR process to produce a film*

about their experience of the services provided in the weeks, months, years of abuse leading up to the incident which triggered the SCR. This is a quite powerful learning tool as it is literally the voice of the children and there are plans in place to do more of this type of work. (Interview)

Public awareness of safeguarding issues was achieved in one example during a *'safeguarding awareness week'* where messages from SCRs were fed into the event. Boards described various ways of gauging workforce awareness of SCRs after their dissemination phase, including the 'mystery shopper' approach:

We do training and we do sort of quick guides and things as well about the issues that come out and then we would follow up afterwards, we do what we call a 'mystery shopper order'…We get an anonymous sample of staff from all different levels, front line right up to Chief Exec and ring around a sample of them and ask them what they know...The last one that was published last, we ran a campaign…and we did we did a sample of forty people across the workforce and thirty-six knew about the campaign relating to the baby…I suppose I think it is trying to do things in more of a business model and...be a bit more creative. (Interview)

6.4.1 Shared learning across different strategic boards

Adult Safeguarding Boards are a requirement of the Care Act 2014 and we were curious to see the extent to which learning from SCRs was shared across these and other strategic or partnership boards (Table 26).

Table 26: Is learning shared across strategic Boards?

Method	Frequency (%) (n=91)
Adult Safeguarding Board	69 (76%)
Health and Wellbeing Board	52 (57%)
Community Safety Partnership	65 (71%)
Other	25 (28%)
Adult Safeguarding Board	69 (76%)

Learning appeared to be regularly shared with other boards including for some respondents across neighbouring or regional LSCBs. We were given many examples of other types of strategic board or similar boards with different titles. These included Children and Families Strategic Partnership Board, Children and Young People Alliance, Clinical Commissioning Group Governing Body, Domestic Abuse Boards, Executive Safeguarding Partnership Board, Youth Justice Management Board, and an array of other boards with local acronyms.

One comment illustrated how learning was shared extensively across strategic boards:

> *Indirectly, the SCRs are shared through LA Public Protection Forum* (PPF); *this is a non-statutory meeting of safeguarding partnership Boards (Adults, Community, Health and Wellbeing Boards) where all chairs can examine cross cutting themes, for example, domestic abuse, information sharing, early help offer, family vulnerabilities. The respective Board Managers meet separately in support of the PPF and regularly share learning from serious adult reviews and domestic homicide reviews*. *The thematic learning framework developed in response to SCRs is also now applied to other statutory reviews, which is further evidence of the common systemic themes.* (Survey)

Some other comments indicated that publishing SCRs online facilitates sharing or noted that they were not currently sharing learning across partnerships but would do so if it were relevant. Another respondent commented that they were planning to share learning across boards in the future.

6.4.2 Types of cases, themes and learning

Survey respondents were asked whether they thought some types of cases were harder to learn from than others. While 39 (43%) of respondents agreed that this was the case, 33 (36%) did not agree and a further 19 (21%) indicated 'don't know'. As one respondent commented, '*each brings their own challenges and opportunities for learning'* and in a similar vein, another commented that a good model should mean that learning can always be identified. Others emphasised that the difficulties were around learning for practice rather than types of case per se: '*the greater difficulty relates to impacting changes in practice'*. Nonetheless, a number of issues affecting learning were identified, most prominently:

Cases where little is known

Most often, respondents highlighted that 'out of the blue' cases, which met the SCR criteria but where little was known about the family prior to the incident, were particularly difficult to extract learning from. These were cases where there had been little in the way

of prior safeguarding concerns or involvement of services and the multi-agency learning was minimal:

> *When there have been few or no safeguarding concerns prior to the event… the learning as to how to predict and prevent a similar event from recurring is very difficult.* (Survey)

> *Where there is very little agency involvement the challenge for the review is to establish if there should have been and the difference that would have made.* (Survey)

Complex cases with many agencies involved

Conversely, for those cases at the other end of the spectrum of agency-involvement, their sheer complexity brought challenges to learning, as one survey respondent commented: '*The greater the number of agencies the more complicated the task is'.* Another described an SCR where '*there was so much involvement that it was hard to see the wood for the trees'.* These types of case included those relating to historical long term abuse, large sibling groups, neglect or children with disabilities:

> *Where children have very significant disabilities or mental health difficulties. The number of professionals and agencies are so numerous that the co-ordination of SCRs are incredibly complex.* (Survey)

> *Neglect based cases are systemically difficult because sometimes there is not a 'single' index incident to focus the SCR upon compared to physical abuse/sexual abuse etc.* (Survey)

Other challenges were posed by cases spanning more than one local authority boundary.

Reviews which are very case-specific

Reviews which had very specific or unusual features were also felt to be harder to learn from, particularly in relation to learning for the wider workforce. A similar point was made in the interviews:

> *You need to make recommendations that everybody can learn from and do something about, you know, as opposed to recommendations that are just about this case.* (Interview)

An implication of this, discussed by some survey respondents, was the limited extent to which systems learning could be drawn from these individual, case specific reviews:

> *If the review is too case specific, i.e. one practitioner failed to follow a basic procedure, then this may not apply systemically.* (Survey)

6.5 Key learning points from local reviews

We asked survey respondents to list their top three learning points from their local SCRs in the period 2014-2017. Responses tended to be brief and topic-based although some comments provided an indication of 'how' the learning occurred. The phone interviews sometimes provided more elaboration on whether and how these learning points are embedded in practice. A full summary of the learning points is available in Appendix H, organised into broad, overlapping headings. Selected findings from two of these main headings are illustrated in this section:

- working together; and
- recognition, assessment and response in relation to specific topics.

6.5.1 Working Together

Commonly reported key learning in relation to working together included information sharing and communication, professional curiosity, professional challenge and escalation.

Survey participants raised specific issues around information sharing and better communication between agencies and across adult and children's services. An example was given of sharing information about histories to assist accurate assessments and develop SMART plans. The need to involve and inform all partner agencies was mentioned by many as was the need for agencies to share information with children's social care:

> *Multi-agency working i.e. gathering all the necessary relevant information available to ALL partners to inform assessment and planning to safeguard the child or vulnerable adult for example, strategy meetings, information sharing, involvement of GP.* (Survey)

> *Not making the assumption that Children's Social Care will be aware of information about the family because they are involved - professional responsibility.* (Survey)

Key learning about professional curiosity tended to draw attention to the deficits in this area of professional practice. Workshops gave examples of tools being used to generate discussion including a '*professional curiosity factsheet'* sent to all practitioners in one area to be used in home visits as a preventive measure. Gaps in practitioners' ability to exercise professional curiosity were said in one survey response to lead to increased monitoring rather than direct work to change family situations. One interviewee felt strongly that professional curiosity should be a core aspect of the job of safeguarding and not something extra that needed to be learnt:

> *The job is about, generally, relationship based practice that is designed to get into families and help them change…and you can only do that if you are, you know, curious about and ready to ask questions and ready to say 'well that is a funny answer, help me understand that some more'.* (Interview)

This emphasis on the importance of relationship based practice was said to be a '*common shared starting point'* so that the '*police, teachers, health visitors, paediatricians, are on the same page'* in terms of this approach:

> …*and where their level of expertise crops up they adopt a similar approach to change, not just to monitoring it and telling the social worker about it.* (Interview)

Challenging decisions made by professionals from other agencies requires confidence and support. Where safeguarding concerns are left unaddressed there can be a lengthy process of challenge and escalation. Oversight by supervisors and managers can enable escalation through support:

> *There should be effective supervision and management oversight of cases that are not progressing or are stuck with appropriate escalation in place where there are differences of professional views.* (Survey)

The case study below is drawn from an interview and is used to explore ways of managing the complex 'working together' issues involved with escalation and challenge.

Case study: Escalation of concerns and professional challenge

One LSCB explained how they addressed problems with staff diffidence about escalation of concerns by reframing the issue as 'resolving professional differences'. Local professionals made it clear that they did not like the word 'escalation' feeling that to escalate a situation made partnership working difficult. What felt more comfortable was to change the term to 'resolving professional differences'. '*We changed things around a bit and said actually…you will have situations in your professional life where you will have differences and that is healthy and that is good and kind of a healthy place for agencies to be at'*.

Problems around escalation or the lack of escalation emerged from this Board's most recent SCRs, as well as from safeguarding adults reviews, practice reviews and case audits. Difficulties arose when staff did not agree with children's social care decisions to 'step down' or close a case. Similarly, there were unresolved differences involving health and the police. Typically concerns would be taken to an immediate manager who would speak to the agency involved and often the concerns remained unresolved. Escalation of concerns was perceived as the responsibility of senior management '*the feeling was very much around we don't escalate it, the Head of Statutory Service, they kind of know best'.*

The Board's view was that escalation was not an issue solely for the lead agency, children's social care, or for managers but that all agencies had a role to play and all views were important. The small semantic change from escalation to resolving professional differences altered the sense of professional empowerment with staff saying '*no we didn't feel that we were empowered enough to escalate but we do feel that we are empowered enough to share a professional difference'.*

Key learning:

As well as changing the wording, the Board changed the process and policy for escalation/professional differences and had a re-launch of the new way of working.

Case audits are already picking up an increase in activity, with local agencies keeping track of where and how the new arrangements are being used across the partnership. This includes *how* professional differences are being resolved, what is working/not working and the resulting impact on the child and the child's experiences rather than the incident of professional difference: '*from the initial findings, what is jumping out is really positive'.*

6.5.2 Recognition, assessment and response in relation to specific topics

Many of the key learning outlined by survey respondents and elaborated on in interviews revolved around recognition, assessment and response to specific topics. Three illustrative topic areas, working with fathers and men, neglect, and vulnerable babies, are discussed below:

Audits in one area were used effectively to collect evidence of **working better with men and fathers,** particularly those no longer in the household, as a means of improving practice:

> *Through our reviews we found that we weren't very good collectively across the agencies at working with fathers particularly in domestic abuse…what we did through our case audits was to ensure that whenever we looked at cases of a similar type that we could evidence that practitioners were engaging with fathers who were no longer in the household. So that they were involved in planning and assessment. And that was quite a cultural change really because I do think across a number of agencies there was a sense of relief if father had moved out of the house it was like 'well problem over' when it wasn't really.* (Interview)

Workshop discussions suggested that learning is given added weight and much easier to embed if it comes from an SCR, for example taking into account men and significant others in the lives of children. An interviewee discussed improvements in working with men and fathers which had been tracked and demonstrated in the Board's yearly analysis and embedded in practice as part of a family safeguarding model. However, sustaining those changes was said to be proving difficult.

The cumulative harm from **neglect** was raised as a learning point as were issues of adolescent neglect and the need for practitioners to use professional judgement when working with children at risk of or experiencing neglect:

> *Determining levels of neglect and their impact on the child requires professional judgement based on sound assessments and analysis.* (Survey)

> *Children's limited capacity to protect themselves as they move into adolescence after experiencing a lack of consistent, supportive parenting in their early years.* (Survey)

One interviewee noted that it was possible to start evidencing the difference in workers' confidence in working with neglect. This was particularly in relation to the pressures of reporting, identifying and assessing neglect and the enhanced confidence that had come from long term local work on training and implementing the Graded Care Profile.

The **vulnerability of babies** and the significance of injuries to this age group was listed as key learning in numerous survey responses and interviews. One example was given of the promotion of awareness among parents and professionals of the 'crying curve' (also known as 'purple crying') and the impact on parents of coping with inconsolable crying. One interviewee also discussed the way their area had strengthened guidance about injuries to non-mobile babies and extended this to non-mobile children of all ages as a recognition of the vulnerability of children with complex health needs and disabilities. A recent review article by Bilson has however found a major disjuncture between research evidence on bruising in pre-mobile babies and its interpretation in guidance. While many LSCB policies require all premobile children found with a bruise to be seen urgently by a paediatrician, Bilson has questioned the rigour of the evidence base on which this is founded (Bilson, 2018).

6.6 Local thematic analyses prompted by SCRs

Over half of LSCBs carried out thematic reviews (51, 56% of responding LSCBs) during the period 2014-17. Discussion in the regional workshops highlighted the potency of a cluster of similar cases in delivering impact and suggested that thematic reviews were a very good way of achieving this.

Some of the topics for thematic review mirrored those for key learning points although new themes were also introduced. Neglect was the single most frequent topic prompting 13 thematic reviews. This was followed by 11 thematic reviews concerning CSE. There was a wider overarching theme of vulnerable adolescents which, in addition to CSE, included issues such as suicide, 'county lines'/child criminal exploitation and youth violence'. Another topic for thematic review was safeguarding babies which together with pre-birth assessments, prompted 12 themed reviews. Child disability or complex health needs was the focus for six themed reviews. A more detailed list of the topics addressed by LSCB thematic reviews is contained in Appendix I.

Summary points

Multi-agency training and the distribution of briefings or bulletins were the most popular methods of disseminating the learning from SCRs. Comments illustrated how many other approaches were used, including social media and ways of involving young people.

Views were divided about whether some types of cases were harder to learn from - with a suggestion that the greater difficulty relates to impacting change in practice. Reviews where there had been limited agency involvement, or conversely reviews with many agencies involved were identified as presenting problems for learning and impact.

Topics for key learning from SCRs included familiar professional issues of information-sharing, professional curiosity, managing professional challenge and escalation. Neglect was commonly mentioned, particularly in relation to gaining enhanced confidence and exercising professional judgment. Improving practice with men and fathers was highlighted as was promoting awareness of the vulnerability of babies, concern with the child's lived experience and understanding behaviour as a form of communication.

Over half of LSCBs carried out thematic reviews on topics, mostly mirroring the key learning points. In addition many themed reviews concerned vulnerable adolescents incorporating child sexual exploitation and child criminal exploitation. Other reviews involved safeguarding babies and pre-birth assessment as well as child disability or complex health needs.

6.7 Impact

This section explores findings relating to evidence of change from SCRs at local and national level, as well as the barriers and enablers to achieving impact.

6.7.1 Local change

The survey showed that of 84 LSCBs which had conducted SCRs during the 2014-17 period, 75 (89%) felt they had evidence that practice had changed locally as a result. However, a small proportion, nine (11%), indicated that they did not have any evidence of local practice change. Some comments illustrated the importance given to achieving impact from these reviews in a way that does not attribute blame, and how this is done:

I am passionate about the impact of SCR on learning and have worked hard to ensure those involved in the case - practitioners and parents - contribute actively to identify the improvements. It is crucial to the success of the SCR impact that all see these processes as constructive learning opportunities and not investigations which attribute blame. (Survey)

I have introduced follow up one-year impact surveys which essentially asks agencies to evidence impact of SCR on practice and the difference it has made. (Survey)

Of the 75 respondents who noted local practice change, a range of evidence sources had been used, with audits (85%) and collation of action plan responses (81%) being the most frequently cited (see Table 27).

Table 27: Source of evidence for local practice change as a result of SCRs

Evidence source	Frequency (%) (n=76)
Audits	65 (86%)
Collation of Action Plan responses	61 (80%)
Section 11 self-assessment	42 (55%)
Consultations with practitioners	30 (40%)
Surveys	15 (20%)
CP statistics	14 (18%)
Other	13 (17%)

One interviewee described their 'other' evidence source as soft, more anecdotal data gathered by the LSCB Business Manager in meetings and conversations with practitioners and managers combined with a check of 'concerns'. This included asking agencies: '*what have they done, how do they know it has gone well and what is their data saying?'* This combination was felt to provide a good, but not perfect, feedback loop.

Audits were sometimes described as 'programmes' of single agency and multi-agency audits, used to ensure that changes to practice as a result of SCR recommendations are explored and evidenced. An example of specific impact from audits in one LSCB included:

Better engagement with fathers in assessment and planning; practitioners being more focussed and effective in gaining the views of siblings in assessments; stronger engagement with adult services (focus on Think Whole Family); and good evidence of constructive multi-agency challenge taking place'. (Survey)

In this LSCB, case audit tools were used to track specific improvements from the learning from both SCRs and learning lessons reviews.

There were also mentions of scrutiny and challenge of section 11 reports and agencies being held to account over a lack of progress on agreed action plans. One example was given of a composite action plan (CAP) which contains all recommendations categorised against a thematic learning framework:

We regularly review this and test it in our section 11 process which includes challenge/peer challenge days. We have also taken the decision to strip out 'business as usual' or good practice recommendations, for example, against assessment, supervision, use of policy, to include in a more regular monitoring cycle so that the CAP is not overwhelmed by recommendations that are difficult to evidence as fully complete. (Survey)

Both survey respondents and interviewees stressed that there has been a positive move over recent years towards more attention and effort paid to evidencing impact, as one survey respondent commented: '*We are much more focused on trying to ensure evidence is gained that they are making a difference'.* Despite these efforts, the ability to confidently evidence and quantify level of impact that the learning from SCRs had on practice was a persistent challenge. This point was repeatedly emphasised by study participants:

While the Board can identify direct impacts on practice and has employed a 'one year on' impact review; claiming this learning leads to consistent and substantial change in practice would be extremely difficult to evidence. (Survey)

A number of interviewees discussed how it is difficult to measure the influence of SCRs in isolation – they are part of a larger whole – and learning is most often drawn from multiple sources including other types of reviews:

We have got evidence that practice has changed, whether it were directly as a result of an SCR I am not that confident. (Interview)

Suggesting that as a result only of the SCR you are delivering this learning, well actually not necessarily, stuff could have been delivered anyway without the SCR or suggesting that you know whole systems, organisational change takes place…it is constantly changing you know, the whole landscape of the public sector is…constantly moving, so to sit there with that one piece of research and one

piece of work could actually, it should be incorporated into those changes but it is not going to be the only instrument of that change. (Interview)

6.7.2 National change

The vast majority of survey respondents, 86/91 (95%), were not aware of any national changes resulting from their SCRs, and some commented that national influence of SCRs had been limited:

> *SCRs have little impact on changing national policy where its influence can be the most beneficial.* (Survey)

Of the small number of LSCBs who did note that their SCRs had contributed to national level impact, 5 (6%), this related to a range of issues including the following:

- Guidance issued by the Magistrates Association in relation to the Special Guardianship Orders;
- Influenced greater focus attention of the issues pertaining to 'county lines' and the growing concerns with gangs/drugs;
- Wonga changed their policy on debt collections and Financial Conduct Authority changed regulation on payday loans; and
- Learning from the '111' service response to reporting of injuries resulted in a recommendation for changes in call handlers procedures.

Other survey respondents mentioned ongoing discussions pertaining to both more recent and earlier SCRs which might result in future national changes. This included some unpublished reviews which may have an impact on secure settings and abusive head trauma in babies. One police force has drawn attention to the growing problem of organised gang affiliation, which is being considered at a national level. Another highlighted the problem of GPs being able to de-register children, and the added impact especially for children with chronic illnesses if parents choose not, to or are not able to register children with another GP. Although this issue was the subject of a review by NHS England, there was no change in policy as GP registration was considered to be a matter of parental choice.

One interviewee expressed the hope that, under Working Together 2018, they might be able to influence the national focus in relation, in particular, to obesity when neglect is a safeguarding issue.

6.7.3 Overarching barriers and enablers to impact from SCRs

Pre-occupation with process

Many respondents highlighted that pre-occupation with the process of completing the SCR, and the following 'easy win' recommendations with a focus on training, policies, procedures or guidance can overshadow embedding improvements in practice:

> *The challenge is to get from the review process to ensuring impact as quickly and as rigorously as possible. Preoccupation with process can exhaust partners so there is little energy left for ensuring impact.* (Survey)

These themes were elaborated on in a number of the interviews:

> *You know we go through a process of gathering information, we sort of build up a picture of the events and then we do some analysis so I feel that there has been too much focus on you know that stage of the process rather than the end result 'what are we going to do?'* (Interview)

Limitations to action plans

The content of action plans - Red Amber Green (RAG) ratings etc. - could be viewed as relatively superficial and their 'tick box' nature not always conducive to delivering the impact required. This is because the focus is short term, rather than on embedding culture shifts and systemic change. There was an acknowledgement that completion of a set of actions does not equate to the eradication of a particular risk:

> *Having an action plan and monitoring completion is focused and will be completed in a timely manner. The danger then of course is the perception from the partnership that it is a "done job" and the monitoring and review thereafter loses priority to revisit whether or not the learning has a long term effect and contributes to a necessary cultural shift of practice.* (Survey)

One interviewee elaborated on these limitations, and how, despite action plan and RAG ratings, practitioners often remained unaware an SCR had even been undertaken:

> *You know there is a thing I used to do, I used to floor-walk to social workers and I would just say you know 'just to pick your brains, oh how many SCRs do you think we have had?' Nobody could tell me how many SCRs we have had, it is on the website but they still don't know, which means as an organisation you don't know about when things have gone wrong, you don't know and there is no focus on the impact and the learning.* (Interview)

Shifting priorities

Changing priorities, including shifts in focus onto new SCRs, can also have the consequence that learning gets lost:

> *Lots of attention is given to a particular set of recs during/ shortly after the SCR but then another SCR commences and focus shifts.* (Survey)

> *If the focus of the case doesn't fit neatly under the Board priorities it is more difficult to get traction on the learning.* (Survey)

One interviewee suggested how focus on 'current' concerns can then overshadow other enduring themes such as neglect which can become sidelined:

> *Most SCRs are about neglect, most of them are about parents being unable to prioritise their child's needs. My concern at the moment nationally is that with our current and appropriate pre-occupation with exploitation, criminal exploitation of children...Boards nationally are becoming more and more preoccupied with that sort of subject area working with their local safety partners, it can actually, if you are not careful, drown out your traditional core child protection agenda…neglect will keep cropping up and if you don't pay attention to it proactively it will keep coming up so Boards need to be very mindful.* (Interview)

Leadership and organisational culture

The culture within an individual organisation and its wider partnership was repeatedly noted as a significant influence on making a difference and delivering impact from reviews and their recommendations. Change and churn affect organisational culture and can hinder the learning being embedded. Periods of high turnover within the workforce can have the effect of depleting *'organisational memory'.*

> *It is leadership it starts from the top, if your leaders don't get involved and set the standards you know, you know staff responsibility…saying 'look, listen this is not acceptable, it cannot happen again and I want reassurance that my middle managers and team managers are taking steps to make sure it doesn't happen again'*. (Interview)

In contrast, another interviewee commented on how, after a period of organisational instability, a stable management team had made a huge difference in terms of implementation and impact:

> *Since we have had a more stable management team and the principal social worker accepts the actions are there and takes responsibility for doing them and reporting that back and really from my perspective that makes all the difference.* (Interview)

It was apparent that reviews have a useful function as an accountability check on the quality of leadership as well as an opportunity for reflection on practice:

> *SCR and other review processes are an essential part of safeguarding children and promoting their welfare. How systems respond to incidents and reviews are an important reality check on the quality of leadership and practice locally.* (Survey)

> *In my professional opinion, the fundamental strengths of SCRs is enabling agencies to reflect on practice, and the strengths/suitability of the system and processes in place to better support agencies to work together to safeguard.* (Survey)

Learning from BAME reviews

Discussions in the regional workshops and some interviews highlighted a failure to learn from numerous local SCRs concerning dual heritage or Black and minority ethnic (BAME) children. Workshops discussed a tendency in some reviews to provide minimal detail on ethnicity or culture in order to preserve family anonymity. However it was felt that this diluted any specific messages, as well as the story of the child and case, and thus served to limit the power of the learning.

An interviewee highlighted a lack of apparent interest in family life in two SCRs:

> *In one, where a baby was murdered, the mother was dual heritage and had been ostracised by her community…and in the other one it was a young South Asian woman and again there were implications there, but actually nobody in that system had* [asked] *'what is life like for this young woman'…If it was a White British child you would say 'what is life like for this particular person in this particular context?' so you would sort of unpick it*. (Interview)

This region held workshops to talk about race specifically and two issues emerged: a *'fear factor'* from white workers of being seen as racist, and black workers not feeling sufficiently empowered to challenge that fearful thinking. One suggested way of addressing these problems was examining data on specific ethnic groups to better understand safeguarding for significant BAME populations:

> *Is anybody doing work and analysis around East Europeans? You know we are seeing perpetrators of CSE, anecdotally there is a view about that happening - do we have the evidence? Is neglect an issue for a Pakistani family? So there is a real need for some in-depth analysis.* (Interview)

Analysis of the needs of specific BAME populations in this way was also argued to help in understanding identity and belonging for young people and addressing how we ask questions around where the young person belongs and what they feel.

The story of the case

The section on learning from BAME reviews highlighted the importance of learning from the story of the case. Workshop participants felt strongly that the most powerful SCR learning came from remembering the story of the child as a person and the impact this had on them personally. Reframing the horror story as an opportunity for learning helped the messages to stick in professionals' thinking. Remembering the child as a real person helped to change behaviour and practice.

As with stories, feeling connected to the SCR was important to embedding learning. A point raised at regional workshops was that this much easier to achieve if the learning came from a local SCR, where the relevance feels 'closer to home'. This theme of closeness also emerged from the interviews:

> *Safeguarding training has so much more impact when they think it is on their doorstep. Although we always do put on the national learning, it is really important to make it real and near to home.* (Interview)

Involvement of practitioners and family

A recurring theme throughout this examination of the impact of SCRs on practice has been on the added value of involving practitioners and family members:

> *I think case reviews are an important part of learning, evidencing reason for change and improvement. Reviews that involve practitioners help them understand a tragic incident within a system and recognise that they are not solely responsible when outcomes are not good but they have a part to play in making the system work well.* (Survey)

Other chapters have emphasised that children's lived experiences should be explored by practitioners and their behaviour assumed to be a way of communicating (Cossar et al.,2013). One interviewee described how ways of improving the involvement of children and young people in the review process prompted learning in practice:

> *The whole process should also be more inclusive of children and their participation is key. We believe that we learn best when we hear from children directly and their experience is key. One child explained to us very clearly that all she really needed was 'safety...and nice adults'. We need to think about that and figure out why that is so difficult when it sounds so simple.* (Interview)

This area was keen to use drama and performance to instil these messages in professionals' thinking and practice.

Repeated themes, repeated findings

A number of respondents commented on the way in which similar themes and findings continue to re-emerge. This issue appeared as both a barrier and an enabler to learning and impact and was a topic for much discussion at both workshops. There were different perspectives offered on this from survey comments. In a more positive light, the role of SCRs was seen to serve as a reminder/refresher to the workforce and a way of keeping these issues in mind. This was particularly so when the learning had moved away from specific procedural recommendations and had become more concerned with finding out why particular parts of the system failed – which required returning to old well-trodden themes:

> *Seems as if the SCRs are about reminder of the way that things can go wrong, and serve to keep long known issues in the eye of senior managers.* (Survey)

> *You have to continually drip feed messages to the workforce - as there can be periods of high turnover for the workforce and organisational memory can be depleted.* (Survey)

Further reinforcement of the need for repeated messages was highlighted at one of the regional workshops, where it was said that sometimes new messages can make professionals 'forget' previous messages and other risks. This issue had been identified in audits.

The repetitive nature of lessons learned was a theme from our 2010 Delphi study of learning from SCRs (Sidebotham et al., 2010). Here we argued that some learning is so important that it needs to be regularly repeated, particularly in the context of workforce turnover and lost organisational memory.

Other comments however, revealed a sense of frustration about this repetition, noting that in the context of similar themes to previous reviews recurring, it feels difficult to get a different angle or different learning from them. Some respondents suggested that the SCR process and the scrutiny of individual cases may not be the best way to bring about change:

> *Not sure that the intense scrutiny of individual cases effects the best change, given so many just come to the same findings and many times the same mistakes are repeated. We say they are systemic reviews and we seek to learn not blame, but it is hard to find any without hindsight bias.* (Survey)

> *When we look back to the Maria Colwell SCR the learning that arises is no different than what we are identifying today, the same themes and issues continue to arise. The SCR process is very bureaucratic and does not always allow for the context that agencies are currently working in.* (Survey)

The overload from carrying out numerous SCRs and their learning was described in one comment as '*SCR fatigue'*:

> *As an LSCB that has done a number of SCRs in the last four years, there is a sense of 'SCR fatigue' and a frustration that lessons are repeated in different guises in these difficult cases.* (Survey)

When there was a perception that there is little new to say, this was felt acutely by professionals.

Summary points

Although the majority (89%) of survey respondents indicated there had been local change as a result of SCRs, evidencing the change was challenging. Where evidence existed it came primarily from audits and action plans, although examples were also given of practice change being apparent from other sources, including subsequent SCRs.

National changes were only linked to five reviews although many boards did not know whether or not their SCRs had achieved a national impact.

Barriers to achieving impact included a preoccupation with process, and the limitations of action plans which could prompt a tick box response rather than a focus on systemic change. Other barriers were organisational change and a depleted organisational memory. Shifting priorities were highlighted by the retrospective nature of reviews.

Strengths in delivering impact included the positive elements that come from providing opportunities for reflection on practice and particularly from the story of the child at the centre of the review. Keeping the learning real, local and close to home was helped by involving practitioners. SCRs were also thought to act as an accountability check on the system and the quality of leadership and practice.

Although repeated themes and learning points were mentioned as a barrier to learning they were also identified as important ways of making sure important lessons were not forgotten.

6.8 The quality of the review and final report

The variable quality of SCRs was recognised as a potential barrier to learning by Ofsted (2011) and by the national panel of independent experts (DfE, 2014; 2015). Key concerns identified in the panel's 2015 report included the inability of some reports to capture clearly and succinctly what went wrong and why; the presence of too much detail; a lack of clear findings and too much emphasis on the methodology rather than the production of a good quality report (Department for Education, 2015c). Previous studies of SCR processes also highlighted issues such as the need for proportionate reviews fit for publication and the need to establish clear learning points (Rawlings et al, 2014; Brandon et al, 2014; Sidebotham et al, 2010). Furthering this learning, a set of 18 quality markers for SCRs were developed (NSPCC/SCIE, 2016) to cover the whole SCR process from setting up to running the review, to looking at outputs and outcomes from the review.

To discern what might constitute a quality report in reviews from 2014-2017, we examined and adapted the 'quality template' for a SCR report used in our previous triennial study of reviews from 2011-2014 (Sidebotham et al., 2016). We tested this revised template against the 63 cases used for the qualitative analysis chapters of this review, examining ten final reports which reflected a range of SCR methods, in depth. As in the last study, we are understanding quality as, primarily, fitness for purpose, and our aim is not to evaluate the reports, but rather to compare and contrast how the SCR reports are constructed. The revised template is in Appendix N.

In line with the improvements noted in our last triennial analysis, SCR reports continue, generally, to be increasingly succinct. In our study of 175 reviews from 2011-2014 the average length of reports was 48 pages (with a range of 3-188 pages). For the 63 reports we studied from 2014-2017, the number of pages has dropped slightly to an average of 46 with a narrower range of 5-143 pages. This time, two thirds of the reports came in at under 50 pages in comparison with just under half of the reports being under 50 pages last time.

Findings from the quality study about models of review, proportionality and the involvement of practitioners and family members are included at the beginning of this chapter in the section on models of review. Other findings are reported here.

6.8.1 Accessibility, clarity and analysis

The ten reviews were, on the whole, well-structured with a good balance of description versus analysis which was a marked improvement on the variable quality of analysis seen in our previous triennial study. All had clear contents pages and were generally written in plain English, easy to read and easy to navigate. Some reviews were repetitive although this was mostly purposeful and was helpful if key information was repeated in

an initial summary of the case, or in summary boxes to aid the understanding of key points. The length of the report was not necessarily an indicator of the likelihood of repetition as one 'atypical' very short report was repetitive and wholly descriptive.

Critical points were mostly set out clearly although in one report a table in the appendix would have been more appropriately located in the main body of the report. The same was true for information about the past although one review provided scant detail about background. In one report the reviewer specifically sought cultural information in order to gain a better understanding of the background and context of the incident.

There were occasionally minor discrepancies evident within the reports but this was not a significant feature. However, as in our previous study, the use of research evidence was rare.

Generally, attention was paid to both individual and systems level issues. There were examples of individual practitioners' acceptance of, for example, injuries without curiosity but the detailed analysis of what went wrong and why in all ten reports took into account systemic features, such as realising change in a context of staff turnover:

> ... *the logistics involved in embedding new practice in an environment of staff turnover.*

All ten reports included key themes and lessons for services including causes or pathways to harm and potential prevention. Implications for local/national practice/policy was variably reported as was the fit with other local SCRs.

6.8.2 Reflecting the child as a person

There was still variability in the extent to which the child or adolescent was reflected as a person. This could be more challenging when the child was very young (for example a new born baby) or because the report was about a group, nevertheless, one report did manage to portray the individual child despite the review concerning a group of young people.

6.9 Looking ahead

Survey comments, interviews and workshop discussions offered reflections on the challenges of discerning impact from SCRs. They also offered thoughts about the content of future national analyses of reviews and the role for this triennial analysis in informing the new arrangements for child practice reviews:

> *The triennial review has been a helpful way of understanding themes in SCRs. Going forward would be good to look at wider systemic learning rather than just about practice improvements.* (Survey)

> *As SCRs are moving to Child Safeguarding Practice Reviews (CSPRs) it would be really helpful if the triennial survey could inform the new approach as it is not entirely clear to me at this stage what the differences will be.* (Survey)

There were also useful comments about the value of our national recommendations survey and its role, not only within the current triennial review, but also in any future analysis. However the fact that our study was retrospective and focusing on cases where partners had *not* worked well together, was said to be a disadvantage:

> *This has been a helpful exercise, but it is retrospective and more thought needs to be given about the value of SCRs/child safeguarding practice reviews moving forward… it would be useful to look at cases where the system worked well so we can learn from a positive rather than deficit learning model. With SCR fatigue, there is a danger that people feel demoralised and anxious in a world where we are asking professionals to manage risk and uncertainty on a daily basis. Reviews should not be political footballs but opportunities for learning in a safe environment.* (Survey)

The transition period between the end of LSCBs and SCRs and the introduction of the new Local Child Safeguarding Practice Reviews (LCSPRs), was a cause for both anxiety and reassurance. The greater opportunity for flexibility in the approach for practice reviews in the new Working Together 2018 guidance was welcomed. The research team's London workshop was pleased that '*one size doesn't fit all'*.

There was optimism from the survey comments about the work of the new national panel for example the opportunity to carry out and learn from national reviews and their themes. More national reviews were also welcomed in both of the workshop discussions where reviews at this level were said to work well as profile raisers. The prospect of continuing local CSPRs was valued particularly in providing access to the emotive human aspect which could then work well as a lever for change. The importance of connecting with the human aspect and the story of the child and family at the centre of the review has already been mentioned as an important theme in both workshops.

6.9.1 Concerns over the SCR industry and the expense incurred

A number of survey comments raised concerns that SCRs are expensive with limited learning. They are felt to not always be proportionate, and lack the flexibility needed to address the complexities that surround them:

> *I think reviews need to be proportionate. I also think that they have their own pace and to do one quickly to an externally imposed time frame can miss out colleagues/ information and not bring them with you in the process. I am a little concerned about Freedom of Information requests / information governance and case reviews as we moved into partnership arrangements. Colleagues are more willing to share information in an environment that feels safe.* (Survey)

> *There seems to be limited evidence to show that SCRs are an effective way of achieving sustainable system wide change and yet a huge industry has been created around it. Smaller more focused learning review allows specific learning points to be addressed but perhaps the wider systems issues cannot be tackled through case reviews alone.* (Survey)

> *An SCR is an expensive method of learning when in the majority of cases partners are aware of the issues.* (Survey)

The point was made by one survey respondent that there should be earlier recognition and action when something has gone 'unforeseeably' wrong with prompt responses tailored accordingly.

6.9.2 Dispelling the 'myth' of SCRs

Both the survey and the workshops talked about the need to reassure staff by explaining SCRs and their purpose better at both a local and national level.

> *There should be public clear message from government about the purpose and premise for SCRs - a lot of anxiety that gets in the way of truly learning from SCRs are based on culpability and civil claims.* (Survey)

Underlining the benefits that come through SCR learning would help to dispel the 'myth' of the review being about blame and a disciplinary matter. There were workshop discussions about the stigma associated with SCRs, with staff not wanting to be identified and wanting to distance themselves from the review:

> *Just the wording 'SCR' just brings out a lot of stress in people and you can understand that.* (Interview)

Having new arrangements for reviews and changing the name of what Alan Wood described as the 'toxic brand' of SCR will help to lift the lid on what was described in a regional workshop as a secret and 'closed door' activity.

Summary points

Primarily positive views were expressed about the flexibility promised by the new arrangements for local and national child safeguarding practice reviews.

Concerns were expressed about the growth of the ‘SCR industry’ and the cost of reviews, which can lack flexibility and are not always proportionate.

Chapter 7: Complexity and challenge: implications for practice and policy

7.1 Introduction

This concluding chapter brings together messages for policy and practice from some of the fresh insights as well as important repeated learning which has emerged from this triennial review. Three overarching issues stood out from our analysis: the complex and cumulative nature of neglect often in a context of poverty, new emerging threats of harm to adolescents and a focus on better assessments for children's care and court.

The challenges facing practitioners were strongly evident in these SCRs, particularly the challenges of working within limited resources, with high case loads, high levels of staff turnover, and fragmented services. A number of lessons for practitioners were highlighted, these included, building on previous lessons, recognition of hearing the voices of children and families; greater rigour in information sharing, assessment and planning at all stages of the process; and opportunities for building effective structures and promoting responsive cultures, even when constrained by limited resources.

7.2 Working with neglect

Responding to neglect and protecting children from its harmful effects is a perpetual and growing challenge for agencies working together in safeguarding work. Neglect is consistently the most common initial category of maltreatment for children with a child protection plan, accounting for nearly half of all plans, and reflecting, as we have shown in chapter 2, a 44% increase over the years 2013-2018 (HM Government, 2013b; 2018a). Neglect is also consistently a major factor in the lives of children who die or are seriously harmed as a consequence of child maltreatment. Neglect was very prominent in these reviews, featuring as an aspect of the case in three-quarters of the 278 reports examined, although it was rarely a primary cause of death. This continues an increasing trend seen in our previous biennial and triennial reviews.

Evidence of the impact of poverty in neglect cases was much more prominent in this triennial review than in our previous reviews, and was apparent in 18 of the neglect cases (56%) compared to 35% of cases in the overall cohort. Poverty created additional complexity, for example, stress and anxiety in families. It is also an important factor alongside other cumulative harms. Where good practice in neglect cases was noted, the quality of relationships with families was apparent as the primary vehicle for supportive and protective practice. This is particularly so when it is rooted in a sound grasp of the family context and roles and relationships, as an effective way of managing the complexity of compound and cumulative risks of harm over time.

7.2.1 Messages for policy and practice

Dealing with challenges of neglect

There were a number of ways in which neglect work was difficult for practitioners to manage as single agencies and when working together. Identifying neglect (as opposed to other forms of harm) poses particular challenges across agencies. The complexity of the situations of these families and the high volume of information held by agencies can hinder identifying the risks of harm faced by children. In addition, professionals can feel reluctant to name neglect, especially where they feel this could present barriers to engagement. Professionals are similarly reluctant to name and discuss poverty, not least for fearing they will further stigmatise the family. The use of clear and straightforward language that properly and explicitly depicts issues in ways that do not dilute impact and harm, or the reality of life for the child, can help professionals to discuss and name difficult topics.

In neglect cases, police officers were found to often take a back-seat role if immediate risks to the child were not recognised, or if the information held seemed insufficient to pursue a criminal investigation. The involvement of police in key child protection enquiries and key meetings should extend beyond merely providing information to active engagement in evaluating risks and effective planning.

These challenges point to the importance of a multi-agency approach to identification and assessment, through which differing views and perspectives can be robustly triangulated.

Clear multi-agency plans at both child in need and child protection levels are central to effective working. This requires all relevant professionals (including those from specialist agencies and third sector organisations) to be involved in drawing up these plans, and a continued focus on the needs of the child(ren) as central to any plan.

Building effective and supportive structures for workers

The experience of working with high case loads and high staff turnover in services that are managing deep cuts, has profound practical and emotional impacts on staff who are struggling to work effectively with families in complex circumstances. Managers and commissioners need to recognise these impacts and put in place structures to provide support, time and guidance for front-line practitioners.

Having a lead professional to coordinate multi-agency work and be a key point of contact with families helps ensure consistency of work and avoids the risk of children slipping through the net.

Supervision offers the opportunity to support practitioners in the challenging and, at times, overwhelming aspects of their work and to help them reflect on and work with the feelings and emotions that arise from this work. When working with cases of neglect,

supervision needs to help practitioners to recognise the complexity of the issues facing the child and family, and to take a rigorous approach to analysing these issues and formulating plans for working with them.

7.3 Working with adolescents

The adolescent analysis found new and emerging themes, consistent with experiences and risks to adolescents in the general population and identified in the 2018 Working Together guidance. The themes included criminal exploitation and social media.

In addition to previous or ongoing harm within the home, adolescents are particularly vulnerable to harm within the community and online. Such harm was often triggered by the opportunity afforded to perpetrators when young people went missing or when they interacted with others online. We found that online harmful activity could be triggered by feelings of loneliness and the lack of a sense of belonging for children looked after as well as children living at home. This was especially the case when adolescents wanted to explore their identity which left them vulnerable to grooming.

Adolescents may not have the skills to manage or even recognise healthy relationships if they have experienced adversity throughout childhood. Their behaviour is, therefore, often a reflection of prior experiences and changes to behaviour are not easily made without consistent, caring relationships from practitioners who work with them.

There was little mention in the reviews of attempts to understand the social and environmental context of adolescent harm, such as exploring places and people who may have a detrimental impact on the adolescent. Despite current or earlier involvement with children's social care, much of the work was reactive as adolescents moved from one crisis to the next. However, we found evidence of some long-term work undertaken by voluntary organisations.

7.3.1 Messages for policy and practice

Risks of harm to adolescents may be hidden and harder to recognise

Adolescents living in situations of neglect and abuse may be particularly vulnerable to having their needs, and the risks they face, overlooked. Clear pathways for transition to adult services are important to ensure young people receive the care and support they need as they age out of services for children.

When confronted with adolescents who engage in risky behaviour, practitioners need to look beyond the immediate issues to consider how the young people might be vulnerable from neglect or other harm, rather than simply seeing them as putting themselves at risk.

Going missing is a powerful signal that all may not be well in an adolescent's life, and it is therefore not enough to find them and bring them home. A timely multiagency safeguarding response is required for all adolescents who go missing

Working with new emerging threats of harm online and in the community

Some reviews indicated that schools may try to manage incidents in-house, like a minor assault or a sexting incident, to avoid criminalising young people. However, that leaves other professionals without the full picture and less able to safeguard the adolescent. Lack of information sharing could also relate to systems failures in the use of electronic databases and the accuracy and completeness of data held within them, as well as familiar problems of the interpretation of confidentiality.

Being a victim and a perpetrator can be very closely related and young people require both support and safeguarding. There must always be a therapeutic and/or safeguarding response to harmful sexual behaviour in addition to any criminal justice response.

Adolescents have access to multiple devices and social media accounts making monitoring unachievable. Ongoing education of parents, practitioners and children must be undertaken. This can be done by subscribing to updates and newsletters from relevant organisations (for example, UK Safer Internet Centre). Internet based companies and those managing social media platforms also share responsibility for ensuring safe use of the internet. This has been recognised and addressed by the White Paper on online harm which has been published (HM Government, 2019).

Challenges of addressing criminal exploitation

There was confusion among safeguarding practitioners when monitoring and managing children at risk of or experiencing CSE. With no specific category in Working Together 2018 for CSE, child protection plans may seem less appropriate than management through a dedicated and specialist CSE team. This raises a wider policy point about the relevance of child protection plans for issues like CCE and other new emerging threats which are outside of the four child protection categories.

Gendered perceptions of vulnerability resulted in some sexually exploited boys not receiving an urgent response by professionals. Such gendered perceptions of vulnerability need to be challenged, for example, by practitioners asking themselves if their response would be different had the victim been a girl (The Children's Society, 2018a).

Working with adolescents vulnerable to exploitation requires time to build relationships.

7.4 Working with care and court cases

There have been major changes to the care proceedings system since 2013, with a significant increase in the number of cases going through proceedings, and a changing pattern of orders, with more children returning to (or remaining with) their parents under supervision orders, or going to kinship carers under special guardianship orders.

The number of care proceedings starting each year rose from just over 11,000 in 2014-15 to 14,226 in 2017-18 (Cafcass, 2019). There has also been an increase in the number of children in care, rising from 68,840 on 31 March 2014 to 75,420 on 31 March 2018. Another significant change has been in the proportion of children looked after under a care order, this rose to almost three-quarters, 73%, (55,240 children) in 2018, up from 58% (40,090) in 2014 (Department for Education, 2018a). Interestingly, these increases have not been apparent in the SCRs of children looked after or on a court order which dropped from 59 children (20%) in our last triennial review (Sidebotham et al., 2016) to 45 children (16%) for this analysis.

Alongside these changes, since 2013 there has been a national drive to speed up care proceedings, through the introduction of a statutory deadline of 26 weeks, for all but 'exceptional' cases. Since the changes in timescales there has been a drop in placement orders and a near-doubling in the proportion of children living with relatives or other 'connected persons' under special guardianship orders, up from 13% to 24% (Masson, 2018).

7.4.1 Messages for policy and practice

The need for thorough assessments

The court's tight timescales should not be allowed to undermine the thorough assessments needed of all potential carers, notably kinship carers. On-going support and monitoring after the proceedings are also important for kinship carers.

Children in kinship care are likely to have demanding needs that are similar to those of children in local authority care. Yet kinship carers may have fewer personal resources and less support than foster carers or residential staff to help the children. This emphasises the need for thorough assessments, followed by on-going support.

When children are cared for by relatives, it is important to understand the experiences and perspectives of these relatives. This helps to understand the child's lived experience and to provide relatives with appropriate support and monitoring.

Social work (and other) assessments should not only look at what has happened to the children in the past and what that implies for their needs now, but also have to look to the future, for what it means for the help they are likely to need as they grow up.

Sensitivity to race and culture

We noted in some cases about Black African children that there were concerns about the impact of cultural beliefs and expectations on the care and wellbeing of the children, and how to investigate and assess this, whilst also respecting diversity and the families' cultural and religious beliefs.

Practitioners need to find out about people's backgrounds, culture and beliefs, and then *apply* that knowledge, not solely in terms of work with families from BAME communities, but more generally to do with understanding the personal identities of service users.

Understanding legal orders.

Safeguarding professionals and other agencies may need help to understand legal orders and the significance of court involvement. Where children are involved in public or private court proceedings it is important not to assume that any professional has a lesser role or that simply because the court is involved it will offer a greater level of protection to the child.

7.5 Concluding points

This was the first of our six consecutive national analyses where poverty featured prominently in SCRs, particularly in the neglect cases. There are ongoing debates about the links between poverty and maltreatment but most studies find a correlation rather than a clear causal relationship between poverty, neglect and abuse (Drake & Pandey,1996; Slack et al, 2004). More recently, inequality has been found to be more powerfully linked to maltreatment than poverty per se (Bywaters et al, 2018; Eckenrode et al, 2014). Perhaps seeking clarity on the complex links between poverty and maltreatment somehow misses the point and it is better to recognise that both poverty and maltreatment are damaging to children's health and development and to the wellbeing of their families. This means that practitioners cannot work to prevent maltreatment or mitigate its effects if the causes and consequences of poverty are not also addressed. David Howe in a foreword to Gardner's edited volume *Tackling Neglect*, (2016, p8) makes this point well:

> *Stress, of course, runs as a corrosive thread through all cases of neglect. Stressed minds find it difficult to think about, or indeed care about others. And minds become stressed if they live in poverty, poor housing and communities of violence. It behoves practitioners always to start with the obvious. Help families deal with their material and nutritional needs whenever possible.*

At the same time, it is vital not to fall into the trap of simply responding to the material needs of a child, providing food, clothing, healthcare, while failing to deal with neglect or abuse when that is present. The majority of children living in poverty do not experience

neglect, but where poverty and neglect co-exist, the adverse outcomes for children will, inevitably, be escalated.

While this is a matter for those working with individual families, addressing poverty is an even more pressing issue for wider policy at local, regional and national levels. The increased prominence of poverty as an issue in the lives of the families in these SCRs suggests that it is a factor that is having an impact on those most vulnerable families in our society.

The stress evident in families in these reviews was also apparent among practitioners working with the children and their families and in the managers supporting them in their practice. The same message about stressed minds finding it difficult to think about or care about others will apply to practitioners as well as families. Stress appeared to be prompted by practitioners feeling overstretched by the volume of work and a steady reduction in resources. There was also the sense of unease noted by the Care Crisis Review (Family Rights Group, 2018) wrought by both the families and the system to support them struggling to cope. Personal impacts on practitioners also came from the new threats to adolescents discussed in Chapter 4. Harmful sexual behaviour, such as sexting, and managing children's social media use, leave parents feeling ill-equipped to help their children. It is sometimes forgotten that practitioners are often parents of adolescents themselves and may feel doubly challenged both at home and at work by a lack of confidence in dealing with these fast-moving new challenges.

These reviews show that child maltreatment is a complex phenomenon with harm to children stemming from numerous sources including parents, carers, children's peers, the wider community and the digital space. The often harrowing story of the child at the centre of a review is very rarely about wilfully cruel parents. It is much more often about the complex interplay of parents' social and psychological adversity and threats from the wider community that contribute to an unsafe or damaging environment for a developing child. The challenge for practitioners is to continue to use their well-honed relationship talents in the context of scarce resources to work with children and alongside parents with both compassion and rigour.

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List of acronyms

ABE	Achieving Best Evidence
ACRO	ACPO Criminal Records Office
ADHD	Attention Deficit Hyperactivity Disorder
APP	Authorised Professional Practice
APPG	All-Party Parliamentary Group
BAME	Black, Asian and Minority Ethnic
CAF	Common Assessment Framework
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CDOP	Child Death Overview Panel
CID	Criminal investigation department
CIN	Child in Need
CP	Child Protection
CPD	Child Protection Database
CPS	Crown Prosecution Service
CSC	Children's Social Care
CSE	Child Sexual Exploitation
DfE	Department for Education
DNA	Did not attend
EDT	Emergency duty team
EWO	Education Welfare Officer
FAO	Family assistance order
GP	General Practitioner

HES	Hospital education service
ICPC	Initial child protection conference
IMR	Individual Management Review
JTAI	Joint Targeted Area Inspection
LA	Local Authority
LAC	Looked after Child
LSCB	Local safeguarding children board
MAPPA	Multi-agency Public Protection Arrangements
MASH	Multi-agency Safeguarding Hub
NEET	Not in education, employment or training
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NRPF	No Recourse to Public Funds
NSPCC	National Society for the Prevention of Cruelty to Children
PPU	Public Protection Unit
RMCA	Runaway and Missing Children and Adults
SCIE	Social Care Institute for Excellence
SCR	SCR
SILP	Significant Incident Learning Process
SMART	Specific Measurable Achievable Realistic Timely
SUDI	Sudden Unexpected Death in Infancy
WHO	World Health Organisation
YOI	Young Offender Institution
YOS	Youth Offending Service

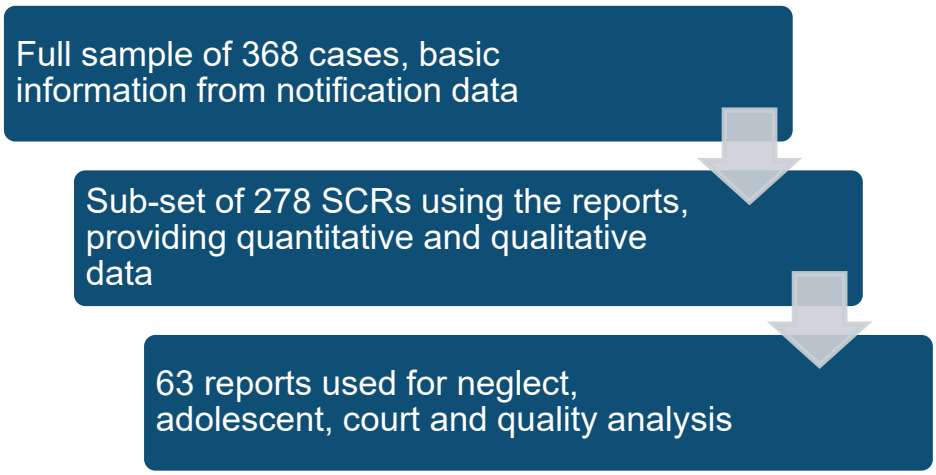
Appendix A: Methodology

Introduction

A mixed-methods approach was used for the project. This involved a quantitative analysis of those child protection notifications that led to an SCR within the specified period, and further quantitative analysis of the sub-sample where final reports were available. These final reports allowed the researchers to add further details to the database, sometimes based on researcher judgement, which enabled more comprehensive quantitative analysis of the sub-sample of cases.

In addition to this, a layered reading approach, developed in earlier studies (Brandon et al, 2008), was adopted for the qualitative aspect of the study. This involved brief reading of all SCR final reports and completing a brief summary sheet for each report (Appendix J). More in-depth reading was undertaken for the smaller sample of final reports used for the adolescent sample which allowed for completion of researcher summaries (Appendix K). This layered approach is demonstrated by the diagram below, followed by more methodological detail.

Figure A.1



Notification data and SCR reports

Notification data were provided by the DfE, and were checked for accuracy and completeness, cleaned and formatted on an SPSS (statistical package for the social sciences) database. The research team was provided with an Excel spreadsheet with 1136 incidents and notifications to Ofsted. From this, all those with an incident date between 1st April 2014 and 31 March 2017, which proceeded to an SCR were included (368 cases). Those with an incident date prior to 1st April 2014, or after 31 March 2017, those that did not proceed to an SCR, and those for which a decision on whether to proceed had not been made, were excluded.

An SPSS database was created from the included cases on the Excel spreadsheet and included incident date, details of the incident, child and family characteristics, child protection plan history and legal status of the child. Additional variable fields were constructed from the information given on each case and certain variables, for example age, were banded. Analysis was undertaken on the completed database of 366 cases, and this forms the core of Chapter 2.

- For the entire cohort of cases, a search was made of the NSPCC national case review repository and on individual LSCB websites for published SCRs. These were matched by at least three of the following variables: responsible LSCB; child's initials or case reference; incident date; child's age or date of birth; name of reviewer/author; incident details.

- Following these searches, the Department for Education was contacted to request any reports that were unavailable on the NSPCC repository or LSCB websites.

A total of 278 completed SCRs (76% of all SCRs notified) were obtained by the research team by 31st August 2018 (a list is in Appendix L). These included 165 fatal cases and 113 non-fatal serious harm cases. Of the 90 cases for which a report was not available, 74 SCRs had not been completed, and 16 had been completed but not published, primarily due to concerns about the impact of publication on surviving family members. A further 54 cases had not been published, but DfE had been provided with a copy which was then made available to the research team for analysis and were included in the 278 available reports.

Of the total 368 notifications that progressed to a full SCR, 23 related to more than one child, including:

- Two reviews of CSE involving a total of 5 young people

- Five reviews of intra-familial CSA involving a total of 11 children

- Five reviews of neglect involving a total of 20 children

- Four reviews of physical abuse involving a total of 8 children, of whom one died and the others were seriously harmed

- Seven reviews of cases of familicide in which multiple family members were killed; a total of 13 children were killed in these incidents, and a further two were seriously harmed.

There were, therefore, 404 children involved in the 368 cases.

Additional quantitative information from the 278 final reports

The 278 available reports were read and summarised by the research team and the database updated. Details extracted for the summary sheets included:

- Demographic characteristics (region, age, gender, ethnicity, parents' ages, family size)
- Notes on household composition
- Category of death or serious harm (using categorisation systems developed by the research team for previous studies)
- Source of harm/perpetrator
- Background characteristics of parents and index child, for example substance misuse, mental health problems, domestic abuse, disability
- The presence of neglect (using our previously developed protocol for identifying neglect in SCRs)
- Case synopsis (researcher summary of key details about the case)
- Methodology used by SCR author
- A summary of key lessons / recommendations / learning points

Numeric and categorical data contained in each summary were coded and entered manually into SPSS and accompanying descriptive text summary case information copied across. The final dataset thus combined data drawn from two sources - notification data provided by DfE and our own researcher summaries.

Detailed qualitative analysis of 63 SCR final reports

Sixty-three final reports were sampled from the 278 available reports, to provide a sub-set for intensive qualitative analysis. The cases in the sub-sample were purposively selected to reflect, as far as possible, the notification data in terms of the age/gender/fatal or non-fatal nature of the incident; whether the incident occurred within the home or in the community or a non-family residential setting, and cases where children may be the perpetrators of harm. Cases were also selected where they seemed to raise particular issues of concern and interest across the spectrum, and include both those cases that have received public attention as well as less well-known cases.

Neglect sample

An initial sample of 32 SCR reports was selected for the neglect analysis. The selection aimed for a stratified sample, representative of age group, gender, ethnicity, geographical region and category of death/serious harm. The sample also specifically included cases where prior disability was identified and cases where extreme neglect was the primary cause of death or harm. The sample was equally divided and two concurrent approaches were taken:

1. Inductive, open coding using NVivo. A coding framework was developed according to themes emerging from the data. These emergent themes were organised into subordinate and superordinate themes as the coding and analysis progresses. Subsequent cases were coded according to the identified themes, and themes modified appropriately.

2. Thematic coding according to a pre-determined framework. The framework was based on the 'pathways to harm/pathways to protection' model, and a public health approach to interventions (Appendix M). Reports were coded manually and data collated within the framework.

The first six cases were jointly coded using both approaches and results compared. A revised, combined coding framework was produced drawing on findings from both approaches. This enabled key themes to be identified that were subsequently applied in the analysis of all the reports.

Adolescent sample

The preliminary adolescent sample of 41 reviews was selected purposively from the 115 SCRs that involved an adolescent in order to facilitate learning related to new themes. A final selection of 25 reviews was then made, chosen from the researcher summaries of reviews likely to best illustrate the new emerging themes (see researcher summary template in Appendix K). One review (included in the 25) was outside the time frame but had not been analysed in the previous triennial review and was important for learning in relation to child sexual exploitation. The selection included six cases from the neglect sample. NVivo 11 software was used to aid the analysis of the 25 reviews in the final selection.

Care and court sample

Ten cases were purposively selected for this part of the study. They were chosen from 41 cases where the children were or had been in care, and/or there had been earlier care proceedings. The cases come from ten different authorities around the country, but it is important to appreciate that this is not a random sample, nor a representative one. For example, it includes all the cases out of the 41 that ended in special guardianship orders

(three). It only includes one case where the child was a teenager, although there were 28 of them, well over half the 41 cases; that is because there is a separate chapter on adolescents. Also, purely by chance, the sample over-represents the number of Black, Asian and minority ethnic children.

Recommendations and impact study methodology

There were five stages of data collection and analysis as detailed below:

1. Learning from the 278 available SCRs. Details about SCR methodology and number of key lessons or recommendations were entered on the SPSS database for the 278 reports available.
2. National survey about recommendations and their implementation to all English local authorities. The online questionnaire was created using the Jisc online survey tool, which is designed specifically for academic research, education and public sector organisations (https://www.jisc.ac.uk/online-surveys). Data analysed using SPSS 25.
3. Following the recommendations survey: phone interviews with 20 survey respondents were transcribed and analysed using thematic analysis (Braun and Clarke, 2006).
4. Two practitioner/leader workshops (one in Birmingham and the other in London) elicited data in the form of written summaries about the impact of SCRs on child protection practice. Data were analysed thematically.
5. Examination of the quality of learning and recommendations from this Triennial in comparison with Triennial 2011-2014.The entire qualitative sample of 57 cases, from the neglect, adolescent, care and court chapters, was used for this stage of analysis. Six further cases were also selected to ensure that all SCR models were included in the sample (total 63). Analysis was aided by a refreshed quality template (Appendix N).

Appendix B: Classification of deaths

The classification of death is based on a review of the data on the child protection database of notifications, supplemented, where possible, by reading the SCR overview report for relevant information pertaining to the child's death. A 'best fit' assignation is given where the information is pointing towards one category of death according to the guide below. Where no relevant information is available, or the assignation is not clear from the information given, this is coded as 'category not clear'. Where information is available, the suspected perpetrator(s) is given. In cases of suicide/self-harm, this is assigned as self; in cases of neglect, this is assigned as 'both parents' unless the information points more clearly to one parent or another carer. Where the SCR gives an indication that the likely perpetrator is not known, that is listed as 'not known'. Where the information is missing or unclear, this is listed as 'not clear'.

Categories

1. ***Fatal Physical Abuse***

   Deaths following severe physical assaults (non-accidental injuries) where the suspected perpetrator is a parent or parent figure, and where there is no clear intent to kill or harm the child. Includes deaths from non-accidental head injuries (shaking or shaking-impact injuries), abdominal injuries, and multiple injuries. May include deaths where an implement has been used, but without evidence of intent to kill or harm the child.

2. ***Overt Filicide***

   Deaths where a child is killed by a parent or parent figure using overtly violent means, or with no attempt to conceal the fact of homicide, and where there appears to have been some intent to kill or harm the child. This includes multiple or extended familicide, or where the suspected perpetrator takes or attempts to take his/her own life. Includes deaths in fires with suspicion of arson and the suspected perpetrator is a parent/parent figure. Includes deaths from stabbings and firearms, or severe assaults with evidence of intent to kill the child.

3. ***Covert Filicide***

   Deaths where a child is killed by a parent or parent figure but using less overtly violent means, and with some apparent attempt to conceal the fact of homicide, and where there appears to have been some intent to kill or harm the child. Includes deaths from abandonment, poisoning, drowning, suffocation or asphyxiation. Includes deaths of newborn babies following concealed pregnancies and deliveries.

4. ***Extreme Neglect/Deprivational Abuse***

Deaths where the child dies as a result of severe deprivation of his/her needs with evidence that this has been deliberate, persistent or extreme. Includes deaths as a result of heat or cold exposure, starvation, or extreme, deliberate withholding of basic health care. Exclude deaths in which the neglect appears be a reflection of parental incompetence, related to learning difficulties, physical or mental ill-health, socio-economic deprivation and lack of access to services, or other environmental circumstances.

5. ***Severe, persistent child cruelty***

Deaths where a child dies as a result of a physical assault or neglect, and in which there is evidence of previous severe and persistent child cruelty. Includes deaths where a post-mortem examination reveals evidence of previous inflicted injuries (for example, healing fractures) or long-standing neglect in addition to the primary cause of death; and children who have previously been on a child protection plan because of identified physical or emotional abuse or neglect.

6. ***Child Homicide***

Deaths where a child is killed by someone other than a parent or parent figure using overtly violent means, or with no attempt to conceal the fact of homicide, and where there appears to have been some intent to kill or harm the child. Includes deaths in fires with suspicion of arson and the suspected perpetrator is someone other than a parent/parent figure. Includes deaths from stabbings and firearms, or severe assaults with evidence of intent to kill or harm the child. Includes deaths following sexual assaults by a non-parent perpetrator. May include gang-related violence where there appears to have been intent to kill the specific victim, but excludes more general gang-related violence.

7. ***Fatal Assaults***

Deaths following severe physical assaults where the suspected perpetrator is someone other than a parent or parent figure, and where there is no clear intent to kill or harm the child. Includes peer-on-peer violence without evidence of intent to kill. Includes gang-related violence without evidence of intent to kill the victim.

8. ***Deaths Related to Maltreatment***

There are a large number of deaths which are felt to be related to maltreatment, but in which the maltreatment cannot be considered a direct cause of death. Includes sudden unexpected deaths in infancy (SUDI) with clear concerns around parental care but where the death remains unexplained or is attributed to a natural cause. Includes fatal accidents where there may be issues of parental supervision and care, including accidental ingestion of drugs or other household substances; drownings; falls; electrocution; gunshot wounds; and fires. Includes those children dying of natural causes whose parents may not have sought medical intervention early enough. Includes deaths of older children with previous maltreatment, but where the maltreatment did not directly lead to the death, for example, death from an overwhelming chest infection in a child severely disabled by a non-accidental head injury, suicide or risk-taking behaviours, including substance abuse in young people with a past history of abuse.

Appendix C: Neglect protocol (from earlier biennial analyses)

- Current CP plan or past CP plan for index child under category of neglect.
- Indications of neglect featuring in the background to the case included one or a combination of the following factors:
    - ‘Neglect’ directly referred to as a feature of the case.
    - Child poorly nourished / failure to thrive,
    - “Poor living conditions” or fuller, more thorough descriptions. (This phrase was also looked for in previous analyses as our best proxy for poverty, which was rarely mentioned).
    - Drug/alcohol misuse in pregnancy,
    - Concealed pregnancy/birth,
    - Persistently not accessing health care for child/ante-natal care/not acting on medical advice/untreated ailments,
    - Repeated missed appointments,
    - Inappropriate supervision of a child, including inappropriate babysitter, supervision while under the influence of alcohol or drugs,
    - Inadequate clothing/hygiene,
    - Sustained reluctance to engage with services,
    - Serious school attendance concerns related to neglect,
    - Child accessing firearm or ingesting a harmful substance (associated with lack of supervision).
    - Evidence of neglect identified after the incident, for example, malnutrition identified at post-mortem examination.

Appendix D: Neglect sub-sample characteristics

DEATHS under 1			n=7	
Age	**Gender**	**Ethnicity**	**Pathways to death or serious harm**	**Characteristics of the case**
17d	M	WB	Neglect in combination with physical abuse	Non-accidental injury. Partner deteriorating MH and lost job. Attempted suicides, overdoses, early psychosis(?). Baby slow weight gain and earlier wounds/bruising. Parents DNA postnatal clinic.
1m	F	WB	Sudden unexpected deaths in infancy	Mother undiagnosed health problems - intensive care. DA from Father. Baby weight loss and lack of alertness. Cardiac arrest due to co-sleeping.
2m	M	WB	Sudden unexpected deaths in infancy	Concerns re: children's hygiene and presentation, home environment, Ms drug use. Baby not socially responsive- died bronchial pneumonia
2m	M	WB	Neglect in combination with physical abuse	Very young mother with frequent health service attendance. Suspected DA, unsafe sleeping and feeding. Older sibling placed in care. Died of NAI - both parents suspected
3m	F	Black	Neglect in combination with physical abuse	Born prematurely - few visits to hospital from mum. CPP prior to discharge under neglect. Transcience, housing issues. Died NAI - old and new fractures evident.
9m	F	WB	Accidents with some element of forewarning	Drowned in bath. Mother difficult childhood - CAMHS, ADD, speech delay, bullying, and school exclusion. Father exp DV in childhood, YOS, sexual offences, alcohol. Children CPP emotional abuse. Parents separated - high contact
10m	M	Other	Sudden unexpected deaths in infancy	Died in care of Ms partner in van; cause not established but multiple old fractures at autopsy. Parents charged with neglect. Partner - substance misuse. M of Roma / traveller heritage. Father - violent crime and drugs, partner violent crime, DV, drug use.
DEATHS 1-10 years			**n=5**	
Age	**Gender**	**Ethnicity**	**Pathways to death or serious harm**	**Characteristics of the case**
15m	M	Other White	Neglect in combination with physical abuse	Brought into country by M and abandoned with half sibling and partner. Not reg with services, no record of entry. Cardiac arrest, multiple NAI's, malnourished.
21m	F	WB	Neglect in combination with physical abuse	On CP for pre-birth concerns and neglect. Mother convicted of murder and boyfriend of allowing death. NAI

2y	F	WB	Accidents with some element of forewarning	Parental habitual substance misuse. Neonatal abstinence syndrome. M in drug treatment programme. Cardiac arrest due to accidental consumption methadone
3y	M	Black	Neglect in combination with physical abuse	Older siblings subject of CP and supervision order - neglect and physical abuse. Parents both with criminal records. M chronic medical condition. CP emotional abuse. Inhalation due to forced feeding.
7y	M	WB	Accidents with some element of forewarning	Reported missing - found on building site stuck in a pipe. Subject CPP. Family background of DV and substance misuse. Child R non-school attendance, behavioural issues, cannabis use.
DEATHS 11-17 years			**n= 7**	
Age	**Gender**	**Ethnicity**	**Pathways to death or serious harm**	**Characteristics**
14y	F	Black	Suicide among young people	Bereavement of single parent mother - period of neglect after mother's death. History of physical and sexual abuse. Suspected abuse by half bro after M's death. Died in foster care.
14y	M	WB	Vulnerable adolescent: criminal exploitation	Poor school attendance, drug taking and criminality lead to CP plan and detention with supervision order. Homicide by 3 older perps
16y	M	WB	Suicide among young people	History of self-harm and suicide behaviours. Foster care since 10 then res place prior to death. Going missing, sub mis and self-harm risk indicators but good school attendance. Background of family bereavement (M and B), emotional and phys abuse and neglect.
16y	M	WB	Vulnerable adolescent: risk-taking behaviour	Died in res care. Mother and sibling were LAC. Subject of pre-birth CP conference. Unconfirmed CSA. History of adoption, LAC - 28 placements in last 5 yrs of life. Fire-setting, extreme self-harm, sub and alc misuse. Death from opiate overdose
16y	F	Black	Medical neglect	Multiple health problems - missed ed, moved between family members, emotional neglect, physical abuse by M and SHB from cousin. Died of diabetic ketoacidosis.
17y	M	WB	Medical neglect	Died from natural causes and delayed med attention. History of truancy, sub mis, going missing, placements with diff family members, homelessness. CSE. Previous CAMHS involvement.
17y	F	WB	Medical neglect	Rare genetic condition. Died from multiple organ failure. Lived with MGM and uncle with same condition. Squalid living conditions, physical neglect. Known to CSC but became 'invisible' to services.
SERIOUS HARM under 1			**n=3**	
Age	**Gender**	**Ethnicity**	**Pathways to death or serious harm**	**Characteristics**

1m	F	NK	Deprivational neglect	Sibling group of 5 removed from fam home - squalid conditions, missed immunisations, parental non-cooperation, alleged phys abuse, poor dental health
2m	F	Mixed	Neglect in combination with physical abuse	Skull fracture - dropped during inc of DV, didn't seek medical intervention for 3 days. Father - criminal conv, mental health, depression, history of DA. Home env sparse, cold, children dirty.
6m	M	WB	Neglect in combination with physical abuse	NAI - mother isolated, lonely: step-father works away - suffered bereavement, lost job - spiralling risk
SERIOUS HARM 1-10 years			**n=6**	
Age	**Gender**	**Ethnicity**	**Pathways to death or serious harm**	**Characteristics**
13m	M	WB	Deprivational neglect	Sig harm -neglect of sibling group. Home env - chaotic, dirty. Children with complex health needs.
14m	M	WB	Accidents with some elements of forewarning	Acc drowning in bath with severe disabilities resulting - father and PGM as carers - father repeated claims that unable to cope and requests to take children into care. Overcrowding, poverty, temp housing issues.
2y	F	Asian	Deprivational neglect	Cardiac arrest -choking incident, lack of bonding, malnourished, failure to thrive
3y	F	WB	Deprivational neglect	Poverty. malnourished, anaemic, gums and teeth, muscle wasting, developmental delay, squalid conditions
4y	M	Mixed	Deprivational neglect	Malnourished - life threatening
6y	F	WB	Neglect in combination with physical abuse	NAI in context of poverty, previous disclosure sexual abuse, parental depression, social anxiety (Mo), personality disorder and anger issues (Father)
SERIOUS HARM 11-17			**n=4**	
Age	**Gender**	**Ethnicity**	**Pathways to death or serious harm**	**Characteristics**
14y	M	WB	Vulnerable adolescent: risk-taking behaviour	Foster then res care, found guilty of murder. Adolescent neglect, going missing, at risk CSE. Mother had previously stabbed a partner.
15y	M	WB	Medical neglect	Life threatening asthma attack whilst with relative. Delay in seeking medical attention, low weight, poor phys appearance, severe eczema. Neglect of teenager.
15y	M	WB	Vulnerable adolescent: risk-taking behaviour	Drug use from age 11. Multiple school moves, missing risk of CSE. Self-harm, suicide notes, lack of MH support. Sectioned and placed in secure.
15y	M	NK	Vulnerable adolescent: risk-taking behaviour	Convicted of sexual assault of younger child, earlier allegations. ADHD, missing, possible CSE. Sexual identity issues

Appendix E: Adolescent cases (25)

Jack is a White British boy who identifies as gay. He was groomed and abused by a number of adult males form the age of 13. He lived in an intact family and had friends at school until he came out as gay. He increasingly used chatrooms to explore his sexuality. He went missing and experienced mental health issues and physical ill health due to the assaults. Parents were proactive in trying to keep him safe but agencies were slow to respond to the seriousness of the abuse. It was not possible to remove all devices and social media accounts that made it possible for the abusers to maintain the abuse. There was a lack of knowledge of technology assisted abuse and understanding of male victims who are sexually exploited.

Child X, Child Y and Child Z are three unrelated female children who were groomed and sexually exploited by a young adult female and older men. Their ethnicity is not stated in the review. The children came from different family backgrounds but shared vulnerabilities such as histories of family dysfunction, rejection and family substance misuse, mental health problems and violence. All children had experienced significant neglect. Their dependency on the alleged perpetrator increased their vulnerability further. Practitioners did not always listen to the children or understand their behaviour and the work by a worker from a local support group produced the most insightful picture of one of the children due to the time and resource intense therapeutic work.

James, was a 17 year old boy of Ghanaian origin who died by suicide the day before he was due to appear in court on a drugs charge. He lived between two families and had been separated from his parents for two years prior to starting primary school when he was sent to live abroad with extended family. He was exploited and went missing as he travelled to other counties to supply drugs. Towards the end of his life he lived in semi-independent accommodation after becoming homeless. He did not engage with services offered and was not always reported missing.

Anita B was 15 years old when she went missing abroad. Her parents originated from West Africa. Her body has never been found. Her parents who originated from West Africa were divorced and she lived with her mother. There is little information about her father but he was a perpetrator of domestic abuse. From the age of 13, she suffered from episodes of severe mental illness that led to her missing over a year of education.

Child AC was a White British boy who was killed at the age of 14 by three older males known to him. He lived with both parents and three siblings. He started minor offending in primary school and was permanently excluded at secondary school. He was eventually sentenced to a secure centre where he made good progress academically and socially. On release, the parents struggled to manage his behaviour in the community. He had missing episodes and remained on a child protection plan. Continued criminal activity

and breach of conditions of his licence. Once his licence expired his risk-taking behaviour escalated and he was not willing to engage with YOS on a voluntary basis.

Charlie and Sam are sisters aged 11 and 12 respectively. They originated from the Roma community in Slovakia and came to the UK after spending time in a camp in their home country where they experienced persecution and other traumatic events. Their English language skills and educational attainment were poor. The sisters were victims of child sexual exploitation and Charlie experienced six incidents of a sexual nature, including three rapes. The rapes occurred whilst on a child protection plan. Social media use and missing episodes increased their vulnerability. Charlie had significant learning disabilities.

Siblings W and X were killed whilst fighting in Syria. Sibling W was aged 18 when he was killed and sibling X was 17 years old. They were British of Syrian origin. A referral to the Channel panel for sibling X did not identify anything to put him at risk of involvement in terror related activities after an older sibling had gone to Turkey to deliver aid. The children witnessed domestic abuse and physical abuse by their father. The family experienced racism and violence in their community.

Child N is a 16-year-old boy who exhibited harmful sexual behaviour. His ethnicity is not stated in the report. He lived with his mother and younger half-siblings. He had irregular contact with his birth father and a troubled relationship with his stepfather. He had a diagnosis of ADHD and special educational needs. He had a disrupted history of education due to his special needs. The first incident of alleged sexual assault of a peer was not prosecuted. Professionals relied on written agreements to keep him and his half-siblings safe.

Child A was 12 years old when she died by suicide. She had a traumatic life which included burns inflicted by her father when she was 2 years old (caused lifelong scarring), sexual assault by 15 year old uncle when she was aged 4, witness to domestic abuse and spent time in refuge with mother aged 6. Mother was a care leaver and father had convictions for neglect and sexual assault of unrelated female. She self-harmed. She was groomed online and experienced intimidating and threatening social media chat from peers.

Alex was 15 years old White British girl who died by suicide. Her parents separated when she was young and she lived with her mother and step-father but had contact with her birth father. Her friends at school reported her self-harm. She was abused over a period of time by an extended family member, including technology-assisted abuse. The abuser was a known sex offender.

Child S and Child Q are two unrelated girls who were victims of child sexual exploitation. They are both aged 12 years. Their ethnicity is not stated in the review. Both experienced neglectful childhoods and were looked after by the local authority.

Child B was a 15 year old South Korean boy who died by suicide. He had lived in the UK with his father since the age of 6years. He had little contact with his mother and was at one point told, incorrectly, that she had died. He cared for his father who had been injured at work. Experienced physical abuse from father and some bullying form peers. Had few out of school friends and spent a lot of time and money gaming online.

Child U was a 15-year-old Black British boy killed by stabbing. He was separated from his parents between the ages of 3 and 10. Parents separated while he was living abroad with extended family and both started new families. His brother served a prison sentence for robbery with a knife. He was criminally exploited. He felt frightened and went missing.

Child F died of stab wounds at the age of 17. He was of Caribbean decent and the family had no recourse to public funds for most of his life. Father was deported after imprisonment for a serious drug offence. Mother had experienced childhood abuse and violence and had a history of depression. He lived in poverty that affected his social and emotional development. Witnessed domestic abuse and community violence. He was fearful when in the community and was stabbed prior to the fatal incident.

Child A was a White British boy looked after by the local authority when he died by suicide at the age of 17. He had been looked after for 12 years prior to his death. He had no contact with his birth father and his mother had significant mental health issues. He was vulnerable to sexual exploitation and also feared that he might commit sexual offences.

Becky was a White British girl murdered at the age of 16. She had experienced neglect and became looked after at age 3. Later she was placed with father and step-mother. She was fearful of leaving the home and received alternative education. She was reluctant to engage with services and was not able to talk about her concerns that included fear of father asking her to move out.

Child B was 16 when she was seriously harmed by her father who was suffering from a psychiatric illness. Her ethnicity is not stated in the report. Mother also had mental health issues and abused alcohol. Parents were assertive and professionals found them believable. The parents' needs were overwhelming and became the focus of intervention. She felt isolated with her worries and caring role.

Child B is a Black British girl attacked by her mother at the age of 16. Mother had severe mental health issues and had previously assaulted her child. Parents separated and she took on a caring role for her mother. She witnessed domestic abuse and had self-

harmed. Previously on child protection plan but professionals were reluctant to re-register her when things worsened for her.

Child J was a 14 year old Black British girl who died by suicide whilst looked after by the Local Authority. She experienced many losses, including the death of her mother. Other harm included neglect, physical and sexual abuse.

Mark, a 15 year old boy started using drugs at the age of 11. His ethnicity is not stated in the review. He moved schools four times due to his drug use. He went missing and was at risk of CSE. Repeated referrals to CSC were not progressed for two years. His parents had separated. He displayed threatening behaviour and self-harmed. There was a lack of mental health facilities and he was eventually detained under the Mental Health Act and placed in a secure unit.

Child K was a White British boy who died by suicide at age 16 years. He was one of ten children and there had been care proceedings on all of them. Child K had been made the subject of a care order in 2007, aged nine. He had extreme trouble coping which was evident in his behaviour, which included self-harm, heavy alcohol use, and going missing. But he had been in a stable foster placement from 2007 until it disrupted in early 2014. Many professionals and agencies were involved in trying to help him. Secure accommodation was considered but not pursued.

James (Family S17) is a 17-year-old male who was looked after from the age of 14. His ethnicity is not stated in the review. He had many missing episodes, was excluded from school and displayed harmful sexual behaviour. He self-harmed and took overdoses on eight occasions. He had an extended stay in hospital as no suitable placement could be found.

Thomas is a 16-year-old boy who was moved to a residential special school at the age of 10. His ethnicity is not stated in the review. He experienced significant abuse and neglect during his childhood, had developmental delay and displayed harmful sexual behaviour. Mother continued to control him as he was home at weekends and school holidays.

Child P is a 15-year-old White British girl who was sexually abused by her stepfather who was a known sex offender. She had poor school attendance and escalating behaviour issues. Mother had a manageable chronic illness and Child P lived in fear that she would die. Several medical presentations indicative of sexual abuse. Poor information sharing and over-reliance on written agreements.

Child E was found dead when aged 16 due to drug use in the home of an older male whilst absent from his residential placement. He originated from a rural community in Lithuania and came to London with his family at the age of 10. He witnessed domestic abuse and became looked after at the age of 13.During the following three years he had nine different residential placements.

Appendix F: Care and court cases (10)

J, a girl of dual race heritage, subject of an SGO, died in July 2014 at the age of 7. She had been taken into care at the age of four, initially under s 20, then care proceedings. She had suffered long-term maltreatment whilst in the care of her mother, and her behaviour was very challenging for her foster carers. During the proceedings, her father proposed that his sister should have care of the child. The aunt had only ever met J once before. J was placed with the aunt in July 2012, and the proceedings ended with an SGO and a one-year Family Assistance Order (FAO). There were repeated concerns about J's welfare and the way she was being cared for by her aunt over the two years that she lived there.

Shi-Anne (in this particular SCR, the girl is given her real name), a girl of dual race heritage, subject of an SGO, died in September 2015 at the age of 18 months. She was her mother's sixth child; the older five had previously been taken into care. Care proceedings were instituted as soon as Shi-Anne was born, in March 2014. A number of relatives were proposed as potential carers, but only one was assessed as suitable, although she did not know Shi-Anne and there were concerns at the time about the quality of the assessment (undertaken in less than seven weeks by an independent agency). However, it was supported by the local authority and the children's guardian (Cafcass). Shi-Anne was placed with the special guardian three days after the proceedings ended in January 2015. Her special guardian was convicted of murder.

A and B, brothers, mixed racial heritage, both under five, subjects of SGOs to relatives. They were removed from the special guardians because of sexual abuse by the male carer. The boys' parents had learning disabilities. A came into care under s 20 when he was 2 years old; B was placed with his paternal grandmother at the age of ten months. Care proceedings were then started. The grandmother was assessed as unsuitable to continue caring for B. The couple who became SGs were distant relatives, and were proposed as a result of a family group conference. The viability assessment raised some concerns, but it went ahead to a full assessment and the boys were placed with them in March 2014. SGOs and a supervision order were made the following month. The boys were removed in March 2015 after the female carer raised the concerns.

Polly, a White British girl, subject to a supervision order, died in May 2014 at the age of 22 months. Her mother had a long history of drug misuse, suffered from mental health problems and domestic abuse, and had been diagnosed with borderline personality disorder. Polly had been on a child protection plan before she was born. Care proceedings were started in May 2013 when she was 10 months old, and she went into foster care. Her mother co-operated with the assessments and the proceedings ended in October 2013 with a one-year supervision order (SO). She was not on a child protection plan after the proceedings. In February 2014, Polly was taken to hospital after a 'sudden

collapse', but she was discharged quickly. The local authority had decided to take new care proceedings but this had not been done before Polly died.

G, a boy from a Black African family, who died from force-feeding at the age of three in November 2015. He had been the subject of police powers of protection and had just over a week in foster care under s 20 in September 2014, after he was discovered 'left alone'. He was returned home under a child protection plan, which was later stepped down to a 'child in need' plan. G had three older siblings, and there had previously been two sets of care proceedings on the younger two of them. The first, from November 2006 to May 2008, started because of a broken hip to the older one of those children, and included a residential assessment. The proceedings ended with SOs on the children. Care proceedings were started again in November 2008, when the older child had a broken leg, but were closed when the parents' explanation was accepted. The family then moved to a new local authority, which was where they were living when the 'home alone' incident occurred. The SCR report notes that the child protection conference called then was not aware of the previous proceedings.

K, a White British adolescent who was in residential care, died in September 2014 at the age of 16 because of self-strangulation. He had been made the subject of a care order in 2007, aged nine. He was one of ten children, and there had been care proceedings on all of them. K had been subject to two sets of care proceedings, along with siblings. The first, starting in 2006, ended without a care order, and seven months later proceedings were started again after the children alleged physical abuse. Those proceedings ended with care orders. K had developed some very worrying behaviour – self-harm, heavy alcohol use, going missing, and he had great trouble coping; but he had been in a stable foster placement from 2007 until it disrupted in early 2014. Many professionals and agencies were involved in trying to help him. Secure accommodation had been considered, but not pursued.

F, a Black African girl, who suffered serious injuries from shaking when she was four months old, on an interim care order. F is one of triplets, and care proceedings were started as soon as they were born. There are two older siblings, who were subjects of interim care orders at the time the triplets were born. These two ended up going to relatives on SGOs. The children's guardian did not support the removal of the triplets, and a residential assessment was ordered. This was ended within a few weeks because of concerns about the mother's capacity to care for the children. The children went to foster care, and there was a complex programme of contact. At the time the SCR was written, it was not known where the injuries to F had occurred – at the foster home, at contact, or in transit – or who had caused them.

Peter, Tom, John and Christopher. These are four White British boys, not related, who were all placed in the same foster home. All were on care orders, with significant needs. The SCR was called because of the discovery that John had been sexually abusing Tom

and Christopher. John was 15 at the time of these events, and had been in that placement for over four years, since he entered care. He came into care after his younger sister alleged that he had sexually abused her. Tom was 11 at the time, he had sexually assaulted his sister when he was seven, and had been in care since then. In July 2015, he told his therapist that he had been sexually abused by his stepfather. Christopher was nine. Peter was 17, and John later alleged sexual behaviour with him, although Peter denied it. Peter had come into care at the age of eight, and had been in one stable placement that had ended when he sexually assaulted a girl in the placement. The SCR report comments that they all needed specialist help, and there had been delay providing it, or it had not been provided.

H1, a Black African girl aged 14 in July 2015, when she alleged that her stepfather had raped her whilst her mother was in hospital under the Mental Health Act. She was then accommodated by the local authority under s20. Her stepfather was subsequently acquitted. She has four siblings. She had been accommodated twice before, once in 2012, for five months after a 'home alone' incident with one of her siblings, and again in May 2014 with three siblings when her mother was in hospital to give birth to her fifth child. In between, December 2014, there was consideration to starting the formal pre-proceedings process, but this was not agreed. The SCR report is critical of the LA for allowing a 'custom and practice' where social workers did not seek and systematically record parental agreement to s. 20 accommodation.

N, a British Asian boy who died in a house fire with his mother in May 2014, aged nearly five. His mother had started the fire. There had been three sets of private law proceedings as well as one set of care proceedings during his life, with long-running concerns about the relationship between his parents and his mother's mental health. In August 2009, soon after N was born, he was removed from his father's care under police powers of protection after his mother alleged domestic abuse from the father; after a short period in s. 20 accommodation he was returned to his mother. Between August 2009 and October 2011 there were 13 separate court hearings, and an 's37 report' (a court-ordered assessment of whether the child is suffering significant harm – it concluded that he was not). Care proceedings were started in September 2012. The local authority wanted a care order and N placed with his father, but the court made a residence order to the father and a one-year Family Assistance Order (FAO). Police protection was considered again in April 2014, but not used. In May 2014, N's mother refused to return him after a contact visit. The court ordered she should; the next day, they died in the fire.

Appendix G: Review models

SCIE Learning together

SCIE's Learning Together model adapts for SCR use an established systems methodology for improving safety in fields marked by 'low probability, high impact' incidents and accidents for example, aviation, nuclear power as well as health. It offers a core set of principles and tools for analysis to unify all learning and improvement activities including SCRs. By 2014, there was not a specific SCIE format for the SCR but rather a range of possible applications including 'reflective audits'; 'focused' and 'speed' versions. Review leads are specifically trained and accredited in the model and are provided with methodological supervision to assure rigour and reliability of analysis.

Welsh child practice reviews

Child Practice Reviews replaced the previous SCR system in Wales from 1st January 2013. The reviews are underpinned by a set of principles and bring together agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice for the future. The focus is said to be on accountability and not culpability and about learning and not about blame. A Review Panel is established to both guide and steer the process and is integral to the learning. At the heart of the review is the learning event, facilitated by the reviewer(s), which brings together the practitioners who were involved in the situation to reflect on what happened and to identify learning for future practice. After the event, a short, anonymised report is prepared, together with an outline action plan and these are presented to the LSCB for discussion and approval. There is also feedback to the family.

Significant incident learning process (SILP)

The key principles of SILP are that alongside members of LSCB SCR Panels and agency Safeguarding Leads, frontline practitioners and first line managers have access to all the agency reports prepared for the review, and fully participate in analysis and debates of all the material, including early drafts of the Overview Report.

Analysis, reflection and learning on a multi-agency basis takes place at one or more learning event where practitioners involved in the case at the time share their experiences and perspectives on what aspects of the whole system influenced them and comment on drafts of the final review report.

Appendix H: Topics noted as 'top three learning points'

The table summarises the 'top-three key learning points' noted by survey respondents, arising from their local SCRs 2014-2017. These are presented in broad overlapping categories, alongside the frequency noted by respondents.

	Frequency
WORKING TOGETHER	
Information sharing and communication between professionals and agencies	46
Lack of professional curiosity	19
Challenge and escalation	11
Supervision and management oversight	7
Understanding professional roles	6
Better recording	4
Strengthening cross-border arrangements	2
ASSESSMENT, PLANNING AND DECISION MAKING	
Voice of the child / understanding child's lived experience	13
Effective assessment and identification of risk	12
Adhering to safeguarding policy and procedure	2
Decision making and drift	5
Lack of co-ordinated early help	4
Disguised compliance	4
Understanding thresholds for intervention	4
Need for authoritative practice	2
Taking a cumulative view when working with children	2
Pre-birth assessments	3
Safer organisational culture, including recruitment of foster carers and professionals	4
The quality of safeguarding practice in health providers	3
The role of schools in keeping children safe	1
Managing complex cases smarter within an environment of reducing resources	1
RECOGNITION, ASSESSMENT AND RESPONSE – in relation to particular child and family issues.	
Neglect	15
Recognition and response to domestic abuse	11
Recognition and response to combined risk factors – domestic abuse, mental health and substance misuse	9
Think family	3
Working with fathers/male partners	6
Working with vulnerable adolescents	9
Support and services for children with emotional health needs	4
Vulnerable babies	4
Safe sleeping	2
Bruising in immobile babies	3
Children with disabilities	2
Child sexual abuse	3
CSE	5
The impact of adverse childhood experiences on adolescents (ACES)	3
Understanding of cultural issues /BAME community	3
Children in care – issues around care planning	3
Post adoption support for birth families	1

	Frequency
Risk of online/internet abuse	1
Bereavement and loss and the impact on family functioning	1
The implications of elective home education	1
The needs of young carers	1
Risks associated with concealed pregnancies	1

Appendix I: Topics for LSCB thematic reviews 2014-17

In total, 51 (56%) of the LSCBS responding to the survey had conducted thematic reviews prompted by SCRs. Topics for thematic review are listed below. Note that an individual LSCB may have undertaken more than one thematic analysis during this period.

TYPES OF HARM	**Frequency**
Neglect	13
Child Sexual Exploitation	11
Child Sexual Abuse	5
Physical Abuse	2
Injuries to pre-mobile babies	4
Safeguarding babies	4
Teenage Suicides	4
Safe sleeping	1
FGM	1
Children and young people going missing	1
County Lines / child drug exploitation	2
Force Marriage Orders	1
Harmful Sexual Behaviour (young people)	2
Serious youth violence /knife crime	2
CHILD / YOUNG PERSON CHARACTERISTICS	
Children with complex needs / disabilities	6
Young Carers	1
Vulnerable adolescents	5
Children in Need	1
Looked after children	1
Emotional health and wellbeing (child)	2
PARENTAL CHARACTERISTICS	
Invisible fathers	1
Parental substance misuse	4
Domestic violence/abuse	6
Parental Mental Health	3
PROFESSIONAL / AGENCY WORKING	
Voice of the Child	4
Pre-birth assessment	3
Early help	2
Interface between children and adult services	2
Poor quality assessments	1
Development of safe organisational cultures	1
Understanding of policy and procedure and procedure	2
Communication and joint working	2
Professional dynamics	1
Services for travellers	1
Inconsistent application of thresholds/ lack of partner escalation	1
Supervision	2
Direct work with families	1

Appendix J: Brief case summary sheet

SYS Number Click here to enter text. **UEA/Warwick SCR code** Click here to enter text.

LSCB Click here to enter text. **Date of incident** Click here to enter text.

Age at incident Click here to enter text.

Gender Choose an item. **Ethnicity** Choose an item.

Maternal age: at incident Click here to enter text.

Paternal age at incident Click here to enter text.

Partner's age at incident Click here to enter text.

Household Composition (eg. siblings' age, gender, adult male in house, relationship to child) Click here to enter text.

Number of siblings Click here to enter text.

☐ Death
Category of death:
Choose an item.
Category of death related to maltreatment:
Choose an item.

If other category of death related to maltreatment, add detail:
Click here to enter text.

☐ Serious Incident
Category of serious incident:
Choose an item.
If other serious incident add further detail:
Click here to enter text.

Presumed perpetrator: Choose an item.

Familicide: Choose an item.

Known to CSC? Choose an item.
Highest Level of CSC involvement:
Choose an item.

Current Level of CSC involvement:
Choose an item.

If past/current child protection plan for child, what category/s? Click here to enter text.

Parental characteristics

Alcohol misuse: Choose an item.
Drug misuse: Choose an item.
Mental health problems: Choose an item.
Adverse childhood experiences: Choose an item.
Parent known to CSC in childhood Choose an item.
Intellectual disability: Choose an item.
Criminal record: Choose an item.
Violent crime (other than DV): Choose an item.
Parental separation: Choose an item.
Acrimonious separation: Choose an item.

Child/Young person characteristics

Disability: Choose an item. If yes, add detail:
Choose an item.
Fabricated or induced illness: Choose an item.
Behaviour problems: Choose an item.

For older children and young people
Alcohol misuse: Choose an item.
Drug misuse: Choose an item.
Mental health problems: Choose an item.
Intimate partner violence: Choose an item.

Parental characteristics

Domestic abuse: Choose an item.
Social isolation: Choose an item.
Transient lifestyle: Choose an item.
Multiple partners: Choose an item.
Poverty: Choose an item.

Child/Young person characteristics

Bullying; Choose an item.
CSE: Choose an item.

Any evidence of neglect? (see indicators checklist) Choose an item.

Case Synopsis

Click here to enter text.

Method of SCR: Choose an item.

Key lessons and recommendations

Click here to enter text.

Number of recommendations / learning points in report

Appendix K: Researcher summary

Researcher Summary of SCR Reports 2014-17

(adapted from 2005-07 work)

The purpose of the summary is to produce notes which help us to understand the story of the case and how professionals worked with/responded to the family. It should help us with the ongoing analysis and the final report.

The summary of each overview report should include the following:

- Summarise the story using some standard 'systemic' headings for example,, features of the case, the family and professional involvement using the 'Case Summary Template'

- Note down useful quotes

CASE SUMMARY TEMPLATE

Key features of the case

Child and Family background

Child's needs/characteristics/behaviour

Mother's/carer's history/profile/parenting capacity

Father's/carer's history/profile/parenting capacity

Wider family and environment

Professional involvement

Which agencies were involved in the build up to the incident/review?

What efforts did professionals make to engage with child/family members? For example, response to missed appointments etc.

How did family members co-operate with professionals? (Different for different family members? For example, mother/father/child? Same or different with different professionals?

How did professionals work together/share information?

Did anyone professional/ sector have a better grasp/analysis of what was happening and risks to the child? If so, did they act on this? Any challenge of other professionals?

How have failings/deficits in inter-agency working been addressed – robust follow up investigation or not?

Analysis of interacting risk and protective factors to include:

Summary of risk and protective factors and supports

Analysis of family/professional cooperation

A hypothesis about the nature, origins and cause of the need/problem/concern.

What could have been done differently?

Quality of the SCR

- Thoughts on the structure and quality of the overview report
  - Ready for publication (for example, redacted or not)
  - Length (page numbers)
  - Easy to understand? (jargon, acronyms)
  - Number of recommendations

Appendix L: List of 278 SCR reports used for analysis

1	Child Reference	Death or Serious Harm
Barking & Dagenham (301)	Child B	Serious harm
Barking & Dagenham (301)	Child C	Death
Barnet (302)	Child A	Death
Barnet (302)	Child E	Death
Barnsley (370)	Child M	Serious harm
Barnsley (370)	Child N	Death
Barnsley (370)	P Children	Death
Barnsley (370)	Child R	Death
Bedford Borough (822)	Patrick	Death
Bedford Borough (822)	Baby Sama	Death
Bedford Borough (822)	Faith	Serious harm
Birmingham (330)	Child S	Death
Birmingham (330)	Child D	Death
Birmingham (330)	Keegan	Death
Blackburn (889)	Child G	Death
Blackburn (889)	Child Y	Death
Blackpool (890)	Child BV	Death
Blackpool (890)	Child BW	Death
Bolton (350)	Child SB	Death
Bolton (350)	Baby D	Death
Bournemouth (837)	Child O	Serious harm
Brighton & Hove (846)	Siblings W and X	Death
Brighton & Hove (846)	Child E	Death
Brighton & Hove (846)	Child A	Death
Bristol City (801)	ZBM	Death
Bristol City (801)	Becky	Death
Bristol City (801)	Aya	Death
Bristol City (801)	Baby L	Death
Buckinghamshire (825)	Baby K	Death
Buckinghamshire (825)	Baby L	Death
Buckinghamshire (825)	Baby M	Serious harm
Buckinghamshire (825)	Baby Q	Serious harm
Camden (202)	Child C	Death
Camden (202)	Child B and family	Serious harm
Central Bedfordshire (823)	Bethany	Death
Central Bedfordshire (823)	Child Z	Serious harm
Central Bedfordshire (823)	Nolan and family	Death
Cheshire West and Chester (896)	Child A	Serious harm
Cheshire West and Chester (896)	Child B	Death
Coventry (331)	Child L	Death
Coventry (331)	Baby C	Death
Coventry (331)	Child E	Death
Croydon (306)	Children R,S,W	Serious harm
Croydon (306)	Children J & K	Serious harm
Croydon (306)	Joe	Serious harm

1	Child Reference	Death or Serious Harm
Cumbria (909)	Children P	Serious harm
Cumbria (909)	Child R	Death
Cumbria (909)	Child AC	Death
Derby, City of (831)	FD17	Serious harm
Derbyshire (830)	Polly	Death
Devon (878)	CN11 Bonnie	Serious harm
Devon (878)	CN12 Thomas	Serious harm
Devon (878)	Amy CN13	Serious harm
Devon (878)	CN14 'Joe'	Serious harm
Doncaster (371)	Child A	Death
Dorset (835)	S18	Death
Dorset (835)	Family S16	Death
Dorset (835)	Family S17	Serious harm
Dorset (835)	S22	Serious harm
Dorset (835)	Child M	Death
Dudley (332)	Child M	Serious harm
Dudley (332)	Child H	Death
Dudley (332)	Child P	Death
Dudley (332)	Peter, John, Tom and Christopher	Serious harm
Durham (840)	Child L	Death
Durham (840)	Child N	Serious harm
Durham (840)	Child K	Death
Durham (840)	Child M	Serious harm
Durham (840)	Ava	Serious harm
Durham (840)	Charlie and Charlotte	Serious harm
Durham (840)	Baby Bailey	Death
East Riding of Yorkshire (811)	Baby A	Serious harm
East Sussex (845)	Family S	Serious harm
East Sussex (845)	Child P	Death
Enfield (308)	YT	Death
Gloucestershire (916)	Lucy	Death
Gloucestershire (916)	Ben	Death
Gloucestershire (916)	Phillip and sibs	Serious harm
Greenwich (203)	WH family	Death
Hackney (204)	Child H	Death
Hackney (204)	Child M	Serious harm
Hackney (204)	Child N and Child O	Death
Halton (876)	No name	Serious harm
Hammersmith & Fulham (205)	Baby Rose	Death
Hampshire (850)	Child M	Death
Hampshire (850)	Child U	Death
Haringey (309)	Child R	Death
Harrow (310)	Baby F	Death
Hartlepool (805)	Olivia	Serious harm
Hartlepool (805)	Yasmine	Serious harm
Havering (311)	A and B	Serious harm
Hertfordshire (919)	Child G	Death

1	Child Reference	Death or Serious Harm
Hertfordshire (919)	Family H	Serious harm
Hillingdon (312)	Young person	Death
Hillingdon (312)	Baby W	Serious harm
Hounslow (313)	Anita B	Death
Isle of Wight (921)	Child D	Death
Isle of Wight (921)	Child G	Death
Islington (206)	Child F	Serious harm
Kensington & Chelsea (207)	Clare and Ann	Death
Kent (886)	Child A	Death
Kent (886)	Child B	Serious harm
Kent (886)	Child C	Death
Kent (886)	Child E	Death
Kent (886)	Child D	Death
Kingston upon Hull (810)	Baby D	Death
Kingston Upon Hull (810)	Baby J	Death
Kingston upon Thames (314)	Child B	Death
Kingston Upon Thames (314)	Family A	Death
Kirklees (382)	Two sisters	Death
Knowsley (340)	Child O	Death
Knowsley (340)	Child Q	Serious harm
Knowsley (340)	Child S	Serious harm
Knowsley (340)	Child R	Death
Lambeth (208)	Child J	Death
Lancashire (888)	Child N	Death
Lancashire (888)	Child O	Death
Lancashire (888)	Child LF	Death
Lancashire (888)	Child LA	Death
Lancashire (888)	Child LE	Death
Lancashire (888)	Child LC	Death
Lancashire (888)	Child LG	Serious harm
Lancashire (888)	Child LH	Death
Lancashire (888)	Child LI	Serious harm
Leicester City (856)	Child B1	Serious harm
Leicester City (856)	C1	Serious harm
Leicestershire (855)	Child A	Death
Lincolnshire (925)	Alex	Death
Liverpool (341)	Alex	Serious harm
Liverpool (341)	Chris	Serious harm
Luton (821)	Child J	Death
Manchester (352)	D1	Death
Manchester (352)	F1	Death
Manchester (352)	G1	Serious harm
Manchester (352)	H1	Serious harm
Manchester (352)	I1 plus sibs	Serious harm
Manchester (352)	K1	Death
Manchester (352)	L1	Serious harm
Medway Towns (887)	Dawn	Death
Medway Towns (887)	Ellie	Death

1	Child Reference	Death or Serious Harm
Merton (315)	Child B	Serious harm
Milton Keynes (826)	Child A	Death
Newcastle (391)	Child J	Death
Norfolk (926)	Case Y	Serious harm
Norfolk (926)	Case Q	Serious harm
Norfolk (926)	Child P	Serious harm
Norfolk (926)	Case R	Serious harm
Norfolk (926)	Case S	Serious harm
North Somerset (802)	Holly	Serious harm
Northamptonshire (928)	Child Q	Death
Northamptonshire (928)	Child R and Family R	Death
Northumberland (929)	Kirsty	Serious harm
Northumberland (929)	Molly	Serious harm
Northumberland (929)	Olivia	Serious harm
Nottingham City (892)	Child J	Death
Nottingham City (892)	Child K	Death
Nottinghamshire (891)	LN15	Death
Nottinghamshire (891)	MN15	Serious harm
Nottinghamshire (891)	ON16	Serious harm
Nottinghamshire (891)	Alex	Death
Oldham (353)	Baby F	Death
Oldham (353)	Child H	Serious harm
Oxfordshire (931)	Child Q	Death
Oxfordshire (931)	Baby L	Death
Oxfordshire (931)	Child A and Child B	Serious harm
Poole (836)	Baby N	Death
Portsmouth (851)	Child E	Death
Redcar & Cleveland (807)	X,Y and Z	Serious harm
Rochdale (354)	Child K	Death
Rochdale (354)	Child L	Death
Shropshire (893)	Children A and B	Serious harm
Solihull (334)	Child A	Serious harm
Somerset (933)	Child L and Child J	Serious harm
Somerset (933)	Sam	Serious harm
South Tyneside (393)	Kevin	Serious harm
Southwark (210)	Child U	Death
Staffordshire (860)	Child B	Death
Stockport (356)	Child N	Serious harm
Stockport (356)	Jaiden	Death
Stockport (356)	Child D	Death
Stockport (356)	Pip	Death
Stoke on Trent (861)	SOT14(1)	Death
Stoke on Trent (861)	SO 14 (2)	Death
Suffolk (935)	Baby D	Death
Sunderland (394)	Baby Penny	Death
Sunderland (394)	Family X	Serious harm
Sunderland (394)	Baby A	Death
Sunderland (394)	Mark	Serious harm

1	Child Reference	Death or Serious Harm
Sunderland (394)	Rachel	Serious harm
Surrey (936)	Child BB	Death
Surrey (936)	Child AA	Serious harm
Surrey (936)	Adult S and Child CC	Death
Surrey (936)	Child GG	Serious harm
Sutton (319)	Child E	Death
Swindon (866)	Child D	Death
Swindon (866)	Child S	Death
Tameside (357)	Child R	Death
Tameside (357)	Child S	Death
Telford & Wrekin (894)	Family Q	Serious harm
Thurrock	Harry	Death
Thurrock (883)	James	Death
Tower Hamlets (211)	Thomas	Serious harm
Trafford (358)	Child N	Serious harm
Trafford (358)	Child PB	Serious harm
Waltham Forest	Child S and Family	Death
Waltham Forest (320)	Child M	Serious harm
Warrington (877)	Child 1	Serious harm
Warwickshire (937)	Child J	Serious harm
Warwickshire (937)	Child K	Serious harm
West Sussex (938)	Baby O	Death
Westminster (213)	Child JJ	Death
Wiltshire (865)	Family M	Serious harm
Wirral (344)	Child J and Child I	Death
Wolverhampton (336)	Child F	Death
Wolverhampton (336)	Child G	Death
ANON	Child BS	Death
ANON	Child H1	Serious harm
ANON	Alex	Death
ANON	Child N	Serious harm
ANON	S and C	Serious harm
ANON	Child AB	Serious harm
ANON	Children U,V and B	Death
ANON	Martin	Death
ANON	Anon	Serious harm
ANON	Child G	Death
ANON	Child F and family	Death

* Details not listed for 51 SCRs ‘not for publication’.

Appendix M: Coding framework

Superordinate Theme	Subordinate Theme
Pathways to harm	Child Vulnerability
	Parent/Perpetrator Risk
	Background Context
Opportunities for Prevention/Protection: Agency	Child
	Parents
	Wider Family
	Wider society
	Statutory Agencies
	Voluntary Agencies
Pathways to protection	Prevention
	Recognition
	Assessment
	Decision Making
	Intervention
Opportunities for Prevention/Protection: Level	Managing Individual Cases
	Working Together Dynamics
	Agency Structures, Processes and Cultures
Opportunities for Prevention/Protection: Type	Education
	Empowerment
	Enforcement
	Engineering

Appendix N: Quality template

QUALITY TEMPLATE FOR SCRs (2014-17)

SCR method:

- ***Accessibility***

Contents page with clear headings?

How long?

How long appendices?

Plain English/easy to read?

Is the report repetitive and, if so, is this purposeful?

SCR process:

Is there an explanation for the choice of review method and why this method is proportionate to the case?

Is the learning from the SCR ***process*** distilled?

Were family members involved in the review, if so is it clear how they contributed to the learning?

- ***Analysis***

Is there a concise account of critical points in the management of the case (rather than lengthy chronology of undifferentiated events?)

Is there too much focus on descriptions of events?

Is there enough information about the past to understand the present?

Is there a detailed analysis of **what** went wrong and **why?**

If **why**? Include individual errors and system failures

Is human motivation examined (for example, fear, overwork, timidity, over-optimism, wilful blindness etc.?)

Is research-based evidence used? (And how?)

- ***The child as a person***

Does the report reflect the child as a person?

Is the child understood within the context of his/her family (background, culture and history) and viewed independently from siblings/other children in SCR?

Is the child's development/wellbeing reflected (in the context of his/her age)?

Learning

Are the key themes from SCR reported?

Is there a focus on what the lessons should be for the services?

Is there a focus on what caused something to happen and how it can be being prevented?

Are implications for local and/or national practice/policy identified?

Is the way the learning from this SCR fits with others, regionally, stated?

- ***Overall***

Is the report well/structured?

Is the report well balanced for example, description v analysis?

Are there accuracy discrepancies? - If so specify

What were the particularly good things about the report?

Were there flaws?

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